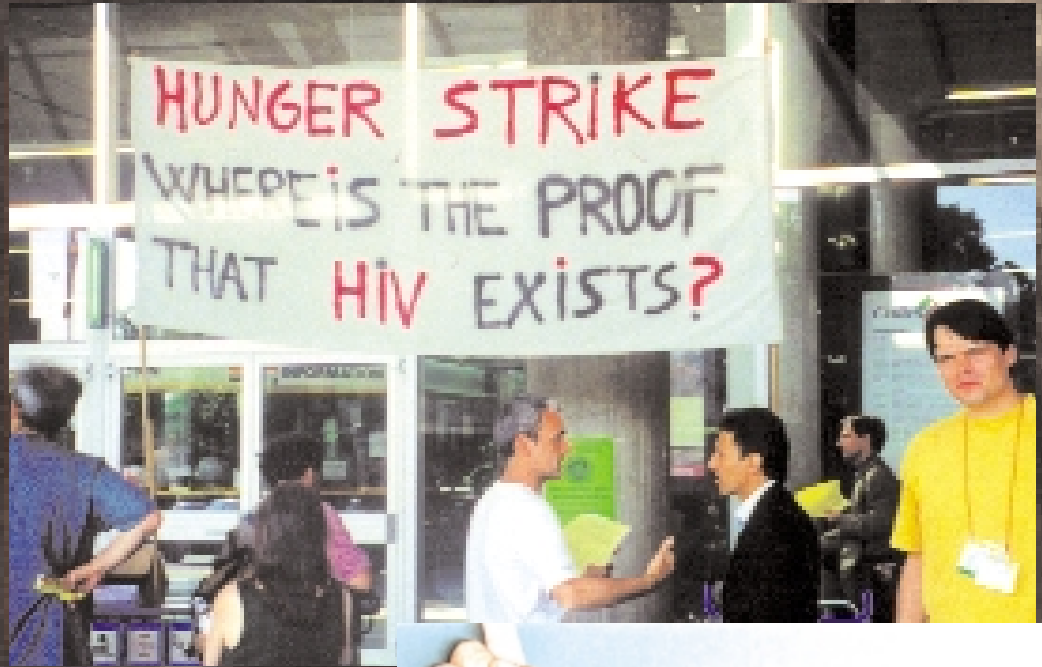


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Everything old is new again

Monkeys and monsters
why no AIDS from testicle transplants?



Skopje 1999



CONTINUUM

towards a healthier body politic

vol 5, no 6 Summer 1999

Consultants

Michael Baumgartner, I.F.A.S., Switzerland
 Lluís Botinas, Co-ordinator COBRA, Spain
 Leon Chaitow, ND, DO, MRO, England
 Kevin Corbett, BA(Hons), HDFA, MSc, RGN, England
 Prof. Peter Duesberg, Molecular Biologist, USA
 Nigel Edwards, MA (Oxon), Journalist/Broadcaster, England
 Michael Ellner, DD, MSH, CHT, President HEAL, USA
 Felix de Fries, Public Relations Consultant, Switzerland
 Volker Gildemeister, MA, DPhil (Oxon), Biochemist, England
 Dmitri Gousskov, PhD, Sociologist, Ukraine
 Prof. Alfred Hässig, Immunologist, Switzerland
 Neville Hodgkinson, Author/Journalist, England
 Christine Johnson, Science Information Co-ordinator, USA
 Dr med. Heinrich Kremer, Germany
 Stefan Lanka, PhD, Virologist, Germany
 John Lauritsen, Publisher and Writer, USA
 Joan Shenton, Broadcaster/Journalist, England
 Prof. emeritus Gordon Stewart, Public Health, England
 Djamel Tahy, Filmmaker, France
 Margaret Turner, BEd, Writer/Equality Consultant, England
 Michael Verney-Elliott, Writer/Journalist, England
 Ian Young, Poet/Author, Canada

Founder Jody Wells

Managing Editor Huw Christie

Assistant Editor Alex Russell

News Alex Russell, Huw Christie and Michael Verney-Elliott, Billi Goldberg, Kevin Corbett, Clair Walton, Martin Walker

Design & layout Huw Christie

Style correction Huw Christie, Alex Russell

Pictures Alex Russell, Huw Christie

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• Published by Continuum

4A Hollybush Place,
London E2 9QX, U.K.

Tel: [+44] (0)171 613 3909

Fax: [+44] (0)171 613 3312

continuum@dircon.co.uk

projects@dircon.co.uk

• Affiliated to the Harrow Association

of Voluntary Service,

The Lodge, 64 Pinner Road, Harrow HA1 4HZ.

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e-mail : calvertspress@demon.co.uk

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time & tide

Was it for this?



US PRESIDENTIAL candidate Al Gore (r) was heckled by American protesters waving placards condemning his opposition to a South African law that would let AIDS drugs be sold more cheaply. The latest Aids therapy costs £530/US\$800 per month in South Africa, where average annual income is £1730/\$2,600. Gore has a liberal record on social issues like AIDS, but is reported to want to protect drug industry patents and revenue. The outgoing South African

Health Minister Nkosazana Zuma promoted forced disclosure of a positive test status to sexual partners, saying, We can't afford to be dictated to by human rights or Aids activists..It is time we treated Aids as a public health issue... . New Health Minister Manto Tshabalala-Msimang says, We don't want to interfere with patent rights, but we want to get drugs of quality at a price we can afford. Her Ministry says the drugs effectiveness is still not proven.

Poster boy dies on HAART

A FORMER Mr Cowboy San Francisco (1991-2) has died of cardiac arrest while taking Highly Active Antiretroviral Therapy (HAART) - an effect of the drugs that is increasingly recognised. According to *The Globe and Mail*, Toronto (4 May '99), "The longterm toxic fallout from drugs hailed for their dramatic ability to combat aids is beginning to alarm experts in the disease." Donald Wright, 36, "became a poster boy for the effectiveness of HAART" though he had not been diagnosed with AIDS. He and his partner were a featured couple in the book *Gay and Lesbian Marriages*. He is survived by his son, and his partner.

Herbal victory

Traditional herbal remedies will not be banned from sale in the UK after lobbying from the alternative health industry resulted in the Government scrapping plans to outlaw them without a licence. The moves would have led to the disappearance of hundreds of remedies because of the £1 million cost of a licence. But Health Minister Baroness Hayman revealed 15th July existing herbal remedies would not need a licence: "This will not affect any products currently sold legally as food supplements or cosmetics and will have no impact on herbal remedies." The Government also abandoned plans to classify herbs as medicines.

The plans also could have effectively banned vitamin supplements. Michael McIntyre, chairman of the European Herbal Practitioners Association, said, "This is wonderful news. The Government has taken on board what we have been saying". Last month thousands of campaigners marched in London to raise awareness of the issue.

The Express London 16 July 1999

De Harven paper

Electron microscope pioneer Professor of Pathology Etienne de Harven has written a guest editorial in the prestigious journal *Haematologica*, entitled *Viral etiology of human cancer: a historical perspective*. The text includes, "...AIDS, hypothetically associated with infection by the HIV retrovirus...the currently used combined antivirals are unacceptably toxic, making the so-called therapy worse than the disease itself!...Kary Mullis' PCR technology is not reliable to measure what has been erroneously labelled *viral load* in AIDS patients."

Haematologica Vol. 84 No. 5 May 1999

Duesberg invite ban

Prof. Peter Duesberg was recently invited to speak by graduate students at Albert Einstein College of Medicine only to have the invitation withdrawn after pressure from some faculty members. Charles Weaver, Dept. of Neuroscience, in his letter inviting Duesberg as speaker, wrote, "I'm tired of the same useless and rehearsed information given to me when asking my peers about HIV. I'm writing with hopes that you'll strengthen your resolve to continue to educate others regarding the truth about HIV and AIDS". Prof. Serge Lang remarked, "I regard as scandalous the continued ostracism of people and points of view which go against the orthodoxy on HIV. Shame on Einstein College of Medicine faculty for participating in this ostracism or tolerating it".

File to cc. List, Serge Lang 7 April 1999

Doctors exposed in profit for drug-recruitment scandals

HUNDREDS of thousands of patients are being recruited by their personal physicians into a booming venture for doctors: the business of testing experimental drugs on people. *The New York Times* (16 May 1999) published a ten month investigation (based on confidential documents and interviews) revealing a system fraught with conflicts of interest; that relies on government and private monitoring that can easily be fooled; and that secretly offers cash to other health professionals who might influence patients to join a study. Some experts said patients were being pushed to participate in drug trials because of the financial interests of their doctors.. Among specific findings: drug companies and their contractors offer large payments to doctors, nurses and other health workers to encourage them to recruit patients quickly. Doctors do not even have to conduct trials to get paid - there are finder's

fees for those who refer patients to other doctors conducting research. Top recruiters earn from US\$500,000 to \$1 million a year; doctors who recruit the most patients receive additional perks, such as the right to claim a coveted authorship of published papers about the studies - even though the true author is a ghostwriter using analysis from the drug company. Those who fail the recruitment goals are usually dropped from future studies; testing companies often use doctors as clinical investigators regardless of their specialty, at times leaving patients in the care of doctors who know little about their condition. For example, psychiatrists have conducted Pap smears and asthma specialists have dispensed experimental psychiatric drugs. A growing number of doctors conducting drug research have limited experience as clinical investigators,

raising questions among some experts about the quality of their data.

Doctors working as researchers "are enticing and cajoling patients who are in no position to resist their blandishments to enter clinical trials. What the patients are not seeing is that the clinical investigator is really a dual agent with divided loyalties between the patient and the pharmaceutical company," said Dr David Shimm, of the ethics committee at Porter Adventist Hospital in Denver who has written about research conflicts.

Dissent grows around Dutch publication

TWENTY FIVE journalists and others attended an Amsterdam press conference by *Ode* magazine July 13th in the central Rode Hoed (venue of the 1992 Amsterdam Alternative AIDS Conference) to research recent developments: this month's Dutch language *Ode* featured a cover with the bold heading AIDS BESTAAT NIET (AIDS does not exist), and radio, press and public in Holland reacted with anger and surprise. Four speakers addressed the pressconference and took questions on the anti-hiv=Aids hypothesis: Prof. Etienne de Harven, Ms. Joan Shenton, Dr Stefan Lanka, and Huw Christie. The Chair was former politician and Chairman of *Medicins sans Frontières*, Holland, Dr Jacques De Miliano.



I-r Huw Christie (*Continuum*), Dr. Stefan Lanka, Prof. Etienne de Harven, Joan Shenton (*Meditel*), Tijn Touber (*Ode*), Jacques DeMiliano, Jurriaan Kamp (*Ode*)

Poppers can cause cancer

New research from America suggests again repeated use of isobutyl nitrite (poppers) can lead to cancer. The ethically controversial research was conducted by injecting captive mice with cancer cells. Those animals who were also exposed to poppers were more than three times more likely to develop tumours than the mice which had not been so exposed. Scientists found when tumours developed in both sets of mice, tumours in the mice exposed to poppers grew four times more rapidly. Three-quarters of the mice given poppers developed tumours.

Positive Nation June 1999

Spotlight on funding

US Republican Representative Tom Coburn stated in a press release: "As a member of Congress and a physician who has cared for patients with HIV/AIDS, I believe that we have a moral obligation to ensure that the nearly \$9 billion directed to federal AIDS programs is spent for purposes for which it is intended. I am deeply concerned by the allegations of fraud in Puerto Rico involving AIDS funds...Because of my concerns about reports of misuse of AIDS funds across the country, I have asked the General Accounting Office to conduct full performance audits of federal AIDS programs. This audit is designed to spotlight lapses in accountability and restore integrity and compassion to federal AIDS programs..."

US House of Representatives 3 May 1999

Chimps lab may close

The laboratory housing the world's largest domesticated chimpanzee colony may be near financial collapse, animal rights activists claim. The Coulston Foundation (TCF) of Alamogordo, New Mexico, has lost two contracts to house 'hiv-infected' chimps and conduct aids vaccine research. Many of the TCF's 620 chimps were 'infected' early in the 'aids' era when scientists were seeking models for the alleged syndrome. In Defense of Animals (IDA), a Californian group opposing use of animals in research, claims the lost contracts could bring the \$10.5 million lab to financial ruin: "The loss of these NIH funds could spell the beginning of the end for TCF", says Suzanne Roy, IDA's programme director.

Nature 22 April 1999

Bladerunners

Two Bangladeshi monkeys trained to deliver drugs to addicts and collect payments in the capital Dhaka have been captured by police. Munni and Hamid were put in a zoo as police investigate other dealers. A huge quantity of bottled phensidyl has been seized.

Socialist leader holds AIDS meeting

INTERNATIONAL Forum for Accessible Science (IFAS) Secretary General Michael Baumgartner met to discuss 'hiv/Aids with President of the Swiss Socialist Party Ursula Koch May 13. Members of the Swiss Socialist Party, the country's largest national party, include two of the seven current Councillors of Switzerland including current Head Of State Councillor Ruth Dreifuss who also heads the Swiss Health Department.

The detailed two hour meeting with party president Koch was devoted to the dissenting views on 'hiv', the alleged virus suggested to cause Aids, and Aids, and on the consequences for human rights and medical science. The atmosphere was described by Baumgartner as "open and friendly...Koch had no idea there is an Aids controversy and showed great interest in the dossier presented by IFAS".

UN Chief offends Indians in first Diana memorial lecture



RED ribbons, white elephant? UN Secretary General Kofi Annan (c.) in London delivered the first Diana, Princess of Wales Memorial Lecture on AIDS at the Bank of England, for the UK's National AIDS Trust (NAT), referring to a "conspiracy of silence and prejudice" and "a threat to human civilisation as a whole". Does he know something covert?

At the reception, NAT's new Ambassador, film producer (Lord) David Putnam (*far I; Midnight Express; The Killing Fields*) stood beside (Baroness) Margaret Jay, unelected leader of the government in the House of Lords and former NAT diva and Diana-prompter. Jay's

current husband AIDS *apparachik* Prof. Michael Adler introduced Annan, recalling Diana's "strong symbolic gesture" of shaking hands with a man diagnosed with AIDS in 1987.

Indian doctor and public health activist Shantilal Kothari of Nagpur wrote to Annan 1st July after reports of the lecture in *The Sunday Times of India*, calling for "an urgent joint meeting" of orthodox and dissenting AIDS scientists. He said Annan's remarks that India has more people infected with HIV than any other country were "not only totally incorrect and irrelevant for my country...but...highly objectionable and humiliating."

Britain's Department of Health says 'modern medicine is threatened' by medical use of antibiotics.

Regular medical use of pharmaceutical prescription antibiotics and other antimicrobial agents is being questioned by the British Department of Health (DoH). In its March 1999 circular (HSC 1999/049) to all health agencies and practitioners, the DoH calls for 'optimising antimicrobial prescribing' to 'reduce inappropriate anti-

microbial prescribing' as 'resistance to antibiotics and other anti-infective agents constitutes a major threat to public health'. It also calls for a public campaign to increase awareness to 'preserve the usefulness and effectiveness of antibiotics', implying the public has been misinformed on the utility of antibiotic therapies.

Also cited is the 1998 NHS report of Britain's NHS Standing Medical Advisory Committee on Antimicrobial Resistance, entitled *The Path*

Antibiotic abyss

of Least Resistance with an ominous sub-section Looking into the Abyss. This report says prescribing habits helped produce the current situation, briefly noting the effects of pharmaceutical corporations on research for newer agents if there is future reduced demand for antibiotics in the health services. The report admits 'with more resistance and few antimicrobial agents modern medicine is threatened.' Both documents are on the British DoH website <http://www.open.gov.uk/doh>.

Metro London 13 July 1999

Longterm drug studies

Dr. Julio Montaner, co-director of the Canadian HIV Trials Network argues drug companies be compelled to follow the impact of toxic aids drugs on patients. Dr Montaner and treatment pioneer Dr. J. Lang criticised drug companies for failing to study long-term toxic effects on patients. Dr. Lang stated: "The drug companies rush their drugs on the market, but they don't know everything. It's not in the industry's interest to leave no stone unturned, to do rigorous post-marketing research. So we have to do it ourselves." Montaner said drug companies should agree to do follow-up studies on effects as part of the approval process for drugs sold for Aids: "We need to know what happens if you take a certain drug, not just for five years, but for 50 years." Dr. Lang said some new 'aids' drugs produce serious toxic conditions.

Toronto Globe and Mail 4 May 1999



Clair Walton at the UNHCR

Photo: Michael Baumgartner

United Nations Commission on Human Rights (55th Session) Geneva, 14th & 15th April 1999

At the 55th Session of the United Nations Commission on Human Rights in Geneva, Switzerland in April, Clair Walton addressed the international community on the grave violations of the rights of women and children through inadequate or biased scientific hiv information. For the official US observer organisation International Educational Development, Walton gave two statements under each agenda item of Women and Children. She demonstrated policies growing out of incomplete scientific information by citing the recent Emerson and Tyson cases in the USA. In each case the state had interfered with the mothers' decision on the best course of action for her child. The mothers' reluctance to administer the toxic cell killing drug AZT to their children was met by the force of the law with the threat of state custody. The Tyson case,

where an hiv positive woman challenged for her right to breastfeed her newborn, raised the urgent need to clarify the highly questionable science, in particular, specificity of the hiv test, and mother to child transmission. The community was told that the fact that pregnancy itself can make a woman test positive, along with sixty other conditions, is not generally disclosed, violating UNAIDS Guidelines for information on hiv/aids and treatments.

The World Health Organisation, UNICEF and UNAIDS were challenged on their policy of discouraging hiv positive women from breastfeeding, by quoting the United Nations statement that 1.5 million of the roughly 12 million children under the age of 5 who die each year around the world could be saved if breastfed: "Children who are not breastfed tend to have weaker immune systems and are at greater risk from infectious disease, especially diarrhoea and respiratory illnesses."

Walton stated that not only were children deprived of their main source of nutrition and immunity if not breastfed but also are often treated with highly toxic and experimental pharmaceutical drugs based on the inadequate and biased hiv/aids model.

UN Human Rights Commission hears pleas again

The international community was asked to seek clarification on specificity of hiv testing, mother to child transmission, heterosexual transmission - in particular woman to man - Aids causation and adverse effects of 'anti-hiv' pharmaceutical treatment.

The community was made aware of the discriminating immigration laws against those with positive hiv test results in operation in 49 countries including USA, Germany, Australia, Belgium and Russia. The meeting was asked to ensure the implementation of the human rights of people living with a positive hiv test result, as outlined in the *Geneva Declaration 1998 of People Living with a Positive Hiv Test Result*, the *UNAIDS Guidelines on HIV/AIDS and Human Rights* and the *Universal Declaration of Human Rights*.

Walton also asked for acknowledgment that many people with a positive hiv test result do not get Aids and live healthily in the absence of so-called anti-hiv treatments, and that this is ignored by many hiv/Aids organisations that are often funded by pharmaceutical companies.

The full statements can be obtained from *Continuum*.

Chimp sanctuary fears

Since Beatrice Hahn *et al.*'s paper (*Nature* 397, 436; 1999) claiming the origin of 'hiv' in chimps, Gloria Grow, founder of Canada's first chimp sanctuary, has faced demonstrations from locals in Carigan, Quebec, who fear being infected by Grow's chimps. Hysteria has spread through the town. "The people have fears that HIV can be spread through water, since there is a stream at the back of the sanctuary, and they are concerned that birds and squirrels can spread HIV," said Grow, adding teachers have been practicing 'chimp drills' instead of fire drills, in the event that a chimp enters the school. Tom Butler, chairman of Laboratory Animal Medicine said, "An HIV-1 infected chimp doesn't even get sick. Therefore, the chimp is not useful for studying disease pathology".

Nature Medicine July 1999

Information Bill retreat

UK Home Secretary Jack Straw published 24th May a draft Freedom of Information bill which creates the first statutory right for access to internal documents from public authorities including hospitals. The bill covers all central government departments and the National Health Service. Straw has been criticised in the media for retreating from the proposals in the White Paper *Your Right To Know* (1998): the draft bill contains 21 exemptions whereby the public will be denied access to information. Maurice Frankel, director of the Campaign for Freedom of Information said, "It abandons the White Paper promise of access to internal discussion where disclosure would not be harmful, and instead creates a blanket exclusion for all information about the development of policy. Even factual information and scientific analysis on matters like BSE and GM food could be withheld".

The Lancet June 5 1999

In the Lyme light

Recent claims of isolation of the spiral bacterium associated with Lyme disease from apparently cured patients may make it difficult to rule out a role for syphilis in causing a variety of health problems, including aids, Canadian researchers maintain. In a paper presented at the 12th International Conference on Lyme Disease and Other Spirochetal and Tick-Borne Disorders, John Scythes, director of Toronto's Community Initiative for AIDS Research (CIFAR), and co-author, Colman Jones, explained how culturing Lyme bacteria from patients presumably cured may offer new insights into the diagnosis of syphilis, especially in the 'hiv' diagnosed. Scythes and Jones suggest it may now be incumbent on the syphilis research community to adapt this technique for the syphilis spirochete and establish a new gold standard in the diagnosis of this STD. The authors advance the aids/syphilis hypothesis: long-standing syphilitics often succumb to early death from pneumonias, rare cancers, and re-activated TB - all 'aids' defining conditions.

J. B. Scythes, C.M. Jones, 9 April 1999
Community Initiative For AIDS Research
colman@ican.net

Thalidomide UK

Thalidomide recipients recently called for an immediate ban on all genetically modified foods. The drug Thalidomide was blamed for abnormalities in more than 12,000 babies after it was prescribed widely to pregnant women during the 1950s and 1960s as a sedative and treatment for morning sickness. Thalidomide UK said more tests on GM foods and their future effects on people's health are needed, noting the crops could be the "most dangerous chemicals of all time." There are fears that GM foods may cause human birth defects.

Metro June 1 1999

Tainted breast milk

The UK Department of Health 11 July urged mothers to continue breast-feeding their babies despite a report which found 350 pollutants in breast-milk. The World Wide Fund for Nature (WWF) study found that two-month-old British babies are consuming levels of dioxins 43 times the recommended safety level. The Department has just finalised a contract with the University of Leeds for further study. The WWF report stated: "Some of the contaminants have the ability to cause cancer and impair the immune system", but the government stressed the pollutants were "an issue not a problem". With less supporting data however, government policy is to discourage hiv-test-positive mothers from breastfeeding.

The Independent 12 July 1999

time & tide

New press insurrections April - July 1999



- 1. How can 'hiv' tests be specific if everybody carries antibodies that turn an HIV test positive? 3 pp.
- 2. Arbitrary results of HIV testing; you have it one minute, lose it the next. 1p.



- Index on Censorship
Vol. 28 No. 3
Tel.:+44-(0)171-278 2313

- BIG SCIENCE AND LITTLE WHITE LIES
- 1. A paradigm under pressure
- Gordon Stewart MD
- 2. Rethinking AIDS
- Huw Christie MA

Critical analyses of the covert world of hiv/Aids censorship and politics. 5pp. & 6pp.



- Ode (Dutch)
No. 27
Tel.:+31-(0)10 436 0995

- AIDS Bestaat Niet (AIDS Does not Exist)
- Juurian Kamp & Tijn Touber

Comprehensive analysis of hiv/Aids construct. 15 pp.

- Current Medical Research and Opinion
Vol. 15 Supp. 1
Tel.:+44-(0)1491-875252

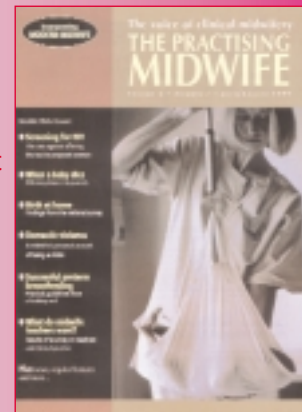
- A Critical Analysis of the Pharmacology of AZT and its uses in AIDS - Eleni Papadopulos-Eleopulos MSc *et al.*



Paradigm shifting scientific paper on toxic pharmacology of AZT with 121 references. Concludes AZT has "neither theoretical nor experimental evidence" for anti-HIV effects. Supplement. 45pp. (see p. 13 of this issue)

- The Practising Midwife
Vol. 2 No. 7
Tel.:+44-(0)161-929 0190

- Screening of pregnant women for HIV: the case against
- Rosalind Harrison FRCOphth DTM&H & Kevin Corbett RGN, MSc



Medical arguments against the universal screening for HIV in pregnant women with 39 references. 6 pp.

- Nexus
Vol. 6 No. 4
Tel.:+44-(0)1342-322854

- The Yin & Yang of HIV: part 1
- Val Turner FRACS & Andrew McIntyre



Full clear analysis of hiv/Aids construct: "Gallo's data, which is still the best of its kind, does not prove the existence of HIV."

6 pp.



Change of change of address! Continuum's agreed new address is definitely 4A Hollybush Place, London E2 9QX, UK

(It's 150 yards from Bethnal Green Tube Station, on the Central Line.)

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Making Sense: Alternative African AIDS Conference in 2000

28th August - 1st Sept. Provisional agreement of excellent venue in Uganda.

For further information email Rosalind Harrison - harrj@dircon.co.uk

Websites

Eleopulos Perth group

www.virusmyth.com/aids/perthgroup.index.html

www.virusmyth.com/aids/perthgroup/geneva

HEAL Toronto

www.geocities.com/WestHollywood/Height/7731/additions.html

Alive and Well

www.aiveandwell.org

Celia Farber in

www.impressionmag.com/aids.html

Reappraising Aids

www.virusmyth.com/aids

www.virusmyth.com/aids/tour/index.htm

www.virusmyth.com/aids/data/cfmother.htm

www.virusmyth.com/aids/data/mgglanka.htm

www.virusmyth.com/aids/data/ah15years.htm

Continuum in development at
www.continuum.org.uk

Meditel news broadcast

need Real Player G2 system

http://www.virusmyth.com/aids/news.htm

Duesberg

www.duesberg.com

ABC (US) News - Nick Regush

www.abcnews.go.com/go/sections/living/SecondOpinion/secondopinion.html

Noam Chomsky Continuum interview at

www.homeusers.prestel.co.uk/littleton/ai_aids.htm

Death Camp

www.angelfire.com/ar/dthcamp

Swedish

www.dn.se/hivwww.virusmyth.com/aids/data/nheuropean.htm

Français

perso.wanadoo.fr/sidasante/

Deutsche

pweb.uunet.de/pr-leitner.DO

privat.schlund.de/mleitner/papadop

Catalán y Castellano

FreeNews.

http://freenews.dragonfire.net/

Informaciones censuradas sobre medicina y salud.

Página en castellano y en catalan.

SIDA, cáncer, manipulación genética, terapias, asociaciones, etc

Italiano, Français

French and Italian translations of Eleopulos interview with Christine Johnson

Continuum vol 5 no. 1 are available on paper from Continuum office, cost £2.00

Editor's note



My early projects included fighting fair (photo left. Hold me back! Here I see I magnanimously allowed my mother to spare a feeble unwary dragon). Dragons turned into windmills, windmills into coffins... A bystander challenged me last week that it's realistic that "AIDS orthodoxy might be right..that a human immunodeficiency virus is causing a well described syndrome of illnesses for which the best drugs have been offered." Is this now some joke? (Mind you, *ortho* 'straight', *doxa* 'opinion' could seem darkly *gai* to some.)

Alas, the coffins... Hasten the day when professional orthodoxes find mercy and intelligence through their higher calling in the name of Hippocrates - and First, do no harm. But being 'right' by now is a matrix of several ever-pressing requirements, moral ones if you will. There must be at least, at or before next year's **World AIDS Conference in Durban in July 2000**, full, open discourse between public policy makers and proponents of heterodox insights into and frames for 'AIDS', in a semi-public or public arena - including *sine qua non* those widely qualified scientists who continue expertly to ask the primary if little respected questions around non-isola-

tion of hiv - and some people labelled by the technology; distinguished efforts and resources are needed now to research and make available non-toxic even non-profit therapies - (albeit modest co-operative re-investable profit isn't the worst human failing); respectfully communicated information on the range of reasonable risk factors for the 29 'AIDS indicator illnesses' (and others) for which there is compelling theory, evidence or proof is so long overdue - and on the underdeveloped range of ways to be well! And let us absent alien prophylaxes from human sexualities. There will be disbelief, anger and recrimination. But this is not child's play.

Continuum recently avoided closure (no money to cover essential costs). The International Coalition for Medical Justice granted US\$8,000 and saved our (then) immediate future, but we're still in trouble. We make no profit and this magazine pays no salaries. But if you can contribute to costs...

Imagine what it could be like to read a *Continuum* for the first time. I trust there are some for whom this collection of discourse and information begins to transform loss, dogmatism and betrayal into vigour and reappraisal.

Deconstructing the 'Immune System'

Michael Verney-Elliott

"There is, arguably, no such thing as an immune system."

That is how Jamie Cunliffe ends the introductory summary to an important article in the March 1999 edition of *Medical Hypotheses*¹, the third of a series of such articles by Cunliffe published by the journal^{2, 3}, outlining a radical rethink of how he believes the body protects itself from disease by a system of cellular self-regulation he calls 'morphostasis'. Although Cunliffe makes no mention of AIDS/'HIV', if his hypothesis is correct, it is further evidence that the assumptions about a 'syndrome' based on an 'acquired immune deficiency', caused by a 'virus', and identified by antibodies, have been wrong since day one of the 'epidemic'.

The prevailing view, based on the germ theory of disease, is that the body is chiefly concerned with protection from invasive organisms - viruses, bacteria etc. - and mounts a two-pronged attack on interlopers using the cellular (phagocytes, natural killer cells etc.) and humoral (antibody producing B cells) arms of the immune system. It was Polly Matzinger in 1994⁴ who first suggested that the body's principal defence against disease was not so much to distinguish self from non-self, and then to attack an 'invader', as to differentiate between dangerous and non-dangerous, and be tolerant of the latter. It is this tolerance which allows many exogenous organisms to enter, and live in apparent harmony with, the body. Most importantly, Cunliffe's proposed defence mechanism differentiates between safe and dangerous cell death.

After the discovery of antibodies, immunologists naturally supposed these proteins were one of the chief weapons in the body's armoury against disease. However, Cunliffe points out that early multi-cellular organisms, what he calls "zygote colonies", had no lymphocentric (or anamnestic) immune system, which was a late arrival in evolution. The metazoans etc. relied on the cells which formed the colony to police themselves, and autodestruct should they become irreparably damaged, and therefore a threat to the rest of the colony. It was this observation which led Cunliffe to suppose that the belief that an immune system based chiefly on thymus-dependent lymphocytes (T cells) arose specifically to combat infection is seriously flawed. He believes that even in highly evolved vertebrates the same basic rules prevail which enabled survival of primitive life forms - autoregulation, surveillance and maintenance of cells, or the morphostatic system.

Cunliffe's theory of 'morphostasis', first published in *Medical Hypotheses* in 1997, proposes that cells have an elaborate system of self-regulation, and rely on intracellular repairs to keep the cells functioning properly. Should the repair mechanisms fail, then the cells self-destruct using a form of cell suicide known as apoptosis. He explains that when cells self-destruct, they first "trash" their contents. "Resident intracellular pathogens will also be trashed in the process...". Cunliffe proposes, contrary to the accepted view that aggressive immune activity primarily targets non-self antigens, that the body learns to distinguish between healthy and what he calls

"other than healthy self cells". It is these unhealthy cells and their debris, rather than invasive organisms, which are the principal target of immune activity. "Immune aggression acts as a backstop - or mop up - mechanism that is poised to remember some caricature of sick cells that previously failed to successfully trash (and so sanitize) themselves. These cells and their debris are a *danger*." Thus Cunliffe divides these self-destructing cells into two categories - those which successfully trash and dispose of their debris via phagocytosis and other mechanisms (the safe, "tidy" kind of cell death), and the more dangerous type of cells which haphazardly spill their contents into the extracellular spaces during autodestruction, damaging cellular communication and causing an inflammatory reaction. These latter are "messy" and thus dangerous cells. In these terms, Cunliffe sees the immune system chiefly as a mechanism to maintain order and 'tidiness' in the body's cells, disposing of aberrant or sick cells, and minimising inflammation. The more orthodox view of immune regulation is that the first priority is to distinguish benign self from pathogenic non-self matter and aggressively to destroy the latter. Whilst to an extent that may be true, Cunliffe states that foreign organisms are generally tolerated in the body provided they do not get in the way or cause a mess. His morphostatic theory proposes that the body more importantly distinguishes the clean, "tidy" cell death from the pathogenic "messy" cell death which typifies disease i.e. safe self v. dangerous self (as opposed to the more orthodox self v. non-self paradigm). The orthodox view of the lymphocentric immune system produces many uncertainties and anomalies which Cunliffe lists in a table, showing by comparison how his own interpretation of the cell-centred regulatory mechanism resolves these awkward paradoxa.

It must be remembered that since the early '80's, the definitions of 'AIDS' have been based on the orthodox view of how the immune system is believed to work - i.e. antibodies are formed against an invader to protect against that invader. Using this paradigm, by 1987, Duesberg argued that once antibodies against a virus are detected, far from being a predictor of future disease as is widely supposed in the case of 'HIV' antibodies, in fact the patient is already vaccinated. Others countered with the argument that antibodies against 'HIV' must be non-neutralising and the hunt was on for a vaccine. Few suggested that if naturally generated antibodies are useless, artificially raised antibodies would probably be so too.

Even now, if the supposed anti-immune system activity of 'HIV', whatever the mechanism is presumed to be this week, is founded on an orthodox but basically mistaken view of how the immune system works, immunologists should scurry back to their drawing boards.

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3. Cunliffe J. - Morphostasis: an evolving perspective. *Med Hypotheses* 1997; 49: 449-460
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Moving pictures, Relax..

Relax it's just...T.C. Carson!

Eddie Garcia (l) as Harvey and T.C.

T.C. as

"The tables aren't balanced. It makes you upset that you have to work so hard to get information that another group of people have readily available. And the black community has a stigma about homosexuality and AIDS so it's harder to get the information to the people."

Los Angeles-based actor T.C. Carson plays gay black artist Buzz in Relax...it's Just Sex. Buzz is refreshingly clear about refuting the standard medical model of AIDS - in the vein of "AIDS doesn't exist. It's just another way they have of controlling sex", "Find me one piece of proof that HIV causes AIDS", "AZT kills you." Although among the film's characters there isn't calm consensus about Buzz's views, the relationships which surround and involve him draw out the complexities of his commitment to dissidence. Recently returned from filming on another project in Italy, a *thru* spoke long distance to Huw Christie:

"As an African American actor here in the States you don't get a lot of... brought to the table for you. I had reservations about the rôle when I was approached about the project, but when I read the script I thought it was... and how often do you get the chance to play someone so different from... That's what drew me to the rôle, the fact that it was a different kind of... me. His beliefs were not that of the *status quo*. They were bucking the system... like. And he was not a stereotypical gay man... Artists have to stretch and... horizons. You cannot just be concerned with views that you know or would be happy knowing. You have to be willing to take the risk and learn. I learnt a lot about HIV and AZT doing that rôle. I had to research the questions and I found new answers. Buzz makes these available to everyone..."

Carson cites friends and acquaintances involved in AIDS work, and diagnosed 'hiv'-positive. He sought the opinion of some orthodox medics about the views his character expresses in the film and decided, especially in relation to AZT, that the medical model had little to offer.

"Much of the holistic AIDS care which is taking place is more beneficial to the patient than all the chemically based treatments which doctors are asking patients to put into their bodies."

T. C. believes an actor has a social responsibility but the first responsibility is to be a worthwhile actor pushing forward the boundaries of his or her work. It's inevitably a part of this search for diversity and depth that the actor gets the opportunity to make public uncommon views.

"That's one of the gifts that actors and artists have. You have the chance to say things which people don't usually hear and you can get people to listen to views that they would normally not hear. How you use that potential is important - art is meant for enjoyment and to inform, not simply to propagandise."

Carson valued the character Buzz in part because he intrinsically challenges views of health care as they are received in the African American community:

"He was challenging the system, challenging the way people think about healthcare and about AIDS. Especially in the African American community and the minority communities there's not enough information..."

Photos courtesy of the producers

Film distribution in US is being done theatrically by Jour de Fête Films. The film has played in 35 cities to date, and is booked for an additional 20 so far. Expected ultimately to play about 60 cities in the US. Opened in New York on March 5, and the distributor has bookings through September. Video release next January. The film opens theatrically in Canada on July 30 through Mongrel Media. Negotiations with Millivers in the UK for distribution. Expected to release in January. The film has already been released theatrically and on video in France by Haut et Court, and will open at the end of the month in the Benelux territories through Cinélibre. Other territories for release in the next few months include Germany, Spain and Italy.

queer politics ..it's just sex!

Written and
Directed by
P. J.
Castal Leneta

Relax..it's just sex! is an honest film portraying some realities of life and its relationship traumas.

It also makes important points about modern 'gay', 'lesbi-an' and 'straight' identities. Set in today's Los Angeles, it's told through each character, who speaks singly on-camera, whilst in-between times also enacting the plot. Lead characters are 'Vincey' (Mitchell Anderson - *Party of Five*), a Gay man, and his gushingly platonic, but gossipy, hetero-womanfriend 'Tara' (Jennifer Tilley - *Bullets Over Broadway, Bella Mafia, Bound*). Other characters surround this central duo, like the lesbian coupling of WASP-y 'Megan' (Serena Scott Thomas - *Nash Bridges*) and Latina ('Girlie-Girl') 'Sarina' (Cynda Williams - *One False Move, Mo' Better Blues*). Megan and Sarina break-up, mocking their political pseudo-sex-life as a virtual "lesbian death bed". It's a Queer film all right ! There are more send-ups of the mantras of '70s P.C. 'identity' culture. When Megan 'comes out' (again) but as 'straight' over lunch with Mum and Dad, they're actually aghast ! Why!? Are they not happy now she's truly 'straight'?? No, 'cos they've invested (heavily) in her 'Lesbian' identity. Of course !! Megan's tipsy Mum whines, "...Your father wrote a book of our experiences as Parents-of-a-Lesbian. *The New York Times* favourably reviewed it. What do we do now ?". Funny film, yet with sharp twists it quickly turns to much darker themes of Homophobia, AIDS death-ideology and the ambiguous nature of these so-called sexual 'identities' we've been force-fed since the '70s, subtly showing how we are encouraged to invest in these 'identities' as if consumer-products from *Safeways*.

But *Relax..* suggests these particular clingwrap 'identities' are not really like *Safeways* as there's no payback in real life when identity-as-a-product makes us sick. In another scene, Vincey is shown being attacked by street homophobes and then fortunately rescued by his friends who hear the fracas. In horror they begin to look on helplessly as Vincey rallies only to chase and catch the male ringleader. 'Gay basher' turns 'victim' as anger-filled Vincey arse-rapes the ringleader at knifepoint, whispering in the ringleader's ear "Relax..it's just sex!..didn't y'know?..Gayboys have learned how to relax..". Vincey goes on to become a high profile Gay Activist, the sought-after guest for L.A. TV talk-show 'phone-ins, one of which is amusingly called *Fags on Line!* But this is serious..on some levels it's a pay-back for Vincey's College gaybash, and retribution for the violence done to Gay men.

The artist character, 'Buzz' (T.C. Carson - *Living Single*), is a strongly caring Black Gay man, rightly suspect of the death-ideology of 'AIDS Inc.' after experiencing his lover's AZT-death. He subtly disturbs other characters' belief in 'H-I-V' and its role in A.I.D.S. When the film's pet-character Harvey (Eddie Garcia) is told he's 'positive', Buzz bonds with Harvey, partly to save him from a Protease Cocktail/AZT-death, and partly because..well Harvey's actually rather cute and plays coy. These characteristics surface in Harvey's consultations with his Avuncular-sounding Male 'H-I-V'

Doctor making Harvey hypochondriacal over his small skin blemish that's actually a freckle ! Buzz's own experiential take on AIDS grates against the others' fatalistic received opinion on 'The Virus' and its Dr. Iatrogenic death agenda. In one dinner party scene, others' reactions to Buzz's controversial views sound more like the noise of fingernails on a blackboard, probably a familiar social experience for regular *Reappraising AIDS/Continuum* readers eh? At such moments in the narrative, AIDS dissident film-goers realise *Relax..* has a seriously important Intellect-Is-Cool message.

It says Dissident AIDS knowledge in-and-of-itself is useful and if made available for people in social settings it's maybe lifesaving too. The film parallels Harvey's 'H-I-V' diagnosis with Tara's pregnancy, which, in the film... (well, you may also cry!). Surprisingly, they both represent artifacts of desire coming from marketed 'identity'. But more than this, they also act as warnings for us to be skeptical of such 'identity(-ies)' because in these ambiguous times, marketed P.C. 'identities' embody their own, somewhat disturbing, *sequelae* and ramifications that may, temptingly for some or dangerously for others, beckon or entrap unknowing consumers. On the post-70s 'community' consumption and promotion (some say 'brainwashing') of Gay, Straight, Lesbian lifestyle 'identities', the film seems to imply 'Let the buyer beware'. The sub-text is 'You could lose a [real] baby. But, does one ever lose a [unreal HIV] diagnosis?'. The film's answer is..well, let's just say I don't want to spoil it totally for you, if (rather, when!!) *Relax..* comes to your local cinema. I'll just say the answer may be, as per usual, quite complicated..you see, the film implies belief (in 'H-I-V') has just about everything to do with it..Well, just go see it, yeah?

Relax..it's just sex! says a lot about our eternal need for intimacy but also puts retribution for homophobic violence alongside retribution for pharmaceutical violence which society literally stuffs down Gay men's throats. AIDS dissidence is shown on screen as hugely viable; when presented uncompromisingly within a social setting it's literally capable of cutting through media brainwashing on AIDS from the Tube and its 'celebs'. Like when Buzz is raising eyebrows stealing the limelight over A.I.D.S. causation at Tara's dinner party wouldn't-you-know: Tara is forced to literally shout out, "Everyone knows AIDS is the biggest killer in the World! Even **Madonna** says so!!" That's telling us! And the film goes further still. It acknowledges the reality of AIDS Dissidence as a growing movement, shown in the scene where an 'ANTI-AZT' slogan appears high on a protest banner which Buzz drops from an L.A. freeway doing his own 'good work for THE Community'. Just like the real Eric Rofes in his last book (*Dry Bones Breathe*), *Relax..* is cleverly saying a big 'Fuck You' to 'AIDS Inc.' and all its ghastly flim-flam artifacts, its 'Red Ribbons', its 'AIDS Quilts', ughhh! and its use of the laughingly trite notion of 'The Gay Community' (*sic*). Questioning all of what our friends and 'doctors' feed us about 'H-I-V' is the **Big Message** ringing out loud and clear from this wonderfully uplifting film. Most surely it's a very healthy one. Literally, this film could save lives and should carry health agency endorsements. Just go see it, yeah ?

- Kevin Corbett





readers' views

All these years

My partner and I have lost many friends to AIDS. From the very beginning we questioned the cause of AIDS. Myself and Paul Blanchard (of Doctor Fax) ran a workshop at the 1984 Southbank Polytechnic AIDS Conference. The workshop was on alternative and complementary approaches to the cause of AIDS. Professor Adler spoke at the conference and described how gay men are under the microscope of the medical profession. Marion McEvoy explained the 'epidemiology of AIDS'. At the time there was many of us who were not satisfied with the explanations of the medical establishment. From 1984 onwards the opportunists slinked their way into the emerging charities and self help organisations and 'ting-a-ling' here we are in 1999. The situation is so hard to bear. One cannot get ill without the baggage of life threatening illness. Such stress does not help ones immunity. People like my partner and I (AIDS dissidents) would appreciate a help and advice column in *Continuum*. It is very positive to subscribe to the idea that one cannot die of something that does not exist. However, the 'worms' have been implanted in our brains - after 15 years of the AIDS industry. One still gets frightened and anxious. Sometimes a person needs advice, where to go, what to do. We are still seeing people die. *Continuum* could help with some advice on how to survive. My partner and I do not want to die, not just yet. We take care of each other and do the right things. But we are only human and our beliefs waiver from time to time. More than fifteen years down the line and we are both still alive. But occasionally one gets tired and afraid again.

Yours sincerely
P. M. [full name supplied]
London

Coming off Combos

(by Stephen Rogers, last issue)

Man...I almost cried when I read your story...I basically had the same experience but didn't know how to put it on paper...You caught me at a time when I needed to hear what you said.

Peace,
Adrian

Your story is extremely important for the aids community to hear. It took courage and for what it's worth would like to say thanks. Unfortunately today physicians are forced to go along with protocols. Most ignore the very Hippocratic oath: DOCTOR DO NOT HARM; - ignoring the patients symptoms and allowing the patient to suffer is extremely cruel. The bottom line is money. There is a medicinal tea out of Canada called Essiac that helps with immune compromised patients without side effects that you might try. Also reticulose from Advanced Viral Research (Yonkers, New York) might help. This is an old antiviral with supposedly no side effects.

Les S [name supplied]

To be blunt I do not believe your story - it sounds too much like dissident trash. If it is true I am sorry for you and hope you continue to do well without medication. Who knows, you may be one of the extremely rare non-progressors. As to my experience on Crixivan, Eпивir, and Zerit it is exactly the reverse of yours (by the way I refused AZT monotherapy; I too saw many die on that therapy). I had a T-cell count of 32, and 500,000 viral load when I started, was suffering from continuous diarrhoea, had lost 58 pounds, was basically bed ridden, had PCP 3 times; each time was harder to get under control than the previous and I believed that I would not last another 6 months. Now after 3 years on the cocktail I have a 340 T-cell

count, viral load of 2,300, have gained back all the weight I lost, have much more energy, no longer have constant diarrhoea, and have not had any OI's. So I guess my point is this, that the vast majority of people who are on combo therapy have experienced similar results, which to my lay person's mind completely refutes the concept that the drugs do more harm than HIV/AIDS and the dissidents' claims otherwise are pure rubbish and should not be repeated by rational intelligent people.

Gary Stein see next page

I particularly enjoyed Stephen Roger's feature in the latest magazine. Late last year I had 5 months of chronic diarrhoea, yet all the tests at my hospital were negative. I was told it must be AIDS-related as my CD4 was only 8 and PCR 331,000. Being told I would die within a year without combination drugs I took the Ritonovir, D4T(Zerit), 3TC combination. For two months now I have been through hell with strange jerking, twitching and tingling in my legs and arms. The doctors make little of it but I have decided to pack in these drugs as I am in an even greater state of fear than with the diarrhoea. Their remedy was 10 mg Diazepam a day to calm my muscles!

I hope to find the root causes of diarrhoea and also Eosinophyllic Folliculitis which has troubled me for 3 years. My weight has returned to normal recently. Digestive Enzymes from the Nutri Centre seem to have stopped my diarrhoea rather than combination therapy which my doctors prefer to believe.

Yours sincerely,
Kevin M., [full name supplied]
London

I read your story and I was really touched and saddened. I'm sorry you went through this. It has left me with questions. How long have you been off the medications now and how are you doing? Are you seeing a doctor? Do you still have viral load tests done? I'm in a very frightening position right now.

Sincerely,
KC

Information network

Continuum has moved to a new address, which most likely was reason for my delayed edition of your magazine. Your magazine contains the very best information on the alleged "HIV" and related subjects, all well documented. Contrary to other publications, *Continuum* is not sponsored by the pharmaceutical camp. Fighting a multi-billion Dollar on drugs manufacturing business is indeed a fantastic challenge. However, I believe, sooner or later, you will succeed with the help of today's international information network. It has been ten years since I was diagnosed with "HIV" and have since then bombarded my body with all those toxic drugs, with no cure in sight. I suppose I am lucky to still be alive - but what a loss of good years during which people live with the stigma, guilt and personal property losses. Would CNN LARRY KING LIVE, from Los Angeles and/or Washington/New York not be the perfect place a discussion with the Gallo group and by doing so, reaching the broadest possible audience? Just a thought.

Wishing you the very best success.

H.M. [full name supplied]
Honolulu

Letters are welcomed. Write to The Editor, *Continuum*, 4A Hollybush Place, London E2 9QX, UK.
Tel: +44 (0)171 613 3909 Fax: 613 3312 continuum@dircon.co.uk
Letters may be edited for publication.

Counterpoint : Coming off Combo Cocktails Stephen Rogers responds



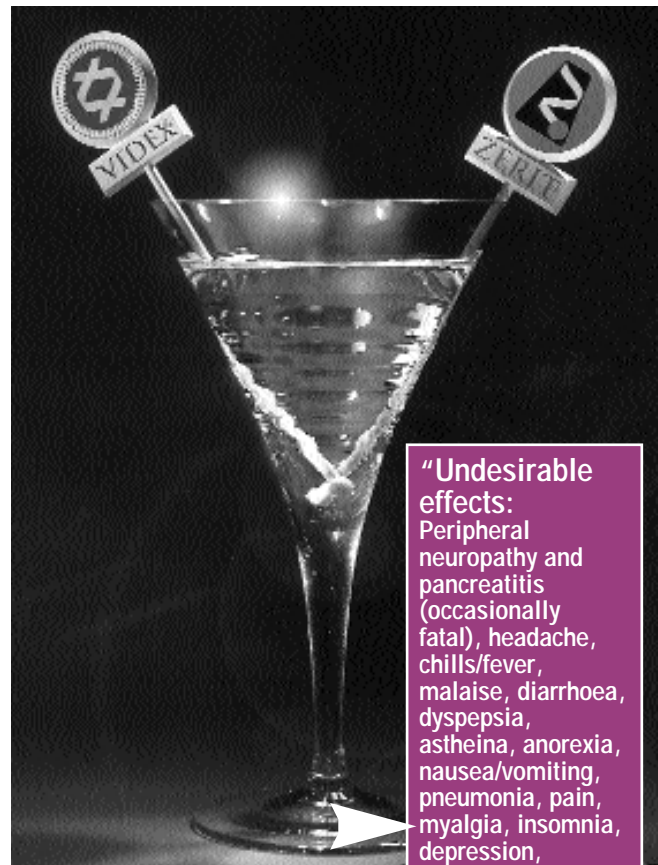
Dear Gary Stein,

For you to dismiss my experiences as *"AIDS dissident trash"* [Letters, previous page] is not only insulting, but deeply hurtful. As you must understand, this was an intensely personal experience, something I lived through, and for you to refer to all this as *"Trash"* is both callous and insensitive. How would you feel if someone dismissed your experiences as *"Trash"*? I gained nothing from writing the article, apart from perhaps the satisfaction that I may have helped others. I found the concept of bearing my soul to the world somewhat daunting, but I saw the need to help others more important than my own feelings. There are plenty of examples of people suffering and dying as a result of 'anti-hiv' drugs and people need to be made aware of this. Publications, both orthodox and dissident, are littered with similar accounts of the never ending list of serious adverse effects. One account which appeared in *Axiom* in February 1999, tells of someone suffering permanent nerve damage to the hands, lower legs and feet, after being on Zerit (D4T), to the point he is reduced to hobbling around and a journey of more than 100 metres leaves him in severe pain. Up to 64% of those on Combos are effected by lypodystrophy (*NAM* April, 1998). Out of all the letters received in response to my article, yours is the only negative one. You talk of your T-cells going up and your 'viral load going down'. In my opinion, these tests are close to meaningless. It was concluded in the early Nineties that taking samples from the peripheral blood is a waste of time, as only 36% to 4% of T-cells exist there, the majority being in the lymph glands. As for the 'viral load test', it is an extremely misleading name as all it does is pick up scraps of RNA and amplifies the result; it is inaccurate and non-specific. People with undetectable 'viral loads' still become sick, and those with high 'viral loads' can remain well: they are not an indication of health. You give an account of your bout of illness three years ago, your recovery and present well-being as evidence that the drugs work. This is what is known as circumstantial evidence, not scientific proof. What you should be asking yourself is what are the long-term effects of Cocktail Combos? Where are the long-term drug trials (5 to 10 to 15 years); why are drug trials only two to three years long at best? Ask yourself: why are they terminated prematurely?

Contrary to your claim *"Who knows, you may be one of the extremely rare non-progressors"*, the fact is that the vast majority of people tested 'hiv' positive are 'non-progressors'. The term 'non-progressor' is verbiage dreamt up by the orthodoxy to explain away people who don't become ill! Indeed, the phrase 'long-term non-progressors' is a euphemism for those not taking the 'anti-HIV' drugs. The fact is people get sick; it's part of human existence. Most seek treatment, recover and enjoy good health. But because you have a spurious 'positive' label, you are made to believe that you will not recover and suffer subsequent OI's until you

die, without the drugs. If you were not branded 'hiv' positive and you suffered serious attacks of pneumonia, recovered and three years later are doing well, you would think nothing of it. It is because you are 'framed' within 'hiv' belief you take the drugs. Because your antibodies react to a few proteins in a phoney non-specific so-called 'hiv' test, you believe that you do not possess the ability to live. Without the drugs, you might still be okay. On the short-term, you may be doing 'well' on the drugs, but there are others who are not as fortunate as yourself. The problem is that it is very much a case of Russian Roulette; you never know if it is going to be you, and sometimes it can be too late. Dismissing any negative accounts of Combos does not sound rational to me. I feel that your fear of what in your mind is the alternative if the drugs don't work, is so great, that it blinds you to the truth. If you suffer another OI doctors will say the drugs no longer work for you, that you have a (mythic) 'drug resistant strain' of 'hiv'. And if you died, they would say they did the best for you they could and they bought you a few more extra years of life but that the 'deadly AIDS virus' got to you in the end. If you believe so passionately in the drugs and the putative 'hiv', then you must also believe in your own demise. The reason I think the way I do is not due to 'denial' or *'AIDS Dissident Trash'*, but due to nine years of existing in the AIDS Industry, listening to lies, pseudo-theories and contradictions which have opened my eyes. You have a lot to learn; I hope you are around long enough to do so.

Yours Sincerely,
Stephen Rogers



"Undesirable effects:
Peripheral neuropathy and pancreatitis (occasionally fatal), headache, chills/fever, malaise, diarrhoea, dyspepsia, astheina, anorexia, nausea/vomiting, pneumonia, pain, myalgia, insomnia, depression, anxiety, flu syndrome, sweating, dizziness, dyspnoea, allergic reactions, benign skin neoplasms, peripheral neuralgic symptoms, lymphadenopathy, neoplasms."



A Highly Important New Paper from Western Australia Debunks AZT

Michael Verney-Elliott



The Perth Group in collaboration with Helman Alphonso of Colombia and Todd Miller of Miami, Florida, have published a very important paper, *A critical analysis of the Pharmacology of AZT and its Use in AIDS*, in *Current Medical Research and Opinion*.

The article, issued as a 45 page supplement to the journal, cites 121 references to support their conclusion: "A critical analysis of the presently available data which claim that AZT has anti-HIV effects shows that there is neither theoretical nor experimental evidence which proves that AZT used either alone or in combination with other drugs, has any such effect." Their study shows the use of the drug, whatever claims are made on its behalf, to be as irresponsible, having due regard to its admitted toxicity, as it is ineffectual in stemming the production of virus.

It is currently supposed, especially by doctors who prescribe AZT (Zidovudine etc.) to treat both people with AIDS and people testing 'HIV-positive', that the drug will block the virus' capacity to infect cells. As the Perth group clearly shows, this belief is totally unsupported by data from *in vitro* (lab cell culture) or *in vivo* (living patient) studies. The Perth group cautions very forcibly against attempting to extrapolate from *in vitro* studies to an *in vivo* context.

The original justification for using AZT, a drug previously demonstrated by cancer researchers to be highly toxic, to treat 'HIV' infection was based on studies which purported to show that the drug acted as a DNA chain terminator. For 'HIV' successfully to infect a cell, after entering the cytoplasm of a permissive target cell, the virus must, with the aid of an enzyme commonly called reverse transcriptase (RT), transcribe its genetic information, carried in the form of RNA, into a double strand of DNA, which it then proceeds to integrate into the cell's nucleic DNA. Thereafter, whenever the cell is stimulated into activity, more virus will be generated. It was claimed, on the basis of *in vitro* studies carried out in 1985/86, that AZT (azidothymidine) was able to inhibit the reverse transcriptase enzyme, thereby stopping the

transcribed DNA chain from being completed. Moreover, it was alleged that the AZT is selective in inhibiting the supposed virus-specific reverse transcriptase without damaging other cellular enzymes or interfering with necessary cellular DNA synthesis.

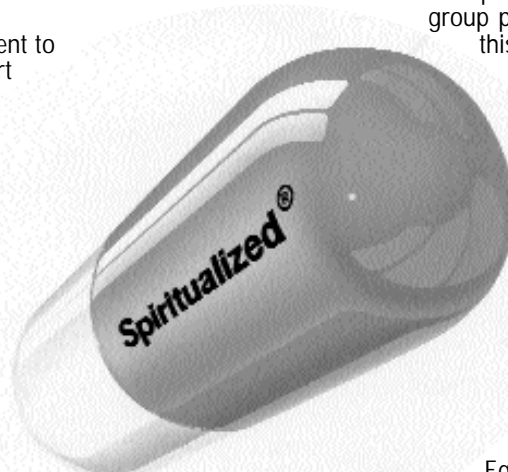
The Perth team first tackle the question of triphosphorylation of AZT to AZTTP. Only this form of AZT is deemed effective in inhibiting RT activity. However, it is acknowledged even by AZT's promoters that this form of AZT is far too toxic to administer to patients directly, so a series of studies were carried out seeking to show that the cells metabolised AZT into AZTTP naturally, thereby conferring an anti-HIV capability on the drug. All these studies were flawed, and indeed later studies showed that the AZT remained ineffective in stopping the reverse transcription of viral RNA into proviral DNA. Moreover, as the

group point out in the *Comments* on this section of the paper, AZT is very efficiently mono-phosphorylated intracellularly, and there is clear evidence that this results in "decreased cellular DNA synthesis". This of course was always one of Peter Duesberg's most telling arguments against the use of AZT - that in order to forestall the virus the drug would have to destroy healthy cells.

Equally damaging to the cell's metabolism is the evidence that the Group quotes to show AZT damages mitochondrial DNA synthesis, which inevitably results in destruction of the cell.

As the Perth group point out, if the theory behind the use of AZT is correct, then this should be reflected in the rapid diminution of the number of viral particles supposed to be found in the blood of alleged "HIV" infectees. However, according to the kinetics of David Ho's 1995 model of 'HIV' viral replication, billions of viral particles are continuously generated daily after infection, and AZT apparently does nothing to prevent this. If the claims made for AZT are correct, then the viral load should diminish rapidly with the use of the drug; and the death of the productively infected cells, which live for only a few days, should see a complete clearance of the infection as no further cells can be infected. None of this has been shown to be the case.

In summary, 'HIV' experts seem to agree that AZT inhibits reverse transcription of 'HIV' RNA into proviral DNA, but only *in vitro* in the form of AZTTP, which cannot be given to patients because of its lethal toxicity; any conversion of AZT to AZTTP occurring intracellularly is below the level



needed to inhibit RT. Thus, the drug does not have an anti-'HIV' effect at all, but has well documented toxic effects on mitochondria, without which the cell cannot survive. Moreover, the drug is known to cause hideous side-effects

The text of the paper is published on World Wide Web: <http://www.librapharm.co.uk>
Listed in Current Contents, MEDLINE, EMBASE/Excerpta Medica etc.

Manufacturer



A spokesperson for the drugs giant commented that despite the new paper there is

"overwhelming data *in vitro* and *in vivo* in favour of AZT as an effective antiviral and anti-HIV drug."

She was advised by company scientists to cite a scientific publication *Zidovudine: an update of its pharmacological and pharmacogenetic properties and therapeutic efficacy*. Wilde M.I. and Langtry H.D. *Drugs* 46 (3):515-578. Sept 1993, a review with 450 references.

in some patients, including severe megaloblastic anaemia, unbearable headaches, nausea, muscle wastage and a huge increase (46.4%!) in the risk of non-Hodgkin's lymphoma.

The Group acknowledge that there is evidence that AZT may have anti-viral and anti-bacterial capabilities - but this leads to complications in the assessment of how successfully the drug treats 'HIV'. Is AZT considered to have helped the patients by a direct effect on the 'HIV' infection or was the efficacy more indirect in that the drug effectively treated opportunistic viruses and bacteria? Could ever improving patient management be responsible for the improvement in the patients, despite the toxicities of AZT? The true risk-benefit ratio in the use of AZT must be thoroughly re-examined, and urgently.

For reasons of space, this is only the briefest overview of this exhaustively researched and closely argued paper, but I hope it conveys something of its seminal importance. Even now, parents in America and pregnant women worldwide are being cajoled, pressured and even legally coerced into taking, or giving to their child, a drug of more than doubtful benefit but proven toxicity. This paper, by the Perth group and their colleagues, should be required reading by all G.P.'s and so-called 'AIDS' specialists who are in a position to prescribe AZT. It should also be acquired by all lawyers specialising in drug injury cases.

1. Eleni Papadopulos-Eleopulos, Valendar F. Turner, John M. Papadimitriou, David Causer, (Perth, Western Australia) Helman Alphonso (Barranquilla, Colombia) and Todd Miller (Miami, Florida) - "A Critical Analysis of the Pharmacology of AZT and its use in AIDS". *Current Medical Research and Opinion*, Vol. 15, Supplement 1, 1999.

Principal author Eleopulos :

Thank you for sending us the "reaction from Glaxo Wellcome" spokesperson on our AZT paper. There are two main reasons why we find the response disappointing.



1. An in depth critical analysis of a subject should not be dismissed by citing a reference, even if it is a review paper.

2. In the introduction to our paper we have made it clear that the purpose of our study was to "evaluate the data which are said to affirm AZT as an antiretroviral agent" and not to analyse the clinical data. However nowhere in the cited review can one find "overwhelming data *in vitro* and *in vivo* in favour of AZT as an effective antiviral and anti-HIV drug". In fact, the effect of AZT on "HIV isolation", "viral burden" ("HIV DNA") or "viral load" ("HIV RNA"), the only parameters by which anti-HIV effect can be evaluated, is not even mentioned.

The authors of the review accept that "Zidovudine triphosphate is the active form", and claimed that Zidovudine triphosphate "has been shown to comprise up to 67% of total phosphorylated zidovudine in peripheral blood mononuclear cells", but cite no reference to substantiate this critical statement. This is not surprising since to date nobody has published such data. According to these authors, "Maintenance of optimal virustatic zidovudine [triphosphate] concentration at greater than 1 (mol/L (a theoretical target based on *in vitro* data) with oral intermittent dosages regimens is difficult because of the short term and dose-limiting adverse effects of zidovudine".

Since, according to the presently available data, even the peak levels of triphosphorylate AZT are less than 1pmol, it is impossible to achieve virustatic levels and thus anti-HIV effects.

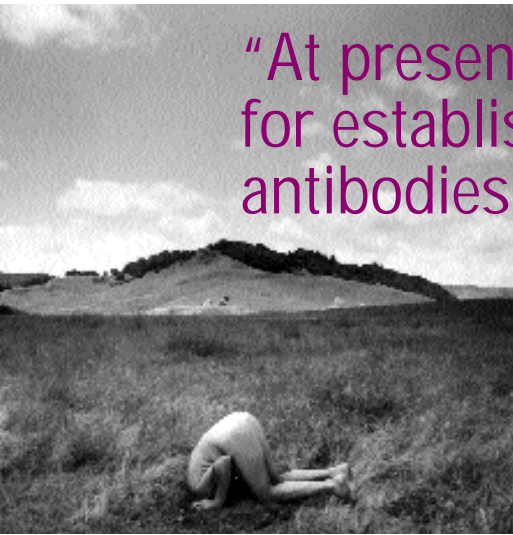
- Eleni Eleopulos



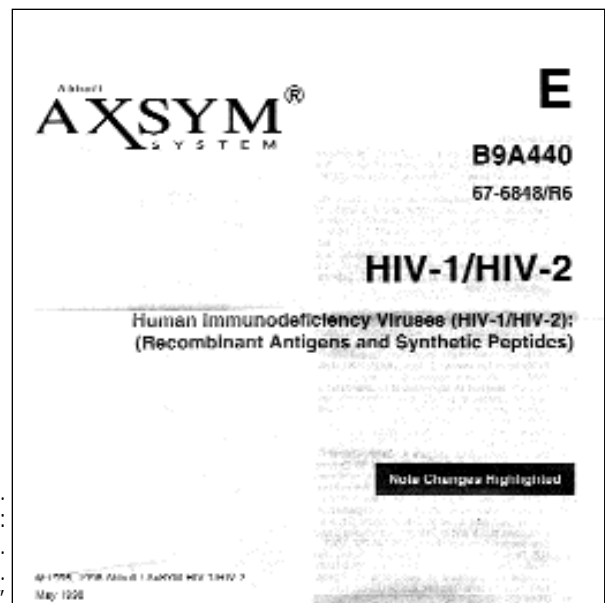
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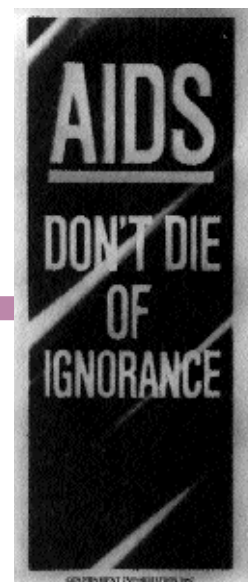
“At present there is **no recognised standard** for establishing the presence or absence of antibodies to HIV-1 and HIV-2 in human blood.”
- *AxSYM System, Abbott Laboratories*



“Abbott AXSYM® System. B9A440. 67-6848/R6. HIV-1/HIV-2. Human Immunodeficiency Viruses (HIV-1/HIV-2): (Recombinant Antigens and Synthetic Peptides). Note Changes Highlighted. © 1995, 1998 Abbott/AxSYM HIV-1/HIV-2. May 1998”

“**False positive results can be expected with any test kit. Falsely elevated results have been observed due to non-specific interactions.**”
- Abbott Laboratories

UK Government information leaflet, 1987



Consequences of Ritual Testing

Monica Gilmore



Monica Gilmore and daughter Julia

In those days, the late eighties, the media pressure was unbearable. I had used heroin for more than two years between 1979 and 1982, so I knew I was at risk.

I still remember the dreadful feelings I had, seeing and hearing the TV and press campaign. They pictured tombs, blood and zombie faces, with frightening headlines: "AIDS KILLS" ... "DON'T DIE OF IGNORANCE". In February 1988, in order to put an end to my psychological torture, I finally summed up the courage to go and be tested for the "AIDS virus".

Even though there was a real chance that I might be positive, within me I was so sure the result would turn out negative that I nearly forgot to go back to the hospital for the results. Of course it was a process of removal, because I wasn't prepared for the worst. It is strange how the mind can hide from itself a situation that it is not capable of dealing with. Then one morning I got up from bed quite disturbed after a vivid dream in which doctors were telling me that I was HIV positive. The fear had escaped from my subconscious. I went straight to the hospital telling myself that the dream didn't mean anything, that I was all right, but the dream was prophetic.

I waited nervously in the Infectious Diseases Clinic. I can still remember the doctors' sad faces as they told me that I was HIV positive and that I shouldn't think to get pregnant, not until more research "on the issue" brought better news. The world fell in on me. I was in the prime of life, 25 years old with lots of expectations. Having successfully fought drug use six years previously and having rebuilt my confidence in life, friendship and work, the last thing I wanted to hear was that I belonged to the category, AIDS. The future looked hopeless.

At first I experienced shock and numbness. Then I began to confront what I had been told and start a process of "clearing up" in my life. What was really important for me at that very critical time? I started to choose friends and people whom I really wanted to be with. My ambition to pursue a career in a bank, where I had worked for a while, vanished. I suddenly had a different sense of time and couldn't stand the thought of a routine of office work, dealing with figures for the rest of my now-to-be short life. According to the impression I was given, I had at best another five years.

At that point I changed my life goals so radically that I nearly became a nun. In fact I believe I had a sort of mystical crisis, spending many hours sitting quietly and praying in the Churches of Rome, the city where I was born and grew up. I began to feel nostalgic for my innocent adolescent past, when I used to go to Church and knew nothing of "the evil people who use drugs". I desperately reached for the memory of that innocent period, with a longing to start again, to rewind the videotape, cancelling all the undesirable memories, erasing about a decade of my life.

I was full of remorse for having used heavy drugs, but at 17 years old I had not been strong enough to say no. In the innocence of youth, I had set out to rescue from heroin a handsome 25 year old man who was in my group of friends. I fell in love with him and he became my regular boyfriend. I wanted to experience what he was feeling with the "forbidden" drug, to try just once without getting a habit. But it didn't work out that way. Heroin addiction is like alcohol addiction: once you get the feeling of disinhibition, you can't be without it. So I carried on using it, at first only at weekends, then more often, then every day, until a personal crisis brought me a way out, and I left him.

I never shared a needle with anyone, not even my former boyfriend, because at that time hepatitis B was quite common among intravenous drug users, and I was conscious of the need to protect myself from it. Reflecting on my experience it was a puzzle to understand how I got HIV. When I questioned the doctors, they answered that I probably got it through sex with my former boyfriend. The picture for them was complete, but not for me.

I was living with my family during the period of the HIV diagnosis, following a stressful year in London working in an Italian bank. I couldn't tell them about my "HIV state". They both suffered from high blood pressure and I wanted to protect them from this awful news. They still don't know anything even now, because as the years have passed by, I have found myself less and less motivated to tell them about it. After all, I thought, HIV was my problem. They couldn't change it, so why worry them with it. I also felt guilty that I had given them enough trouble in my late teenage years, especially during the month in hospital coming off the drugs. Anyway, I promised myself that I would tell my parents and my brother of being HIV+ when "HIV research" found a cure, a vaccine perhaps, and AIDS would no longer be a threat. I was obviously very naive when I made that resolution, ignoring completely the

possibility of questioning the existence of HIV itself.

In retrospect, being tested for HIV proved beneficial to me in one respect: it brought about a radical change in my lifestyle. I gave up smoking and drinking alcohol. Late night parties and smoky disco clubs were no longer suitable for me. I wanted to make more sense of my life. After a few months of maturing the decision with my parents, I decided to go back to university. In Italy, university costs are largely born by students' families. So my parents agreed to support me for the next four years. At 26 years old, this was the beginning of a big challenge.

I chose to study philosophy at the Jesuit University in Rome. I studied with great interest and increasing involvement with the life of the university. I am glad to have had the Jesuits as teachers. I learned from them to take nothing in life for granted: questioning is the very basis of philosophy. I had a good training not only in a subject that I found fascinating, but even more in thinking independently.

I graduated in 1992 the year I met my husband, Michael, who was teaching at the same university. Before getting more sentimentally involved, I told him about my HIV+ status. I was prepared to be rejected as had happened to me before with another man. To my surprise he accepted my HIV+ state, and assured me that he wanted to spend his life with me.

During that period I was still going regularly to the hospital for the routine blood check. Although I did question things that the doctors said to me, I didn't have any HIV dissident information then. In Italy there were very few dissident voices and they generally went unheard. Then late in 1993, I read an article of Duesberg and my doubts were confirmed.

Unfortunately by then I had been on AZT for two years. I had kept saying no to the doctors until autumn 1991, when my T4 cells count dropped from a stable 250 to 180. Since then I have learned that the count fluctuates in the peripheral blood, which is normal, but the way the doctors put it in 1991, it sounded so menacing that they made me believe I was on a dangerous "border line". The count was evidence for them that my immune system was weakening. I was lured into their trap. If only I had trusted my own health, which has continued to be "asymptomatic", as the jargon describes it, I probably would have continued to say no to AZT. I surrendered to AZT but not to prophylactic antibiotic SEPTIN, which I categorically refused. I hope I reduced the damage to my cells by not taking it.

The doctors made me sign a statement that I, the patient accepting AZT, was "symptomatic", which I never was, as I had had none of the alleged 29 AIDS defining diseases. When I asked them about this, they said that it was just an internal formality with no relevance for me. It didn't sound right, but the pressure and the fear then was still playing a major part in my decision-making. So though unwillingly, I did sign. I asked for a copy of it which I still have.

Then something very fortunate happened to me. Before coming to live in England, I met in Rome a medical biochemist, Dr. Siro Passi, who agreed with Duesberg's theory that drugs abuse, rather than the harmless retrovirus, is the cause of immune system depletion, a theory which included, on its list of responsible toxic agents, "HIV" medication. "HIV" drugs would actually lead people to AIDS. I immediately stopped taking AZT, and under the biochemist's direction, started a detoxification programme, taking antioxidant supplements as well as a proper balanced diet.

I suppose it was at that time that my dissident journey began, but it was not without further confusion and doubts. First of all, I wanted to know more about HIV and AIDS, and as soon I came to England I seized on every piece of information that I could find on the issue, although

most of the time the media coverage was disappointing. Meanwhile I carried on preparing for our wedding in Rome and settling in a new home in England.

After we got married in August 1994, we started to think about having a child. I knew that if I didn't have any particular health problem and if I maintained a healthy diet during pregnancy, my baby should be as "normal" as any other. But I was still having regular blood checks done at the hospital, and the doctors there tried hard to discourage me from the idea of conceiving. I listened to them for two years and then got pregnant.

I wasn't as sure in my own views then as I am now. I was disturbed by their conviction that it would be advisable to take AZT during pregnancy, to have a caesarean section and to refrain from breast feeding. They said exactly the same things that the doctors in Italy would say. There is no flexibility in this "protocol" followed diligently by the medical establishment world-wide.

Looking back I can see how easy it is, in a moment of doubt, to succumb to pressure. At a sensitive time like pregnancy, particularly a first one, a woman in my situation has very mixed feelings. I avoided the pressure until the last four weeks of the pregnancy, when I started to listen to my fears of having an HIV+ baby and to what I would do or feel if it remained so. So again I surrendered. I took AZT

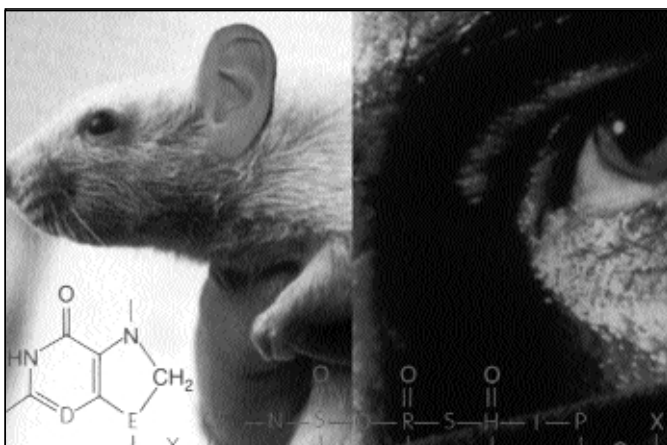
for one month only, without thinking too much. I just wanted to do the "best", to reduce the "risk of transmission" to my baby, and probably to feel in peace with the doctors. I was

overcautious and, of course on the wrong path again. It might sound rhetoric, but in the end we are only human, with a complicated network of relationships, and we can't always be objective and coherent with ourselves.

Anyway I had a wonderful, bouncy baby girl in May 1997! She was born with a "bloodless caesarean section". The surgeon during the operation used a special procedure to keep the membrane of the uterus away from the baby. It was bloodless for my daughter but not for me. I lost a great deal of blood. I was conscious all the time in the theatre because I had had a spinal injection rather than a general anaesthetic. I don't know how I found the courage to be conscious for that hour, hearing all the instructions of the doctors, but I was so happy to see and hear my baby that I didn't mind too much what was going on in the theatre. This glorious moment lasted only a few minutes, because I had a sudden drop in blood pressure and nearly passed out. The anaesthetist said that the systolic went to 48, and they had a moment of panic. I felt very sick but remained conscious. They rescued me with a quick adrenaline injection and kept me under observation for a few hours afterwards.

I lost so much blood with the "bloodless caesarean" that I became anaemic. Although I was thrilled that Julia





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had come into this world, I have to say that I had a very tough time in the maternity unit for the next five days. She was left in my room constantly, and from day two I had to change and bottle feed her night and day. I couldn't walk properly or even sit comfortably on the bed because of the pain of the operation and I was feeling very weak due to the severe anaemia.

A trolley was put outside my door with disposable gloves, masks, yellow plastic bags and a big written warning "BLOOD-BORN INFECTION". Then I was given a toilet and a shower next door "especially for me", with another big warning sign "MRS. GILMORE ONLY", so that every person who passed in that corridor would know that I was very "infectious" indeed. Fortunately I was able to remove my name and some of the warnings before my colleagues came to visit me.

The last straw came on the second and third nights when the midwives on night duty refused to take my baby to the nursery, even though I desperately needed a few hours rest. I hadn't had a wink of sleep since the event of birth, and I felt that I would go mad if I couldn't sleep those nights. They said that because of the HIV, they were told not to take my baby to the nursery. I cried desperately with anger but they were not in the least understanding. They fed and changed my baby for me in the night, but in my room only.

During one of the best events of my life, becoming a mother, I felt run down and hopeless. My family was in Italy and my mother didn't come to England until two weeks after my daughter's birth, as we had previously planned. My husband came to the hospital in the evening after work, but he couldn't be there in the daytime or at night. I was discharged after five nightmare days, coming home still very anaemic because I had refused a blood transfusion, but relieved to have left that horrendous experience. When I began to recover from the anaemia, I made a complaint to the head of the maternity unit through the local AIDS support service. The complaint was taken very seriously, but the apologies didn't change what had happened to me during my stay. I wonder how many women like me have been subjected to similar treatment and discrimination in hospital.

My daughter had her first HIV test done when she was still in the hospital, which was positive, and then when she was three and six months old, and was still positive. I resisted the intense pressure to administer AZT to her. The last test was done when she was one year old and was negative. I didn't like blood being taken from her little chubby arms, but I needed to be reassured about what I was always hoping for her, to become HIV negative, at least for my own peace of mind.

Only recently, after reading more and more dissenting views on HIV, I ask myself whether all the stress of eleven years of HIV testing and its consequences was really necessary. It took me more than a decade of "HIV experiences", characterised by different stages of emotions and discriminations, to acknowledge that the best doctor we can trust is ourselves. Of course if we fall ill, we might need specific medication until we recover, but we certainly do not need a "prophylaxis" of highly questionable, toxic "HIV drugs".

I have decided not to go any more for the ritual blood tests. What is the point now if I am convinced that there is a gross error at the very base of the HIV theory. Sometimes I wonder if the medical practitioners are being brainwashed by the financial interests and power, not to ask elementary questions like: Given contrary evidence, are we sure that HIV really causes AIDS? If it doesn't, what does cause AIDS? Are we at all sure about the existence of HIV? I hope that time will confirm the value of such questions for the sake of scientific and medical progress. Meanwhile I hope to remain as healthy as I am, enjoying my life together with Michael and our daughter.

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A Critical Analysis of the Pharmacology of AZT and its Use in AIDS

Eleni Papadopulos-Eleopulos, Valendar F. Turner, John M. Papadimitriou, David Causer, Helman Alphonso and Todd Miller

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Yet more monkey business from the AIDS scientists

Rosalind Harrison MB BSc FRCOphth, DO, DTM&H

The New Zealand parliament recently considered a bill which would have granted nonhuman great apes - gorillas, chimpanzees, bonobos (pygmy chimpanzees) and orang-utans - legal rights which presently are granted only to humans.

These rights include the right not to be deprived of life, not to be subjected to cruel and degrading treatment, and the right not to be subjected to medical and scientific experiments.^{1,2} For chimpanzees this would have set a timely precedent, as a sub-species of chimpanzee, *Pan troglodytes troglodytes*, has been, according to a paper published in 4th February edition of the science journal *Nature*, identified as the source of the Human Immunodeficiency Virus.³

I have been reading publications about AIDS, particularly those pertaining to Africa, for more than 15 years, and never cease to be astounded how the most grandiose claims are made from the thinnest research material. This paper from *Nature* is no exception. The authors of the *Nature* paper state that five lines of evidence have been used to substantiate zoonotic (animal to human) transmission of primate lentiviruses : first, similarities in viral genome organization; second, phylogenetic relatedness; third, prevalence in the natural host; fourth, geographic coincidence; and fifth, plausible routes of transmission. They claim that the primate reservoir of HIV-2, one of the AIDS viruses, has been clearly identified as the sooty mangabey, because the immune deficiency virus in the sooty mangabey, SIVsm, is similar to HIV-2, their habitat coincides with the epicentre of the HIV-2 epidemic, and sooty mangabeys have close contacts with humans because they are hunted for food and kept as pets. The origin of HIV-1, they say, has been much less certain. They fail to mention the much trumpeted but completely discredited African green monkey origin for HIV-1, but do explain why the chimpanzee has not, until now, been considered a likely source.^{4,5} "HIV-1 is most similar in sequence and genomic organization to viruses found in chimpanzees (SIVcpz), but a wide spectrum of diversity between HIV-1 and SIVcpz, an apparent low prevalence of SIVcpz infection in wild-living animals, and the presence of chimpanzees in geographic regions of Africa where AIDS was not initially recognized have cast doubt on chimpanzees as a natural host and reservoir for HIV-1.

Rather, it has been suggested that another, as yet unidentified, primate species could be the natural host for SIVcpz and HIV-1." Despite the impression of substantial research, in fact the gene sequence of SIVcpz had, until this publication, only been completely determined in two chimpanzees, and incompletely in a third. Now a virus has been found in a fourth chimpanzee that is more like HIV. Eureka, proof, Africans hunting chimpanzees caught SIVcpz, it turned into HIV-1 and the AIDS epidemic began.

The chimpanzee in question, called Marilyn, was wild-caught in Africa (country of origin unknown) and exported to the United States as an infant. She was used as a breeding female in a primate facility until her death at age 26 years, after giving birth to still-born twins. At autopsy she had retained placenta and secondary infection of the uterus (womb), but no evidence of AIDS. Her serum was strongly positive for HIV when tested with ELISA and Western blot, but no virus could be isolated: "Because virus isolation from the autopsy tissues was unsuccessful, we used PCR to amplify and sequence four overlapping subgenomic fragments that together comprised a complete proviral genome, which we termed SIVcpzUS." [Emphasis added] PCR, or polymerase chain reaction, is a technique for making a large number of copies of a small fragment of genetic material. In this case the genetic material was taken from Marilyn's own cells. More than one percent of human DNA (and presumably also chimpanzee DNA) consists of sequences of genes similar to those found in retroviruses, so finding these gene sequences does not prove virus infection. Virus isolation is necessary to prove virus infection.⁶ (Failure to isolate virus is not a problem unique to Marilyn's frozen autopsy tissue. Retrovirologists have laid down a set of criteria to distinguish spurious from genuine retroviruses. Human Immunodeficiency Virus (HIV) does not fulfil these criteria, but AIDS researchers accept PCR tests as sufficient proof. If traditional retrovirology is right and AIDS research is wrong, all current AIDS research is fundamentally flawed.)

Yet even if we accept the PCR evidence, does Marilyn's case prove anything? We are told that she had not been used in AIDS research nor had received human blood products after 1969, and we are therefore led to assume that she could only have acquired her HIV positivity (more correctly termed SIVcpzUS positivity) in Africa, presumably from her mother. But let us pause for a moment here. Marilyn was kept as a breeding female in a primate facility for 26 years but the possibility she may have acquired an infection from any of the chimpanzees with whom she was mated during that time is not even considered. We are told Africans can catch HIV from monkeys that they hunt or keep as pets (presumably by biting, scratching etc.), yet it does not seem that Marilyn could have caught an infection by such means from a fellow inmate in the primate facility or from any HIV positive human handlers!

Now to the subject of geographic coincidence. Superficially, this can seem plausible enough - apes and

Africans are all there together on the African continent. In truth, apes, like any other human or material resource of value in Africa have been acquired by fair means or foul and taken to Europe and America. If African hunters can acquire AIDS from chimpanzees, so can European and American scientists who subject them to experiments, and the staff at the primate research establishments and breeding centres that supply the animals to the scientists. Then there are zoo keepers and circus trainers, Tarzan, Jane and the film crew, Ronald Reagan in "Bedtime for Bonzo", the makers of the advertisements for Tetley tea—all these Europeans and Americans would have been at no less risk of AIDS than any African hunter.

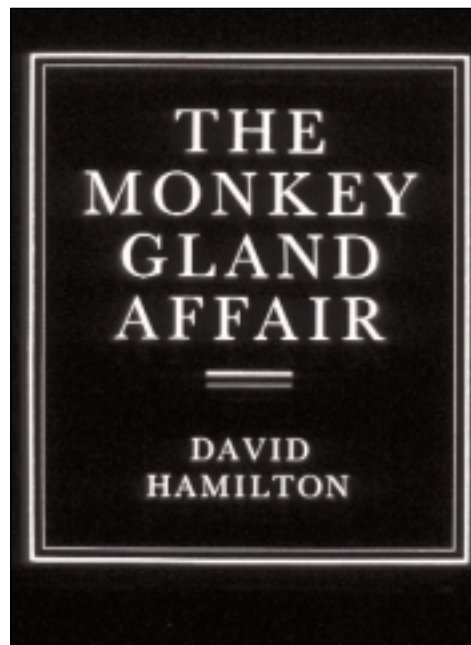
The difficulty here is that HIV is not transmitted by non-sexual contact - shaking hands, kissing, biting or scratching, by sharing food or cooking utensils. Unlike hepatitis B, it is not transmitted by sharing razors or even by being pricked by a needle that has just pricked an infected person, for there have been very few reports of HIV conversion following "needlestick" injuries to medical personnel, and these have been challenged. If HIV cannot be transmitted from one human to another, infection with chimpanzee or sooty mangabey immune deficiency virus would be even more difficult. It is accepted that even blood to blood transmission requires an injection or transfusion of blood, not just, for example, infected blood coming in contact with an open wound. (AIDS scientists have claimed that some Africans inject their pubic areas and thighs with monkey blood to improve sexual performance. I cannot think of anything less likely to increase sexual arousal.⁷ They have also claimed that Africans could have been infected by eating raw or undercooked monkey flesh.⁸ Obviously there are no studies of human to human transmission by such a route, but I would be very surprised if there was any documentation of Africans eating raw monkey flesh!)

Mercifully Africans have not been accused of having sexual intercourse with apes or monkeys, at least not in the recent scientific literature, but even here the evidence for the transmission of HIV in humans is surprising. A well conducted prospective study from northern California of transmission between heterosexual couples, one of whom was infected, found that an average of around 1,000 acts of intercourse were required to transmit HIV positivity from an infected man to uninfected woman, and about 7,000 from infected woman to uninfected man.⁹ Transmission was reported higher with anal sexual intercourse, but there is little evidence for transmission by oral sex. (This inevitably begs the question as to how HIV is being so easily transmitted in Africa when it is so difficult in Northern California. Facilitation by other sexually transmitted diseases (STD's) has been proposed¹⁰, a nonsense as the incidence of STD's in Africa is lower than

HIV positivity- the facilitator cannot be more prevalent than the facilitated- and a recent study from Uganda has found that reducing the incidence of STD did not reduce the rate of conversion from HIV negative to positive.¹¹ "Dry sex" is another suggestion found in the scientific literature. African men, so it is claimed, do not engage in foreplay before sexual intercourse, and the trauma this causes the woman increases the transmission of HIV.)

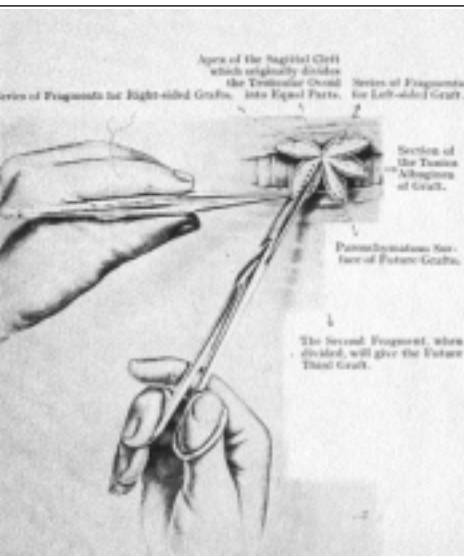
One route by which HIV is considered readily transmitted is organ transplantation, and, extraordinary as it may seem, until the early 1930's many thousands of European men received transplants from monkeys, mostly chimpanzees.¹² As far back as 1889, at the Société de Biologie in Paris, Charles Edouard Brown-Séquard, an important French physiologist at the end of his distinguished career, announced that he had succeeded in using an injection of testis extract to revive his failing powers. In subsequent scientific publications Brown-Séquard described how his impotence had gone, and how he had regained better control of his bladder. Although this was greeted with scepticism, several practitioners in London obtained supplies of the testis extract. By the end of the first world war, medical science had progressed from the injection of testicular extracts to the transplantation of animal testes. One of the leading practitioners of this operation was Dr Serge Voronoff, a Russian who was trained and spent all his working life in Paris. After conducting animal experiments, he began transplantations into humans in 1920 and for a decade personally performed this surgery on many thousands of European men. He considered the chimpanzee the most suitable donor, and in his clinic in Paris the chimpanzee was castrated under general anaesthesia in one theatre whilst in an adjacent theatre the human, under local anaesthesia, was prepared to receive the transplant. As Dr Voronoff's own drawings demonstrate [see next page], the chimpanzee testicle was cut into slices and attached to the human testicle, the surface of which was roughened to promote the growth of blood vessels into the transplant. Although not appreciated at the time, there was no prospect that these gland transplants could be effective, as the transplanted tissue was rejected and transformed into scar tissue in a matter of days or weeks. Notwithstanding, there were few disappointed customers, and three quarters of the recipients reported improved sexual performance. One of Dr Voronoff's earliest patients and staunchest supporter, Edward Liardet, is recorded as suffering with two bouts of gonorrhoea after his operation, before he died of *delirium tremens*.

Even at an early stage of his work Voronoff experienced difficulties in obtaining a steady supply of chimpanzees, which came largely from the African colonies of Spain and Belgium. The French authorities refused him permission to establish a breeding colony in France, so he bought a

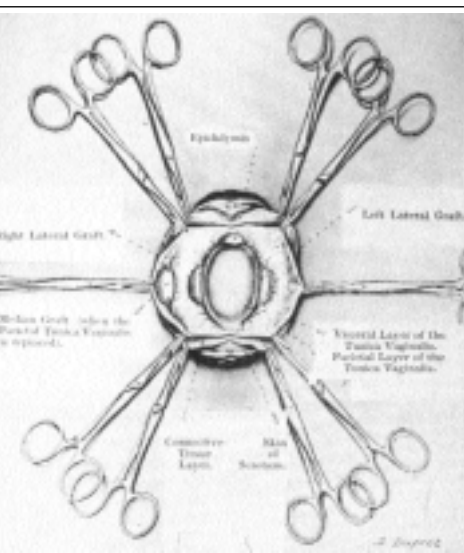


Sergei





killing of monkeys for their skins monkeys could only be captured by



how have Africans succeeded? Do they even hunt chimpanzees? No evidence has even been presented that they do. Do they carry syringes and needles with them and, after killing the chimpanzee extract some chimpanzee blood (difficult, but even more difficult from the living) and inject themselves with it? Have sex with the poor dead creature (7,000 times assuming a male hunter and female chimp)? Eat the raw flesh? At every step the hypothesis that monkey viruses infected Africans and caused the AIDS epidemic is so improbable as to be realistically impossible. Unfortunately in the mad world of AIDS research, this passes as science.

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chateau in Italy for that purpose, although he had little success. The Pasteur Institute also experienced difficulties in obtaining monkeys for research, and tried to establish a reservation for apes in West Africa. The Americans, in competition, formed a syndicate to organise an African expedition to round up chimpanzees and so corner the market, although nothing apparently came of it. Voronoff campaigned against the use of monkey skins for clothing and decoration, and in September 1923, the governor of French West Africa banned the killing of monkeys for their skins and issued a decree that those with a permit issued by the governor-general, with permits only given for obtaining monkeys for medical research. Similar edicts were issued in the Belgian Congo. In 1925 Voronoff himself travelled to French West Africa, through Senegal, the Sudan and the Upper Volta. At Kindia, in French Guinea, he demonstrated his method of gland-grafting in a laboratory of the Pasteur Institute building, and endowed the unit with 100,000 francs to enable them to build a monkey menagerie.

If many thousands of European men failed to get AIDS after receiving chimpanzee transplants,



Joan Shenton
of Meditel Productions

FORCE FEEDING

He wore a black skullcap - a big burly man with a gentle smile, who sat still as an ebony sculpture. Next to him, absorbed in his drawing, was his son - a slightly built boy, slim to the point of frailty but chirpy and completely at ease.

We were sitting round a huge table at George Washington University, invited by the Washington DC HEAL group and ICMJ (International Coalition for Medical Justice). It was Memorial Day, Sunday May 30th, 1999. Outside in the streets thousands of bikers streamed by in a parade commemorating their dead in Vietnam. Inside our room we were remembering others who have died - victims of AZT toxicity, caused by gross negligence, the pursuit of patent profits, general stupidity and the overwhelming conservatism of the medical profession. This combination has led to a new form of fascism - health fascism - whereby gay men, pregnant women, babies and anyone who



tests 'HIV positive' - that is to say whose immune system throws up an antibody profile that tests high on the parameters set by one or other of the wide variety of HIV test kits on the market - have to take AZT, or a combination of so-called antiviral drugs. If they don't conform, there are penalties. In one recent case in Maine USA, a child narrowly escaped being taken into care because the mother refused to give it AZT after seeing her elder child die on it. In

another case in Oregon, an HIV diagnosed mother lost the right to breast feed her child. In addition, an official health visitor has to ensure every day that the child receives a daily dose of AZT syrup.

And now, here we were in Washington with lawyer Bob Beard and Deane Collie both of ICMJ, listening to this father tell us how his eight year old son had suffered muscle wasting, vomiting, and recurrent high fevers whilst taking AZT, so he had stopped it. Instead he gave his son a selection of vitamins, minerals and tonics (he can't quite remember which and asks his son to remind him) and look at him now! The boy smiles quietly to himself and continues with his drawing.

What had made the father take the dramatic step of going against the clinic's doctors, of risking alienating the health support structures around him and of challenging the wisdom of the entire scientific establishment?

"I saw my son dying before me," he said, "and now he is well."

When will this idiocy end? When will they stop trying to force medicine down people's throats? Medicine that is supposed to combat a putative virus, identified through a set of antibodies to proteins that are not specific to HIV and can be found in any one of us who might be at risk for different reasons?

By the way, the father in the skullcap is also 'HIV positive', has never taken an antiviral in his life and looks like a wrestling champion!

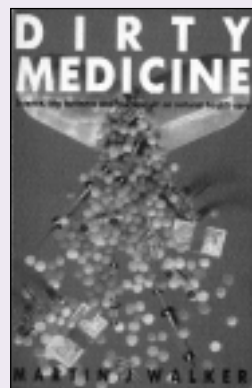
"Men like you we need in Aids research," admired **Dr Robert C. Gallo** (*far r.*) to **Dr Stefan Lanka** (*c.*), one of the younger Aids critics, at the Geneva World AIDS Conference last year. Senior Aids critic Gallo was among the earliest to discredit LAV (later named HIV) as a "laboratory artefact".*

* documented by the German parliament, Deutscher Bundestag, *Drucksache 12/8591 vom 25.10.1994, p.63*: "[In September 1983] at the Cold Spring Harbour Conference Dr Gallo...heavily attacked the French results and called them laboratory artefacts...".

[*"Dr Gallo..hat auf der Cold Spring Harbour Konferenz die franzusischen Ergebnisse hast angegriffen und sie also Laborartefakte bezeichnet..."*.]

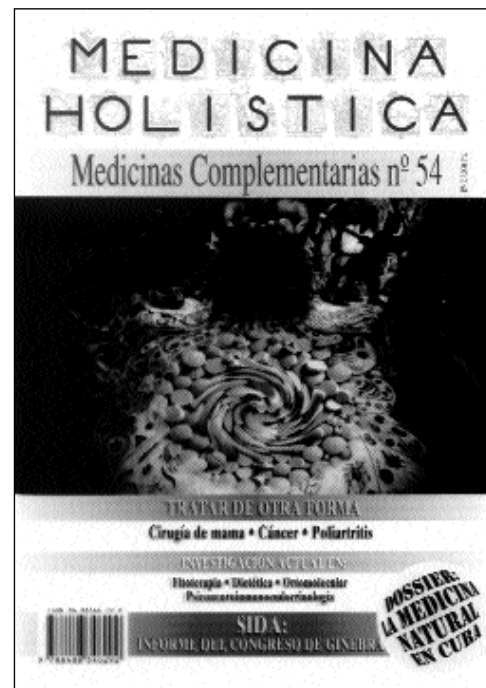


DIRTY MEDICINE



Since its first publication in 1993, *Dirty Medicine* by Martin J. Walker has been published in a second edition and has sold in total 7,000 copies. It has come to be regarded in some quarters as a reference source and handbook of research and writing method on pharmaceutical companies and the contemporary battle between allopathic and alternative and complementary medicine. Publishing the first two editions of the book has been costly for Slingshot Publications, the author's company. Now that the book is out of print, Slingshot is unable to publish a third edition and is looking for either a backer to finance a reprint and then distribute the book, or a publishing company to republish it. Anyone interested should contact Martin J. Walker at Slingshot Publications, BM Box 8314, London WC1N 3XX, UK.

Si te interesa recibir información actual, rigurosa sobre las medicinas complementarias y muy crítica con la medicina ortodoxa, colabora con la ASOCIACION DE MEDICINAS COMPLEMENTARIAS suscribiéndote a



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Prado de Torrejón 27, Pozuelo de Alarcón 28224,
Madrid, España
Tel: +34 91 351 21 11 Fax 351 21 71
amcmh@amcmh.org www.amcmh.org



Legal eagles at the ICMJ

Celia Farber interviews Deane Collie, Executive Director, International Coalition for Medical Justice

How would you describe ICMJ's main function?

ICMJ's primary purpose is to fight for the rights of consumers and parents to reclaim responsibility for their own health without government intrusion into the decision making. We insist on accountable scientific and medical research and try to help people make "true" informed decisions rather than simply trust the hypotheses set forth by the CDC and NIH. When that very basic right of the consumer is violated, ICMJ steps in .

How do you fight medical tyranny through the court system? Are there other ways in which ICMJ is helping to look for answers?

ICMJ provides a realistic alternative to the debate surrounding HIV and AIDS by taking the question out of the prejudiced scientific community and into the judicial system. We feel very strongly that the courts will recognize that science is, in its essence, subject to new ideas. With that in mind, we are helping people to fight the battle where it counts. ICMJ is also fortunate to be able to provide other ways to lend a hand: Tia's Triumph (named in honor of Valerie Emerson's daughter who died from toxic effects of AZT) provides research grant funds for scientists and clinicians who look for valid options to everything from alternative hypotheses to proving that testing mechanisms are faulty and unreliable. The Robert Leppo Education Initiative provides funding to promote media visibility and educational tools specifically targeted to inform the general public about viable scientific research and realistic options to standard drug treatments. ICMJ was pleased to announce earlier this year that Continuum magazine was one of the 1999 education grant recipients.

The ICMJ Legal Defense Fund affords patients, families and parents legal information, advice and legal funding when they have been stripped of their rights to have control over their medical treatment and when the right to informed consent has been abused by the government. The legal defense fund will also establish an initiative in the United States to hold all health departments and medical practitioners to standards as they relate to testing, the toxic effects of conventional treatment and the "true" cause of AIDS and other diseases and conditions.

What galvanized you and Bob Beard to devote yourselves to fighting medical tyranny?

Both Bob and I had worked for many years with mainstream ASOs (AIDS Services Organizations). I started

working actively when AIDS was called GRID - I had been a "buddy", Bob had spent

countless hours doing *pro-bono* work for PWAs - usually doing bankruptcy and wills and lecturing other practitioners about HIV and ADA law. We had both served on local ASO boards and had written newsletters and articles. Most important, over the last twelve years, we had watched good friends and good people die. AIDS wasn't new to us and like every other "thinking" person in the world, we believed the rhetoric about HIV as the cause of AIDS.

When we moved to Northern Virginia, we immediately started to investigate the various ways in which we could once again volunteer to help. On the same week that UVA hospital invited Bob to speak to a group of social workers and counsellors about HIV and ADA law, I picked up Peter Deuschel's book, *Inventing the AIDS Virus*. I couldn't put it down. All the rhetoric started to fall away and years of unanswered questions begin to resolve themselves, only to be replaced with new questions. "How could the government be successful in such a huge cover-up?" "Why isn't the public better educated so that they can make informed choices?" "We have lost huge numbers of gifted artists, musicians and other talented people in this world - all on a hoax!" and....."Is the government, now, forcing us to kill babies and little children - all in the name of health?"

I read through the night and woke Bob up. The conversation went something like this:

"Bob - you have to get up. I think we've been killing people."

"Deane, I haven't killed anyone. I'm going back to sleep."

He didn't go back to sleep.

Over the next week, Bob played "devil's advocate" as I answered questions with hard evidence from Peter's book, and Christine Maggiore's fine book *What If....*. At the end of that week, he was more than convinced. We both agreed that we felt an immense responsibility, an obligation in fact, to use our time and experience to help in some way. We called Peter's lab at UC Berkeley and spoke with David Rasnick. During several long conversations, we discussed the invaluable work that the Group, Alive & Well, HEAL and others had been doing and how we might fit in. We offered our help and experience in law, non-profit development and political action. David came to Virginia - ICMJ was born and our lives have changed forever.

What are some of the ways that you would define "medical tyranny?" What are some of the common situations you have encountered?

What a scary phrase, don't you think? Medical oppression, medical dictatorship, medical totalitarianism - these are the phrases we use every day with cases that are presented to us. However, it isn't isolated to just the medical community. "Medical tyranny" has become a tool for science, social services, mental health workers, ASO counselors and the judicial system as well. Parents are routinely charged with medical neglect and are legally separated from their kids simply because they refuse to inject their children with AZT. Kids are being literally torn from their parents' arms because Mom and Dad question risky treatments or ask for second opinions.

HIV positive employees are being refused the right to return to work unless they succumb to the treatment options that their employers subscribe to. Consumers are in danger of losing their health care coverage unless they agree to be tested. Pregnant women are being forced to leave their support systems during the last part of their pregnancy and resort to an "underground railroad" just to ensure the right to keep their newborn child.

People are led to believe that the CDC and NIH are the only authority responsible for providing scientific research and treatment guidelines for a myriad of diseases and conditions. As those "guidelines" are transferred to the medical community, they very easily become "mandates" for standard of care. The minute a parent questions that standard of care for his/her child, a report is filed with child protective services. If the parent refuses treatment, or even hesitates, the state intervenes "on behalf" of the child, charging the parents with abuse or neglect. If they "catch" Mom during labor and delivery, she is given mandatory doses of AZT during labor and the child, no matter what the status, is given mandatory doses of AZT. If the parents are lucky enough to retain physical custody of the baby, the state administers the AZT in the home, sometimes in the presence of a guard. Mom and Dad have no choice, but to stare in horror as their new baby is poisoned.

How many cases have you taken on so far, and how do you prioritize?

Since we opened in March of this year, ICMJ has had requests from 43 people from all parts of the United States as well as from Canada, Europe, Australia and Africa. Because of funding limitations, we have actively been involved in 11 cases and have been instrumental in preventing legal interference in a half dozen more. We take a case based on it's merits in several different areas. Bob Beard reviews the case in terms of the actual abuse of consumer or parents rights, interference by social services, malpractice or ethical misconduct, and finally, whether the case is viable in terms of a positive decision. Priority is always given to those cases that are life threatening or involve the removal of a child.

Is there any other organization that comes close to ICMJ's function that you know of?

Certainly, there are many fine groups all over the world that are doing pieces of the work that we do. I am not aware of another organization that can act as an "umbrella" to provide the types of services that ICMJ does.

How did you think of the name?

This name was a true labor of love, blood, sweat and immense amounts of laughter. At one point, I think David and I traded emails about a name something like "The Alliance to Wake Up Those *%\$#@s at the _____ - (fill in

the blank with whatever you choose : CDC, NIH, any mainstream medical journal, etc)"! Seriously, I think we are all quite tired of being viewed as "dissidents" and "crazy people". We wanted to promote the idea that we are very much "citizen trustees" - seeking truth, nurturing people, providing real options and, most important, insisting on scientific and medical accountability through the judicial system.

How is the need for ICMJ "international" and how is it localized to the United States?

We are receiving calls for information and referral from all over the world with cases specifically involving toxic and risky therapies and the need for more information regarding the true causes of disease. Many of those calls involve some entanglement with the judicial system. The glaring differences in the calls from the United States are the overwhelming cases involving immediate government interference with regard to treatment and the abuse of the system in removing children and separating families. It is reminiscent of W.W.II Germany in many ways.

What do you think is going on right now, culturally and socially, that has created the conditions ICMJ opposes? What are the main forces?

We have evolved into a very sick society where c o m p l a c e n t bureaucrats are coupled with tame judges and physicians far too arrogant to admit that they make mistakes. Pair that with consumers who still view doctor as "God" and are frightened into submission, and you have a perfect prescription for "medical tyranny". The media has played such an important role in both creating fear and making it fashionable to be an activist in this entire AIDS scandal, that the CDC and NIH have had to do very little work in providing substantive answers to bad research. It is an ethical crime that they haven't given equal time to challenging opinions. The pharmaceutical companies expect that we are as shallow as they are and that we will buy into their false advertisements without reading the fine print. We are so oriented, as a society, to equate knowledge with wisdom and we have been conditioned to accept without questioning. But, I see that changing because we

Photo : courtesy of Deane



Deane Collie, Executive Director, International Coalition for Medical Justice

are also a society that insists, more and more, on instant gratification. We can't get answers from the lofty authorities because they answers just aren't there. So, we are learning to think again. Questions are being asked. Finally.

What kinds of people do you expect to attract, (or have attracted?) Right wing? Left wing? Libertarian? Perhaps none of the above. Can we say anything about how this fits into the political landscape?

The fact that people are beginning to question medical and scientific authority is inherent to what every person feels is their basic right: to have decision making in their choice of health care without government intrusion. This very fundamental privilege transcends any political party or agenda and includes the politics of all people. Republicans, Democrats, Libertarians - all subject to losing their jobs, losing their kids, losing their lives.

Surely you hear horror stories every day. Tell us about one that particularly affected you.

There are plenty of horror stories from which to choose. I could tell you about the young child who was hit by a car and was given an HIV test because of a needle prick - test came back positive and the arrogant doctor informed the terrified Mother that the child must have been a victim of sexual abuse. The test was repeated and came back negative this time - but not before Mom had been terrorized. I could tell you about the HIV+ pregnant Mom who had social services and the police chasing her, who had to deliver her baby with strangers in a strange house and has had to leave the state in fear with her newborn. I could tell you about the Dad with nine children who tested positive while he had the flu and has been refused the right to return to work until he submits to drug therapy - how do his kids eat? I could tell you about the Mom whose child is in her sixth foster home and was taken from Mom under armed guard when her Mother simply questioned the benefits of therapy. There is a litany of cases like these. I feel passionately about them all. Perhaps the scariest case, though, involves many people in a large area of the United States. A clinic in that area has been taking grant funds from the CDC in exchange for horrific clinical trials, subjecting many young kids to toxic drugs with horrifying effects - muscle wasting, speech deformities, eye disease. The surreal part, however, is that the atrocity is about to strike again. This

clinic is due for a second round of funding in exchange for yet another trial. This time they have actually isolated a "target" group - babies of "trick" Moms, or Moms who use IV drugs. This clinic doesn't have any grand plans for studying these children. In fact, these babies were isolated because they are "expendable". The reasoning being that "these Mom's would be lousy parents anyway, so if the babies die during trials, well.....". Tuskegee, come to mind? How about Hitler?

What population or populations do you see as being most vulnerable to medical tyranny?

Surely, people who are disenfranchised are much more likely to become victims in the court system - folks with no money cannot access adequate legal help. Their rights are stripped quickly and the process for them is more lengthy. African Americans are 3 times more likely to have their children taken away and those kids are kept in the system much longer. People without private insurance, who have no option in their choice of physicians, are more likely to be subjected to risky therapy in order to keep their jobs or insurance. But, don't feel too safe. Many, many cases which have come to us have been middle and upper class folks who have been put into jeopardy - at least they WERE financially stable before the nightmare. Many are in dire financial straits after legal expenses - a situation which only provides extra ammunition for the courts.

Is there hope for the future? Can ICMJ really make a difference?

ABSOLUTELY. There are more and more people and groups opening their minds to this much more acceptable way of thinking. I see Kai Thorup and his group of Students Reappraising AIDS who are questioning - Christine Maggiore and Mothers Against Mandatory Medications make a dramatic impact in many different arenas - new members at HEAL, new groups in London, activists galvanized in France and Alive and Well groups springing up in small towns. ICMJ is an integral part of educating the broader public by taking what has been a scientific debate into a public arena. We have already made a difference - case by case, town by town. And one day, I envision a time when HIV goes on trial by default and dissidents are dissidents no more.

The Effectiveness of *Coriolus Versicolor* Supplementation in the Treatment of Kaposi's Sarcoma.

J. Tindall and E. Clegg

Gateway Clinic, Community Health, South London NHS Trust, 108 Landor Road, London SW9 9NT England.
Mycology Research Laboratories Ltd.

Poster 8.16 - Submitted to the 10th International Congress of Mucosal Immunology, June 27-July 1, 1999. Amsterdam, the Netherlands.

[Excerpt]

"...Aim of Study

To assess the efficacy of non-fractionalized *Coriolus versicolor* supplementation in HIV+ patients with Kaposi's Sarcoma...

DISCUSSION

There were positive signs in the study, with the partial remission in Kaposi Sarcoma for all three (3) patients, at *Coriolus* supplementation levels equal to or greater than 6 grams per day. In addition, all patients noted increased energy while taking supplementation as compared to not taking *Coriolus* supplementation. With the cessation of *Coriolus* supplementation, the relapse in Kaposi's Sarcoma symptoms in three patients may indicate that supplementation nutrition may play a role in host mediated immune response.

Taking into account the limitations of such a small sample size, we have a curiosity. Further research is required to confirm that

Coriolus versicolor supplementation at 6.0 grams or higher is an effective adjuvant nutrition therapy for HIV+ patients with Kaposi's Sarcoma. Future studies should consider incorporating a gradual increase in monthly *Coriolus* supplementation, from 3.0 grams, to 6.0 grams to 9.0 grams, with 9.0 gram/day supplementation level reached in the third month of supplementation period...

A supplementation reduction to 6.0 grams per day should be considered to test if host-mediated response could be sustained with lower supplementation levels. We invite other researchers to explore the hypothesis that *Coriolus versicolor* plays a role in initiating host-mediated response...

CONCLUSION

The results of this open label study indicate that non-fractionalized *Coriolus versicolor* supplementation could be an effective nutrition adjuvant for HIV+ patients with Kaposi's Sarcoma..."



UNAIDS targets "denial of the existence...of HIV"

International Forum for Accessible Science (IFAS)

Secretary General: Michael Baumgartner, Switzerland

Chair Board of Scientists
Eleni Papadopulos-Eleopulos
Biophysicist
Perth, Australia

Chair Public Access Board
Karen Parker
Human Rights Attorney
California, USA

Bern, 12th May

1999

[Open letter](#)

Dear Mr. Piot,

It has been brought to our attention that you intend "to counter the denial of the existence or threat of HIV, and prejudice and discrimination against those infected", as issued in the UNAIDS Policy Statement HIV And Infant Feeding, Guidelines For Decision-Makers WHO/FRH/NUT/CHD/98.1.

As an international educational human rights organisation in the fields of medical science and practice and health we too, fight prejudice and discrimination against those living with either a so-called hiv-positive test result or aids. When a mother labelled 'hiv+' is forced to refrain from breast-feeding and to administer highly toxic drugs to her infant, then such prejudice and discrimination comes from within the aids-establishment.

IFAS, having a mandate in aids - although with no commercial strings attached - is still waiting to receive the proper scientific data for both 'hiv-isolation' and 'hiv-aids-causation' which has been promised by UNAIDS since 1993 on many occasions yet never made its way to our office. Hence, we are as ever interested to learn just how you plan "to counter the denial" as mentioned above. As an international organisation reaching into national, and phrasing international, policies on aids, it must be easy for you simply to refer to the proper scientific references.

Viral isolation and disease causation are a matter of scientific proof. As a science-bound human rights organisation IFAS relates its actions to, and requests, such proof from public policy making organisations such as UNAIDS. If no scientific basis is given to "counter the denial" - as promulgated by your organisation - it could easily lead to some sort of religious warfare, wherein simply belief is requested. Surely this cannot be the practice of UNAIDS? IFAS, therefore, asks for the scientific data which form the basis for your actions including the intent "to counter denial of the existence...of HIV". If UNAIDS still refuses to lay such bases open, you would directly contribute to further hostile environments for human rights defenders, health activists and people living with the 'hiv' label, who demand scientific facts - the only acceptable basis for current aids perceptions and policies. In our view this is the only way to responsibly counter any denial.

It is in your hands to responsibly deal with the issue of scientific dissent on 'hiv', the alleged virus suggested to cause aids, and aids. While time certainly will reveal truth for history to record, people's lives depend on scientific clarification now.

As an independent NGO we ask the publicly funded UNAIDS, again, please to lay open the scientific references on which you base your actions.

In anticipation of such long awaited information we remain

Yours sincerely

Secretary General

HIV and Infant Feeding Guidelines for decision-makers

WHO/FRH/NUT/CHD/98.1
UNAIDS/98.3
UNICEF/PD/NUT/(I)98-1
Distrib.: General
Original: English

Reprinted with revisions, June 1998
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[...]
Information, Education and
Communication (IEC)

An IEC campaign aimed at encouraging awareness and public debate about HIV and infant feeding issues should have the following aims:

- to move beyond simple messages of prevention that tend to reinforce the image of HIV/AIDS as a "no hope" disease
- to counter denial of the existence or threat of HIV, and prejudice and discrimination against those infected...

Call for letters

The International Forum for Accessible Science is calling for readers to write to Peter Piot, Director, UNAIDS, requesting the scientific validation for his agency's campaign to counter denials of the existence of HIV. In an open letter (see this page) delivered to the Director, Michael Baumgartner asserts such scientific information "is the only way to responsibly counter any denial".

Peter Piot,
Director, UNAIDS,
20, Avenue Appia,
1211 Geneva 27,
Switzerland
to encourage an open debate.
• IFAS email-
michubaga@access.ch

Protective Stupidity

2 : The Social Function of Self-Deception



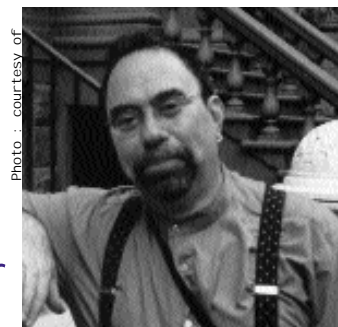
Thank God It Could Never Happen Here

Imagine that in some parallel universe, let's say Planet X, everyone's freedoms and responsibilities have been surrendered to the Corporate State - and everyone calls it "democratic";

a society where everything is backwards and upside down, where doctors destroy health, psychiatrists destroy minds, lawyers destroy justice, the major media destroy information, governments destroy freedom and religions destroy spirituality - yet it is claimed to be healthy, just, informed, free and spiritual; a social system whose community, wealth, love and life is derived from alienation, poverty, self-hate and medical murder - yet is supposedly biologically and ecologically sustainable?

Hypnosis 101

Faster than the speed of thought, more powerful than any logic and able to bend the course of mighty observations, the self-deception reflex (SDR) is unconsciously activated every time we attempt a creative thought or act. It automatically shifts into high gear every time an entranced person is in danger of noticing his or her trance. It is this instinctive impulse to ignore, reject, modify and/or deny anything and everything that is in conflict with one's pre-programmed world view, that self-hypnotises and makes it almost impossible for an unknowingly hypnotised



Michael Ellner

individual to appreciate that he/she is in a trance. When it comes to "self-hypnosis", no hypnotist or induced trance is needed; we are already unknowingly hypnotised.

If the people in our imaginary society were unaware that they were hypnotised slaves, how could they liberate themselves? It's impossible to know that you are participating in a collective nightmare if you are unaware that you are asleep and dreaming in the first place, especially if the "dream" both depends upon and simultaneously works to disguise the self-deception reflex. Imagine the many different ways that the social and cultural trances that enslaved them could be deepened with any of a variety of anxiety-provoking situations every day of their lives. (Thank God it could never happen here).

Protective Stupidity In a Nutshell

The folks on Planet X unconsciously know that direct consciousness of the harsh reality of life on Planet X would be emotionally devastating, and so protect themselves by hypnotically deceiving themselves. Back on Earth, the social visionary George Orwell wrote about fictional people who were oppressed by their big brothers and called the equivalent affliction of self-deception "protective stupidity".*

Stripped of their imaginary shields, the little brothers and sisters on Planet X would not only be forced to let go of their cherished myths and fabrications, they would also be forced to take responsibility for cleaning up the mess. But instead, they unknowingly hypnotise and re-hypnotise themselves to police their thoughts, feelings and, of course, each other by instinctively ignoring, rejecting, modifying and/or denying everything and anything that threatens exposure of the self-deception (We are so lucky that we don't have to think about such things).

The Social Function of Self-Deception

Now let's shift these dynamics to the social realm. Here too the social and cultural trances these tortured people collectively slip into serve powerful survivalistic and anxiety-regulating functions, but on the "group level". On this level, the fantasy "they are free" would, once effectively exposed as a fantasy, be socially devastating. Stripped of the shield of self-deception one is faced with a profoundly different world view of freedom and social responsibility, a view which painfully demands nothing less than a dramatic shift in self-perception. (Thank God we don't know from such things)

Better Red than Dead on Planet X

Here, the collective imaginary "Red" menace (before the Cold War ended on Planet X those pesky, "evil Russians" were a constant threat) was eventually replaced by a much

more insidious, individual and equally imaginary viral menace. The social function of the viral menace too is to scapegoat all the social problems in the X-er's lives, with just enough hysteria to induce the dreaded cleansing ritual.

Welcome to the AIDS ZONE

The AIDS Zone is the ultimate protective group-fantasy trance within many other social and cultural trances. The AIDS Zone is the empty little self-hypnotic box in which HIV=AIDS, AIDS is always fatal, poisons prolong life and the doctor knows best.

Socially, the AIDS Zone enables folks to ignore the psycho-physiological consequences of the destructive social realities on Planet X. Thankfully, no one on the planet has to deal with messy little things like sexual terrorism, alienation, isolation, homophobia, racism, poverty, malnutrition, self-hate, medical murder, drug use and/or slavery.

Economically, the AIDS Zone justifies the multi-billion dollar AIDS War industries which reinforce, through their mystery, the manufactured belief that the folks on Planet X need to invest in medical experts, Public Health operations and chemotherapies of mass destruction to protect themselves.

Epidemics of Hysteria and Parallel Universes 102

The AIDS Zone is a formidable killing machine on Planet X because seductive and titillating triggers like sex, anal sex, the threat of sexual transmission, disease, death and drug use automatically tap into and hypnotically amplify any and all hysterical and "hyper"-hypochondria tendencies. Here, normal flus, colds, etc., i.e., symptoms perceived by themselves and others as AIDS-related symptoms, *actually do* become life-threatening as they take on an imaginary life of their own. Every day that the X-er's are trapped in the Zone, the subliminal-hypnotic commands to get sick and die which are embedded in every communication they receive about HIV/AIDS becomes more potent. The push for vaccines, prenatal testing, notifiable diagnosis, enforced drugtherapies, contact tracing and the ever present threat of quarantine and segregation make the imaginary monster more frightening. Potential symptoms magically appear every where the X-er's focus their attention. Psychogenic symptoms are unconsciously generated as the X-er's invest more and more time and energy into the belief that they are very sick and dying, until getting sick and dying becomes the only thing they can think about.

X-er's who believe they are contaminated by "HIV" are being exterminated by lethal doses of alienation, isolation, homophobia, racism, sexism, poverty, malnutrition, selfhate, toxic medications and drug use, all the stuff that their self-deception reflex protects" them from noticing. Their self-deception reflex obscures the social pressures and the intense, chronic hysteria, depression, anger, shame, guilt and the life styles they engender, which are the true causes of their so-called opportunistic diseases. (Thank God something like this could never happen here).

How Could Something Like This Happen?

The social engineers and behavioural scientists working for the unseen military/industrial-medical complex that ruled Planet X erected their imaginary killing machine with a press release. Under the cloak of "science" and "public health", the murderers at the National Institutes of Wealth warned health officials, doctors and the public that a new sexually transmitted monster was threatening to kill everybody on the planet. Their guardians of (mis)-information repeated the message over and over until everybody was sure they were at risk.

Since everybody on Planet X was already pre-conditioned to believe what they read in the *New York Times* or saw on TV, especially when nine out of ten experts agree, it was relatively easy to convince those gullible folk on planet X that sex=death. After all, the X-er's had been unknowingly programmed to surrender their power to experts, germs and other government officials who know what's best for them, and they unconsciously depended on these authorities to help them tune out those painful realities.

Put simply: X-er's believed in the entity of AIDS through the mechanisms of brainwashing, protective stupidity and the social function of the deception.

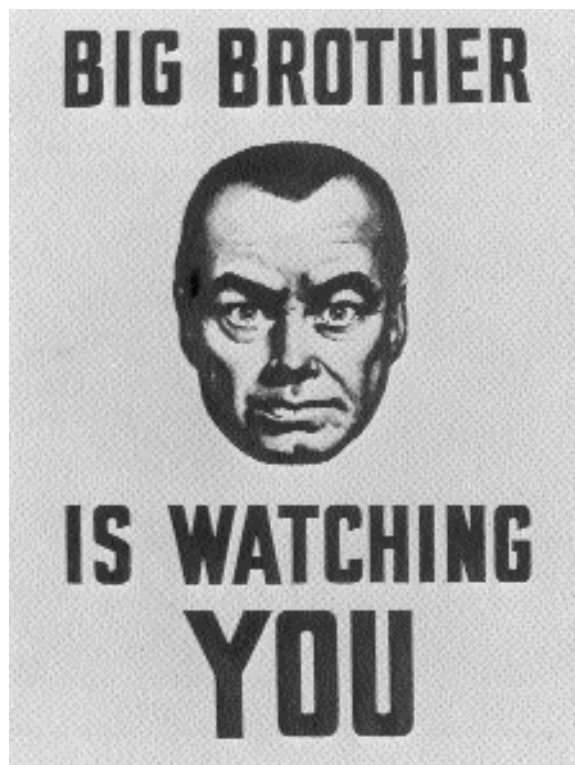
From there it was simply a matter of everybody mindlessly acting out their preconditioned roles. X-er's who test virtual HIV+ get sick and die; X-er's who are doctors test for an antibody, make healthy people sick and sick people die, and then blame the virus; X-er's who are gay AIDS activists insure that unproven treatments get into

everyone's body and that everyone wears a condom as if everyone's at risk, AIDS organisations on Planet X deliver HIV+'s to the pharmaceutical ovens and silence anyone who questions the insanity; and X-er's who are not in any of these groups wear a red ribbon, a latex condom (sometimes) and act like they care.

Understand that the "AIDS crisis" on Planet X is a high-powered hallucination fuelled by sexual terrorism, enforced by medical genocide and maintained by self-deception. It all serves to keep X-er's from knowing what's truly going on in their world. The rampant death and subsequent social cleansing artificially absolves everyone of the repressed tensions generated by the preexisting social conditions on Planet X. Meanwhile and more importantly they

simultaneously help in evading the harsh realities which gave rise to both AIDS and the need for self-deception in the first place.

The "Glaxo Wellcome" of their world thrive on this kind of ignorance, while the bigger vested interests continue to maintain and profit from the very psychospiritual/sociopolitical and economic abuses that poison their air, their water, their lands, their foods and finally their hearts, minds and souls.



Poster from the film 1984

Meanwhile Back on planet Earth

We are facing a "real" viral epidemic, one which threatens to wipe out a huge segment of the world's population. Thanks to the many billions of dollars of research funds we have 'donated' for our defence, the best medical minds in the world are on the job and we can count on them to save us. The National Institutes of Health had already identified the sexually transmitted viral culprit and as long as we don't have or think about extra-marital sex, anal sex or share needles when we inject drugs, most of us are safe.

Nevermind that there are no standard references that scientifically demonstrate that AIDS is infectious, or that testing "HIV" positive is proof of infection. Nevermind that the "AIDS definition" is a deceptive and phoney medical construct. Nevermind that the hallmark of AIDS - Immune Deficiency as measured by CD4 T cells - itself is problematic and evasive in that it calls attention to a physiological phenomenon that occurs after the fact. Nevermind that it is practically common knowledge that T-cells do not, I repeat, do not correlate to disease progression and death in people with HIV/AIDS, as was dramatically demonstrated in the longest and largest study to date (the 1993 Concorde study).

Nevermind that fifty percent of current "AIDS" cases are comprised of people with nothing more than these so-called T-cell deficiencies, people who don't, I repeat, don't actually have "AIDS" indicator diseases. Nevermind that within the social risk groups developing so-called AIDS indicator diseases there are well known, common, non-infectious factors which can easily explain why these people are getting sick, namely, the "risks" themselves: IV drug users; among a select subset of gay men in the late seventies and early eighties there were at least two significant health risks - 1) repeated sexually transmitted diseases which were already treatment resistant because of the indiscriminate "preventative" use of antibiotics, and 2) also in this same subset of gay men there was a heavy and unprecedented use of oral aphrodisiacs and other "recreational" drugs, particularly "poppers"; in haemophiliacs and blood recipients, the preexisting condition along with its treatment alone are high-risk factors; and then there is the iatrogenic risk group, the people using AZT, "anti-virals", protease inhibitors and "preventative antibiotics". Nevermind that the people who are developing these opportunistic conditions are developing symptoms that are unique to the different health risks which are unique to each group. Nevermind that hundreds of thousands of lives have already been cut short, and hundreds of thousands more await a similar fate. Which brings me to a very unsettling paper written by the late Earthian psychohistorian Casper Schmidt, MD, published in 1984**.

Dr. Schmidt offered considerable evidence that there are many unconscious motivations for embracing "infectious" group fantasies like "HIV" to explain the AIDS crisis, motivations that are analogous to earlier societies that used "poisoned blood" fantasies and epidemic



hysteria in their attempt to unconsciously purge their social body of poisonous feelings. Does anybody remember the "witch hunts" on Planet X?

The Only Way Out is Tuning In

We live in a society that is built on self-deceptions and this crucial factor of denial and self-deception is the only thing keeping people stuck in the AIDS Zone.

For example, if we allow ourselves to notice that the "HIV=AIDS=Death" construct has been profoundly discredited, even for a moment, we would be at risk of seeing that what we have here is the deadliest fraud in history, a fraud that is woven into and a direct expression of the abusive social system we participate within. Not to mention the attending crimes committed by a multi-billion dollar transnational government/ medical/ pharmaceutical industry which, by way of this terrorism and genocide, feeds off the lives of disenfranchised (i.e. "undesirable") citizens.

In addition to appreciating the nature and scope of the social conditioning and mass hypnosis that rules our lives, we must first admit to ourselves that we can be hypnotised and programmed on how to live and die without our knowledge or consent. We must also understand that

rather than being free to meet our natural and life fulfilling needs, that we are caught up in the unconscious needs of a group that is grossly malnourished spiritually, emotionally and physically, and thus insane. We must appreciate that we are in the midst of a tremendous unconscious push for freedom and the self-regulation that defines it. So, the choice is there. We can tune in and escape from the AIDS Zone any time we sense that we are in it. Or we can just continue to pretend that "HIV=AIDS=Death" and that we are free to live healthy, just, informed and spiritual lives.

Michael Ellner is an AIDS Zone de-programmer who lives and works in New York City. He is a driving force in alternative health-care and has earned international recognition as the President of HEAL (Health Education AIDS Liaison, Inc.). A prominent hypno-healer, Ellner has received many honours including his second National Guild of Hypnotist's Hypnosis Humanities Award (1989 & 1994). Michael received the International Medical and Dental Hypnotherapy Association's highest honour - the Founder's Award - for excellence in hypnotherapy. In 1995 he was the National Guild of Hypnotist's Educator of the Year and inducted into the International Hypnosis Hall of Fame. He also received the National Federation of NeuroLinguistic Psychology's 1997 Educator of the Year Award. His new book *Quantum Focus*, co-written with Richard Jamison, PhD is being hailed by leading Mind/Body experts. He can be reached c/o HEAL, PO Box 1103, Old Chelsea Station, New York, NY 10113, USA, or by phone 212-873-0780 or E-mail: revdocnyc@aol.com

* George Orwell, 1984

** Originally published in the *Journal of Psychohistory*, Summer 1984, and republished as the centre piece of essays on the psychodynamics of AIDS in *The AIDS Cult - Essays on the Gay Health Crisis* edited by John Lauritsen and Ian Young, 1997. I highly recommend you read this very insightful book.

Activating an Alternative anti-aids Archive



Alex Russell MA

Continuum's dissenting disclosures are an explosive arsenal of anti-aids-war articles, files, letters and posters soon publicly available for reading between the li(n)es.

"To an extent that undermines classical standards of science, some purported scientific results concerning 'HIV' and 'AIDS' have been handled by press releases, by disinformation, by low-quality studies, and by some suppression of information, manipulating the media and people at large. When the official scientific press does not report correctly, or obstructs views dissenting from those of the scientific establishment, it loses credibility and leaves no alternative but to find information elsewhere."

Prof. Serge Lang, *Challenges*, Springer, 1998.

Excavating an 'anti-aids' Heterotopian Archive

The concept of *heterotopia* is of a relatively segregated site in which several heterogenic spatial settings coexist simultaneously. Continuum's library-archive is such a heterotopian zone where two textual-spatial-grids (dissident *anti-aids* and official *aids* discourses) reside within the confine of the site. By containing *both* discourses our *heterotopian archive* constitutes an 'interface' of contesting knowledges. The concept of 'interface' conveys the image of a 'face-to-face' encounter between bodies of knowledges and how these 'grids of specification' intersect/interact. The *heterotopian archive* becomes a microcosmic zone (a 'space of configuration') representing the *field of struggle* between these dissenting/contesting counterforces and dominant/orthodox forces within the 'hiv/aids' field. Thus activated, our *anti-aids* and *aids* archives become a living history and testimony where this configuration of competing and conflicting knowledges collide and clash in combat. The immediate juxtaposition between heterogeneous 'anti-hiv/aids' discourses and the totalizing 'hiv/aids' discourse documented and represented in our *hetero-habitus* will ignite in the reader a sense of conflict and hopefully instigate an opening for critical debate.

The heterotopian archive houses *anti-aids* books, files, letters, campaign leaflets, dossiers, posters, and 'aids' dissident articles from *Bay Area Reporter*, *California Monthly*, *Diario 16*, *Echo*, *Genre*, *Icon*, *High Times*, *Index on Censorship*, *Insight*, *Lifeforce*, *Medicina Holistica*, *Mothering*, *New African*, *New York Native*, *Ode*, *Open Eye*, *Prism*, *Raum & Zeit*, *Reason*, *San Francisco Bay Times*, *San Francisco Sentinel*, *Skeptic*, *Spin*, *Sydney Star*



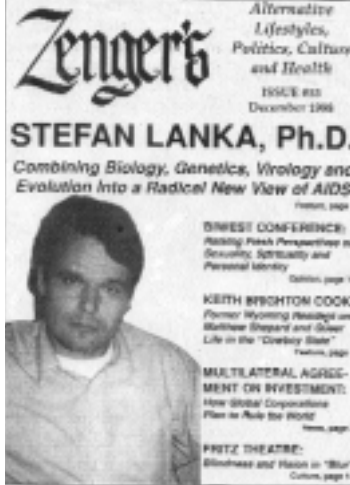
Observer, *The Big Issue*, *The Daily Californian*, *The European*, *The Times*, *The Sunday Times*, *The Uncensored Times*, *Thud*, *Zenger's*.

Those first engaging with the arsenal of activated *anti-aids* articles will be momentarily shell-shocked by a bombardment of intellectual shrapnel that cuts deep into the cancerous organs of the 'aids' body politic; explosive critiques that combat the 'comforting lies' of mindless 'hiv/aids' beliefs which stem from subservient science journals and the mimetic mainstream mass media. We hope our *hetero-house* offers an *aids-free-zone* where a re-learning, re-thinking process can flourish; and a forum for deprogramming/rehabilitation for those who have become indoctrinated by the 'hiv/aids' *death-drive* occultist-group fantasy-trance (what Michael Ellner aptly calls the 'AIDS Zone'). Even so, Continuum's archive houses many HIV™ Propaganda publications including: *AIDS Treatment News*, *Axiom*, *Equilibrium*, *Living Room News*, *News Line*, *Poz*, *Positively Aware*, *Positive Nation*, *Positive Times*, *Provincetown Positive* - pointing readers to the ramps of the combo-cocktail cleansing chambers: *send in the clones*. The ghoulish editorials in *POZ* by Sean O'Strub reveal HIV™ Propaganda to be a vulgar mixture of revolting sentimentality, mimetic-desire disease(d)-identity politics, psycho-sexual terrorism and *mock-epidemic* hysteria. This auto-genocidal 'hiv' authoritarianism emits a lethal form of 'symbolic violence'. A *Positive Nation* editorial (July-August, 1997); 'power to the (positive) people' exemplifies the 'symbolic violence' of

homofascist 'hiv' blood-brotherhood occultism - what Julia Kristeva calls "the homofascist community of which there is no other race" - with rhetoric worthy of Mussolini:

"We now have our own HIV revolution and can learn from the history of those old liberation movements to help us develop a modern philosophy of self determination for the new era."

Those tested 'positive' who have an 'authoritarian personality' are archetypes for the 'hiv' homofascist movement: willingly participating in auto-iatrogenocidal slaughter (Jonestown-style). With such a hermetically sealed 'hiv' homofascist totalizing discourse we have entered madness because any critique of this pernicious 'hiv' patriarchy is perceived as abhorrent by the community of proto-fascist positive people and their



authoritarian allies. To contest this conformism and closure, publications such as *Continuum*, *Viral Resistance*, *HEAL Bulletin*, *Death Camp*, *MuM*, *Reappraising AIDS and The Daily Plague* were initiated. *Viral Resistance* (10 September, 1997, Vol.1, Issue 1) - 'Confronting the lies, challenging the hype, and overcoming the fear of the HIV to AIDS theory - a newsletter from ACT UP San Francisco' commented on how the gay media have been bought-off by 'AIDS Inc.' :

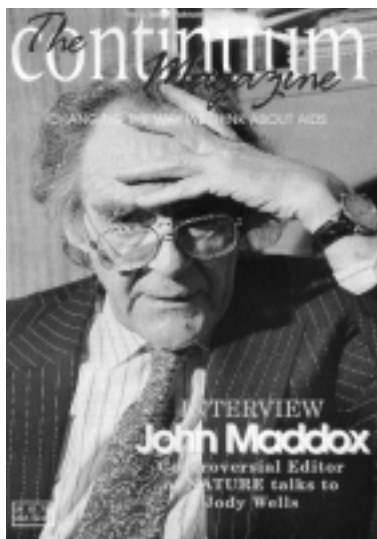
"The queer media, bought off by drug company multicoloured full page ads, has presented a biased and unscientific albeit profitable view of AIDS. Unable to question their donors, blood stained editors suppress any dissent. We give voice to those questioning AIDS Inc. and the oppression, greed, fear, deathworship, pitying, cronyism and profit it represents. Silence still equals Death."

Exposing Corrupt Science Journal Editors

"The AIDS research establishment are responsible for this tragedy. The marketing of HIV, through press releases and statements, as a killer virus, has so distorted research and treatment that it may have caused thousands of people to suffer and die."

Dr. Joseph Sonnabend, *The Sunday Times*, 17 May 1992

The archive contains letters from scientists/activists to *The Lancet*, *Nature* and *Science* whose editors' point of view in the 'hiv/aids' field is strictly settled, sealed and situated as orthodox and monotheistic. The major science journals have *invested* in propagating the 'hiv' paradigm as the *official game* in this contested *field of play*. Science journal editors represent the institutionalised site where they are situated as authorised agents of 'aids' discourse, thus sanctioning the 'hiv' paradigm as the authenticated *game of play*. Sociologist Pierre Bourdieu states, "Each field calls forth and gives life to a specific form of interest, a specific *illusio*, as tacit recognition of the value of the stakes of the game and as practical mastery of its rules. Furthermore, this specific interest implied by one's participation in the game differentiates itself according to the position occupied in the game (dominant vs. dominated or orthodox vs. heretic) and with the trajectory that leads each participant to this position...As a space of potential and active forces, the field is also a *field of struggles* aimed at preserving or transforming the configuration of these forces." The stakes are *high* in protecting and reproducing the profitable 'hiv' polity because so many (Curran, Fauci, Francis, Essex, Gallo, Ho, Montagnier, Shaw, Tedder, Weiss, etc) have had long-term *vested-stakes* in rigging and maintaining the 'hiv' poker game (at all costs). These *aids-players* have placed their bets on the 'hiv' casino-economy where cheating *always* ensures lucrative pay-outs. As the dominant players, they *gamble* with the 'hiv' game "only insofar as their interest in following it outweighs their interest in overlooking it." (Bourdieu). And since journals like *Nature*, *Nature Medicine*, *New Scientist*, *Science*, *Scientific American*, *British Medical Journal*, *NEJM*, *JAMA*, and *The Lancet* have had *high stakes* in gambling the rigged 'hiv' game (in a deplorable way) for so long now they can hardly do a *volte face* and confess to a gross-error of misjudgement; since such an admission would damage their scientific credibility. So these science journals will have to hold-out as long as possible in trying to salvage the 'hiv' fraud in order to save-face and fortune. They have to keep (what Duesberg calls) *moving the goal posts* or *change the rules of the game* in order to extend the 'hiv' casino's gambling licence. Examples of this desperate 'hiv' subterfuge salvaging farce are to be found in fraudulent papers published in



Nature by: Michael Ascher *et al.*, (11 March, 1993); Giuseppe Pantaleo/Anthony Fauci *et al.*, (25 March, 1993); Sarah Darby *et al.*, (7 September, 1995); Feng Gao/Beatrice Hahn *et al.*, (4 February, 1999); and the articles by Xiping Wei/George Shaw, *et al.*, and David Ho/Martin Markowitz *et al.*, (12 January, 1995) - all of which should *never* have passed the peer-review process. Yet astonishingly these invalid papers are still being invoked by the 'hiv' faithful to maintain the fraud.

Concerning the Ascher *et al* 'Commentary' article: 'Does drug use cause AIDS?', *Nature* (in a pre-emptive strike) had the affront to issue a press-release hard-selling the 'Commentary' a week before it was published! Regarding this scandalous hype, Prof. Serge Lang wrote: 'To the Council, National Academy of Sciences' (20 March, 1993):

Numerous members of the press started calling Duesberg to get his comments on the forthcoming article in *Nature*, but the article had not been available to Duesberg...He received a copy from *Nature* only on 9 March. Thus does *Nature* and the authors of the article use the media to manipulate public opinion before their article has been submitted to the scientific scrutiny of other scientists, especially Duesberg who is principally concerned...I wish to warn you here against Maddox's unscientific, irresponsible and manipulative journalism.

Duesberg wrote to *Nature* pointing out the logical-holes in the Ascher article but Maddox not only refused to publish his letter but had the audacity to advertise the censorship in a vindictive full-page editorial entitled: 'Has Duesberg a right of reply?' - part of which read (*Nature*, 13 May, 1993):

Whatever Duesberg's friends say, the right of reply must be modulated by its content. Duesberg will not be alone in protesting that this is merely a recipe for suppressing challenges to received wisdom...When he offers a text for publication that can be authenticated, it will if possible be published - not least in hope and expectation that his next offering will be an admission of recent error. John Maddox.

An Editorial from *The New York Native* was mortified by Maddox's malevolent manoeuvre (31 May, 1993):

John Maddox, *Big Brother: The latest attempt to silence Duesberg comes from the man who thinks he is England's Queen Mum of Science: John Maddox, the editor of Nature magazine. Several weeks ago, a study was published in Nature which was supposed to destroy Duesberg's hypothesis about 'AIDS'. Duesberg wrote a response and sent it to Nature. Maddox is refusing to publish it. Duesberg was attacked and Maddox is refusing to let him defend himself. Rather than just publish Duesberg's letter, Maddox spent an entire page of his over-rated scientific journal telling his readers why he would not publish Duesberg's reply...If Duesberg chooses to recant his position, this fascist pig will be only too glad to publish his letter...if it can be authenticated. This is just one more indication that 'AIDS' science is now controlled by crypto-Nazis.*

Bryan Ellison wrote to Maddox (31 Jan, 1994):

Dear Dr. Maddox: We submit the enclosed paper, entitled 'HIV as a surrogate marker for drug use: A re-analysis of the San Francisco Men's Health Study', for publication in *Nature*...We are submitting this paper to take you up on your offer made last May that 'When he [Duesberg] offers a text for publication that can be authenticated, it will if possible be published'...Naturally, we presume this offer, made no doubt in the spirit of scientific inquiry, still holds...We look forward to hearing from you shortly. Sincerely, Bryan J. Ellison.



Maddox's (fake) offer was off so the Duesberg-Ellison-Downey critique of the Ascher *et al Nature* article appeared in *Genetica*, Vol. 95: 1-3, 1995.

In an interview with Bob Guccione, Jr., Duesberg referred to the fraudulent Ascher, *et al* article:

This is my battle with John Maddox [editor of Nature] and with people who are actually fabricating the data [Ascher, et al in Nature, March 11, 1993]. They claim to have such a group that had not used any drugs. When I analysed the data, it turned out that there was not a single person in their paper that was drug-free. I submitted a critique to Maddox, but his response was, I could no longer respond. I was censored. (Spin magazine, September, 1993).

As major players within the hiv game and propagating the game the dominant science journals are defensive when contesters challenge the legitimacy of game and its arbitrary rules. This 'hiv' paradigm-protectionist racket is illustrated in letters I received from John Maddox, *Nature*, 19 September, 1995; Dr. Maxine Clarke, *Nature*, 17 April, 1996, 22 April, 1999; Stephanie Clark, *The Lancet*, 14 December, 1998, 27 April, 1999 and 12 May, 1999. These letters contain insult, verbiage, evasion and obfuscation when giving their reactionary reasons for rejecting my proposals regarding 'hiv' virtuality. These and many more letters will give the public an 'insiders eye' into how the most prestigious science journals in the world deal with 'hiv' dissenters in an unscientific but deeply political manner. While *The Lancet* has published 'hiv' dissenting letters by Stewart, Duesberg and Eleopulos, this is only a handful in comparison to the hundreds of 'hiv' propaganda papers and letters they have published during the *aids war* years. I wrote to Stephanie Clark, Senior Editor, *The Lancet*, offering a proposal concerning the non-isolation of 'hiv' for their 'view point' platform - accompanied by copies of *Continuum* for references. This was her abysmal reply (27 April, 1999):

Dear Mr Russell, I have shown your letter and magazines to Richard Horton and we have been pondering here about your suggestion of a viewpoint. I am afraid that our conclusion is that we would not wish to publish a view point along the lines you suggest. We did, indeed, give J Levy a platform in our view point section and we also published correspondence as a result of that. We therefore feel that at this point in time we would not wish to provide more space for this particular topic. I am sorry that I cannot be more helpful. Yours sincerely, Stephanie Clark Ph D, Senior Editor.

I responded to her letter (5 May, 1999):

Dear Stephanie Clark, Thank you for your letter of 27 April, 1999. Please could you give me the real reasons why you and Richard Horton do "not wish to publish a view point along the lines" that I suggested? The Lancet's 'view point' space is for dissenting or controversial points-of-view which are independent of your editorial bias! Why are you censoring my legitimate questions concerning the non-isolation, non-purification, and non-existence of the putative 'HIV'? I even invited you to publish responses from Robin Weiss, Richard Tedder and Robert Gallo to try and prove the existence of 'HIV'. What could be more 'democratic' than that? Please reconsider my view point. Yours sincerely, Alex Russell. cc: Gordon Stewart, Neville Hodgkinson, Serge Lang

I recently wrote to Dr Maxine Clarke, Executive Editor, *Nature*, offering an article on the non-existence of 'hiv'; this was her repugnant reply (22 April, 1999):

Dear Dr Russell,

Thank you for your letter offering us an article on why you think 'HIV does not exist'. As you and we are aware, this is by no means a new assertion. If you have a significant new perspective to offer on this well-trodden issue, then by all means send us something and we will consider it in the usual way. We would not wish to consider an article covering old ground and/or reviewing old papers, or repeating the message in countless books and articles by people who think as you do, as this is counter to our editorial

criteria of novelty. So on the face of it, an article along the lines you propose does not seem well-suited to Nature....If you wish to discover what scientific evidence exists for the existence of HIV, then we suggest you write to one of the scientists involved in HIV research, for example Anthony Fauci, David Ho or anyone, really.

Yours sincerely Dr Maxine Clarke, Executive Editor.

So Clarke concedes that the arguments for the non-existence of 'hiv' have been disseminated in countless books and articles yet such novel argument (she states) is counter to our editorial criteria of novelty. If *Nature* has an editorial criteria of novelty why have they not published the numerous novel papers offered to them by the Perth group (e.g. 'gp120 and HIV Infection - A Plea For Clarification', Eleopulos *et al*) and others, who have offered novel critiques of the 'hiv' hypothesis - or reported in their news columns the novel arguments for the non-existence of 'hiv'? It would surely be novel for *Nature* readers to be presented with the arguments for the non-existence of 'hiv'. Neville Hodgkinson on Clarke's letter (3 May, 1999):

Dear Alex, Thanks for letting me see the letter from Maxine Clarke. It is certainly insulting and absurd. It suggests to me that she is extremely worried. Best wishes, Neville.

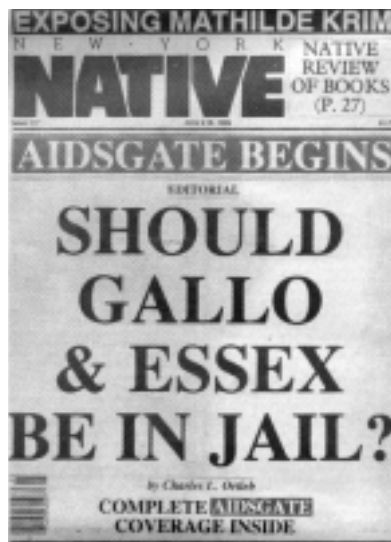
Maddox displayed an appalling ignorance of the Oxford Haemophilia paper by Sarah Darby *et al* (*Nature*, 7 September, 1995), which was published in his journal but he had obviously not (critically) read it! None of the people with haemophilia in this study died with Kaposi's sarcoma, but Maddox wrote to me (19 September, 1995):

"It is no shame that Darby et al. did not specify the AIDS-related diseases, because their concern was simply with the mortality of the two groups, but it's clear that they meant Kaposi's sarcoma, etc."

Nature refused to publish letters and extensive critiques by Mark Craddock, Peter Duesberg, Eleni Eleopulos and myself concerning the deficient Darby *et al* study. *Continuum* (Vol.3, No.4, Nov/Dec 1995) published Eleni Eleopulos *et al*'s rejected paper. *Nature* has had a long history in rejecting the Perth Groups 'anti-hiv' critiques as Dr. Val Turner stated:

"Nature has repeatedly rejected every paper and letter submitted by Eleopulos and her colleagues since 1986, without providing a single scientific reason and invariably citing space constraints in the journal." (Nexus, June-July, 1999).

Nature's arch-rival, *Science*, also plays 'hiv' paradigm protectionism. We must not forget that it was *Science* (4 May, 1984) that authorised the 'HTLV-III' ('HIV') paradigm by publishing the four fraudulent Gallo-Popovic papers so they have had a long-term vested interest in protecting both Gallo and the 'HIV' hypothesis; (and it is *Science's* in-house 'hiv' public-relations propagandist, Jon Cohen, who serves-up inane HIV™ Newspeak on a regular basis).



Charles Orlieb of *The New York Native* coined the term 'AIDSGATE' when exposing the countless fraudulent 'hiv/aids' papers published in *Science*, *Nature*, etc - with such cover headlines as 'AIDSGATE BEGINS - SHOULD GALLO & ESSEX BE IN JAIL?' (3-16, June, 1985). On the cover of an issue from 17 October, 1994, the *Native* depicted two covers from *Science* with the headline: "This is the most prestigious scientific publication in the world. Why is it contributing to the deaths of thousands by covering up Robert Gallo's fraud and incompetence?"

The *Native* exposed how *Science* censored twice critiques by Marlys Witte *et al* who reported irregularities in the published figures of Gallo's paper (*Science*, 255:1437, March, 1992) claiming that a compound developed by a Japanese pharmaceutical company is able to inhibit the development of KS lesions in mice. In a unprecedented move, Witte *et al*'s criticisms of Gallo *et al*'s *Science* paper was published in the June 1994 issue of *JAMA!* Richard A. Knox wrote in *The Boston Globe* (3 October, 1994): "Most provocatively they [Witte *et al*] darkly implied that the Gallo group may have been guilty of deliberate misrepresentation, and that *Science* was unwilling to air the evidence."

Our archive reveals *The Native* was the only gay community broad-sheet that took a consistent and critical position on the 'hiv/aids' hypothesis (even if its overt-agenda was to push the equally absurd HHV-6 hypothesis). *The Native* also gave strong warnings against AZT with such cover headlines as: 'AZT:Government Approved killer?' (28 March, 1988); 'It's Official: The *New York Times* Now Admits That AZT Is Bad for You' (16 January, 1989); 'Dr. AZT Fauci To New York: DROP DEAD' (20 November, 1989); '76% of AZT Patients May Develop Cancer' (27 August, 1990); 'The Evil Queen of AZT' (8 October, 1990: on Margaret Fischl); 'WARNING: If You Speak Out Against AZT in England, This Man Will Sue You' (20 May, 1991: on Duncan Campbell); and: 'POISON MAKES A COME BACK - Will Patients Be Forced To Take a Cocktail of Toxic Drugs?' (15 July, 1996). On 5 October, 1992, the *Native* put Duesberg on its cover with a caption calling him 'An International Hero' (because) 'Peter Duesberg Bravely Speaks Truth to Power in His Battle Against AZT and HIV Apartheid'.

In stark contrast to the autonomy of 'anti-hiv' critiques offered by the *Native* and Guccione's *Spin* magazine (Celia Farber's *AIDS - words from the front* column), the British gay press ran a mercenary 'hiv' paradigm-protectionist racket from the mid '80s to the mid '90s: *The Pink Paper* (Edward King), *Capital Gay* (Keith Alcorn), and *Gay Times* (Simon Watney), constituted an 'hiv-hegemonic-bloc' (who disseminated a deadly discourse instigating iatrogenic-aids and psychogenic-aids). During this period *The Pink Paper* and *Capital Gay* published many 'hiv' dissident letters to counter the fanatical 'hiv' dogma mimetically scribed by King, Alcorn, Watney (whom cultural critic Mark Simpson referred to as the 'AIDS clergy'). In a Preview, 'Unholy trinity', Simpson stated:

"Mind you, given the stranglehold of the AIDS clergy on the gay press, and their smug, censorious, sanctimonious and shamelessly shroud-waving response to any criticism of their position, I'm inclined to think that a spot of anti-clericalism wouldn't go amiss either". (*Time Out*, 8-15 February, 1995). Watney displayed a schizoid analysis of 'aids' when he stated in his column: "...positions like that of Continuum's Jody Wells, who argues that it is 'the gay lifestyle' (whatever that may be) rather than HIV that leads to Aids..." but then goes on to argue that 'aids': "...in Britain overwhelmingly affects gay and bisexual men..." and called for "re-gaying Aids". ('1994, the year ahead', *Gay Times*, January 1994). Hence, Watney seems to agree that 'aids' (whatever that may be) is largely a 'symptom' of the homosexual habitus: "the gay lifestyle".

The 'AIDS' Files

"You have systematically evaded answering my scientific, documented challenges to specific points in your review essay...I accuse you, Richard Horton, of scientific and journalistic irresponsibility. Horton is still accountable to the scientific community for his tendentious selectivity in presenting the HIV/AIDS issues..."

The Horton-New York Review File by Serge Lang

Continuum's collection includes Serge Lang's legendary 'files'. Lang has produced his own activated-archive in the form of 'the file'. Lang's 'files' are a strategic device to record the ways in which the 'hiv' orthodoxy operate when dealing with dissenters; as Lang stated:

"I had to create my own medium. Thus I created what I called the 'file' as a stage on which documentation and confrontations of views could be presented...Since it is frequently very difficult, and often impossible, to achieve immediate action, I use a file to establish a clear record which can then be used to provide information and impetus for later corrective action....In file making I present very concrete cases..."

Lang's 'files' include: 'The Case of HIV: We Have Been Misled', 'The Horton - New York Review File', 'HIV/AIDS: Journalistic Suppression and Manipulation: *Science*, *New York Times*, *Chemical and Engineering News*, *The Lancet*, *Nature*, and 'HIV & AIDS - Throwing Math and Statistics at People'. In these 'files' Lang documents how Richard Horton, Stephanie Clark (*The Lancet*), John Maddox, Philip Campbell (*Nature*), Jon Cohen, Floyd Bloom, Ellis Rubinstein (*Science*), Madeleine Jacobs (*C&EM*), Lawrence Altman, (*New York Times*) "push the orthodoxy about HIV, and obstruct both countering information and debate" - by using "unscientific, irresponsible, and manipulative journalism" when reporting on 'hiv/aids'. Lang's file 'HIV/AIDS: Journalistic Suppression and Manipulation' records how 'hiv' dissenters have been treated with malicious contempt, *ad hominem* attacks and censorship by the evasive editors of these sedentary science journals. One such example is the correspondence between Gordon Stewart and Stephanie Clark, Senior Editor, of *The Lancet*. Stewart offered *The Lancet* a letter for publication entitled 'Is HIV the cause of AIDS?'. Clark's reply read (15 January, 1996):

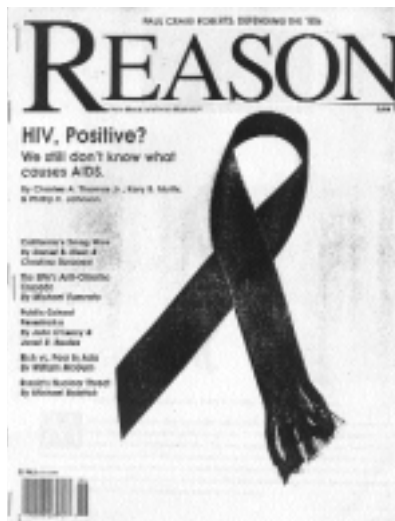
Dear Professor Stewart, Thank you for your letter entitled "Is HIV the cause of AIDS?" We have decided against publication, I am afraid. We have received many letters on this topic and after an initial round have decided to close this debate in the pages of *The Lancet* for now. No doubt in time Duesberg will be proved wrong. Yours sincerely Stephanie Clark.

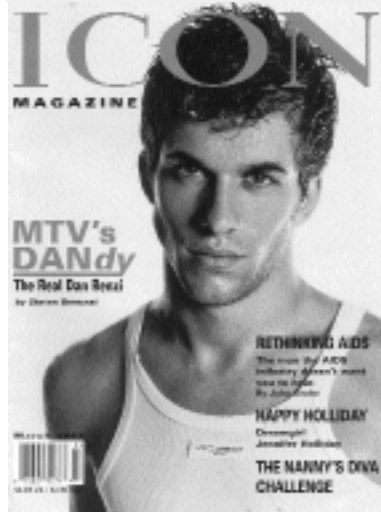
Contrary to Clark's claim, "in time", Duesberg's predictions have been proved right - (as Robert F. Siliciano *et al.*, *Nature Medicine*, May, 1999 confirms!)

Gordon Stewart replied to Richard Horton, Editor of *The Lancet*, (18 January, 1996):

Dear Dr Horton, This is in reply to Stephanie Clark's letter of 15th January. If the *Lancet* is so keen to prove Duesberg wrong, surely the best way to do so would be to publish some of the many letters to which she refers instead of leaving Duesberg's legitimate questions unanswered. I realise that this subject is making disproportionate demands upon your space as indeed it is upon almost everything. Even so, how can you close a debate which you have never opened? With kind regards, Yours sincerely, G T Stewart.

Serge Lang, in a 'file' letter to his 'cc' list on Clark stated (19 February, 1996): Dear cc list: Stephanie Clark wrote to Stewart: 'No doubt in time Duesberg will be proved wrong.' How does a senior editor of *The Lancet* know what history will prove before appropriate scientific experiments are





made? Furthermore, the phrase 'no doubt...will be proved' implies that according to Clark, he hasn't been 'proved wrong' yet...Clark's reply to Stewart gives one more example of unscientific dealings by one of those who control the flow of information in top scientific publications throughout the world. As Gordon Stewart wrote to Clark, '...how can you close a debate which you have never opened?'

Peter Duesberg wrote to Horton (8 February, 1996):

Dear Richard, Are you aware that a Senior Editor of *The Lancet*, Dr. Stephanie Clark, wrote to a contributing scientist on Jan 15, 1996, on *Lancet* letter head: "No doubt in time Duesberg will be proved wrong." (copy enclosed)? Does she express an editorial policy? Best, Peter Duesberg.

Horton sarcastically replied (1 March, 1996):

Dear Peter, *The Lancet* always tries to be perfect but sometimes we don't quite succeed. I suspect that my colleague, Dr Stephanie Clark, was writing out of enthusiasm. As you know we do not have an "editorial policy" on this matter. Many thanks for sending over all those articles to me. I am building up a huge file and will try and do something about it soon. With best wishes, yours sincerely, Richard Horton, Editor.

Horton is being insidiously disingenuous here; *The Lancet* has an overt editorial policy in propagating the 'hiv' paradigm. Horton stated he has a huge file on 'aids' dissident literature "and will try and do something about it soon" yet that was over three years ago and he has done nothing about bringing his 'aids' dissident huge file to the attention of *The Lancet* readership. Horton displayed his true colours in his 8,500-9,000 word 'hiv' propaganda article in the *New York Review of Books* (23 May, 1996) which was thinly disguised as a 'review' of three books by Duesberg et al. Horton uncritically endorsed the defective Darby et al *Nature* study as "another crucial, and decisive, line of evidence refuting Duesberg". It did nothing of the kind. On the contrary, the study (inadvertently) supports the view that 'hiv' does not exist. The study presented no proof that the excess of deaths in the seropositive patients was caused by 'hiv', or even that the haemophiliacs were 'infected' with 'hiv'. Furthermore, 'hiv' has never been detected in, isolated from or otherwise demonstrated to be present in Factor VIII used by haemophiliacs. No explanation was given as to why the deaths escalated between 1989-1992 yet this 10-fold rise in mortality directly coincided with the introduction of AZT. Lang's 'The Horton- *New York Review File*' documented how his 14 page *Review of a Review* of Horton's NYR 'review' was rejected for publication in the *New York Review*. Lang then asked Horton to print his critique in *The Lancet* but he never did. The *New York Review* eventually agreed to a published letter by Lang, - and then, only after Lang had offered them a cheque for \$3,500 for advert space for the letter. After returning the cheque to Lang, editor of *New York Review*, Bob Silvers, published his reply, *Review of a Review*, concerning an exchange between Horton and Duesberg in the *New York Review*, (2 August, 1996):

To the Editors - Richard Horton's review article "Truth and Heresy About AIDS" [NYR, May 23], with its many footnotes, gives a false impression of scientific scholarship. Horton's selectivity did not properly allow readers to evaluate (a) the books under review; (b) the relative merits of competing hypotheses with the orthodox hypothesis that HIV is a cause of certain diseases; (c) the positions of a number of scientists who have challenged the orthodoxy. I documented these assertions in a 14-page 'Review of a Review,' rejected for publication by the *New York Review*. However, Horton's reply on August 8 introduces a major new issue, namely Horton's ad hominem attack on Duesberg...Horton in the journalistic context of the *New York Review* shifted the discussion from what might have been a scientific exchange to an ad hominem exchange...I object

not only to Horton's unscientific journalistic and rhetorical thrust, but also that Duesberg did not reject outright the terms Horton was setting for the discussion....

Gordon Stewart has also compiled his own archive 'files' of correspondence beginning in 1985 with WHO, the *BMJ*, *Nature*, the Royal Society, the Royal Statistical Society, the *NEJM*, *Science*, the Medical Research Council, the All-Party (UK) Parliamentary Committee on AIDS, documenting over a decade of censorship and corrupt *aids politics*. Stewart wrote to me (5 November, 1998): "re-CENSORSHIP

ON AIDS BY MEDICAL JOURNALS": My files of correspondence in these matters, dating from 1985, contain many examples of evasion and rejection of verifiable factual issues...Although I have been repeatedly infuriated by the attitude of the *Lancet*, *BMJ* and *Nature*, I can make some allowance for their dependence on market forces which could affect their revenue and editors' survival... Stewart wrote to Lang (18 October, 1996):

These files relate largely to articles rejected outright or unpublished after answers and endless modifications demanded by peer reviewers and editors. They also contain comments on uncorrected errors, deceptions, expenditure and what not during the 13 crazy years of my involvement in the perverted epidemiology of AIDS.

Continuum's archive thus records that the orthodox science journals have been inundated with challenges to the 'hiv' charade which they have censored from their pages and hence from the 'scientific community' and the 'diagnosed'.

"The truth is out there." Motto from the *X Files*

Does HIV really exist? Huw Christie thinks not. He argues that scientists have mistaken bodily proteins and chemicals as part of the virus and asks why no one has isolated it yet.
the HIV debate, *Positive Times*, Issue No.17, July, 1996

Our archive documents many media have published articles and letters on the non-existence of 'hiv': these include *Icon Magazine*, March, 1997; *Financial Times*, Weekend 4-5 July, 1998; *The European*, 22-28 June, 1998; *Bay Area Reporter*, 6 August, 1998; *Positive Times*, 17 July, 1996, *Echo Magazine*, Oct. 30-Nov. 12, 1997; *Index on Censorship*, No.3, May/June 1999; *Ode*, July/August, 1999, *Positive Nation*: February, 1997; Dec. 1997 - Jan. 1998; *Reappraising AIDS*, Vol.5, No.6; Vol.7; *International Journal of Alternative & Complementary Medicine*, September, 1998; *Nexus*, October-November, 1998, June-July, 1999; *Zenger's*, December, 1998; - as well as *Continuum*, *Death Camp*, *Raum & Zeit*, *Freedom*, *Thud* and *The Pink Paper*. *Nature*, *New Scientist*, *Science* and *The Lancet* have been sent many of these publications to point out that while other media have opened their pages to debate the non-existence of 'hiv' these journals have kept such dissenting disclosures locked-up in their archive vaults (preferring to deceive the world with worthless papers propagating libelous 'hiv' lies). The editors of the prominent science journals are principally responsible for perpetuating the 'hiv' fraud; they must be held to account for their persistent refusal to publish evidence concerning the non-existence of 'hiv'. Dr. Val Turner stated: "The longevity of the HIV theory has been considerably boosted by the virtual refusal of editors of leading medical journals to publish any material which takes HIV to task." (*Nexus*, June, 1999). To counter this corruption and censorship, we offer you combating critiques that these journals have consistently and deliberately suppressed. Continuum's heterotopian terrain will offer you archival ammunition waiting to be detonated for your empowerment; counter-knowledge is counter-power; so use it now to challenge the monstrous 'hiv' machiavellian misinformation machine; 'hiv' and 'aids' do not exist: the truth is out there.

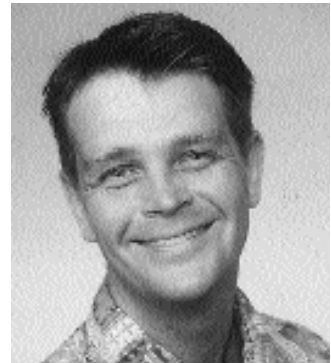
Conquering *candidiasis* naturally

Stephen C. Byrnes, N.D., R.N.C.P.

Stephen C. Byrnes is a Naturopathic Doctor and Clinical Nutritionist living in Honolulu, Hawaii.

He writes frequently and is the author of *Overcoming AIDS with Natural Medicine* and other books available from www.amazon.com.

Email: sbyrnes@chaminade.edu



Candida *albicans* and *candida tropicalis* are the names given to common yeasts that live within our intestines and certain mucous membranes - the throat, for example. Everyone has candida within them: we are born with it.

THE NIGHTMARE OF CANDIDA OVERGROWTH

Candida usually lives at peace with our other intestinal fauna, the acidophilus and bifido bacteria, and it is these bacterial residents that keep candida under control, preventing a "population burst." *Candida's* function in the body is mainly to gobble up any putrefied food matter in our digestive system (mostly caused by improper digestion due to low stomach acid) before any potentially harmful bacteria can have a feast, multiply, and become threatening to our health. After we die, candida acts to decompose the body, feeding off our corpse, much like a fungal mold on a dead tree.

Candida is usually kept in check by the gastrointestinal "good" bacteria and the immune system, but trouble can arise when certain conditions are present. It is in the presence of these conditions that *candida* can begin growing out of control in the intestines, branching out and colonising the gut. In this process, *candida* can eat away at the intestinal walls, spread into the bloodstream, and infiltrate other tissues. The normally benign yeast has literally transformed itself into an aggressive, destructive, fungal pathogen that can cause a variety of seemingly unrelated health problems. This condition/disease is known as systemic *candidiasis*.

SYMPTOMS & CAUSES

Systemic *candidiasis*, as a separate disease, was not recognised or defined until the 1980's, mostly because its symptoms were so varied and duplicated those of other illnesses, leading doctors to conclude that the patient was suffering from, for example, sinusitis instead of yeast infiltration of the nasal passages. Additionally, since one of the main causes of systemic *candidiasis* are doctor prescribed antibiotics, which kill the intestinal bacteria that control *candida*, the medical

profession was probably not too eager to admit the existence of this disease.

Diagnoses of *candidiasis* were limited to its visible manifestations, e.g., a vaginal or oral yeast infection. Treatment was directed towards eradicating these conditions alone without addressing the reality of a more serious, but hidden, infection.

The symptoms of *candidiasis*, and their severity, vary from person to person but the main ones are: chronic fatigue, especially after eating, depression, craving for breads and sugars (yeast eats sugar), extreme mood swings, feelings of rage, especially after eating sugary foods, feeling "drunk" after eating a meal high in carbohydrates (*candida's* waste is alcohol), hypoglycaemia, excessive mucus of the throat, nose, and lungs, chronic fungal infections of the skin (jock itch, athlete's foot) or vaginal/oral thrush, diarrhoea, anal itching, short term memory loss, feeling "spacy," and bloating or gassiness after eating.

In addition to these, lymphatic swelling, difficult PMS, night sweats, chest and joint pain, memory loss, incoordination, blurred vision, intense, random headaches, intermittent vertigo, insomnia, sneezing fits, and increased food allergies are also fairly common. A person tends to get extremely sensitive to damp, mildewy environments and, sometimes, to extreme humidity as well as perfumes, colognes, and smoke. Since *candida* can infiltrate the urinary tract, acute kidney infections, cystitis, and prostatitis are possible.

While these symptoms can indicate other illnesses, if certain factors are present in one's personal history the symptoms are likely to indicate *candida* overgrowth. These factors are:

(1) Prolonged, or repeated, use of antibiotics, corticosteroid drugs, and/or birth control pills, at any time in the past, (2) a diet high in processed sugars which encourages candida growth, and (3) preexisting immunosuppression caused by drug or alcohol abuse, multiple blood transfusions, debilitating illness, organ transplants, or chemotherapy. All three are NOT required to bring on a case of *candidiasis*: excessive "sugar bingeing" can cause it just as surely as antibiotics can. Pregnancy also predisposes women to the condition since pregnancy alters the body's delicate hormonal and pH balance: *candida* thrives in an alkaline environment.

Contributing factors are (1) low stomach acidity leading to poorly digested food and (2) improper bowel movements leading to prolonged retention of fecal matter in the colon: these conditions promote yeast overgrowth.

A 20TH CENTURY DISEASE

Candidiasis is truly a modern disease, brought on by medical "innovations" like antibiotics and the Pill and a more "civilised" diet of refined, sugary foods and candy. In some naturopathic circles, the illness is derisively known as "Candy Disease."

In all seriousness, however, *candidiasis* is a serious condition for two main reasons: (1) It often goes undiagnosed, allowing the yeast to spread unhampered, and (2) the numerous symptoms it produces severely tax the immune system, forcing it to deal with, not only the yeast infection, but the other conditions the yeast causes. A truly vicious cycle can ensue: a person is weakened by a candida caused problem, say *cystitis*, and goes to a doctor who then prescribes antibiotics for it. The drugs kill off more of the intestinal bacteria which control *candida*, making the *candida* overgrowth worse, leading to more infections and more antibiotics, etc.. At its most destructive, *candida* can exhaust the adrenal glands, leading to Addison's disease, can interfere with digestion so much that virtually no nutrients are absorbed from food, and can cause life threatening infestations of the vital organs and the brain.

TREATMENTS & RECOVERY

The standard allopathic treatment for candidiasis is the drug Nystatin, a mold which inhibits the growth of other molds like *candida*. Two other popular drugs are Nizoral and Fluconazole. While these drugs certainly kill candida, they do not work forever due to *candida's* ability to mutate into drug resistant strains, nor do they prevent *candida* from coming back.

Natural therapies are the most potent and effective weapons against this disease and recovery time lasts about 6 to 12 months (or longer depending on the length of time one has had the condition and the severity of symptoms). This might seem long, but once *candida* has colonised the body, it takes quite an effort to drive it out. Let's now take a look at the natural therapies most effective against this adaptable and extremely tenacious invader.

DIGESTION

The key to conquering *candida* is in cleaning up the digestive system, the ultimate source of the problem. In general, one must avoid constipation at all costs so high water (4 - 5 glasses a day) and adequate fibre intake is recommended. Drinking lots of water will also help flush the dead yeast cells out of your system as you progress with your treatment. If diarrhoea is a problem, psyllium or yellow dock herb, both available in capsule form, will tighten the colon. These two herbs are also effective for constipation - they are bowel regulators. Yellow dock is also known as a blood builder, effective for anaemia and low white blood cell counts. If you decide to take yellow dock, be sure to take it separately from any herb containing tannic acid to avoid stomach upset.

Supplementation with *acidophilus* and *bifido* bacteria is essential to recolonise the intestines. While these bacteria will not kill *candida*, they inhibit *candida's* growth and, generally, clean up the bowels, making it more difficult for *candida* to thrive. Look for a high potency supplement, either freeze dried or refrigerated, made without cow's milk. You will need to supplement heavily with these "probiotics" throughout your recovery and well after all your symptoms have gone. Chlorophyll rich foods, like leafy green vegetables and alfalfa, also promote *acidophilus* growth and discourage yeast reproduction.

Proper food digestion is an absolute MUST as nothing makes *candida* happier than putrefied, poorly digested food. Unless you have an ulcer, consider taking a digestive enzyme supplement with hydrochloric acid (HCL) immediately before or after each meal. If you have an ulcer, look for digestive enzyme supplements without HCL. Plant enzyme supplements are excellent. Both pancreatin and plant enzymes can be taken between meals to hinder yeast growth. Using digestive enzymes will help your condition dramatically and also take some stress off your pancreas which might be weary from dealing with possible *candida*-caused hypoglycaemia. (If you notice any stomach irritation when using HCL supplements, cut back on the dose at once to prevent possible ulcer formation.)

If enzyme supplements are not available, a cup of German chamomile tea just before or after eating will stimulate HCL production by the stomach. Chamomile will also ease any

gassiness and/or bloating and contains potent anti *c a n d i d a* compounds. If you have a history of ragweed allergy do not use chamomile; fennel or cardamon are fine substitutes. Another herb to consider for digestion is wormwood. Wormwood, while extremely bitter, is probably the best digestive herb around, stimulating HCL and bile production. Side benefits of wormwood are ridding you of any parasites, gas, nervousness, and weak stomach. Wormwood extract or tincture can be found at any health food store; take the recommended dose just before eating in a little water.

C A U T I O N : Wormwood should not be used by pregnant women. Since the liver can get overburdened with *candida's* toxins because it filters the blood, cleansing this organ is essential for your recovery. Daily supplementation with hepatic herbs like, dandelion root, golden seal, wormwood, barberry, Oregon grape root, or bayberry, is highly recommended. Again, the need for increased water intake is emphasised here to facilitate internal cleansing. **CAUTION:** Avoid goldenseal and barberry if you are pregnant.

DIETARY DO'S AND DONT'S

Since *candida* loves sugar, it must be avoided in all its forms (dextrose, sucrose, glucose, maltose, lactose, fructose). Say goodbye to all fruits, except the low sugar ones like strawberries, cherries, and papayas which can be eaten in strict moderation. Read the label of every food product you buy to be sure there is no added sugar (a near impossible task these days!).

Diet is your main weapon against *candida*, but also the most frustrating as you will have to give up a number of foods. Bid farewell to: wheat, rye, milk, cheese, alcoholic or caffeinated beverages, potatoes, honey, mushrooms, and vinegar: all these foods promote yeast growth or can aggravate already present yeast colonies. Keep your food well covered in the refrigerator to prevent mold formation. When eating out, be sure to ask how a dish is prepared and tell the server to hold any undesirable ingredients like soy sauce or mayonnaise.

In general, a low carbohydrate diet is preferred.

The *candida* connection: Yeast growth can give rise to a positive HIV™ test

"...1. 'One half of the molecular weight of [HIV] gp120 is represented by oligomannosidic oligosaccharides.... Polyclonal antibodies to mannan from yeast also recognise the carbohydrate structure of gp120 of the AIDS virus';¹²

2. 'The immunochemical determinants of the antigenic factors of *Candida albicans* display a high identity with the glycoprotein (gp) 120 of HIV-1: they contain (x(1 -> 2)- and (x(1 -> 3)-linked mannose terminal residues';¹³

3. Antibodies to the mannans of *Candida albicans* 'block infection of H9 cells by HIV- 1' as well as the binding of lectins to gp 120;¹³

4. Recognition of gp 120 by antibodies to a synthetic peptide of the same antigen was 'partially abolished if it was absorbed with the total polysaccharide fraction of *C. albicans*' while the antigen recognition by antibodies to 'gp 120 from human T-cell lymphotropic virus type IIIB ... was totally blocked'. From these data the authors concluded: 'These results indicate that mannan residues of *C. albicans* can serve as antigens to raise neutralising antibodies against HIV infection';¹³....

7. Not only mycobacteria (*M. leprae*, *M. tuberculosis*, *M. avium-intracellulare*) but also the walls of all fungi (*Candida albicans*, *Cryptococcus neoformans*, *Coccidioides immitis*, *Histoplasma capsulatum*, including *Pneumocystis carinii*),¹⁶⁻¹⁸ contain carbohydrate (mannans).

One hundred per cent of AIDS patients (even those with 'no *Candida* clinically') have *C. albicans* antibodies, leading researchers from St. Bartholomew's and St. Stephen's Hospitals to state: 'It is possible that *Candida* may act as a cofactor in the development of overt AIDS in HIV-infected individuals'.¹⁹ It may also be of interest to note that in gay men the only sexual act which is a risk factor for seroconversion is passive anal intercourse (exposure to semen)²⁰ and that mannose is present in both sperm and seminal plasma..."

from *HIV antibodies: further questions and a plea for clarification*. E. Papadopoulos-Eleopoulos, V.F. Turner, J.M. Papadimitriou, G. Stewart, D. Causer. *Current Medical Research and Opinion*. Vol. 13, No.10, 1997. pp627-634

Carbohydrates, even complex ones, eventually break down to glucose (sugar) in the digestive tract, and sugar feeds *candida*. Its also advisable to avoid the starchier vegetables like sweet potatoes, parsnips, and winter squashes. Different people, however, have different sensitivities. I've worked with patients who can handle wheat, despite a candida problem. You and your body are your best guide as to which foods to avoid. At rock bottom, however, all sugars MUST be avoided.

Due to the restrictions, you may be wondering at times, "What the hell am I supposed to eat?!" Books will be listed at the end of the article to help with food selections and recipes. On the positive side, assuming you have no allergic reactions, you can enjoy all of the following: fish, poultry, meat, all vegetables, brown rice*, eggs, seeds, all nuts except cashews and peanuts, herb teas, beans* and lentils*, goat milk*, corn*, amaranth*, kamut*, quinoa*, buckwheat*, oats*, and spelt*. Check with a local health food store for sugar free breads made of kamut, millet, or spelt and consider eating corn tortillas to replace wheat bread. (*: moderate amounts only.) To ease their digestion, all nuts, seeds, and whole grains should be soaked for at least seven hours before cooking or drying. Soaking initiates the sprouting process and breaks up the enzyme inhibitors and phytates found in these foods. Contrary to popular belief, foods containing yeast may be eaten if no allergic reactions are present. Brewer's yeast, for example, is a very nutritious and immune enhancing food and can be eaten for nutritional support during one's recovery.

As your symptoms disappear, you can cautiously add back the forbidden foods, one at a time and slowly. Do not eat any refined sugars for at least 6 months after your recovery. Having *candidiasis* once predisposes one to getting it again so be very careful after you are well. Indulging in too many foods too quickly can, as I can painfully attest to, cause a relapse.

HERBS & SUPPLEMENTS

The following herbs should assist in recovery:

Garlic a powerful antifungal and immune stimulant. Garlic will also help with constipation, gas, excess mucous, and blood cleansing; it is antiparasitic and hypotensive also. Some people are sensitive to garlic so increase your dosage slowly to discern any unpleasant side effects. If there are none, include it liberally in your diet, everyday. If you prefer to take garlic tablets, look for ones that are enteric coated to insure that the garlic is released deep inside the intestines where *candida* thrives.

Golden Seal, Barberry, Oregon Grape Root the berberine in these herbs is lethal to *candida*. Berberine is also a powerful immune stimulant. Don't overuse golden seal as too much will irritate the liver: take for 2 weeks on, one week off. All of these herbs can also be used to assist digestion. Golden seal can be

topically applied to ringworm, and made into a tea for athlete's foot. These three herbs are excellent for urinary tract problems, being diuretic, antibacterial, and antifungal. Like wormwood, golden seal and barberry should not be used by pregnant women.

Licorice root Though not antifungal, licorice will soothe the inflamed intestines so common with *candida*, thus helping to prevent malabsorption of nutrients and food allergies. Licorice also tones the adrenal glands and helps regulate blood glucose, controlling sugar cravings. This herb is also excellent for excessive mucous, cough, and constipation. **Astragalus** This popular Chinese herb is excellent for stimulating the immune system, essential for recovering from *candida* or any other infective condition.

Aloe Vera a must if suffering from fungal skin infections. The fresh gel is effective against ringworm, jock itch, and athlete's foot and will also help heal cracked, damaged skin. Use bottled gel if the fresh herb is not available.

Other useful herbs are clove, ginseng (all varieties), ginger, pau diarco, and cinnamon. For proper doses, check the labels, but higher doses may be taken without fear of toxicity except as noted above.

Tea tree oil, from Australia and New Zealand, is very deadly to *candida* and may be used topically for athlete's foot, jock itch, and ringworm. It can also be used as a gargle or douche when mixed with water and can be safely taken internally (3-4 drops, 3 times a day, do not exceed this dose). Be absolutely certain the brand you buy does NOT say "For external use only" on its label.

Caprylic acid, a short chain fatty acid, is extremely effective against *candida* and is, fortunately, available over the counter at health food stores. Look for a slow release formula of about 300-500 mg. and arrange for a dose of 500 to 1000 mg. with each meal. Colloidal silver, and the newer olive leaf extract, are excellent antifungal agents and

lethal to *candida*. Though expensive, my clients have had excellent results with these products. Look for a silver supplement of at least 40 ppm with a micron size of no more than .001. Follow the instructions on the labels for the correct dosages.

Oxygen is an antifungal compound. Taking stabilised oxygen products, like flavoured peroxide combinations found in health food stores, can also be employed in one's recovery.

The latest in *candida* treatment are enteric coated essential oils. Oregano, peppermint, and rosemary oils are all extremely powerful against *candida* and some supplement companies already have formulas using these oils on the market. Oregano oil is estimated at being 100 times more powerful than caprylic acid. Be prepared for some explosive diarrhoea when using this product. As the yeast cells die, the body makes every effort to expel them.

Toxic P.I.s limit *candida* "with an efficacy comparable to fluconazole"

An article in the August '99 *Journal of Infectious Diseases* concerns the anti-*candida* activity of 'HIV PIs', which inhibit the activity of *Candida albicans* Secretory Aspartyl Proteases (Sap). Cassone *et al.* state: "Our *in vitro* data show that PIs inhibit Sap activity and production most effectively between 1 and 10 M. At these concentrations, fungal growth was also inhibited in a medium in which Sap activity is critically required for nitrogen supply and growth. Overall, the inhibitory activities of PIs were comparable to those exerted by pepstatin A, a prototypal inhibitor of aspartyl protease enzymes."

They also state: "In summary, our data demonstrate that indinavir and ritonavir, two major components of HAART regimens, have direct anticandidal effects *in vitro* and *in vivo*."

Journal of Infectious Diseases, August 1999
In Vitro and In Vivo Anticandidal Activity of Human Immunodeficiency Virus Protease Inhibitors
 Antonio Cassone¹ Flavia De Bernardis¹ Antonella Torosantucci¹ Evelina Tacconelli² Mario Tumbarello² and Roberto Cauda²

¹ Department of Bacteriology and Medical Mycology, Istituto Superiore di Sanità; ² Department of Infectious Diseases, Catholic University, Rome, Italy

Reprints or correspondence: Dr. Antonio Cassone, Dept. of Bacteriology and Medical Mycology, Istituto Superiore di Sanità, Viale Regina Elena 299, 00161 Rome, Italy (cassone@iss.it).

Abstract: Highly active antiretroviral therapy that includes human immunodeficiency virus (HIV) aspartyl protease inhibitors (PIs) causes a decline in the incidence of some opportunistic infections in AIDS, and this decline is currently attributed to the restoration of specific immunity. The effect of two PIs (indinavir and ritonavir) on the enzymatic activity of a secretory aspartyl protease (Sap) of *Candida albicans* (a major agent of mucosal disease in HIV-infected subjects) and on growth and experimental pathogenicity of this fungus was evaluated.

Both PIs strongly (90%) and dose dependently (0.110 M) inhibited Sap activity and production. They also significantly reduced *Candida* growth in a nitrogen-limited, Sap expression-dependent growth medium and exerted a therapeutic effect in an experimental model of vaginal *candidiasis*, with an efficacy comparable to that of fluconazole. Thus, besides the expected immunorestitution, patients receiving PI therapy may benefit from a direct anticandidal activity of these drugs.

Vitamin/mineral supplementation is a good idea to not only insure that adequate nutrients are ingested, but also to help the immune system fight the infection. The following are suggested daily guidelines. For individual needs, its best to see a health practitioner who is familiar with approaching candidiasis: Vitamin A (as retinol and beta carotene) 75,000 iu; vitamin C 3 to 5 gms.; selenium 200 mcg.; zinc 50 mg.; vitamin E 400 iu; iron 10 mg.; essential fatty acids 4 gms; high potency multi vitamin/mineral 1 a day.

One particularly useful nutrient is the free-form amino acid glutamine. Glutamine is very pivotal in maintaining proper muscle mass, brain function, intestinal integrity, and stable blood sugar levels. It is often prescribed to recovering alcoholics by natural therapists to control alcohol cravings. 1-3 grams before each meal is suggested. Glutamine is excellent for helping to heal 'leaky gut syndrome,' a very common symptom of intestinal *Candidiasis*. Also, since weight loss is usual with severe *Candida* infestations, this amino acid helps protect against muscle loss. Glutamine is also very stimulating to the immune system. Do everything you can, then, to acquire it and be diligent about taking it.

There are homeopathic preparations of *Candida albicans* on the market. From personal and professional experience, you have to be very careful with these products as they can cause a severe 'Herxheimer Reaction,' or temporary worsening of your symptoms due to the rapid die off of yeast cells in the body. The best way to use homeopathics is to start with a weaker preparation of about 12X potency, and gradually work your way up to more powerful doses - 30C and above. A slow build up avoids the unpleasant hassle of aggravated die off. You will sometimes feel like a walking medicine chest from all of the supplements, herbs, probiotics, and antifungal products you'll be taking. Inconvenience aside, it is necessary as *Candida* is a

very tenacious organism. You must be persistent and unwavering in your efforts to recover or you will get nowhere; the total approach is necessary.

DIE OFF

When you take away *Candida's* food, sugar, and attack the yeast with herbs and supplements, it will die, causing a condition known as die off. Die off will last from a few days to a few weeks and the severity of symptoms will vary from person to person. Usually present are nausea, headaches, gas, irritability, diarrhoea, severe energy loss, sugar cravings, and blurred vision.

Exercise and water will reduce your symptoms by flushing the dead yeast cells more quickly from your system. Use your herbs smartly as many of those listed before can help, e.g., cinnamon or clove tea will help allay nausea and gas, as well as help disinfect your digestive tract.

YOUR GREATEST WEAPON

As a former *Candida* sufferer, and a naturopath who has dealt with affected individuals, I can confidently tell you that your greatest weapons against it are your diet and your patience. Frustration is likely to run high during your recovery as *Candida* is an incredibly tenacious organism. Stick it out, however, and know that you will eventually recover for the rewards are great.

SOURCES & RECOMMENDED READING

The Candida Directory and Cookbook by Helen Gustafson and Helen O'Shea. 1992; Celestial Arts Publishing.
The Yeast Connection by William Crook, M.D.. 1986; Vintage Books.
Candida Albicans: Could Yeast Be Your Problem? by Leon Chaitow, N.D. 1985; Thorsons, U.K.

PATHWAYS : UK Exhibitions, Conferences, Trainings & Other Events

August 1999

Sun	1st	from 10am	£2/£1.50	THE EARTH, HEALTH & MYSTIC FAYRE	Starburst Promotions	Hall for Cornwall. Truro 0800-048473
Mon	2nd	6.45-9pm	£1.50	What Effect Does Sleep Have on Our Bodily Functions?	Hamilton Williams	39 Brandon St. WI 0181-800-1850
Thu	5th	one-day	£89/£79	SACRED SITES TOUR & EVENING MEDITATION	David Furlong & Jude Stammers	CPS-Stonehenge & back 0171-589-3202/3
RES	5-9	5-day	enquire	Healing & Alternative Therapies for People & Animals	APACHE	Cirencester, Royal Agr 07050-244196
RES	6-15	10-day	enquire	RAINBOW CIRCLE: 12th Astrology Camp	David Baker	Forest of Dean 0181-980-5246
RES	6-31	flexible	from £5	ECLIPSE PERMACULTURE CAMP Deborah Fox	Camborne, Cornwall	01209-711701
Sat	7th	10-4.30	£1/50p	THE EARTH, HEALTH & MYSTIC FAYRE	Starburst Promotions	Penzance, St John's Hall 0800-0748473
RES	10-16	7-day	enquire	ANNUAL SUMMER GATHERING & ECLIPSE	And Associates	Gaunts House, Dorset 01202-841522
S/S	14/15	10.30-4pm	£7	PSYCHIC FAIR	Elementals	Alford, Lincs, White Horse 01977-517250
Sun	15th	one-day	enquire	THE ANGEL CONFERENCE	Starburst Promotions	Hall for Cornwall. Truro 0800-0748473
Sun	15th	1-3.3.30pm	enquire	Get-together Good Voggie Food & Good Company	Leaves of Life	CLR. 8 Warwick St., W1 0181-800-1850
RES	19-22	3 full days	£135	BEYOND THE BRAIN: Frontiers in Consciousness	Scientific & Medical	Cambridge 012333-340490
S/S	21/22	10-6pm	£2/£1.50	Edinburgh Festival BODY & SOUL HEALTH FAIR	Body & Soul Edinburgh Academy	0131-226-7601
Sat	21 St	11-6pm	£45	Workshop: ANGELS	Diana Cooper	Edinburgh Academy 0131-226-7601
Sun	22nd	11-6pm	£45	Workshop: ASCENSION	Diana Cooper	Edinburgh Academy 0131-226-7601
S/S	25/27	weekend	£1.50/£1	NATURAL HEALTH AND ECOLOGY MAROUEE	Creativity Bristol Flower Show	01934-813407
FSS	28-30	3-days	£7.95(enq)	FESTIVAL OF HOLISTIC LIVING Brainwave	Camden Centre, Kings X	0181-677-8000
Sat	28th	1 0-6pm	£2/£1.50	BODY & SOUL HEALTH FAIR Body & Soul	Dundee, Calrd Hall	0131-226-7601
S/M	29/30	11-7pm	£3.50	FESTIVAL FOR LIFE Destiny Fairs	Concert Halls, Blackheath	01992-850357
RES	31 et	4-days	enquire	N.L.P. DIPLOMA TFIAINING COURSE	WEB Training, Haybergill Centre	01943-873390

September

Thu	2nd	7-9pm	£15	TAROT beginners workshop Thoth School of Tarot	Clapham SW4	0171-385-1169
F-S	2-5	4-day	varies	MIND-BODY-SPIRIT (London North) FESTIVAL	New Life Promotions, Alexandrra Palace	0171-938-3788
Tue	9th	6.30pm	Free	Intro to Ethical & Green Investment (please phone)	Dominic Stuart & Barry Brown	1-3 Canfield Place NW6 0171-372-5000
Sat	4th	4 days	£2.50	CRYSTAL LIGHT ENERGY Diploma Part One starts	Karin Taylor London NWS	0171-385-1169
S/S	4/5th	one-day	£75/day	REIKI and SEICHEM second degree course	Raphael Radiame School	Muswell Hill, London 01844-201338
F-M	10-12	3-day	varies	MIND-BODY-SPIRIT (Manchester) FESTIVAL	Now Life Promotions	G-Mex, Manchester 0171-938-3788
S/S	11/12	2 wknds	£195	TAROT Pffessional Diploma Part One starts	Thoth Shoot of Tarot	Clapham SW4 0171-385-1169
S/S	11+18	10-6pm	£120/100	YOU CAN HEAL YOUR LIFE (two Saturdays)	Susan Gorrie Hampstead, NW3	0171-380-1035
Sun	12th	10-6pm	£2.50	NATURAL HEALTH AND HEALING FESTIVAL	Third Eye Promotions	Guildford Civic Hall 01626-783107
Sun	12th	10-6pm	£2	FESTIVAL f Natural Healing & Alternative Therapies	S.ndr. 13ooth	Cleethorpe, Winter 01469-575007
S/S	18/19	two-day	£3/ £1.50	THE NATUFLAL HEALTH FESTIVAL	Naturally UK	Naturaly UK 01748-886377
S/8	18/19	2-days	enquire	HEALTH & SPIRITUALITY FESTIVAL	Eulinda at Suntar	Reading 01188-944-8413
Sun	1 0th	10-6pm	£2/£1.50	FIESTIVAL OF HEALING North Star	Moat House. Nottiingham	0115-938-2768
FSS	24-26	3 days	enquire	THE GOOD HEALTH FAIR Niky McGarry	Cork: Fitzpatrick Hotel	01232-422274
S/S	26/26	10-6pm	£3.50/2.50	NATURAL HEALING EXHIBITION	Julie Saunders	Colchester, Essex 01206-500999
S/S	25/26	2 days plus	enquire	4th International MAYAN DREAMTIME FESTIVAL	Mikhail & Alloa	Glastonbury 01206-298881
S/S	25/26	10-6pm	£2/£1.50	BODY & SOUL HEALTH FAIR Body & Soul	Newcastle Civic Centre	0131-226-7601
S/S	26/26	10-5.30pm	£160	INTEGRATIVE OSTEOPATHIC TECHNIQUE	Prof Lauri Hartman	IATE, London NI 0171-283-8551
S/S	25th	weekend	enquire	ONE IN 2000: The Individual inthe Millennium	Bright Idea London	08700-783783
Sun	26th	10-6pm	£2-50	PSYCHIC ARTS & NATURAL THERAPIES	Third Eye Promotions	Portsmouth, 01628-783107
Sun	26th	10-5pm	£35	'ONLY CHILD' WORKSHOP: un-themed	Ann Richardson	Little Venice, W2 0161-994-5964
Sun	26th	one day	enquire	THE FIRST PEACE FORUM	contact Marilyn Lovall	Manchester, Armitage 01386-858778

PATHWAYS distributes leaflets at Exhibitions UK-wide and by mail with our own publication "The PATHWAYS BULLETIN"
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IS IT RATIONAL TO TREAT OR PREVENT AIDS WITH TOXIC ANTIRETROVIRAL DRUGS IN PREGNANT WOMEN, INFANTS, CHILDREN, AND ANYBODY ELSE?

THE ANSWER IS NEGATIVE

Roberto A. Giraldo¹, Michael Ellner², Celia Farber³, Barnett J. Weiss⁴, Francis R. Buianouckas⁵, Tom DiFerdinando⁶, Ray Vagg⁷, and Edward A. Lieb⁸.

1 Physician, Specialist in Infectious and Tropical Diseases. Member of the Board of Directors of the Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis and of Health Education AIDS Liaison, HEAL - New York.

2 Medical Hypnotherapist. President of HEAL - New York.

3 Journalist. Member of the Board of Directors of the Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis. New York.

4 CSW. Member of the Board of directors of HEAL - New York.

5 Ph.D. Professor of Mathematics. Member of the Board of Directors and Scientific Adviser of HEAL - New York.

6 Alternative Physical Therapist. Executive Director of HEAL - New York.

7 AIDS Activist. Member of the Board of Directors of HEAL - New York.

8 Producer of Accent on Wellness. Owner of Planet Health. Member of the Board of Directors of HEAL - New York.

Summary

The treatment and prevention of AIDS with antiretroviral medications is based on a singular set of well known beliefs: that AIDS is an infectious disease caused by a virulent virus called HIV; that HIV belongs to family of retroviruses; that AIDS can therefore be treated with antiretroviral drugs; that AIDS is a transmissible disease that is transmitted through body fluids including blood, genital secretions, and breast milk; that a positive result on the so-called "AIDS test" is indicative of infection with HIV; that once positive on the "AIDS test" the individual will develop AIDS; that a person who reacts positive on the "AIDS test" can prevent the development of AIDS by using several antiretroviral drugs; that the consumption of antiretroviral drugs will prevent the transmission of HIV from HIV positive pregnant women to their babies; that the use of antiretroviral drugs is safe and free of harmful effects; and that, therefore, it is rational to treat and to prevent AIDS with antiretroviral medications.

However, not a single one of the above beliefs can be scientifically substantiated. On the contrary, there are many scientific facts indicating that: the tests used for the diagnosis of HIV are extraordinarily inaccurate; that being HIV positive does not mean that the person is infected with HIV, the so-called "AIDS virus"; that there are more than 70 different non-HIV related reasons to have a positive result on the "AIDS test"; that the transmission and infectivity of AIDS is not real; that the risk of developing AIDS after being labelled "HIV positive" is unknown; that HIV is not the cause of AIDS; that HIV may not even exist as a virus; that what is called "AIDS" is a toxic and nutritional syndrome; that all antiretroviral drugs are highly toxic to humans; that the antiretroviral medications can by themselves cause AIDS; and that pregnant women, infants, and children are especially vulnerable to the toxic effects of antiretroviral medications.

The scientific data presented here will demonstrate, once and for all, it is not only irrational but unethical to treat or prevent AIDS with toxic antiretroviral drugs, and that to do so is a violation of the Universal Declaration of Human Rights.

If, as claimed, there is a genuine interest in doing the best for our fellow human beings, the use of these "AIDS medications" should cease immediately. It is urgent that the entire infectious model of AIDS be reappraised.

Introduction

The treatment and prevention of the Acquired Immunodeficiency Syndrome, AIDS, with antiretroviral drugs is singularly based on the following set of well known beliefs:

that AIDS is an infectious disease, that it is caused by a virus, and that this virulent virus, which belongs to the family of retroviruses, is named the human immunodeficiency, HIV, or simply "the AIDS virus"⁽¹⁻⁷⁾, that AIDS can be successfully treated with antiretroviral medications⁽⁸⁻¹²⁾, that AIDS is a physically contagious disease that is transmissible through body fluids including blood, genital secretions, breast milk, etc.⁽¹³⁻¹⁶⁾, and that as a consequence, is believed to be transmitted both homosexually and heterosexually, as well as from mother to child during pregnancy or after birth through breastfeeding⁽¹³⁻¹⁸⁾, that a positive reaction on the "AIDS test" is indicative of infection with the so-called "AIDS virus" or HIV^(2,19-22), that once reacting positive on the "AIDS test" the reactant person will very likely develop AIDS at some totally undetermined time in the future^(3,5,7,23,24), that a person infected with "the virus that causes AIDS" can delay the development of AIDS by the use of several antiretroviral drugs^(10,11,25-27), that the use of antiretroviral drugs may prevent the transmission of HIV from HIV-positive mothers to their fetuses^(12,25,26), resulting in the worldwide promotion of their use for HIV-positive pregnant women^(12,26-29), that the antiretroviral drugs are safe, and that only in a few cases do they induce some light side effects^(10,12,26,30), and so are promoted worldwide for children's use⁽³¹⁾, and that therefore it is absolutely rational and ethical to treat and to prevent AIDS with the use of antiretroviral drugs in pregnant, children and anybody else^(12,25,30-34).

However the above list of beliefs and assumptions, all of which collectively serve as the foundation for the infectious hypothesis of AIDS, have never been scientifically validated. On the contrary, there are many scientific facts indicating that these beliefs are not only unfounded but that the entire model of AIDS as an infectious condition must be reappraised immediately. The following comprehensive list of facts support our statement:

1. The tests used for the diagnosis of "HIV infection" are highly inaccurate.

The following scientific facts support the assertion that "the tests used in the diagnosis of HIV infection are highly inaccurate":

1.1. The definition of AIDS, as developed by the United States Federal Government's Centers for Disease Control and Prevention, requires a positive result on the antibody test for HIV⁽³⁵⁾. This definition is accepted worldwide. The importance of HIV in this definition is so strong that, currently, many AIDS researchers, health care professionals and lay people, in following the lead of the United States Institute of Medicine, the National Academy of Sciences and most AIDS researchers now refer to "AIDS" as "HIV Disease"^(1,4,6,23,36,37).

1.2. The tests that are used most frequently to diagnose HIV status are the ELISA "screening test", the Western blot "confirmatory test" and the PCR "Viral Load test"⁽¹⁹⁻²²⁾. In the United States the ELISA and Western blot tests, when done together, have become known as "the AIDS test". These tests supposedly detect antibodies against HIV. The "Viral Load" or PCR test is a genetic test that makes copies of small fragments of nucleic acids that, it is claimed, belong exclusively to HIV. These are the same tests that are used to check for HIV in mothers, infants, children, and in the population at large. The problem with all of these tests is that a positive HIV reaction does not guarantee that the person is really infected with HIV at all⁽³⁸⁻⁴⁷⁾.

1.3. Currently, a positive result on "the AIDS test" - ELISA and Western blot antibody tests - is synonymous with HIV infection and the attendant risk of developing AIDS⁽¹⁹⁻²²⁾. However, these antibody tests are neither standardized nor reproducible, with respect to HIV they are themselves meaningless because they mean different things in different individuals, they also mean different things in different laboratories and in different countries⁽³⁸⁾. They are interpreted differently in the United States, Russia, Canada, Australia, Africa, Europe and South America⁽⁴⁸⁻⁵³⁾, which means that a person who is positive in Africa can be negative when tested in Australia; or a person who is negative in Canada can become positive when tested in Africa⁽⁵⁴⁾. The other problem is that the same sample of blood when tested in 19 different laboratories gets 19 different results on the Western blot test⁽⁵⁵⁾.

1.4. The Western blot antigens, proteins or bands - p120, p41, p32, p24/25, p17/18 - which are considered to be specific to HIV, may not be encoded by the HIV genome and may in fact represent human cellular proteins^(38-40,46,56).

1.5. The only valid method of establishing the sensitivity and the specificity of a diagnostic test in clinical medicine is to compare the test in question with its gold standard. The only possible gold standard for the HIV tests is the human immunodeficiency virus itself. Since HIV has never been isolated as an independent free and purified viral entity⁽⁵⁷⁾, it is not possible to properly define the sensitivity or the specificity of any of the tests for HIV⁽³⁸⁾. Currently, the sensitivity and the specificity of the tests for HIV are defined not by comparison to purified HIV itself, but by comparison of the tests in question with the clinical manifestations of AIDS, or with T4 cell counts⁽³⁸⁾. "At present there is no recognized standard for establishing the presence and absence of HIV-1 antibody in human blood. Therefore sensitivity was computed based on the

clinical diagnosis of AIDS and specificity based on random donors"⁽⁵⁸⁾. Since there is no gold standard for defining the specificity of the tests used for the diagnosis of HIV infection, all HIV-positive results for HIV infection must be considered false-positives.

1.6. There are abundant scientific publications explaining that there are more than 70 different documented conditions that can cause the antibody tests to react positive without an HIV infection^(38-40,43,45,56). In other words, there are more than 70 scientifically acknowledged reasons for false positives when testing for HIV. This fact has been abundantly documented in the scientific literature.

1.7. Of course, it is shocking to find out that a diagnosis of HIV infection is based on tests that are not specific for HIV. However, the scientific evidence tells us that a person can react positive on the test for HIV even though he or she is not infected with HIV^(38-40,43,47,56,59).

1.8. The pharmaceutical companies that make and commercialize the kits for these tests acknowledge the inaccuracy of them, and this is why the inserts that come with the kits typically state the following: "Elisa testing alone cannot be used to diagnose AIDS, even if the recommended investigation of reactive specimens suggests a high probability that the antibody to HIV-1 is present"⁽⁵⁸⁾. The insert for one of the kits for administering the Western blot warns, "Do not use this kit as the sole basis of diagnosis of HIV-1 infection"⁽⁶⁰⁾. The insert that comes with a popular kit to run viral load warns, "The amplicor HIV-1 Monitor test is not intended to be used as a screening test for HIV or as a diagnostic test to confirm the presence of HIV infection"⁽⁶¹⁾. The problem is that not only most AIDS researchers, journalists and lay people but health care workers themselves do not know these facts about the tests because they do not have access to them. There likewise appears to be little or no concern on the part of the knowing faculty of institutions to communicate these facts to physicians, let alone the general public.

1.9. Since the Viral Load results are given in copies *per ml* of plasma⁽⁶¹⁾ AIDS researchers, health care professionals, and lay people may think that they represent copies or counts of the virus itself^(38,62-67). However, the Viral Load test only makes copies of fragments of nucleic acids. It does not count HIV itself. A positive viral load test cannot be regarded as signifying the presence of the whole HIV genome, and therefore the test cannot be used to measure virus.

1.10. Results of the Viral Load test cannot be reproduced. This can be seen in the wide range of variability that is accepted in the quality controls set by the companies that make and commercialize the test kits. For example, Roche accepts low control having a variability between 880 and 7,900 copies per ml [Lot # 0034], and high control having a variability between 79,000 and 710,000 copies per ml [Lot # 0041] [Roche, Amplicor HIV-1 Monitor test Lot # 88618, expiration January 1999]. Most important of all, the problems with the lack of a gold standard for HIV infection also apply to the evaluation of the accuracy of the PCR or Viral load test^(38,67,68). As a consequence, the specificity of the Viral Load test for HIV has never been defined properly. Therefore, all Viral Load positive results are likewise potential false-positives for HIV.

1.11. People have the right to make informed choices⁽⁶⁹⁻⁷¹⁾. However, the right of informed choice implies a right to correct information. There is no justification for the fact that most people have not been informed about the serious

inaccuracy of the tests for HIV infection. Withholding or obscuring these facts is a serious breach of public trust, violating as it does a person's right to informed consent when making decisions about their health care. The legal implications of this situation has been noted ⁽⁷²⁾.

2. Being "HIV-positive" does not mean that a person is infected with "HIV".

The following scientific facts support the assertion that "being HIV-positive does not mean that the person is infected with HIV":

2.1. There are a growing number of scientific publications explaining in detail that the tests for HIV infection are not specific for HIV^(38-40,73). There are many reasons other than a past or present HIV infection to explain why an individual reacts positive on these tests. In other words these tests can react positive in the absence of HIV^(38-40,43-45,56).

2.2. Some of the conditions that cause false positives on the so-called "AIDS test" are: past or present infection with a variety of bacteria, parasites, viruses, and fungi including tuberculosis, malaria, leishmaniasis, influenza, the common cold, leprosy and a history of sexually transmitted diseases; the presence of polyspecific antibodies, hypergammaglobulinemias, the presence of auto-antibodies against a variety of cells and tissues, vaccinations, and the administration of gammaglobulins or immunoglobulins; the presence of auto-immune diseases like erythematous systemic lupus, sclerodermia, dermatomyositis and rheumatoid arthritis; the existence of pregnancy and multiparity; a history of rectal insemination; addiction to recreational drugs; several kidney diseases, renal failure and hemodialysis; a history of organ transplantation; presence of a variety of tumors and cancer chemotherapy; many liver diseases including alcoholic liver disease; hemophilia, blood transfusions and the administration of coagulation factor; and even the simple condition of aging, to mention a few of them^(38-40,43,44,56).

2.3. It is interesting to note that all of these conditions that cause the "HIV tests" to react positive in the absence of HIV, are conditions which are present with varied distribution and concentration in all of the conventionally recognized AIDS risk groups in the developed countries, as well as in the vast majority of inhabitants of the underdeveloped world. This means that in all probability many drug users [including mothers], certain gay males, and some hemophiliacs in the developed countries, as well as the vast majority of inhabitants in most countries of Africa, Asia, South America and the Caribbean, who have positive reactions to the tests, for HIV, may very well do so due to conditions other than being infected with HIV^(38-40,56,74).

2.4. Further, it is well known that people with or at risk for AIDS have high levels of antibodies - immunoglobulins - as a consequence of having been exposed to significant quantities of a variety of foreign substances such as recreational drugs, semen, Factor VIII, blood and blood components, sexually transmitted infections and other infections^(38-40,75). All these substances are oxidizing agents that cause oxidative stress^(73,76,77). Recently, one of us showed that all blood react positively on the ELISA test when run the test with neat or non-diluted serum⁽³⁶¹⁾. This can indicate that everybody has antibodies against what is supposed to be HIV. The ones that only react positively with straight or neat serum may have fewer amount of antibodies than the ones that continue reacting positively even when the serum is diluted 400 times⁽³⁶¹⁾, as it is usually run in the test⁽⁵⁸⁾. Since there is no scientific evidence that the ELISA test is specific for HIV antibodies, a

reactive ELISA test at any concentration of the serum would mean presence of non-specific or polyspecific antibodies⁽³⁶¹⁾.

2.5. There is also a great deal of scientific data indicating the widespread presence of non-specific interactions between what are considered to be retroviral antigens and unrelated antibodies ^(38,78-80). It is then possible to conclude that the tests for HIV react positively in the presence of those antibodies; in other words, that a positive antibody test for HIV may be the result of previous antigenic over-stimulation, rather than a result of an HIV or any other retroviral infection⁽³⁸⁻⁴⁰⁾.

2.6. Finally, it has been proposed that antibodies against HIV are surrogate markers for recreational drug use in the United States and in Europe^(81,82).

2.7. Being "HIV-positive" - reacting positive on the tests for HIV - would then mean simply that the person has been exposed to many antigenic and toxic challenges, i.e., to many oxidizing agents⁽⁷³⁾. His or her immune system has been responding a lot to these immunogenic and immunotoxic challenges^(77,83). The immune system of these "HIV-positive" individuals could eventually be debilitated - oxidized - after it has been over-stimulated, and therefore their risk for AIDS may be higher than those who are "HIV-negative"^(75,77).

2.8. On the other hand, even if "the AIDS test" were able to detect antibodies to HIV, it would not be logical to say that the presence of those antibodies indicate an active infection. The presence of antibodies to any virus simply means humoral immune response to that virus and not necessarily that the virus is still active and pathogenic^(74,84). One can have antibodies against many germs without those germs being active, pathogenically active or even present at all ^(84,85). In most instances, antibodies against viruses indicate immunity. This is the very basis of vaccination against viral diseases^(74,84,86). Even if the tests were specific for antibodies against HIV, the question would then be the following: Why is it that only in the case of AIDS the presence of antibodies indicates the presence of disease, rather than protection against it?

2.9. There is no justification for the fact that both patients and the general public have had all of the preceding facts withheld from them. Without the merits and demerits of the tests for HIV, people cannot make informed decisions.

3. The transmission and infectivity of AIDS is not real.

The following scientific facts support the assertion that "the transmission and infectivity of AIDS is not real":

3.1. Today, there is an alarming worldwide increase in toxic agents environmentally, in the workplace and in the home. Many new diseases can be attributed to exposure to these agents⁽⁸⁷⁾. The same is true for people at risk for AIDS. Different AIDS risk groups develop the same AIDS related diseases simply because they are exposed to the same agents - the same toxins or stressors - and not because they get or transmit a new virulent germ.

3.2. Within the groups at risk for AIDS, the trends of AIDS incidence parallel the trends of immunological stressor agents^(73,76,81,82,87,88).

For example, drug-addicted gay men who develop AIDS are usually exposed for long periods of time to alcohol, drugs, nitrite inhalants, sperm, STD's, other infections, anti-infective therapy, mental distress, and malnutrition^(77,81,83,87,88), all immunological stressor agents that although sexually related, are not sexually transmitted. In

hemophiliacs' blood, Factor VIII, infections, anti-infective therapy, and mental distress are present^(77,83,87,89,90); all these are immunological stressor agents that are related to their basic illness and not only to the transfusions. In babies born to drug addicted mothers immunological stressors like alcohol and other street drugs, congenital infections, and anti-infective therapy are present and can alter the baby's immune and other systems^(77,81-83,87). In the "third world", malnourished mothers transmit malnutrition to their babies with all its adverse immune and biological consequences^(83,91).

All these immunological stressor agents are enough to weaken and even destroy the immune and other systems. One does not need HIV - or any other germ - to either perform or explain this destructive job^(75,77,81-83,88,92).

3.3. The homosexual transmission of AIDS⁽⁹³⁾ is an assumption based on the high frequency of AIDS in a very specific group of drug-addicted gay men⁽⁹⁴⁾.

The belief in the heterosexual transmission of AIDS in Africa is also unsubstantiated^(91,95-98). It is based on the fact that in Africa both men and women have the same possibility of developing "AIDS". However, the conditions of life in Africa are bad for both men and women and instead of getting better, every day these conditions are getting worse⁽⁸³⁾. Very often, the diagnosis of "AIDS" in Africa is indistinguishable from the rampant symptoms of common tropical diseases^(91,93,99). In Africa, both men and women are exposed to the same immunological stressor agents. Therefore, no matter the sexual preference, everybody in Africa is at risk for AIDS. The same is true in places with similar conditions to Africa.

3.4. In the early 80's it was postulated that HIV was a highly contagious virus. However, now it is even accepted by mainstream researchers^(94,100-102) that seroconversion depends upon as many as 1000 sexual contacts of vaginal intercourse, and from 100 to 500 contacts for anal intercourse^(81,82).

Note also that seroconversion from HIV-negative to HIV-positive can occur in the absence of sexual transmission because of continued exposure to immunological stressor agents - oxidizing agents - during sexual activities, such as pharmaceutical aphrodisiacs^(38-40,73,76,77,83).

3.5. Mainstream researchers do not consider immunological stressor agents as risk factors for AIDS^(83,92,94,103,104). They do not feel the need to do that. In fact, everybody seems to be hypnotized by HIV, using as they do an HIV diagnosis not to reveal, but to conceal these risks, the true etiologic, or causal factors for AIDS⁽¹⁰⁵⁻¹¹¹⁾.

3.6. If AIDS were a physically contagious disease, an exponential growth of cases would be seen in the general population, at least during the early phase of the outbreak. But instead, AIDS remains confined to the same groups in which it was first observed^(94,103).

3.7. There is still not a single case of AIDS acquired by health care professionals at their work sites^(81,82,94,112). In all the alleged cases it is found that the health care worker who tested positive for HIV, or who developed AIDS, did so due to their exposure to immunological stressors other than HIV^(77,81-85).

3.8. There is still no scientific proof of the wife of a hemophiliac with AIDS contracting the syndrome from her husband^(89,94,113,114).

3.9. The perinatal transmission of HIV from HIV positive mothers to their babies is likewise theoretical. Even the HIV/AIDS supporters agree that vertical transmission of HIV is very inefficient⁽¹¹⁵⁾.

3.10. UNAIDS, UNICEF and the WHO, all agencies of the United Nations, are currently promoting a worldwide campaign to stop HIV-positive mothers from engaging in the healthy practice of breastfeeding their babies on the pretext that in this way it is possible to prevent the transmission of HIV⁽¹¹⁶⁻¹¹⁸⁾. However, after carefully studying 167 publications on this issue, a recent review states clearly that, "From the database analysis, we know that the relative role of breastfeeding in the epidemiology of AIDS is still uncertain"⁽¹¹⁹⁾. The transmission of HIV through breast milk is a scientifically invalidated assumption⁽¹²⁰⁻¹²²⁾. It is both illogical and counter intuitive to discourage HIV positive mothers from breastfeeding their babies. To do so is a dangerous and erroneous policy based on an unproven assumption. This is a violation of both the right of women to breastfeed their babies, and the right of babies to be fed with the breast milk of their mothers⁽¹²³⁾.

The logical conclusion of the foregoing is that the transmission and infectivity of AIDS has never been scientifically validated. It is merely an assumption that has morphed into dogma.

4. The risk of developing AIDS after being labelled "HIV positive" is unknown.

The following scientific facts support the assertion that "the risk of developing AIDS after being labelled HIV positive is unknown":

4.1. It is believed internationally that once receiving a positive result on the "AIDS test", an individual will develop AIDS at some moment in the future, this despite the fact that the latency period has increased every year since 1985^(13,16). However, the equation "HIV = AIDS" has never been scientifically validated. Even the pharmaceutical company that makes and commercializes the most popular test to run the ELISA test for HIV warns in the test kit, "The risk of an asymptomatic person with a repeatable reactive serum sample developing AIDS or an AIDS-related condition is not known"^(58,124).

4.2. According to the claims made at the 12th World AIDS Conference in Geneva, there are 31 million people throughout the world who are HIV positive⁽¹²⁵⁾. The vast majority of these people are absolutely healthy, and this is the reason why these persons are called "Long term survivors" or cases of "non-progressive HIV infection"^(6,126).

4.3. Even mainstream researchers state that "5-10% of HIV-infected people live for 10 years - perhaps 20 or more years - without developing AIDS-related symptoms or having any laboratory evidence of progression to AIDS"^(126,127).

4.4. Mainstream AIDS researchers are looking at the absence of the so-called "cofactors" in these "long term survivors" or "non-progressive HIV infections". These "cofactors" include "other sexually transmitted diseases, drug use, nutrition and stress", as well as genetic factors⁽¹²⁶⁻¹³⁰⁾.

4.5. It is also important to remember that in the scientific literature there are more than 5,000 individuals that have AIDS and are HIV-negative⁽¹³¹⁻¹³⁵⁾. These patients are dying from AIDS-related diseases that are not called "AIDS" because they are HIV-negative. In reality, they are dying from conditions caused by the same agents as the HIV-positive cases diagnosed as AIDS^(74,82,103). The supporters of the HIV-AIDS model arbitrarily decided to call these HIV-negative AIDS cases "Idiopathic CD4 T-lymphocytopenia"^(131,133).

4.6. The mortality in AIDS has been related to the presence of other factors such as the use of street-drugs, anti-viral medications, and not to HIV by itself (136).

4.7. In both HIV-positive and HIV-negative AIDS cases, it is always possible to find a variety of "cofactors" to which the patients were exposed, generally for long periods of time and always prior to the development of clinical AIDS (81-83,92). Since all these "cofactors" are well known agents able to cause immunodeficiency (73,76,77,81,104,137), it is much more correct to call them immunological stressor agents (77,83,104,137).

4.8. It is also interesting to note that there are some examples of HIV-positive individuals seroconverting to a negative state, then remaining that way for years (138,139).

4.9. As was stated above, reacting positive on the tests for antibodies to HIV most likely means that the person has been exposed to many antigenic and toxic challenges, i.e., to many oxidizing agents (38,73,76,77,83,92,137). His or her immune system has been responding to too many immunogenic and immunotoxic challenges (75,77,83). It is in this way that the immune system of "HIV-positive" individuals may be more debilitated - oxidized - than those who are "HIV-negative". And it is in this way that the risk for AIDS in "HIV-positives" may be higher. In other words: it is the exposure to immunological stressor agents that cause an individual to react positive on "the AIDS test". And it is this exposure which, if not stopped, could eventually cause the "HIV-positive" individual to go on to develop AIDS (75,77,83).

5. HIV is not the cause of AIDS.

The following scientific facts support the assertion that "HIV is not the cause of AIDS":

5.1. Most people believe that AIDS scientists know the mechanisms by which HIV destroys the immune system and causes AIDS. However, after more than a decade of "HIV science", no one has the answer for this basic question. The ways in which HIV supposedly destroys the immune system (1,3,140) are highly speculative (74,77,92,103,141-143). In a recent survey done by the journal *Science*, it was found that the main question that bothers most of the mainstream AIDS researchers is how it is that HIV destroys the immune system and causes AIDS (144).

5.2. Within both lay and scientific circles it is virtually unknown that for more than a decade, there has been a scientific debate about the etiology or cause of AIDS. In the March 1987 issue of the journal *Cancer Research*, Peter Duesberg from the University of California wrote his first article questioning the infectious model of AIDS (141). Since then many scientific articles, documents, and books have been written in different countries by dissident researchers and AIDS activists, trying to get a reappraisal of the unproven viral hypothesis for AIDS (75,88,92,105,106,113,141,143,145-151).

5.3. There are many scientific facts which show that HIV fails to fulfill the epidemiological, biological, even the common sense requirements to be the cause of AIDS (73,75,113,143,148-153).

5.4. HIV is neither necessary nor sufficient to cause AIDS, nor does it always precede the development of the syndrome (94,104,154). This is demonstrated by thousands of AIDS cases that are HIV negative (131,133,155). It is also demonstrated by a host of HIV-positive people who remain healthy and have never developed AIDS (74,104,113,146,154,156,157).

5.5. There are many individuals who first develop immunodeficiency and only later they become "HIV-positive" (158-162). It is however, a natural law that in all situations, including human diseases, the effect comes after cause.

5.6. The scientific data do not prove that HIV preferentially destroys T4 cells or has any cytopathic effect; they do not demonstrate that T4 cells are preferentially destroyed in AIDS patients, they do not demonstrate that T4 cell destruction is either necessary or sufficient as a prerequisite for the development of AIDS (92,103).

5.7. HIV like all retroviruses, has never been proven to be a pathogenic agent; therefore it cannot explain the immunological alterations, pathogenesis, natural history nor different clinical forms within the groups of people that develop AIDS (77,92,94,103,104,141,146).

5.8. Since it has never been proven that HIV can cause AIDS, the investigators that enthusiastically defend HIV as its cause have proposed a vast variety of agents as helpers or "cofactors" in the genesis of AIDS (1,140). However, these "cofactors" are by themselves causal agents of immunodeficiency and can generate AIDS with or without the presence of HIV (77,81,92,137,146). Again, it is for more accurate to call the "cofactors" primary immunological stressor agents (74,77,83,87,104,137,154). They are the real risk factors for AIDS. They are the etiological or causal factors of AIDS. They are the cause of AIDS.

5.9. It simply goes against common sense to propose an infectious cause of AIDS. The new and real circumstances that surround all the groups of people that develop AIDS with the greatest frequency is their exaggerated exposure in the last decades to a variety of stressor agents that have a chemical, physical, biological, mental or nutritional origin (77,104,137). People who develop AIDS are exposed both voluntarily and involuntarily to immunological stressor agents that are unique to either their conditions of life, or to their style of life (81-83,94,163).

5.10. The toxic and non-infectious nature of AIDS has been suspected since 1981, when the very first publication on it announced the first 5 cases (164).

6. The so-called "AIDS virus", HIV, may not even exist.

Biophysicist Eleni Papadopulos-Eleopulos and her group of researchers at Royal Perth Hospital in Perth, Western Australia, were the very first scientists to mention the fact that HIV has never been isolated (38). For several years Papadopulos-Eleopulos and co-workers have been publishing papers where they have described in detail the scientific facts that support the assertion that "the so-called AIDS virus, HIV, may not even exist". (38-40, 46, 56, 57, 73, 76, 168, 175, 177,179);

6.1. The correct procedures (57) employed for over half a century to achieve isolation of a retrovirus are: a) to find in infected cell cultures particles with a diameter of 100-120 nM that contain the so-called condensed inner bodies or cores and that have surfaces studded with projections - spikes, knobs - b) In sucrose density gradients the particles band at a density of 1.16 gm/ml; c) At the density of 1.16 gm/ml there is nothing else but particles with the morphological characteristics of retroviral particles; d) The particles contain only RNA and not DNA, and the RNA consistently has the same length [number of bases] and composition no matter how many times the experiment is repeated; e) When the particles are introduced into secondary cultures they are taken up by the cells, the entire RNA is reverse transcribed into cDNA, the entire cDNA is inserted into the cellular DNA, and the DNA is

transcribed back into RNA which is then translated into proteins; f) As a result of the cells in the secondary cultures release particles into the culture medium; g) The particles released into the secondary culture medium have exactly the same characteristics as the original particles, that is, they must have identical morphology, band at 1.16 gm/ml and contain the same RNA and proteins⁽⁵⁷⁾.

None of these procedures have been achieved in the case of HIV^(38,40,57,73).

6.2. None of the researchers who claim to have isolated HIV have shown the presence of particles with the morphological characteristics of retroviruses banding at 1.16 gm/ml⁽⁵⁷⁾.

Even the word "isolation" as used by the most noted researchers⁽¹⁶⁵⁻¹⁶⁷⁾ is incorrect and misleading since neither Montagnier, Gallo nor Levy isolated HIV particles, particles of any other human retrovirus, or even virus-like-particles at all^(38-40,56,57,73,142,168-174).

6.3. Since no "retroviral particles" [retroviruses] have ever been isolated from any culture^(38-40,57,73,168-177), the existence of HIV has been established indirectly: by the presence in blood cultures of AIDS and "HIV-positive" individuals, proteins/glycoproteins such as gp 160/150, gp120, gp41/45/40, p34/32, p24, and p18/17, each claimed to belong to HIV; by the presence of enzymes such as reverse transcriptase that supposedly belongs to HIV; and by the presence of RNA or DNA fragments that supposedly belong to HIV^(38, 40,57,73,168-175).

However, none of these substances have been proven to belong to HIV at all^(38-40,57,73,168-175). How can anybody prove that the substances found in those cultures belong to a viral particle that has never been found at 1.16 gm/ml? To prove that those substances are part of a retrovirus named HIV, it is absolutely necessary that the retroviral particles have been previously separated - isolated - from everything else. This has never been done with HIV⁽⁵⁷⁾.

6.4. It is interesting to note that the substances listed in 6.3. are claimed to appear exclusively when one culture supposedly infected blood with abnormal cells from leukemic patients, or from umbilical cord lymphocytes⁽⁵⁷⁾. The problem is that the same substances can be obtained from the same cultures in the absence of the supposedly HIV-infected blood⁽⁵⁷⁾.

6.5. The cultures where the above substances have been found are cultures that have been heavily stimulated with substances such as phytohemagglutinin, IL-2, antiserum to human interferon, and other agents⁽⁵⁷⁾. These culture stimulants are oxidizing agents^(57,73). The problem is that the same type of material can be observed in stimulated cultures of lymphocytes from healthy persons^(57,178).

It is interesting to note than in the presence of antioxidants, no HIV phenomena can be observed in culture; nor can HIV substances be found^(38,178,179).

6.6. The substances listed in 6.3. are not specific to HIV at all⁽⁵⁷⁾. For instance, it is currently known that reverse transcriptase can be found associated with entities other than retroviruses, including eukaryotic cells, some animal and plant DNA viruses, and even some introns⁽¹⁸⁰⁾. Gallo and co-workers have claimed that the cell-free supernatants from "infected" cultures have HIV-DNA^(181,182). They forgot that by definition retroviruses are infectious particles which contain only RNA. When retroviruses enter a cell the RNA is reverse transcribed into DNA, which is then integrated into cellular DNA as a provirus, which means that "HIV DNA" will be present only in the cell and no where else⁽⁵⁷⁾.

There is also ample evidence that any RNA or DNA present in the supernatant of the cultures is there as an

effect of stimulation by polycations and oxidizing agents, rather than as an effect of the presence of a retrovirus⁽⁵⁷⁾.

"HIV cloning" is likewise misleading. Without isolating a retroviral particle containing RNA inside its core, the cloning of that "specific HIV-RNA" is not possible⁽⁵⁷⁾.

6.7. To date nobody has presented evidence that the so-called HIV proteins or antigens [gp160/150, gp120, gp41/45/40, p34/32, p24, p18/17], are constituents of a retrovirus particle or even retrovirus-like particle let alone a unique retrovirus, HIV⁽⁵⁷⁾.

6.8. The proteins or antigens derived from stimulated cultures form the basis for the ELISA and Western blot HIV antibody tests^(57,173). Fragments of RNA from stimulated cultures form the basis of the HIV Viral Load test^(57,173). This is the main reason why the current tests used for the diagnosis of HIV are not specific for it^(38-40,57,168,175).

6.9. In the January 1997 issue of the journal *Virology*, two independent groups of researchers published experiments claiming to isolate HIV. For the first time in the history of HIV, the researchers followed the internationally accepted procedures to isolate retroviral particles. Not surprisingly, in the sedimented bands at 1.16 gm/ml of sucrose, where retroviruses are known to be located, nothing was found but cellular debris. At 1.16 gm/ml there was nothing that even looked like a retroviral particle^(183,184). They could not have isolated HIV simply because HIV was not there to be isolated.

It has been proposed that all those substances that indicate the existence of HIV are nothing more than non-viral material altogether, induced by the agents to which the AIDS patients and cultures are exposed⁽⁵⁷⁾. When found in people, these substances would be seen as regular products of the stress response⁽¹⁸⁵⁾, secondary to exposure to chemical, physical, biological, mental, and nutritional stressor agents^(74,77,83,87,104,137, 148,154).

6.10. It is therefore possible to conclude that the entire model of AIDS as an infectious and transmissible viral disease has its basis on a non-existing organism. The foundation stone for the HIV-AIDS model then, is a ghost.

7. "AIDS" is a toxic and nutritional syndrome.

The following scientific facts support the assertion that "AIDS is a toxic and nutritional syndrome":

7.1. The toxic nature of AIDS was suspected since the announcement of the very first five cases of AIDS in Los Angeles: "All 5 reported using inhalant drugs"⁽¹⁶⁴⁾.

7.2. In the early 80's, researchers proposed the possibility that drugs were the cause of the new disease first diagnosed in young drug-using gay males⁽¹⁸⁶⁻¹⁸⁹⁾. Nitrite inhalants or "poppers" were the recreational drugs suspected of being the culprit^(186,190).

This logical hypothesis was supported by studies demonstrating the immunotoxic and carcinogenic effects of nitrite inhalants^(158,191-193). Also the first epidemiologic studies both in Europe and the United States linked AIDS to inhaled nitrites and to other recreational drugs such as cocaine and amphetamines^(194,195).

7.3. The hypothesis that street drugs could cause AIDS was then known as "the lifestyle hypothesis"⁽¹⁸⁹⁾. In 1983, just a year after the first cases of AIDS were announced, researchers from the CDC abandoned the lifestyle hypothesis in favor of a transmissible agent⁽¹⁹⁶⁾. They even conducted research to try to prove that the lifestyle hypothesis was wrong^(195,197).

7.4. Early during the HIV era, John Lauritsen and Frank Buianouckas were some of the first who began to warn about the possibility that recreational drugs were the real cause of AIDS (147,163,198).

Peter H. Duesberg, the retrovirologist from the University of California at Berkeley named this possibility the "drug-AIDS hypothesis" and has used very elegant and detailed arguments to describe it (81,82,94,145,146,156,199,200).

Supporters of the HIV-AIDS hypothesis have recently published attempts to falsify the drug-AIDS hypothesis (201,202). However, neither of these efforts was able to show a single case of AIDS without previous exposure to recreational or antiretroviral drugs in the developed countries (201,202). The HIV believers have gone even further in their attempt to diminish the etiologic role of drugs with assertions such as "heroin is a blessedly un toxic drug" (203).

7.5. Almost 100% of the gay male AIDS cases occur within gay male drug users (82,153,204,205).

Many reports link AIDS and more specifically Kaposi's sarcoma to the use of nitrite inhalants, otherwise known as "poppers" or the "gay drug" (152,163,192,193,201, 206,207).

Also, a large proportion of gay men are now using steroids cosmetically (208).

About 30 % of the AIDS cases in Europe and the United States occur in intravenous users of cocaine, heroin, and other drugs (82,209). Practically all of the female and heterosexual AIDS cases in the developed world are intravenous drug users (82,210).

Supporters of the HIV-AIDS hypothesis reject drug use as a risk factor for AIDS, going only so far as to accept it as a risk factor for "unsafe sex" (211,212).

7.6. About 1% of all AIDS patients in the developed countries are intoxicated babies born to drug addicted mothers (209,213-218).

Intoxicated babies "used drugs" because their mothers used drugs while carrying the fetus (219,220). It is interesting to note that T-cell levels of these babies went up to "normal" one or two years after birth, despite being HIV-positives. The ones who did not recover were the ones treated with AZT (219).

In Europe, most of the babies born to drug-addicted mothers are able to recover from bacterial infections, pneumonia, yeast and cryptosporidial infections, despite being HIV positive, and stay healthy at 6 years of age (213,221).

In the European study, 40% of the children died. Those who died were exactly the same ones who were treated with AZT (213,214).

7.7. The HIV/AIDS supporters accuse us of not being able to differentiate cause from confounding factors (222). We think that it is time for them to start watching their own epidemiological steps.

The epidemiological association between chemical, physical, biological, mental and nutritional immunological stressor agents and AIDS is easily demonstrable (74,77,83,87,104).

One can always find immunological stressors acting as etiologic factors in AIDS [predisposing, starting, and keeping risk factors]. They are always present in the groups of people developing the syndrome: drug abusing gay men, IV and non-IV drug users and alcoholics, prostitutes, babies born to drug-using or malnourished mothers, hemophiliacs, users of antiretroviral medications, AIDS-phobic people, Central African, Caribbean and similar people, African and Hispanic Americans, and in individuals exposed to immunological stressors in their work places (77,83).

7.8. Malnutrition is known as the world's first cause of

immunodeficiency (223). Poverty is the main risk factor for malnutrition. Economic disparities have increased all over the world, but mainly in Africa, Asia, Latin America, and the Caribbean, as well as in the large impoverished strips of the developed cities. Never before has poverty been so prevalent and intense, nor has affluence been so big and concentrated in the hands of so few (87,224,225).

Recreational drugs also induce suppression of appetite and fatigue (81,226-229).

7.9. There is an enormous amount of scientific evidence showing the cytotoxic and immunotoxic properties of all recreational drugs (158,193,226,229-232). Recreational drugs can also act as carcinogens in animals and humans (233).

The immunosuppressive effects of recreational drugs are decreased after stopping their use. This immunological improvement has been recorded for both adults (234-237) and babies after birth (213,219,238).

The degenerative effects of immunological stressors on the immune system network have well known immunotoxic and immunogenic mechanisms (75,77,137). At a molecular level, these immunotoxic and immunogenic effects generate a state of oxidative stress (73,77,179,239), which is generally concentrated in the mitochondria (240,241). A causal relationship between immunological stressors and AIDS has been documented (77).

7.10. The metabolic disturbances, infections, opportunistic infections and tumors seen in AIDS patients are a consequence of the action of immunological stressor agents on the immune and other human systems (75,83;Giraldo 1997c).

The varied clinical manifestations of AIDS, otherwise known as "AIDS-defining diseases", are different for each group of people developing the syndrome, simply because different stressors generate different diseases. Each group of people at risk for AIDS is exposed to group specific stressors (75,82,83,89,242-244).

7.11. AIDS is a new syndrome because in developed countries the recreational drug epidemic is new (87,217,218,245-247), and because never before have the people of Central African countries and similar countries in the under developed world been as poor and malnourished as they are now (83,87,224,225).

Street drugs and malnutrition are the main etiologic risk factors for AIDS in both developed and in under-developed countries. The recreational drug epidemic is reaching such a high level in the United States that almost 80% of all one dollar bills have detectable amounts of cocaine, since the bills have been rolled for drug inhalation (248).

7.12. In short, AIDS is a severe acquired immunodeficiency due to multiple, repeated, and chronic exposures to immunological stressor agents, with degenerative immunotoxic and/or immunogenic effects on immunocompetent cells and immunological chemical reactions. These progressive and continuous assaults on the immune system network bring the individual into a functional immunological deficit, with the subsequent appearance of infections, neoplasias, and metabolic conditions, all leading to a probable early death. Therefore AIDS rather than being an infectious syndrome, is a chronic degenerative toxic/nutritional one (83,104).

7.13. At the molecular level, AIDS is caused by an excess of reactive free radicals, specially oxidizing agents (73,77,179).

8. All antiretroviral drugs are highly toxic to humans.

The following scientific facts support the assertion that "all antiretroviral drugs are highly toxic to humans":

8.1. After more than a decade of treating and trying to prevent AIDS with antiretroviral therapies, neither individual nor public health benefits have been achieved (200,249,250).

8.2. Zidovudine [AZT], the most popular of the AIDS medications, was originally developed for chemotherapy in cancer, but due to its toxicity it was never approved for human use (251). AZT is now licensed by the Food and Drug Administration [FDA] as an anti-HIV medication (81,252,253).

AZT is a potent cytotoxic DNA chain-terminator (81,82).

The toxicity of AZT, the drug now prescribed indefinitely to both healthy HIV-positive individuals and to AIDS patients, has been solidly documented (81,88,152,198,254-257).

AZT is highly toxic to human cells, including T4 lymphocytes, at the "antiretroviral" dosage recommended by the manufacturer (256).

The immunotoxicity of AZT, as well as its myelotoxicity [toxicity to the bone marrow], are very well recognized (258). Granulocytopenia [decrease of white blood cells called granulocytes] is one of the most common effects seen in persons treated with AZT (259,260).

There are also very well documented investigations showing that AZT has carcinogenic properties with respect to fast growing human and animal immune and other cells (256). In humans, AZT increases the risk of lymphomas by 50 times (261). And AZT has been confirmed to be carcinogenic in mice (262-264). However, AZT is sold in the United States, where it is illegal to sell drugs that are carcinogenic (114,263,265).

AZT can also cause anemia, lymphocytopenia, hepatitis, pancreatitis, myositis, muscle atrophy, wasting disease, dementia, lactic acidosis, severe hepatomegaly with steatosis, vasculitis, and it prevents mitochondrial DNA synthesis (266-270).

The toxicity of AZT is so well documented that the pharmaceutical company that makes and commercializes it typically writes, "Retrovir (Zidovudine) may be associated with severe hematologic toxicity including granulocytopenia and severe anemia particularly in patients with advanced HIV disease" and they add that, "Myopathy and myositis with pathologic changes similar to that produced by HIV disease, have been associated with prolonged use of Retrovir" (253).

The use of AZT for pregnant women can induce abortion, congenital malformation such as cavities in the chest, abnormal indentations at the base of the spine, misplaced ears, triangular faces, heart defects, extra digits and albinism (271). This toxicity for embryos has also been documented in animals (272).

The American National Institute of Child Health and Human Development has warned about the toxicity of AZT for children (273). It is recognized that AZT impedes normal child growth and development (273).

AZT can also destroy non-growing cells, such as neurons and muscle cells (270), thus causing muscle atrophy (266,275-280), and dementia (269,281).

It is well known that a great deal of illegal actions were carried out to achieve the 1987 FDA marketing approval of AZT (282).

8.3. The toxicity of AZT can be potentialized by other DNA chain terminators such as gancyclovir and acyclovir, drugs that are frequently prescribed together with AZT in the treatment and prevention of opportunistic viral infections (283,284).

8.4. Currently, the HIV-AIDS supporters are prescribing hydroxyurea, an inexpensive drug used for chemotherapy of leukemia (285). This too is an inhibitor of DNA synthesis.

8.5. The toxicity of the new protease inhibitors, prescribed as part of the so-called AIDS treatment "cocktails", is also well documented (286). The "cocktails" contain a protease

inhibitor in conjunction with two DNA chain-terminators (286).

Researchers have been documenting that persons on protease inhibitors are developing abnormal fat accumulations, termed "buffalo humps" and "crixibelly" (287-289).

The hepatotoxicity of protease inhibitors has also been documented (290). Dogs and rats treated with protease inhibitors develop hepatic cell necrosis 30 minutes after administration of the drug (291).

As time passes, more and more metabolic and endocrine disturbances are described in individuals placed on protease inhibitors. Recent studies report hypertrophy of the breasts; increase of blood sugar [diabetes], cholesterol, and triglycerides; abnormal subcutaneous and visceral fat accumulation; peripheral fat wasting and lipomatosis; pancreatitis and angina (287,288,292-294). Hypertriglyceridemia [high level of one of the fat components of blood] is being described in 79% of the individuals taking protease inhibitors (295). It has even been documented that protease inhibitors can induce the development of AIDS-defining diseases such as mycobacterial infections (296).

All these effects of the protease inhibitors are taking the edge off cocktail euphoria (297).

The scientific evidence shows that antiretroviral drugs are highly toxic to both humans and animals.

9. Antiretroviral drugs can by themselves cause AIDS.

The following scientific facts support the assertion that the "antiretroviral drugs can by themselves cause AIDS":

9.1. Many healthy HIV-positive individuals along with AIDS patients, are being placed on lifetime prescriptions of nucleoside analogues that act as DNA chain-terminators, such as AZT, the analogue of the nucleoside thymidine (25,26).

Currently, protease inhibitors are being prescribed as anti-HIV medications for the lifetime of the individual (11,27). All the drugs that are currently used as antiretroviral medications are drugs that act specifically on cells that are either metabolically active or in constant division (298). By definition, immunocompetent cells, as well as bone marrow cells, are cells that are dividing constantly. A very unique characteristic of the cells of the immune system is that they have to divide during the immune response (299,300). This makes the cells of the immune system much more vulnerable to the actions of these chemicals.

All the antiretroviral medications are known to be very toxic chemicals (81,114,143,152,301).

The toxic effects of AZT on people's immune systems have been documented (302). AZT was given to 14 healthy health care professionals who were exposed to AIDS blood through needle sticks and similar accidents. Fully half of the 14 health professionals had to quit the drug because of severe toxic effects. Neutropenia [low count of one type of white blood cells] developed in 36% of the 11 persons who completed at least 4 weeks of AZT treatment. 5 of the 14 individuals could not even make it to four weeks due to "severe subjective symptoms". One professional had to be stopped prematurely because his neutropenia was so severe that he developed a respiratory infection. These toxic effects developed in only weeks, while persons with an HIV-positive diagnosis often take AZT for years (302).

9.2. There is a great deal of scientific evidence showing that the antiretroviral drugs can induce the development of AIDS-defining diseases. The possibility that AZT may actually contribute to the pathogenesis of AIDS is real (77,81,88,137,152,256,257).

The British-French Concorde Trial found that AZT was unable to prevent AIDS, and instead increased mortality by 25%, compared to the untreated controls (303). Another

British study found that AZT prophylaxis decreased survival and induced wasting syndrome, cryptosporidiosis, and cytomegalovirus infection⁽³⁰⁴⁾.

The American MAC study showed that AZT increases of the risk of pneumonia, one of the AIDS defining diseases⁽³⁰⁵⁾. Studies often show that individuals given AZT have a worse prognosis⁽⁸²⁾, but the mainstream researchers prefer to blame HIV⁽³⁰⁶⁾.

Lymphocyte counts decreased significantly in humans treated with AZT, but not in the non-treated controls^(266,307). Interestingly, these are the experiments that the Food and Drug Administration Office evaluated before the licensing of AZT^(81,82,88,143).

Another study similarly found that AZT users experienced more rapid CD4+ cell depletion⁽³⁰⁸⁾.

Prophylactic AZT has also been shown to increase significantly the risk of AIDS in hemophiliacs when compared with the untreated controls⁽¹⁵⁹⁾.

Since AZT use has begun, the mortality of British HIV-positive hemophiliacs has increased 10-fold⁽³⁰⁹⁾. A similar finding has occurred with American hemophiliacs⁽³¹⁰⁾.

However, most of the AIDS researchers insist on blaming HIV⁽³⁰⁹⁻³¹²⁾.

9.3. The immunological alterations secondary to antiretroviral therapy and described in section 8, can be reversed after individuals stop taking these medications. 10 out of 11 individuals recovered their cellular immunity after stopping AZT⁽³¹³⁾.

Even patients suffering from severe pancytopenia and bone marrow aplasia recover after discontinuing AZT⁽²⁵⁴⁾. Clinical manifestations of mycobacterial infection started 1-3 weeks after starting the protease inhibitor Indinavir. Symptoms disappeared after the patients stopped the medication⁽²⁹⁶⁾.

Two babies born to mothers treated with AZT for 6 months and then treated themselves for an additional month and a half, developed *Pneumocystis carinii pneumonia*, one of the clinical manifestations of AIDS. Since the babies were HIV-negative, AZT was suspended and they completely recovered, remaining healthy beyond the one year period of observation^(115,314).

9.4. Merck itself, the pharmaceutical company that produces and commercializes the protease inhibitor Crixivan warns, "It is not yet known whether taking Crixivan will extend your life or reduce your chances of getting other illnesses associated with HIV"⁽³¹⁵⁾.

9.5. In animals, there are several examples of immunotoxicity due to antiretroviral medications:

Rats and mice treated with AZT for 7 weeks developed anemia, neutropenia, lymphopenia, thrombocytopenia, bone marrow depletion and weight loss⁽³¹⁶⁾.

In a similar experiment, mice were also treated with AZT for 7 weeks and developed anemia, leukopenia, thrombocytopenia and myelodysplasia⁽³¹⁷⁾.

Hamsters treated with AZT for one or two weeks developed T-cell depletion and atrophy of the thymus⁽³¹⁸⁾.

Mice treated with the drug for 2 weeks developed anemia, nephrotoxicity, and lymphotoxicity⁽³¹⁹⁾.

AZT is also toxic to the liver⁽³²⁰⁾.

The carcinogenic properties of AZT have been documented in animal experiments⁽³¹⁸⁾. AZT can stimulate leukemias⁽³¹⁷⁾.

9.6. Besides the antiretroviral drugs, healthy people who are "HIV-positive" are taking lots of prescribed antibiotics, anti-mycobacterials, antifungals, antivirals, antidepressants, as well as many over-the-counter medications^(321,322). All are potentially immunotoxic stressor agents⁽⁷⁷⁾, and all

help in generating AIDS⁽⁸³⁾.

The HIV-AIDS supporters will always have the excuse that HIV is mutating and developing resistance to the current medications. However, there is no scientific substantiation for the assertion that "HIV is mutating"⁽³²³⁾.

9.7. AIDS patients are also taking a polypharmacy of immunotoxic medications⁽⁸²⁾ that, rather than improving, very often debilitate the patient's immune and other systems, and therefore contribute to the eventual death of the individual. Medications such as metronidazol, pyrimethamine, daraprim, amphotericin B, clotrimazole, dapsone, interferon, pentamidine, vincristine, flucytosine, adriamycin, vinblastine, to mention some of the more frequently used, are potent immunotoxic, myelotoxic, lymphotoxic, nephrotoxic, hepatotoxic drugs^(77,284).

9.8. It is unethical, to say the least, to treat or prevent AIDS with medications known to be highly toxic to the cells of the immune system, of the bone marrow, and to the cells of other tissues and systems. The mainstream AIDS researchers are simply trying to stop the fire with gasoline.

10. Pregnant women, infants, and children are much more vulnerable to the toxic effects of antiretroviral drugs.

The following scientific facts support the assertion that "pregnant women and children are much more vulnerable to the toxic effects of antiretroviral drugs":

10.1. For decades, medical science has known that growing cells are much more vulnerable to the toxic effects of many different agents^(324,325). This has been the very basis for the effort to avoid exposing as much as possible, pregnant women and their fetuses to any potential toxic agent^(326,327).

It is also important to keep in mind that the immune system of a child only attains its own maturity after the age of ten^(299,300).

10.2. However, in the era of AIDS, AIDS researchers are changing all the rules. Currently, toxic medications are recommended and prescribed worldwide to pregnant women and children^(328,329). As of 1993, even HIV-free babies are taking AZT: this is because HIV-positive pregnant women are prescribed AZT for the last two trimesters in the hope of preventing HIV transmission from mothers to babies⁽¹¹⁵⁾.

Babies who test "HIV-negative" but who are born to HIV-positive mothers, are prescribed AZT anyway for six weeks after birth^(115,328,330).

10.3. Many HIV-positive healthy newborns, infants, and young children are placed on combinations of potentially immunotoxic medications such as antiretrovirals, antifungals, antivirals, and antibiotics. All are currently prescribed indefinitely as prophylactic drugs^(31,331).

It is as if they have forgotten the vulnerability of newborns and young children to toxic substances⁽³³²⁾.

10.4. The toxicity of antiretroviral drugs for embryos and fetuses has been documented in both humans and animals, as well as *in vitro*: AZT is a potent cytotoxic DNA chain-terminator^(81,82) and "it has been well known for many years that the compounds which can alter DNA metabolism often exhibit pronounced prenatal toxicity"⁽²⁹⁸⁾. The use of AZT for pregnant women can induce abortion, congenital malformation such as cavities in the chest, abnormal indentations at the base of the spine, misplaced ears, triangular faces, heart defects, extra digits and albinism⁽²⁷¹⁾. In some instances intrauterine growth retar-

dition has been documented⁽³³³⁾. The hemoglobin at birth in infants exposed to AZT was found to be significantly lower than in the placebo group^(115,334,335).

The American National Institute of Child Health and Human Development is well aware of the toxicity of AZT⁽²⁷³⁾. AZT has been shown to impede normal child growth and development.⁽²⁷³⁾

The toxicity of AZT in animal embryos has been recognized; if used before the implantation of the embryos, the effects seem to be even worse⁽²⁷²⁾.

When administered to pregnant mice, AZT reduced the number of fetuses by 60%, altered the liver of newborns, and caused a significant reduction of hematocrit in the pregnant animals⁽³³⁶⁾. A similar experiment with pregnant mice also showed a significant reduction in the number of fetuses⁽³³⁷⁾. These effects are worse if mice embryos are preimplanted⁽³³⁸⁾.

There are also *in vitro* data documenting the toxicity of AZT: it induces reduction in the number of thymocytes in cultured thymic lobes from rat fetuses⁽³³⁹⁾. It inhibited the erythroid colony formation of liver cells from mouse fetuses⁽³²⁰⁾. Also, exposure of two-cell mice embryos to zidovudine was consistently associated with significant inhibition of blastocyst formation⁽³⁴⁰⁾.

10.5. A recent comprehensive review of this issue concluded:

"Sufficient data regarding the safety of zidovudine in human pregnancy are not available"⁽²⁹⁸⁾.

In spite of the scientific evidence about the toxicity of AZT for pregnant women, a review of the issue by the National Center for Toxicological Research of the Food and Drug Administration [FDA] states that, "Initial human studies suggest that maternal use of AZT during pregnancy is very well tolerated by both mother and child and provides a promising degree of protection from vertical HIV transmission to the infant". And that, "Although *in vitro* and *in vivo* laboratory animal studies suggest the potential for toxicity with preimplantation exposure, the risk for teratogenic events after postimplantational exposures appears to be low at therapeutically effective concentrations of these dideoxynucleosides"⁽³⁴¹⁾.

It is unethical, to say the least, to insist on prescribing AZT and other antiretrovirals to prevent AIDS in healthy HIV-positive pregnant women, in infants, and in children. The potential cytotoxic, mutagenic, teratogenic, immunotoxic, carcinogenic properties of these chemicals have been scientifically documented^(82,137,329,342).

Before the AIDS epidemic, antimicrobials were only prescribed prophylactically for the prevention of a relapse of rheumatic fever⁽³⁴³⁾. There were no other exceptions. Besides, antimicrobial, especially antibiotics were only prescribed for short periods of time, like a few days for the treatment of an infectious disease. Why are they changing the rules now? Where is the scientific justification that researchers have for changing the rules now?

Conclusions and recommendations.

1. There are no scientific facts to support the following beliefs: that AIDS is an infectious disease caused by a retrovirus named HIV; that AIDS is a physically contagious illness transmitted through body fluids including blood, genital secretions and breast milk; that a positive result in the so-called "AIDS test" is indicative of infection with HIV; that once positive on the "AIDS test" the individual will develop AIDS; that a person who has a positive reaction to the "AIDS test" can prevent the development of AIDS by using several antiretroviral drugs; that the use of antiretroviral drugs can prevent the transmission of HIV from HIV-positive pregnant women to their babies; that AIDS can be treated with antiretroviral drugs; that the use of antiretro-

viral drugs is safe and free of harmful effects; and that therefore, it is rational to treat and prevent AIDS with antiretroviral medications. These are just unvalidated assumptions.

2. On the contrary, there are many scientific facts indicating that:

the tests used for the diagnosis of HIV are extraordinarily inaccurate; being HIV positive does not mean that the person is infected with HIV, the so-called "AIDS virus"; there are more than 70 different non-HIV related reasons to have a positive result on the "AIDS test"; the transmission and infectivity of AIDS is not real; the risk of developing AIDS after being labelled "HIV positive" is unknown; HIV is not the cause of AIDS; HIV may not even exist as a virus; what is called "AIDS" is a toxic and nutritional syndrome; all antiretroviral drugs are highly toxic to humans; the antiretroviral medications can by themselves cause AIDS; and that pregnant women, infants, and children are especially vulnerable to the toxic effects of antiretroviral medications.

3. The scientific data presented here demonstrate that it is not only irrational but indeed unethical to treat or prevent AIDS with toxic antiretroviral drugs in anybody⁽³⁴⁴⁻³⁴⁶⁾. Besides that, it is contrary to common sense to treat or prevent a highly toxicological syndrome with even more toxicity.

4. To treat or prevent AIDS with toxic antiretroviral medications is also a violation of the Universal Declaration of Human Rights.

Article 5 of the Universal Declaration of Human Rights states: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment"⁽³⁴⁷⁾. Therefore, no one has the right to "subject persons with HIV or AIDS to inhuman and degrading treatment even if purportedly in the community's interests"⁽³⁴⁷⁾.

5. The use of antiretroviral medications to treat or prevent AIDS should therefore be stopped immediately.

At the very least, there are serious legal implications with respect to the damage caused by these irrational treatments, as well as possibilities for legal suits and monetary compensation^(72,348-350).

6. It is likewise urgent that the entire conception of AIDS as an infectious and transmissible viral disease caused by HIV be reappraised immediately.

7. People have the right to know both sides of a story, especially when they have to make decisions regarding their own health care. Not informing people of all the facts - as mentioned in this article - is a serious violation of the person's right to make informed consent medical decisions^(69,71).

"Self-determination and autonomy have been recognized, in fact, as a fundamental moral value in US law and are routinely applied to a medical context. In the 1914 Schloendorff case, Justice N Benjamin Cordozo opined: "Every Human Being of adult years and sound mind has a right to determine what shall be done with his own body"⁽⁷⁰⁾.

"The requirements for informed consent are as follows: 1) The practitioner must disclose all information, including risks and benefits that a reasonable person would need to know in order to make a decision. 2) The one consenting must be competent and must understand the information provided. 3) The consent must be given voluntarily and without coercion"⁽⁷⁰⁾.

Is it really rational or even ethical to use toxic antiretroviral drugs in the treatment and prevention of AIDS in

pregnant women, infants, children or anybody else ?

It is the hope of the authors of this paper that the scientific arguments contained in this document can be used to alert people to the other side of the story.

DEDICATION

With this investigation, we want to honor the memory of Dr. Eduardo A. Verzini, MD, from La Plata, Argentina. Dr. Verzini died in May, 1998 of stress-related heart conditions after facing several years of court trials against him. He was accused of causing the HIV-positivity of some of his patients at "El Centro de Dialysis", a hospital for the treatment of kidney patients. Dr. Verzini was the Director of this hospital until it was closed by the Argentinean Health authorities, who argued that patients were infected with the "AIDS virus" there.

There is a huge amount of scientific documentation which shows that patients with renal insufficiency or in chronic dialysis programs - like Dr. Verzini's patients - react positive in the tests for HIV due to their deteriorated health, rather than due to infection with HIV⁽³⁵¹⁻³⁶⁰⁾.

Dr. Verzini's name is now added to the long list of people killed by the horrendous consequences of the belief that AIDS is an infectious and contagious condition.

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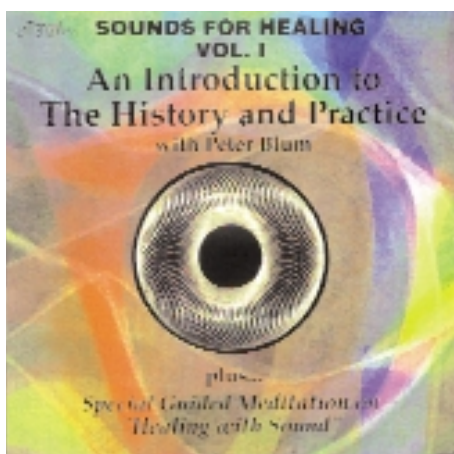
Good vibrations and the doctors of sound



Photo : courtesy of

Chloe Lola read psychology, physiology and philosophy at Oxford University. She is a regular contributor to *Time Out* and an avid clubber.

Music can provide solace. Whether you disappear inside the sound alone, or amongst others, music has a transporting power.



inner soundtrack. On reaching my destination, I'll carry on walking round a block, not wanting to stop the music, and re-assimilate into the outside world. My mother worries that I will go deaf, or not notice danger when crossing roads or walking home at night. But I need the sounds in my head, to get through the day, or forget the day as the case may be! Music: the best way to turn on tune in and drop out, without going into freefall...

Once my mother asked me to attend a birthing session for a pregnant family friend. I was sceptical as we sat in a circle with the other women, who began to tell stories, rich in calming imagery. Placing their hands on our friend, they began chanting. It was a far cry from the sounds I was used to, but within a minute I felt myself swoon and had to resist

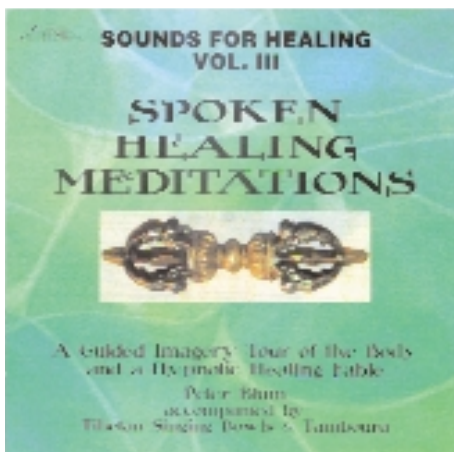
relaxing into a faint. I was shocked at the effect the sounds had on me, and subsequently not at all surprised to see a warning on volume IV of Peter Blum's *Music for Healing* CDs, not to "drive or operate machinery when listening...". A musician and therapist, Blum draws on ideas from all the ancient

cultures, who used music for healing, and combines them with recent research suggesting that the shape and form of sound waves can impact on the body beyond the senses, at a molecular level. The affect of 'good vibrations', just like that Beach Boys song, has a scientific basis: in changes to brainwave frequencies, respiration and heartbeat. This in turn affects the listener's mental state and physical health. The series of 4 CDs aims to impart these ideas and



evoke a more tranquil self-healing state. The first is an introduction wherein Peter speaks about the healing nature of sound; how it can 'help to centre you', this set against a backdrop of sounds. Tibetan 'singing' bowls, drums and tamboura (an Indian stringed drone instrument), are all introduced here. The sounds these produce are focused on without words in the second volume. In the third, a 'full body relaxation and guided healing dream story', Peter's monologues take on a hypnotic quality, as he guides the listener in a form of calming visualisation. Finally, the fourth volume is a series of explorations in similar sounds that have a (dangerously!) soothing effect.

My personal favourite was the second volume. Imagine sounds similar to wind chimes, or sitting quietly outside at dusk, after a summer party; that moment when the wind is in the trees is louder than faraway traffic. If this seems a bit airy-fairy, try the set for yourself! It's a showcase for the healing power of sound and rhythm.



For CDs contact Peter Blum
 pbtrance@ulster.net
 Tel + 1 914 247 8839
 PO Box 1027, Woodstock, NY 12490, USA

Towards the Construction of discourse on AIDS psycho-neuro-immunology

Russian data can suggest some insights

Dmitri Gousov

MS in Biochemistry; Kandidat of Sociological Sciences.

School of Health and Community Studies, Anglia Polytechnic University (Cambridge, UK), doctoral research fee student studying prospects of AIDS social work in Ukraine. Head of Club of Users and Practitioners of Naturopathy 'Mria' (Kiev, Ukraine); NGO-coordinator, Tacis LIEN Project 'Establishment of an informational and promotional network with a multidisciplinary approach to HIV/AIDS, focusing on natural and complementary therapies, social support and counselling for HIV+ diagnosed people in Ukraine' in partnership with NGO Therapeutic Self Help Group 'Mria' and Continuum.



Photo : Martin J. Walker

Veronica Kirichenko

MS in Human Physiology; Kandidat of Biological Sciences.

Biology Faculty, Dnepropetrovsk State University, assistant professor. Member of Club of Users and Practitioners of Naturopathy 'Mria' (Kiev, Ukraine) and human physiology consultant in Tacis LIEN Project 'Establishment of an informational and promotional network with a multidisciplinary approach to HIV/AIDS, focusing on natural and complementary therapies, social support and counselling for HIV+ diagnosed people in Ukraine' in partnership with NGO Therapeutic Self Help Group 'Mria' and Continuum.



Photo : courtesy of the author

Since 1984 when the lifestyle hypothesis of AIDS lost out to competition and was declared misleading, mainstream AIDS science has been focused on entirely micro-biological causes of progressing to AIDS-defining illnesses in hiv-diagnosed people - germs, cells, fluids, macro-molecules, etc.

On the contrary, the discourse of the anti-orthodox AIDS paradigm paid significant attention to behavioural and psychological causation of AIDS and death related to hiv+ diagnosis. Scientists ranging from virologists to immunologists, as well as alternative therapists along with journalists, writers and laymen directly affected by their hiv+ diagnosis, often mention the importance of psychological state of hiv-labelled people in progression to immunodeficiency and death, on the one side, and in long-term or possibly unlimited survival, on the other.

In the discourse of the latter the concept of 'bone-pointing' or voodoo death, which might be alternatively defined as a psycho-coding for death, is widespread now at both coasts of the Pacific Ocean.. The problem with this concept is, however, that obviously not everyone among 'HIV' believers is 'threatened to death'. Pure 'voodoo death' should be expected in a very small proportion of hiv+ diagnosed individuals with certain personality characteristics, especially suggestibility, along with specific circumstances facilitating psychological self-destruction up to death. If death by suggestion/hypnosis were such a universal weapon, it would be recognised by a number of experts and 'specialists' besides shamans and widely reflected in both scientific and public discourse, which is

not the case.

Of course 'bone-pointing' could be mildly understood as signifying only the development of psycho-somatic AIDS-defining illnesses as the result of deep internalisation of the commonly shared, 'truth about HIV' with its implied and announced necessity for hiv+ diagnosed individuals eventually to get ill. Indeed, clinical psychology and psychotherapy document a phenomenon of developing psycho-somatic symptoms of different illnesses ranging from heart diseases to those usually associated with infections in people who expect or sometimes even cherish the illness, if the inevitability of which they have been convinced by the referent group of others (first of all doctors, but also relatives, partners, friends and key communication circles). Nevertheless, clinical data of this sort deal with only exceptional cases, whereas publications on 'epidemic hysterias' despite being well argued, seem not to be recognised in the scientific community as reliable accounts worthy of further detailed examination. Thus, the occurrence of the possible less tragic effects of 'bone-pointing' expressed in mind-induced recoverable AIDS-defining illnesses perhaps should not be exaggerated. The 'AIDS Zone', another anti-orthodox concept to define a variety of psycho-coding pressures from the whole AIDS industry and its facilitators on the victims trapped by their diagnosis, is essentially a well-kept zoo where one can find different species, different kinds of t custodians, and different tolerance to the restrictions in freedom, the cases of death despite excellent care and the cases of apparent enjoyment of a full life.

We deem that 'voodoo death' as a public concept is both helpful and not. On the one hand, its metaphoric strength helps to draw attention to the multiple realities it signifies. On the other, it makes many specialists and laymen sceptical about its crucial importance, since for the majority of people it is hard to imagine how it would work with them or others. Our own observation of the immediate and long-term reaction on the introduction of this term shows that most people while recognising a real existence of

denotatum reflected by the concept of voodoo death, tend either to think with time about its irrelevancy for them or for the culture that creates the context of their existence: "I am definitely not a primitive aborigine", "I am quite sceptical about doctors", "I am not that paranoid about my health and death", or to misuse it for merely re-defining stigmatisation and all other forms of social and psychological pressures. It is not (only) about protective stupidity or mass hypnosis of people caught by 'AIDS Zone'. It seems that many hiv-non-believers and other escapers from the 'AIDS Zone' tend not to apply the concept of 'bone-pointing' reflexively and reactively. And some of them still fall down, who knows from really what.

In the scientifically shaped anti-orthodox AIDS discourse psychological conditions are included in a multi-factorial, system concept of AIDS under the broadly understood notion of stress. At the same time, whereas chemical and biological forms of stress affecting hiv-diagnosed individuals are explored extensively by the anti-orthodoxies and discussed in detail with many fine hypotheses suggested, psychological stress is usually appealed to either with the help of metaphors like 'bone-pointing' or with general references to psycho-neuro-immunology (PNI), a discipline studying the role of psychological stresses in immune functioning. The very fact of PNI's existence is often used as a proof for the possibility of psychogenic causation of immune collapse in general, and AIDS in particular. While appreciating this spontaneously developed scientific consideration of the role of psychological factors in AIDS causation, we feel that in a way it still gives implicitly a secondary priority to psychological impact in the range of multiple factors of possible AIDS causation. Our perspective is that anti-orthodox AIDS discourse has yet to develop a detailed trend focused on psycho-physiological accounts for biological disorders caused by hiv+ diagnosis, namely by the message about it.

Indeed, the best grounds for developing such a discourse could be PNI along with Psycho-neuro-endocrine Behavioural Medicine, Mind-Body Immunology and clinical psychology dealing with psychosomatic manifestations of illnesses, which all together could encompass almost the whole area of psychological factors of AIDS, including voodoo death. However, after more than 15 years of AIDS research AIDS-PNI in fact is still an abstract notion. Moreover, surprisingly, at present PNI is rather ambivalent about the causative effect of different stresses on weakening immunity.

Thus, in their recent report Vedhara and Nott (1996) described many current problems of PNI in the studies of stress-related immune dysfunction. First of all, it is the short-term stressor paradigm that has been used extensively in PNI research. Although PNI data 'suggest that the physiological effects of acute stress may persist long after the apparent departure of the stressor' and simultaneously 'impairments in cellular and humoral immunity have also been noted' (*Ibid*), a long-term or chronic stress is usually beyond the main research focus of PNI.

This is partly related to methodological difficulties in empirical studies of the connection between stress and immune impairment. One of the most important is a lack of agreement on what to mean by stress, either the stressor (e.g. the death sentencing message about HIV+ diagnosis) or the response (shock and other forms of emotional distress). In their own empirical study, for example, Vedhara and Nott found that usage of the definition of stress as stimulus can mislead PNI research with the results demonstrating allegedly no significant connection between the stress and immune dysfunction. If, however, the notion of stress used is of a response measured, in particular, by the levels of emotional distresses or other psychological disorders, then the reinterpretation of the

same observations can clearly demonstrate a strong connection.

There are many reasons in favour of using the notion of stress in the meaning of response. Whatever the nature of the stressor (chemical, physiological, psychological), the response will vary in different individuals and under different circumstances. Adaptive capacities will also vary. For instance, many people can easily stand for decades the intensive intake of toxic pharmaceutical anti-hiv drugs, which by no means should be interpreted as evidence of their harmlessness. Likewise, some people might not give a damn for their hiv+ diagnosis or easily cope with it, which by no means implies that this death-sentencing message on its own cannot lead others to the worst result. PNI itself has well-documented the existence of individual differences in responses to stressors and emphasises the role of mediating factors in the stress process (see *Ibid*).

Nevertheless, even PNI researchers oriented towards interpretation of psychological stress as an emotional distress lasting longer than exposure to the stressor rarely approach chronic stress (response) and the dynamic of its impact on the immune system, presumably because of numerous additional methodological difficulties in approaching it, let alone fundamental difficulties in monitoring immunity in the stressed individuals. However, voodoo death and other possible less severe ultimate physiological consequences of death-sentencing by hiv+ message (stressor) could well be a result of not a single acute stress, but rather of chronic stresses. If so, it would bear certain implications and recommendations in self-management for individuals stressed by their hiv+ diagnosis.

Given these considerations, has AIDS-PNI any chances to progress fast in the near future and to create a basis for anti-orthodox AIDS discourse on psycho-causation, while giving useful practical implications for the diagnosed people?

In suggesting a positive answer to this question, we think that anti-orthodox AIDS discourse on psycho-causation could be built up in a postmodern way. This would mean that given the current limitations of academic research in PNI and other relevant scientific disciplines and trends, while making the most of them and using part of their language and rules of action, the discourse should be constructed with the involvement of other non-academic languages and rules of action: the plurality of counter 'local' knowledges/discourses. Any boundaries and restrictions should be prohibited in the construction of new discourses, and only 'will to knowledge' should be appreciated and celebrated. Scientifically exotic concepts like 'bone pointing' and 'AIDS Zone', conventional theories, emotional personal accounts of stress experiences, dry empirical reports, insights of investigative journalists, judgements of experts, etc., etc. - all of them should be integrated in a multi-style, yet solid construction. And this construction should be exposed wherever possible, in places ranging from pubs and shooting galleries to international scientific forums, with a right for anyone to (try to) add his/her bit to the composition. At least for the sake of having a pass into scientific establishment it must comply with the notions and laws acting in the scientific community.

Discourse analysis focused on a variety of already existing knowledge claims could be helpful at the initial stage. A set of plausible models, insights and hypothesis for new AIDS-PNI may originate simply from the attention to the worldly discourse of the affected people, different AIDS practitioners and even 'HIV' researchers. As an example we would like to suggest some bits of our discourse analysis of the general immunology literature and HIV research reports published in Russian, as well as of the data of qualitative sociological study recently conducted

Science of stress

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Stress-Induced Immunomodulation. Implications for Infectious Diseases?

Ronald Glaser, PhD
Bruce Rabin, MD, PhD
Margaret Chesney, PhD
Sheldon Cohen, PhD
Benjamin Natelson, MD

Abstract

"There is now significant literature showing that psychological stress can down-regulate various aspects of the cellular immune response. It is also established that communication between the central nervous system and the immune system occurs through bidirectional signals linking the nervous, endocrine, and immune systems. Psychological stressors affect the immune system by disrupting these networks. In this overview, we discuss the implications of psychological stress-associated immune modulation and risk for infectious disease..."

Stress and Immune Function

At a molecular level, human immune function is mediated by the release of cytokines, nonantibody messenger molecules, from a variety of cells of the immune system, and from other cells, such as endothelial cells....These cytokines subsequently stimulate cellular release of specific compounds involved in the inflammatory response. Such biochemical alterations in immune function are, in part, induced by plasma hormone concentration changes elicited by a stressor subsequent to activation of the sympathetic nervous system and the sympathetic adrenal medullary and hypothalamic pituitary adrenal axes.^[1] The hormonal alterations induced by stress are responsible for the changes in cytokine concentrations because stress hormones alter the synthesis and release of the cytokines by leukocytes...."

Author Affiliations:

Department of Medical Microbiology and Immunology, Ohio State University Medical Center, Columbus (Dr Glaser); Pathology Department, University of Pittsburgh Medical Center, Clinical Immunopathology-CLSI, Pittsburgh, Pa (Dr Rabin); Department of Medicine, University of California, San Francisco (Dr Chesney); Department of Psychology, Carnegie-Mellon University, Pittsburgh (Dr Cohen); and Department of Neurosciences, New Jersey Medical School, University of Medicine and Dentistry of New Jersey, East Orange (Dr Natelson).

Corresponding Author and Reprints: Ronald Glaser, PhD, Department of Medical Microbiology and Immunology, Ohio State University Medical Center, 2175 Graves Hall, 333 W 10th Ave, Columbus, OH 43210-1239 (e-mail: glaser.1@postbox.acs.ohio-state.edu).

with our participation in Ukraine.

One of the facts, which drew our attention in the analysis of Russian orthodox AIDS publications was an observation of neurological disorders in hiv diagnosed patients regularly preceding any other health problems. In one Russian clinical study of 1992 (Yourin *et al.*) they reported that on the admission to clinic 92% of 'the infected' did not have any health complains and regarded themselves healthy. After the follow up lasting from 3 months to 1 year after the



Sergey Bratkov,
Untitled, 1998, Ukraine

registration of patients without symptoms or those with generalised lymphadenopathy, considerable shifts in the state of health were not determined in the observed group. Later, the first two deaths in the observed group in the context of the absence of the opportunistic infections were from a form of encephalitis, an illness of nervous system. Another clinical study reported that 10% of patients had neurological disorders as the first symptoms of AIDS development (Tkachenko, 1991).

Indeed, unlike AIDS patients, most hiv-diagnosed people receive their positive result while being clinically healthy, unless they are drug users and suffer from illnesses associated with their drug consumption. Usually they start to develop AIDS-defining symptoms after a lag period that may last from a couple of months to very many years. Orthodox AIDS science explains this merely as a latent period of hiv's inactivity in human body. However, an equally plausible explanation is possible.

Hiv+ diagnosis as a powerful stressor might immediately trigger some essential psychological mechanisms, which sooner or later, and to the extent dependent on individual psychological characteristics and other variables, damage first the nervous system. In turn, damages to the nervous system could affect the state of immunity, not the way around. At present it is not a subject for further discussion, for it is taken for granted and described even in student textbooks, that in a very complex way the nervous system controls all other systems of the body in general, and the immune system in particular. Obviously the morphological and biochemical mutilations in nervous system can cause the dysfunction of the immune system up to its total collapse. The task, however, remains to explore in depth how under which conditions stress itself can lead to neurological disorders.

That neurological impairments are hard to avoid for great many hiv-diagnosed people is suggested by many data of 'HIV' researchers worldwide. In particular, it was reported in Russian specialist literature that (1) patho-anatomic examination of the bodies of dead AIDS patients showed that 70-90% of cases had morphologically manifested changes in the neuro-tissues, and (2) 40% of people with full blown AIDS had neurological disorders (*Ibid.*).

The AIDS orthodoxy would offer a quick answer to a puzzling question: what are the mechanisms by which people diagnosed positive on antibodies allegedly to a virus supposed to cause immune-deficiency are quick to develop even morphologically observed changes in their nervous systems. It would be the bloody virus, which is attributed the capacity of damaging not only lymphocytes, but also brain tissues, thus causing dementia/encephalopathy, one of the official AIDS-indicator diseases. Yet, who apart from few practitioners and explorers focused on 'HIV-related encephalopathy' or 'AIDS Dementia Complex' (broadly defined so as to include a diversity of physiopathologic, psychological and psychiatric conditions such as perivascular multinucleated giant cells, microgliosis, reactive astrocytosis, lethargy, altered mentation, personality changes and memory loss) knows how dubious are the

data and theories in this messy trend of mainstream AIDS science? It is just amazing to see how easily 'hiv' infectionists detect fine psychiatric conditions and psychological disorders and speak about the efficacy of anti-retroviral administration in fighting them. And how reluctant they are to admit at least a possibility of entirely psycho-physiological and psychiatric accounts for the observed neurological impairments in 'hiv' labelled individuals.

Meanwhile, what would be a logical counter-argument to the knowledge claim that these impairments are caused by hiv-diagnosis-related psychological stress, but not by the assumed virus? A claim that 'HIV-related encephalopathy' is observed in infants who have no idea of viruses, death sentencing, treatments, etc.? Yes, there is even a fashion to report 'encephalopathy' in 'hiv' diagnosed kids. For example, if one undertakes a computer search of the 12th AIDS Conference *Abstracts-On-Disk* using 'encephalopathy' as the key word, (s)he will see that, in the context of claims like 'HIV' encephalopathy remains a major concern among HIV infected children (19 to 31% of children with AIDS) [abstract 12177] or that HIV encephalopathy is observed as the first AIDS symptom in 32% of paediatric cases [abstract 13375], out of 22 findings 9 report on 'HIV-related encephalopathy' in paediatric patients. However, one can ask further questions with which criteria so-called 'encephalopathy' diagnosed in kids? what was the pre-diagnosis neurological status of paediatric patients?, and, most importantly, to which extent these patients were really stress-free after hiv+ diagnosis? Hiv-diagnosis-related psychological stress does not necessarily amount to conscious fear of killing virus, and in the case of kids it might include post-diagnosis isolation and treatment regimes to which children are usually so sensitive. Without these considerations one cannot claim that paediatric cases of encephalopathy disprove the suggestions that it is hiv-diagnosis-related psychological stress that might cause first complications in neurological conditions and then, or via neurological disorders, the impairments in immunity.

Now, we have to clarify what main forms of psychological stress stimulus hiv-diagnosed adults are usually exposed to and what could be the responses to them.

It is commonly accepted that the message about HIV+ diagnosis is a stressor that has a psycho-traumatic effect on individuals, the scope, composition and activity period of which depend, in particular, on the features of individuals' personalities. In most cases, however, the immediate response is what is defined in the discourse of both specialists and the affected people themselves as shock or 'post-diagnosis Acute Stress Disorder (ASD)'. As our data demonstrate, and they are equivocal with other research, this extreme stress condition may last from one day to more than half a year extending this period in extremely rare cases, the typical period being a couple of days. This immediate emotional distress has its natural compensatory mechanism and in general it is not crucially harmful for the body and/or mind, unless its period grossly exceeds the norm. Nevertheless, for the majority of hiv-diagnosed people the shock in fact is not the only and final response to the stressor.

Although most hiv diagnosed individuals in their self-reports declare that the shock evoked by the message about their hiv+ status is gone relatively quickly, it does not mean they become stress-free and do not start suffering from a long term, chronic stress which substitutes the acute stress condition. This secondary form of stress often is not reported by hiv diagnosed individuals asked about stresses they experienced, because its emotional experience quite differs from that of the shock appearing immediately on receiving the message of a deadly diagnosis, which becomes for the diagnosed an internalised concept

of 'real stress'.

Chronic stress is also rarely recognised by health professionals as a common problem of hiv diagnosed people, for among psychological disorders characteristic for hiv+s the depression conditions are those most explicitly manifested and, thus, better studied. However, it is hard to define depression as a stress either in terms of stimulus or response. At the same time, although it may be true that depressed people are more vulnerable to infections, which signifies their weakened immunity, and that depression is often reported in hiv diagnosed individuals, it might hardly be caused by the message of an hiv+ result itself. Depression response is usually elaborated as one of the possible forms of secondary reaction to the stressors, sometimes a long time after the immediate activity of the stressor. Moreover, depression is a counter-stress reaction, since the very biological meaning of stress is to mobilise all internal resources of an organism, whereas depression is a demobilising condition. In hiv-diagnosed people it is most likely to happen at the stage when AIDS-defining illnesses start to emerge or conventional treatment regimes prove not to help.

Furthermore, the consensus about frequent occurrence of severe depression in hiv-diagnosed people might be challenged. For example, the data of Ukrainian research we participated in suggest that the occurrence, forms and levels of depression do not significantly differ in hiv+ (ex)drug users and non-tested people representing the same general population. What has been found, however, was that the levels of anxiety measured by relevant tests were abnormally high in hiv-diagnosed individuals. It is of no surprise, for almost all empirical psychological studies of hiv-diagnosed people univocally report observed anxieties. At the same time anxiety is definitely a stressful condition. Therefore, we reckon that it is anxiety that could be a measurable indicator of chronic stress permanently experienced by hiv+s as the result of receiving message about their diagnosis.

Permanent anxiety is often reflected by hiv-diagnosed people in the form of different fears and recurrent thoughts. One Russian study found that common psycho-traumatic results of hiv+ diagnosis are fears about losing jobs, social isolation, negative changes in relationships with friends and relatives, refusals of medical assistance (Belyaeva *et al.*, 1992). All these and other fears and anxiety thoughts could contribute to the patterns of chronic stress, which sometimes may not be detected without special techniques and may not be realised by the affected personalities themselves. However, the strongest among the fears, the fear of relatively quick death to which people are sentenced by the implications hiv+ diagnosis, is significantly underreported. Nevertheless, appreciating the quality of psychological research in the field we do not think that the data should be treated straightforwardly as the rare occurrence of this experience. There might be a methodological obstacle in monitoring this fear. Fears and thoughts of death are perhaps the last things people would be willing to talk about in mundane situations or if asked by practitioners or researchers, for it is one of the most existential experiences of human beings, as many trends in psychoanalysis and philosophy suggest. We hope that none will challenge an assumption that even hiv-diagnosed people with good skills in psychological self-management and coping cannot totally avoid fears and recurrent thoughts of death, and that these fears could be in the core of permanent anxiety.

With these considerations we would like to suggest that in building up the construction of anti-orthodox AIDS discourse on AIDS-PNI, latent chronic stress in the form of permanent anxiety with key fears of death create a basic framework for the next floors of the building.

There are numerous ways in which stress can affect an immune-system either directly or via causing structural and/or functional changes in organs and systems on which the immune response is dependent, including the nervous system. Anti-orthodox discourse contains a number of references to independent literature exposing relevant data and explaining the probable mechanisms of stress-related impacts on immunity. In the discourse of Russian experts in immunology it is also possible to find evidences to this. For example, the discourse suggests that stress can be accompanied with abnormalities like

- a) long increase in blood level of glucocorticoids causing the involution of thymus-lymphatic system and a brake on cellular mechanisms of immunity (Baraboy & Sutkovoy, 1997),
- b) involution of thymus and lymph nodes, which leads to lower immune resistance of the body (Abramov, 1992),
- c) changes in cerebro-vascular functions (Abramov, 1988),
- d) the appearance of 'stress proteins,' - auto-antibodies to normal body tissues (Tkachenko, 1990),
- e) oppression of the system of mononuclear phagocytes, decrease in T-helpers and increase in numbers and activities of T-suppressors (Korneeva & Shkhinek, 1988),
- f) increase in blood concentration of b-endorphins, which leads to the decrease of T4 cells in CD4/CD8 ratio (Uteshev & Korostelev, 1990),
- g) lower sensitivity of b-adreno-receptors (*Ibid.*).

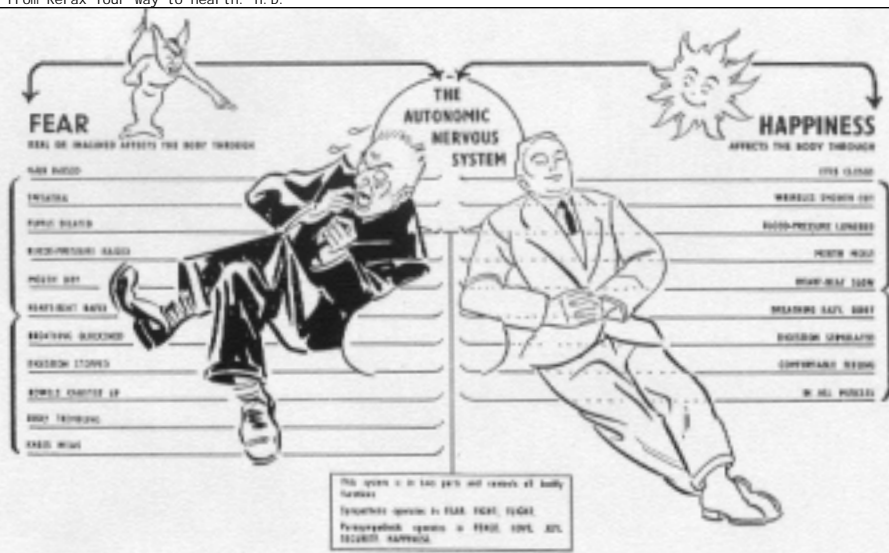
which the situation of forthcoming school exams is considered to be a stressor capable of resulting in high level stress, the CD4/Viral Load tests have to be automatically classified as high-stress bringers. In emphasising the importance of careful and detailed explorations in the cumulative effect of simultaneously acting stresses, we would also like to draw attention to our observation that in many cases of death attributed to AIDS an acute emotional distress immediately preceded the sharp collapse of health.

To sum up, while awaiting an AIDS-PNI anti-orthodox paradigm, as a matter of priority we should develop a consistent, yet plural, discourse on the psycho-neuro-causation of AIDS. This development has already been initiated by a number of *CONTINUUM* authors. However, many insights for it may originate from analysis of a variety of sources published all round the world in different fields and trends, in scientific, popular and mass media literature, as well as from not yet documented observations and anecdotal claims.

The importance of developing this thematic repertoire of anti-orthodox discourse is not only its contribution to further challenging the orthodoxy, but also in its practical implications helpful in the survival with hiv+ diagnosis. In particular, we believe that in the prevention of health crises in hiv+ diagnosed individuals, the development of the mechanisms of self-management and coping targeted at the reduction of permanent anxiety is of crucial importance. Adequately focused and properly conducted external psychotherapeutic intervention could help, but perhaps the majority of people have an internal potential sufficient, if fully mobilised, to prevent them from getting psychogenically ill.

If one looks at the long list of typical features of long-term survivors with hiv+ diagnosis published in *CONTINUUM* (V4, #4: 5), (s)he will note that more than half of them have something to do with sceptical, yet ultimately Positive Mental Attitudes (PMA) and naturally acquired skills in effective self-management. Usually the survivors of hiv+ diagnosis are people strong enough psychologically. But the clear sight of masked enemies, a rationality-based belief in the possibility to overcome them, and the weapon of adequate strategies could create an army of winners recruited from all sort of personalities. The grounded doubts about HIV existence coupled with hope and determination for survival with hiv+ diagnosis might empower the weakest with the ability to combat effectively undue health crises. Everybody can escape from the 'AIDS Zone,' if (s)he wants to and knows how. In this meaning *CONTINUUM* and other literature representing anti-orthodox AIDS discourse construct a sort of knowledge that has a health-bringing power.

From Relax Your Way to Heal th. H. D.



We would like to draw special attention to the last point in the list. The information link between nervous and immune systems of the body is served by endogenous opiate peptides, which carry out the role of neurotransmitters. Lymphocytes have relevant receptors to be regulated by endogenous opiate peptides. Given that stress might cause lower sensitivity of b-adreno-receptors and overproduction of opiate hormones naturally elaborated in stress conditions, it might result in damaged or broken regulatory links between the nervous system and cellular immunity, the ultimate consequences of which can be devastating for the immune system.

It seems that science has not yet got precise data on different changes in the organs and systems of the organism caused by acute and chronic stress conditions. Also, a cumulative affect of different stresses has yet to be examined. At the same time, social and medical conditions of a large proportion of hiv-diagnosed people present them with many occasional or recurrent acute stresses experienced in the context of the chronic stress. In particular, given that an examination model is widely used in PNI, in

and knows how. In this meaning *CONTINUUM* and other literature representing anti-orthodox AIDS discourse construct a sort of knowledge that has a health-bringing power.

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Healthcare professionals and public doubt over the value of medical biotechnology

"...the commonest exclamation which will be instantly made is - Would you do nothing, then, in cholera, fever, &c. ? - so deep rooted and universal is the conviction that to give medicine is to be doing something or rather everything: to give air, warmth, cleanliness, &c., is to do nothing. The reply is, that in these and many other similar diseases the exact value of particular remedies is by no means ascertained, while there is universal experience as to the extreme importance of careful nursing in determining the issue of disease."

Florence Nightingale (1859).
Notes on Nursing. What it is and what it is not.

It seems that a crucial issue for modern health care is the public's response to medical biotechnology, witness the current open debates raging about the value of screening technology in detecting illness and disease.

I will describe why this issue is an important one by using an approach that takes account of the diversity in public responses to biotechnology and the particular artifacts⁽¹⁾ of screening technology, like medical 'tests', often routinely applied to populations under the apparent guise of 'bettering' the 'public health'. A useful approach is to think seriously about these technologies, by paying attention to their characteristics as technical objects, or artifacts, and the meaning those characteristics often imperceptibly convey to the 'general public', who after all, comprise the 'end' consumer in modern day health services. This approach is useful because it may help both public and professional to focus on the way medical tests aim to detect phenomena of ill-health solely in terms of cellular or molecular events⁽²⁾. Armed with such technologies, health professionals are charged with marketing to a seemingly healthy public the message that they must '...come to us [health professionals], go through this procedure, and there will be a subsequent benefit'⁽³⁾. In practice, screening 'tests' bring few benefits and are often imprecise⁽⁴⁾; a fact now openly admitted by a British Government authority, the National Screening Committee (NSC). In 1998, the NSC, charged with determining U.K. standards in screening for all diseases, stated: 'Any [medical screening] test will find true and false positives, and true and false negatives. An ideal test only finds true positives and true negatives. In practice this is rarely possible, and there is a trade off between not missing real cases (sensitivity) and not finding false cases (specificity). It is because screening is rarely precise that much of the potential for harm may come.'⁽⁴⁾

Given the latter sort of 'official' disclosure on the efficacy

Kevin Corbett RN



Photo : courtesy of

of modern biotechnology it is not difficult to work out why this issue is so political for modern health services and why the debates on modern biotechnology and its safety are increasingly common amongst the 'general public'; fuelled by an ever increasing, some say justified, public skepticism over the politics of science and of course the tabloids' circulation wars. In the U.K., for example, women have notably impacted the efficacy debates on Cervical Screening; parents have contested the received wisdom on Mass Childhood Immunization⁽⁵⁾ and many groups are actively involved in the debates on Genetic Modification (GM) of foods. Also, scientific experts are seen to disagree on the 'correct' interpretation of scientific research as well as on how best to go about doing the research in the first place. This crisis point now reached in the public understanding of science is reflected in the current Eurocentric debates on what exactly are the criteria for an 'abnormal' Cervical smear⁽⁶⁾, what is really 'safe' about GM foods, or what 'really' causes 'BSE'/'new variant CJD'⁽⁷⁾; also it is reflected in the British public's reduced level of trust in scientists, reportedly now lower than its trust in the police force according to a recent U.K. poll⁽⁸⁾.

To further illustrate the nature of these debates, I will describe two differing responses that suggest a spectrum, or perhaps, a continuum exists in public responses to medical biotechnology. I practice as a Registered Nurse (RN) in a men's health service where often young men request sperm counts to measure their 'fertility' without any intent to father children. The way that they speak of this so-called 'simple' measure shows they actually perceive it as a test of their 'virility'. This is one style of response, a form of social incorporation of the available technology; it can alter the so-called purely 'technical' meaning in line with the social or 'technosocial' realm of the particular individual; a mode of self-reinvention, or self-encounter, within a technological 'space' or domain itself perceived as a 'socio-physical' environment - a form of *techno-nature*⁽⁹⁾. This consumerist style of response may impact health care via public expectations and also may be of utility in future commercial design or manufacture of the technology itself. For example, this year it was noted how public litigation in the U.K. has already influenced the industrial development and production of medical devices to be marketed in the new Millennium⁽¹⁰⁾.

Another response-style can be more difficult for health services to appreciate. It can arise after experts' endorsement of the specificity and reliability of screening technologies, based upon scientists perceptions of consensus on disease causation⁽¹¹⁾. For example, the British Department of Health



now says that HIV screening of all pregnant women, having no AIDS risk factors, is 'Better for your baby'⁽¹²⁾. Their leaflet says '...you will have time to think about your choices for care and treatment during pregnancy and labour...you can decide whether or not you want to breastfeed.'⁽¹³⁾ Yet the biomedical literature also cites evidence that pharmaceutical treatment with the anti-HIV drug AZT (zidovudine) damages human blood cells and bone marrow⁽¹⁴⁾; AZT has not been extensively tested in Phase 3 clinical trials and is still considered toxic for both adults and foetus. Some pregnant women and biomedical scientists⁽¹⁴⁾ now imply, what if 'Better for baby' is really misguided coercion to swallow pharmaceutical 'poison'; perhaps (yet) another dose of thalidomide or stilboestrol, yet another bitter pill to swallow with who-knows-what real (iatrogenic) effects?⁽¹⁵⁾

For example, in Oregon United States in October 1998, Kathleen Tyson - a woman with no AIDS risk factors - tested HIV antibody-positive after mandatory HIV screening whilst seven months

pregnant⁽¹⁶⁾. Tyson describes how by stealth she evaded perinatal transfusion of the anti-HIV drug AZT (zidovudine). Tyson's rebuttal to the doctors cited biomedical data on AZT's 'side-effects'; further data questioning HIV as the sole causative agent in AIDS; as well as querying the specificity and sensitivity of the HIV antibody test-kits (patronisingly 'dumbed-down' for the so-called 'general public' into a misnomer - 'the HIV test'), which incredibly, manufacturers' themselves warn may test 'false-positive' after a prior pregnancy⁽¹⁷⁾. Following the birth of Tyson's second child, named Felix, the State of Oregon judged Tyson to be endangering his welfare and legally enforced the administration of AZT syrup to Felix. Tyson's second 'option', if she was non-compliant, involved the State taking legal custody of Felix; some 'choice' for any new mother. Armed guards were reportedly posted outside her hospital room so insuring her compliance with court orders to medicate Felix and to stop Tyson breastfeeding her newborn. In 1999, this scenario was presented to the United Nations Commission on the Human Rights of Women⁽¹⁸⁾, cited as an example of abuse fuelled by the U.S. evangelical-style AIDS health legislation - the Ryan White Health Care Act. This U.S. legislation promotes screening of all pregnant women for antibodies to HIV, via the stick-and-carrot of increased central government funding.

Leaving aside the important issues over whether this increasingly common scenario represents either 'prevention-of-infection' or actually 'biomedical fascism' (and its ethical dilemmas for midwives, obstetric nurses, or RNs), what's different about Tyson's uptake of science is that her decision-making was perceived of as a danger to the baby, in context of the medical opinion that her positive HIV antibody-test result was a 'true' positive, perceived by the attending infectious diseases paediatrician as indicative of an infectious agency. Tyson's 'resistant' response-style incorporated so-called 'dissenting' biomedical views on AIDS causation and treatment. It parallels the current British parental opposition to Mass Childhood Immunization that is waging a lengthy battle in the British High Court against the U.K. Department of Health for allegedly suppressing information on the effects of Measles, Mumps and Rubella vaccines⁽¹⁹⁾. This all serves to

show how public resistance has great potential to subvert medical orthodoxy. It does represent a form of public dissidence or dissent, often only acknowledged as such in *samizdat*-style columns of public action magazines, like *CONTINUUM* or the *INDEX ON CENSORSHIP*, or within more academic journals. Unfortunately, this particular form of public resistance runs the precipitous gauntlet of coercion from health care professionals. For those who respond like Tyson, the discourse on 'informed consent/prevention of infection' reads more like 'enforced compliance/adherence', yet surprisingly the health professionals directly involved with Tyson (apart from her infectious diseases paediatrician), who may have done nothing verbally, behaviourally or politically in support of Tyson's view, could perceive they were 'truly' caring. How such disparity between the perceptions of 'patient' and 'professional' arise is partly influenced by the prevailing ideology, in this case the 'science-related social currents'⁽²⁰⁾ which institutionalize mandatory HIV antibody screening as a 'standard of care' (*sic*) in the U.S. and likewise for the U.K.⁽²¹⁾. Ideological currents can have their own peculiar agnostic effect on our professional view about exactly what it is we, as health professionals, think we are doing to people during institutionalized care-giving. For example, German doctors interviewed after the Second World War said they perceived they were 'caring' for inpatients on the wards of the Nazi's prison camps⁽²²⁾. Nurse Rivers reportedly thought she was instrumental in 'caring' for men from deprived communities throughout the Tuskegee Syphilis experiment⁽²³⁾. Knowing that ideology underpins health professionals' actions and decision-making in institutional care does not exempt us from a duty to look beyond medical ideology and its dogmas. To be able to look beyond the ideology and the dogma means that to begin with, you, have to be willing to see. And to see alternatives to a status quo, you need to know, not where to look, but how to see.

For today's end user of bio-technology (who is aware of its pitfalls) - the 'patient' (now 'client/consumer') - scenarios like Tyson's stand as *caveats* for the uptake of modern biotechnology, a consumer's warning, for those openly contesting dominant biomedical opinion that underwrites commercial development of ever newer biotechnologies. It is also implied that Tyson faced not only State-enforced medication but also ideological conformity to a perceived biomedical consensus, aided and abetted it seems by attending physicians and staff RNs directly involved - (but by all?). Health services appeared to enforce conformity by duping Tyson into thinking 'informed consent' meant she could refuse administration of AZT to her child; in reality what was meant was 'no choice'. Just 'knowing' that biomedical science embodies differing views on AIDS causation seemed to fail Tyson. Does the old adage 'knowledge-is-power' no longer apply if one dissents from a medical orthodoxy? Dissenting knowledge leads to the exercise of power through legal and other behavioural strategies, so the old adage likely still stands.

Differing public responses to medical biotechnology may indicate that specific skills and knowledge are needed so that health professionals can apprehend the nature and *caveats* of screening. If the education of health practitioners only attends to the technical tools and uncritically promotes biotechnical medicine, ignoring public apprehension over the design and arrangement of its artifacts, like screening tests, then health care practitioners may become ever more agnostic to that which is intellectually and practically crucial about modern biotechnology⁽²⁴⁾. In Britain, the professional body governing the Nursing and Midwifery profession, the United Kingdom Central Council (UKCC) for Nursing Midwifery and Health Visiting, determines that, "...each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to...recognize and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other



factor."⁽²⁵⁾ Therefore it can be argued that some health care professionals, like RNs, have a professional duty to respond to the public's need for 'care', independent of their response-style to medical biotechnology. From this, several implications may follow about the nature of the service we offer the public, if an increasingly science-aware and consumer-active public are not to be further turned off by established health services. The 'end consumer' of health services is the 'general public'. When consumers of care are discerning over biomedical science it must have a knock-on effect upon professional care providers and their educators. Professional practitioners and their educators need to be seen as accountable, open to scrutiny and mindful of the very real limitations of institutionalized science and the plurality of its public uptake. This highlights a rationale for a more knowledgeable and reflexive awareness on behalf of health professionals about the problems, (and not just the so-called advantages) of modern biotechnology which have demanded greater and greater slices of the health budget. In the case of increasing antibiotic resistance, health authorities are now reluctantly beginning to see some benefit in other strategies: the non-prescription of antibiotics ('watchful waiting'); people being encouraged to have a 'normal' bacterial flora (meaning 'free of chronic use of prescription antibiotics'); the potential negative public effects of pharmaceutical corporations on health service research; which have all fostered to a greater or lesser degree a blind faith in the efficacy of the 'magic [antibiotic] bullet' for every common symptom from the sore throat to ear ache⁽²⁶⁾.

The educators of health professionals also facilitate technical 'know-how' on behalf of health practitioners within the context of promoting their caring and empathetic skills, which are often highly valued by the public. If the education of health practitioners is politically entrusted with only the crafting of 'bio-technical' health professionals, to oversee the public's 'compliance' or 'adherence' to biomedical prescriptions, this may only act to bolster existing norms and power relationships, benefiting powerful pharmaceutical corporations and medical researchers in the process. Although it is known that some health professionals, like RNs, want to stay abreast of developing technology whilst also wanting to promote humane caring⁽²⁷⁾, nevertheless in reality the professional involved in the established health services too easily becomes just an uncritical prosthesis of modern day biotechnology. Using the example of nursing, the public's choice in terms of nursing personae may come to resemble little more than the 'choice' between, on the one hand the pharmaceutical straight-jacket of 'Nurse Ratched' in Milos Forman's film *One Flew Over The Cuckoos Nest*, or on the other hand the humane prowess of 'Carol Hathaway', the Charge Nurse of T.V.'s *ER*, whose technical proficiency always seems secondary to her humane caring. The question is not just one of health services being politically charged with producing bio-technical 'Nurse Ratched's' or humane 'Carol Hathaways', but more like how does the trade-off work between such power-laden and 'skillful' professional personae in order for a knowledgeable and critical public to have a proper choice when it comes to their own health care options? The education and training of health professionals is a tentative balance between public need and public expectation and is subject to commercial market forces and political involvement from Government⁽²⁸⁾. It may foster positive alliances between the public and health professionals, and encourage reflexive understanding on behalf of professionals of such issues⁽²⁹⁾; but these insightful developments should not be dependent upon enforcing public belief in the so-called 'rightness' of biotechnical options over other health choices. Health professionals need to apprehend how differing ideologies engender power-laden conflicts; within which professionals can never be truly neutral. The education and training of health care professionals can reflect a philosophy of science which embraces public challenge, like those on AIDS published by *CONTINUUM*, as well as varying degrees of scientific uncertainty or skepticism. In itself public challenge like that

described above, and in the other columns of *CONTINUUM*, should not replace the need for professionals' support of public decision to refuse biotechnology, health professionals' regard for human rights or their care for an increasingly knowledgeable and ever challenging public. The ambiguous nature of modern biotechnology and the diversity in the public uptake of such must mean that whilst a dissenting public may reject modern biomedicine, health care professionals cannot themselves choose ethically or scientifically to ignore those who dissent from modern biomedicine nor enforce public 'consent'. If so, then health care professionals are truly entering into a biomedical era more akin to Huxley's *Brave New World* or the agnostic *modus operandi* of some 'doctors' and 'nurses' in the Nazi era.

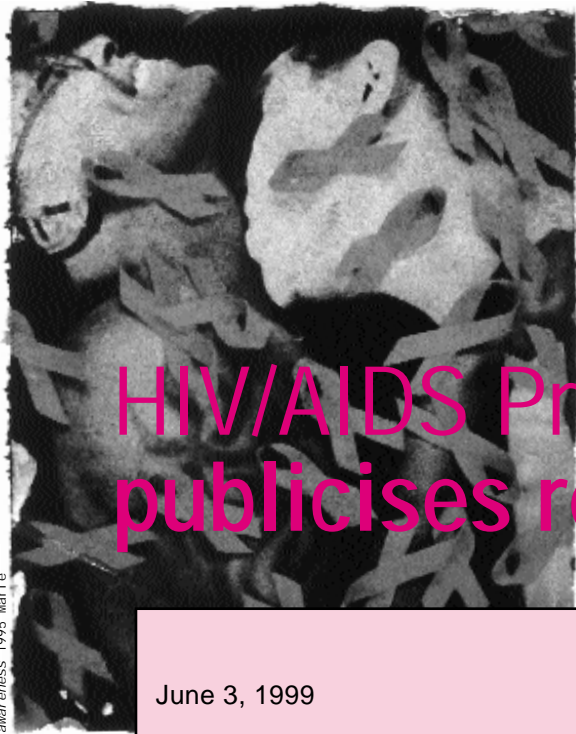
Comments on this article are welcomed. You can e-mail the author - kevincorbett@compuserve.com

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In Florida, the heat is on

HIV/AIDS Prevention Coordinator publicises resignation

June 3, 1999

Robin Keene, SCHNS, Communicable Disease Supervisor
Manatee County Health Department

Dear Ms. Keene,

Please accept my resignation from employment with the Health Department, effective two weeks from today, June 17, 1999.

After months of struggle and extensive research, I regret that I can no longer fulfill the Public Health mandated requirements of this position in good conscience. As you know, over the past year I have investigated scientific material that calls into question the very foundations of the Public Health response to AIDS. After careful consideration, I find that I can no longer promote HIV/AIDS Education or HIV Testing as mandated by the State of Florida, Department of Health. In addition, I cannot present AIDS education according to Public Health mandates. In doing so, I would be violating my own conscience, as those mandates acknowledge and promote only one scientific opinion regarding the cause of AIDS.

Upon careful investigation, it is woefully apparent that a grand schism has existed in AIDS research since Robert Gallo's politically charged announcement to the world that HIV is the probable cause of AIDS (1984). Unfortunately, only one side of the scientific data has been made readily available to the public. This side is far more powerful, backed by the financial storehouses of federal government agencies like the CDC and the NIH, who fund most public information campaigns and research programs. This dominant science is promoted and even manipulated by pharmaceutical giants, who have an obvious profit motive. The Public Health system and the pharmaceutical companies are the main source of information regarding AIDS for health care providers, and limit their information to one side of the scientific debate, ignoring and even suppressing contrary scientific research. Aided by a willing media, the Public Health Service has all but silenced contrary scientific opinions and thus denied the people their fundamental right to informed consent.

I hereby withdraw my participation from what may one day be seen as the greatest violation of the principle of informed consent in the history of Public Health.

Most sincerely,

Mark Pierpont
HIV/AIDS Prevention Program Coordinator

CC: Dr. Gladys Branich, Director, MCHD
Alice Gross, Nursing Director, MCHD
Wayne Walker, Human Resources, MCHD
Lisle House, HIV/AIDS Program Coordinator, Area 6

awareness 1995 Marie

Getting the hump with medicine

Martin J. Walker



Photo : Nigel Luckhurst

More Doctors Smoke Camels; Eye opening research and expert opinion on the soundness of medical beliefs.
by James Hilton.

ISBN 0-473-05921-5 International Press Publications, 150 Kings Street, Whakatane, New Zealand
90 pages, perfect bound, soft back.

Anyone wanting to set foot in the alternative history of medicine enters an informational labyrinth which makes the World Wide Web seem like a straight path to a suburban front door.

This is partially because what we think of as medicine is actually a many faceted, complex social phenomenon which shuns categorisation.

A body of bourgeois general doctors came into existence in the mid-nineteenth century, to service the health of the new middle class created by industrialisation. Now at the end of the twentieth century, in a post-industrial era, their power is on the wane and their position in the iconology of the developed world is being usurped by scientists. The doctors of the nineteenth century, were from the beginning, as a consequence of male insecurity, greed, class and individualism, part of an almost 'secret' professional cabal which like the legal profession, approached its 'clients' with a bleak disdain.

Since the birth of the General Practitioner, orthodox doctors have made little attempt to popularise their work. To the great majority of the population their own bodies remain the ultimate intellectual black hole; more mysterious than masonic rites and less governable than divine conception. Because society demands no public medical or scientific audit of doctors and because medicine is still seen mistakenly as a philanthropic vocation, the medical profession has literally got away with murder. They have escaped censure while holding the most whacky and perverse notions; spoken gibberish to the laity while posturing authoritatively; pursued racist, inhuman, sexually humiliating and sometimes criminal practices and they have thrown in their lot with industrial vested interests in blatant disregard of professional integrity.

It is therefore good to come across a short well written and thoroughly referenced text which successfully embraces, all the vital issues for which all good dissenters should reach when they hear the word doctor. Even I was surprised, despite being pickled with scepticism after writing *Dirty Medicine*, when I saw the scope of the material which James Hilton PhD has condensed in his book *More Doctors Smoke Camels*.

In an easily readable narrative, Hilton weaves his way across the minefield of medical madness discussing all the flash-points of phoney science including; orthodox responses to progressive medical innovation, the germ

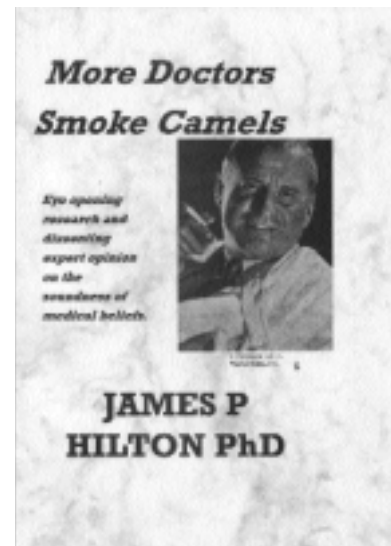
theory of illness, Rockefeller and profit driven medicine, the Vitamin C controversy, the IG Farben pharmaceutical cartel, drug companies and the Universities, medical testing - including testing for 'HIV antibody' positivity, the marketing of AZT, orthodoxy's defence of smoking, infant formula, lobotomy and medical experimentation, vaccination and water fluoridation.

In lesser texts this litany of medical perversity would read like a childish catechism of conspiracy; in the hands of Dr Hilton, who trained as a paramedic and now has a PhD in Public Health, it all appears eminently sensible. Hilton has written five other books, including populist anti-orthodox tides like *Burden of Proof* - *Surviving Cancer*, *AIDS*, and most other diseases.

It is not only the scope of this work which is impressive but also Hilton's exacting radicalism. All too often radical intent in this area translates into reformist conclusions or radicalism in one area is boxed-in with orthodox or even 'reactionary' arguments in another. Hilton's work, however, is the genuine article, radical and fundamentally challenging from its periphery to its core. If I have one criticism of the book's content, it is that while he cites almost one hundred references, he does not once mention *Dirty Medicine*!

To a young contemporary generation, the title of the book probably has a Pythonesque ring; older readers will guess almost immediately that it refers to Camel cigarettes. The title diminishes the book, turning, at first glance, a devastating critique of everything medical into something resembling a joky satire. This first impression of the book is not helped by the design of the cover, which would win any competition for the world's most moribund piece of graphics sight unseen.

Unfortunately the book which was published by Dr Hilton himself, bears other hallmarks of self-publication. Graphic or typographical *faux pas* include setting Chapter title pages on the left, having title headers on chapter title pages, setting the text in lines which are slightly too long for easy reading and horror of horrors, failing to provide an index. It is a shame that someone with such a good critical grasp of medical professionalism is apparently happy being professionally lax in typography, graphics and book design. While the text sparkles like diamonds, visually the book begs you to seek refuge in a migraine.



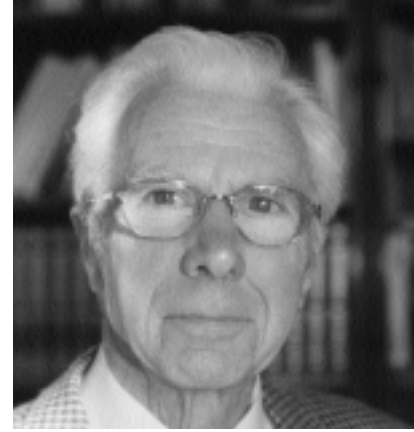
The AIDS Dilemma

Drug Diseases Blamed On A Passenger Virus

by Peter Duesberg¹ and David Rasnick¹

Genetica 1998; 104;85-132.

¹Department of Molecular and Cell Biology,
Stanley Hall, UC Berkeley, Berkeley,
CA 94729, USA



Prof. Gordon Stewart

A review of the above paper, by **Gordon Stewart, M.D.**,
Emeritus Professor of Public Health in the University of Glasgow;
former consultant, NHS, WHO and other Health Authorities.

Buried deeply within the secretive and well-guarded dogma that AIDS is a plague caused by a lethal virus HIV there is a time-bomb of potentially-explosive contrary information.

The chief guardians of this dogma are the selected, sometimes self-selected, high priests and scribes of medical science whose prestige discourages or threatens, and usually defeats any challenge from professional quarters. However, the academic publisher Kluwer is a bold exception which has, once again, in its peer-reviewed journal *Genetica* published a challenge by two scientific heavy-weights in the HQ of dissent in Berkeley, CA: Peter Duesberg and David Rasnick. So also is *CONTINUUM* which regularly opens its columns for debate, and is doing so again in inviting me to comment on this recent paper which expands the arguments Duesberg began to use in 1987, challenging the view that HIV was a lethal virus capable of causing AIDS in any or all of its many clinical variants. In the 38 pages of this article, he and David Rasnick have compressed evidence from many sources into a highly-readable, amply-referenced alternative viewpoint which should be listed as required reading for high priests, scribes and professionals, and helpful reading for patients, their contacts, families and indeed anyone else who is interested.

RELEVANT RECALL

When Peter Magee, as Editor of *Cancer Research*, invited Duesberg, as a recognised expert, to contribute an article on retroviruses in 1987, he did so because the preceding decade had produced evidence that retroviruses might cause cancer and leukaemia. Meanwhile HIV had become the most prominent retrovirus as the postulated cause of AIDS and its associated neoplasms. In the second part of his paper⁽¹⁾, Duesberg focussed upon HIV, but concluded that the virus lacked the energy while the



collateral evidence lacked the conviction to justify this postulate. Doubts about causation by any single agent had been expressed before⁽²⁻⁴⁾, but not by a member of the inner circle of retrovirologists all others of whom had instantly embraced HIV as their scientific passport to fame, funds and fortune. They greeted the contradiction with, at first, a deafening silence and then with orchestrated disapproval culminating in a continuing attempt to

demolish Duesberg and anyone who failed to applaud their condemnation. Duesberg's survival through the ensuing ordeal is matched in courage only by those who have endured the threat and suffering of AIDS. The present paper testifies again to his ability, shared by David Rasnick, to defend his reasons for dissent from the orthodox dogma.

Although I was one of the first to doubt the unique role of HIV⁽³⁾ and then to defend Duesberg⁽⁵⁾, I am not going to pretend that I have ever agreed entirely with him or Rasnick. This is because, in my view, their evidence is in some respects over-argued and debatable for reasons stated below. But, by comparison with my objections to the main dogma and with my amazement at the attitude and behaviour of those who support it, my differences are matters of detail. When Peter sent me a reprint, I was very pleased indeed, as I am now renewing the debate which their article merits.

A DRUG-INDUCED DISEASE?

Duesberg and Rasnick believe that various drugs entirely replace HIV as main causes of AIDS. They point out (page 92), that the rapidly enlarging catalogue of drugs now regarded as recreational are "The common denominator of AIDS in America and Europe". And there is no doubt at all that some of these drugs, especially volatile nitrites, are immediately damaging to vitality and, more slowly, to immunity⁽⁷⁻⁹⁾. Equally, there is no doubt that use of these drugs by homosexual men engaging frequently in



Photo : courtesy of

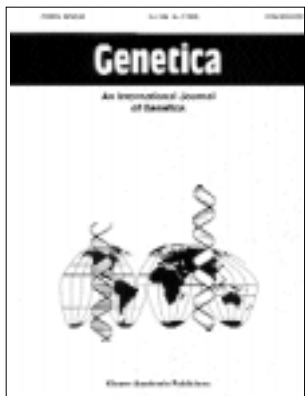
David Rasnick PhD

anal intercourse is the downtown express to full-blown AIDS. There are also intermediate levels of risk in which other drugs, either by their direct toxic effect, by causing infections when given in contaminated injections or just by releasing reckless behaviour, contribute to symptomatology

registrable as AIDS, especially in women who are partners of men with AIDS or at risk of AIDS. In the late 1960's when drug abusers became rampant in the USA, it was easy to recognise in them the loss of appetite, weight, energy, self-control and opportunistic infections which are now accepted as AIDS-defining conditions under the classifications which have been so irresponsibly enlarged by changes agreed by the WHO in 1987 and 1992.

INFECTIONS IN PATIENTS WITH AIDS

The increase in diversity and frequency of sexual intercourse with multiple partners which also began then overlapped with the use of drugs and caused an enormous increase not only in all the traditional sexually-transmissible infections, but also in amoebic and bacillary dysenteries, uncontrollable diarrhoeas, oral, oesophageal and intestinal thrush, skin diseases, pulmonary and post-traumatic infections resulting from the expanded agenda of the sexual pleasure principle. This led to self-medication with antibiotics and cross-infections with resistant organisms. Details of what went on are given more explicitly in the first hand accounts of Jad Adams, Michael Callen, Randy Schilts and other insiders⁽⁹⁻¹¹⁾. Even to non-insiders and passers-by, some of this was readily visible in some waterfront and inland streets of San Francisco, which was and is one of the main epicentres of AIDS. Drugs were an essential part of this scenario but so also were a multiplicity of concomitant, highly-transmissible, shared infections which overwhelmed immunity and characterised the fast track to the horrors of full-blown AIDS⁽⁸⁾.



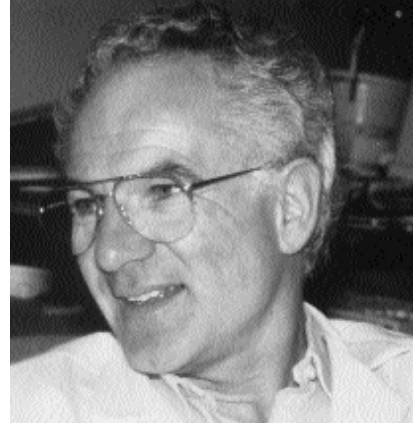
Cover ©

OVERLAPS IN CAUSATION

Having helped to investigate the transmission of AIDS since 1983, I find it impossible to overlook these overloads of transmissible viral, bacterial, protozoal and fungal infections as main contributors to the pathogenesis of registrable AIDS. I do not for a moment deny the equal or sometimes greater role of psycho-active and other drugs but it is a fact nowadays in Europe at least that many people in the worst-affected age group of 20 - 39 habitually engage in prolonged raves with cocktails of drugs without developing AIDS. In several countries, AIDS is decreasing while drug-based raves are exploding.

In saying this, I am perhaps committing the academic fault of agreeing while disagreeing with the authors. But the reason is far from academic because it affects the way we detect, treat and control the spread of AIDS. Irrespectively of other doubts about HIV and the specificity of sero-testing - and this is a book in itself⁽¹¹⁾ - it is impossible to deny that patients with incipient or established AIDS suffer and die mainly because they develop unmanageable infections some of which are highly transmissible to their partners. I agree with the authors that HIV is extremely difficult to transmit or, for that matter, to isolate, cultivate and recognise. This is why HIV seropositives

Prof. Peter Duesberg



remain well until they develop the AIDS-defining infections which spread among persons who engage in risk i.e. *infection prone behaviour* and *lifestyle*. HIV might well be, as they say, a mere passenger with low infectivity to close attendants and even to those

who suffer needle-stick injuries. If you want to acquire a needle-stick infection, try a real virus like Hep B, HSV, EBV, CMV.....! If you prefer to get AIDS, go to a bathhouse or romp with men with AIDS and share with them the infectivity of Pneumocystis, Varicella-zoster etc which are rightly listed as AIDS-defining. To a patient, the symptoms of AIDS are more overwhelming than uncertainties and arguments about causation; to his doctor, symptomatic treatment soon becomes a full-time job even if they avoid giving AZT and other nucleosides, as many of them do, even in the USA.

OTHER ASPECTS OF AIDS

There are other questions requiring debate. Duesberg and Rasnick attribute AIDS in the third world, especially in sub-Saharan Africa, to recurrences of poverty, malnutrition and traditional infections like tuberculosis. Certainly this is happening but there are other differences geographically, socially and clinically between communities and countries: huge AIDS-free zones in deprived regions contrasting with AIDS in well-nourished men in privileged strata; young women in poverty showing signs of AIDS (Kaposi's sarcoma, gross *candidiasis*, weakness and wasting), without drugs; abandoned and excluded children; and much else. The local situation often defeats investigation because evidence about intimate activities may be withheld or distorted. There is little doubt that, as in industrial countries, life style is a major factor in the onset and distribution of AIDS but there is a great deal of doubt about the underlying reasons for this.

If these matters where reliable information is difficult to obtain and impossible to verify are set aside, there is plenty of room for agreement with Duesberg and Rasnick in their misgivings about the reliability of tests for HIV and AIDS, especially in haemophiliacs and their partners, and in children; in the reckless use of AZT; in their call for a halt to monstrous and futile expenditure boosted by misleading messages about risks. In deflecting attention, knowledgeably, from the questionable role of HIV to the visible role of recreational drugs in the pathogenesis of AIDS, they are writing what needs to be read and said more widely and more often so that the health authorities who accept the HIV dogma so slavishly will become aware of the scale and danger of their deception.

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Prof. Gordon Stewart : g.stewart@gifford.co.uk

Genetica : <http://www.wkap.nl/journals/genetica>

What *is* AIDS?



Photo: Hwa Christie

George Kent

Professor and Chair,
Department of Political
Science, University of
Hawai'i, Honolulu,
Hawai'i 96822 2281, U. S. A.

Phone : +1(808) 956-7536

Fax : +1(808) 956-6877

Email : kent@hawaii.edu



There are many serious debates underway relating to HIV/AIDS, including the question of whether HIV has really been isolated and whether it really causes AIDS.

My purpose here, specifically and narrowly, is to review the issues surrounding the definition of AIDS itself. The dominant theme in the debates has been the character of HIV, while little attention has been given to exploring the meaning of AIDS. Some people talk about HIV as if it were a disease, while for others it is a hypothesized cause of disease. The premise of this essay is that there is little point in debating the causes of something if there is no clear and agreed specification of what that thing is.

The history of AIDS definitions varying over time is well documented elsewhere (e.g., Duesberg; Giraldo; Koliadin; Root-Bernstein; Shenton). Changes over time can be expected as science advances. Here, I want to focus on the definitions that are in use as we come into the new millenium. What is the current definition of AIDS? Presumably that definition must be clear before we can sensibly explore the possible linkages between HIV and AIDS. The discussion here is not about empirical questions that can be addressed through the tools of science. Rather, we are talking here about a precursor of good science: the formulation of good definitions and good questions.

Individuals hold many different views of what AIDS 'really' is. The approach adopted here is to go to the highest official sources to find their official, technical specifications of what constitutes AIDS.

Global definitions

The website of UNAIDS, the Joint United Nations Programme on HIV/AIDS, offers no definition of AIDS, and does not suggest any source of a definition. The World Health Organization, a member of UNAIDS, takes the lead in setting out the global definition, and it is the WHO definition that guides UNAIDS data collection efforts.

The World Health Organization's official definition of AIDS

is presented in its WHO Recommended Surveillance Standards of 1997. Although AIDS is called a syndrome (Acquired Immune Deficiency Syndrome), WHO lists it under the category of diseases rather than syndromes, and says 'AIDS is a disease (WHO 1997, p. 21).' WHO's *Recommended Case Definition* is presented here in Table 1 (next page). The numbers in parentheses are links to journal references; they are omitted from the table. Items 1 and 2 in the table draw heavily from the CDC's definition, discussed in the following section. Item 2 in WHO's definition ends with a colon, as shown in Table 1. The text above these two numbered items acknowledges that a variety of other definitions of AIDS are used as well, especially in countries with limited laboratory facilities.

Centers for Disease Control, United States

The dominant definition currently is that developed by the Centers for Disease Control in the United States. It offers the following summary definition (at http://www.cdc.gov/nchstp/hiv_aids/pubs/faq/faq2.htm):

AIDS stands for acquired immunodeficiency syndrome. An HIV-infected person receives a diagnosis of AIDS after developing one of the CDC-defined AIDS indicator illnesses. An HIV-positive person who has not had any serious illnesses also can receive an AIDS diagnosis on the basis of certain blood tests (CD4+ counts).

A positive HIV test result does not mean that a person has AIDS. A diagnosis of AIDS is made by a physician using certain clinical criteria (e.g., AIDS indicator illnesses).

This summary definition is an attempt to make the technical definition comprehensible. The full technical definition effective January 1, 1993, is as follows:

CDC has expanded the acquired immunodeficiency syndrome (AIDS) surveillance case definition to include all human immunodeficiency virus (HIV)-infected adolescents and adults aged greater than or equal to 13 years who have either a) less than 200 CD4+ T-lymphocytes/uL; b) a CD4+ T-lymphocyte percentage of total lymphocytes of less than 14%; or

WHO'S RECOMMENDED CASE DEFINITION FOR AIDS

Different case definitions are used in different countries, depending on population factors (children, adults, relative occurrence of opportunistic infection) and on the laboratory infrastructure and training available. Current most used case definitions include for countries with . . .

more sophisticated laboratory facilities

CDC 1987 (1)

CDC/CD4 (2)

European (3)

limited laboratory facilities

Abidjan/WHO (4)

Bangui/WHO (clinical) (5)

Caracas/PAHO (6) revised Caracas/PAHO (7)

1. 1987 CENTERS FOR DISEASE CONTROL AND PREVENTION SURVEILLANCE DEFINITION FOR AIDS

Without laboratory evidence of HIV infection (in the absence of other causes of immune suppression)

Indicator disease diagnosed definitively

Candidiasis of the oesophagus, trachea, bronchi, or lungs

Cryptococcosis, extrapulmonary

Cryptosporidiosis with diarrhoea persisting > 1 month

Cytomegalovirus diseases of an organ other than liver spleen, or lymph nodes in a patient >1 month of age

Herpes simplex virus infection causing a mucocutaneous ulcer

persisting > 1 month; or bronchitis, pneumonitis, or

oesophagitis for any duration in a patient > 1 month of age

Kaposi' s sarcoma in a patient < 60 years of age

Lymphoma of the brain(primary) affecting a patient < 60 years of age

Mycobacterium avium complex or M .kansasii disease, disseminated (at a site other than or in addition to

lungs, skin, or cervical or hilar lymph nodes)

Pneumocystis carinii pneumonia

Progressive multifocal leukoencephalopathy

Toxoplasmosis of the brain in a patient > 1 month of age

With laboratory evidence of HIV infection

Indicator diseases diagnosed definitively

Coccidiomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)

HIV encephalopathy

Histoplasmosis, disseminated(at a sit other than or in addition to lungs or cervical or hilar lymph nodes)

Isosporiasis with diarrhoea persisting > 1 month

Kaposi' s sarcoma at any age

Lymphoma of the brain (primary) at any age

Non-Hodgkin' s lymphoma

Any mycobacterial disease caused by mycobacteria other than M. tuberculosis, disseminated

Disease caused by M. tuberculosis, extrapulmonary

Salmonella (non-typhoid) septicaemia, recurrent

HIV wasting syndrome

Indicator diseases diagnosed presumptively

Candidiasis of the oesophagus

Cytomegalovirus retinitis with loss of vision

Kaposi' s sarcoma

Mycobacterial disease, disseminated

Pneumocystis carinii pneumonia

Toxoplasmosis of the brain in a patient > 1 month of age

2. CONDITIONS* ADDED TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION 1993 SURVEILLANCE DEFINITION FOR AIDS (WITH LABORATORY EVIDENCE OF HIV INFECTION in addition to those in the 1987 surveillance definition:

Source: WHO Recommended Surveillance Standards.

(Geneva: World Health Organization, WHO/EMC/DIS/97.1, 1997). See

<http://www.who.int/emc>

c) any of the following three clinical conditions: pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer.

The expanded definition retains the 23 clinical conditions in the AIDS surveillance case definition published in 1987. (See publication (1) in Publications List in this section for complete information referring to this case definition.)

The AIDS surveillance case definition for children aged less than 13 years has not changed and retains the clinical conditions listed in the AIDS surveillance case definition published in 1987. However, definitions for HIV encephalopathy, HIV wasting syndrome, and HIV infection in children have been revised and the 1987 definition has been updated. (See Publication (2) in Publications List for complete information pertaining to this case definition.)

Publication 1 is the 1993 revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults, published in the *Morbidity and Mortality Weekly Report*, 1992 Dec 18;41(RR-17):1-19. The following abstract can be obtained through a search on <http://www.aegis.com>

Abstract: CDC has revised the classification system for HIV infection to emphasize the clinical importance of the CD4+ T-lymphocyte count in the categorization of HIV-related clinical conditions. This classification system replaces the system published by CDC in 1986 (1) and is primarily intended for use in public health practice. Consistent with the 1993 revised classification system, CDC has also expanded the AIDS surveillance case definition to include all HIV-infected persons who have < 200 CD4+ T-lymphocytes/microL, or a CD4+ T-lymphocyte percentage of total lymphocytes of < 14. This expansion includes the addition of three clinical conditions--pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer--and retains the 23 clinical conditions in the AIDS surveillance case definition published in 1987 (2); it is to be used by all states for AIDS case reporting effective January 1, 1993.

At the same website one can find technical explanations by searching for the title, *Questions and Answers on 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS*.

Publication 2, mentioned in CDC's definition of AIDS, 1994 *Revised Classification System for Human Immunodeficiency Virus Infection in Children less than 13 years of age* was published in *Morbidity and Mortality Weekly Report*, 1994; 43 (No. RR-12). One of the major functions of this study is to classify infected children into mutually exclusive categories according to three parameters: infection status, clinical status, and immunologic status. This study offers no clear explanation of the relationship between HIV and AIDS, and at several points it appears to treat the two terms as synonymous.

Laboratory Centre for Disease Control, Health Canada

WHO's recommended case definition acknowledges that there are differences in the definition of AIDS in countries with limited laboratory facilities as compared with those with sophisticated laboratory facilities. However, there are many variations beyond that. Canada, for example, uses a definition different from that used in the United States (Health Canada). Indeed, the Canadians take the position that the U.S. definition distorts the data:

The U.S. revised definition to include CD4<200 has limited the usefulness of AIDS surveillance to illustrate the trend of the HIV/AIDS epidemic. One effect is an abrupt increase in the growth in the number of cases diagnosed per calendar quarter beginning in early 1991, and a peak in incidence in the first quarter of 1993. This change of AIDS definition distorts the trend of AIDS incidence data (Health Canada, p. 38)

The difference in definitions helps to account for the apparently higher per capita incidence of AIDS in the U.S. than in Canada. Through 1997, more than 28 % of the AIDS cases in the United States were based on CD4 counts (CDC 1997, p. 17). As indicated in the following table, AIDS diagnosed on the basis of CD4 counts has accounted for a steadily rising share of the cases in the United States, amounting to almost two-thirds in 1997.

PERIOD OF DIAGNOSIS	PROPORTION BASED ON SEVERE HIV-RELATED IMMUNOSUPPRESSION
Before 1994	14.8 %
1994	45.6 %
1995	53.2 %
1996	59.4 %
1997	64.9 %

Source : Centers for Disease Control. HIV/AIDS Surveillance Report. 1997:9 (No. 2), Table 11, p. 17.

Thus, this difference in definitions is not trivial.

Regardless of which definition is better, it is clear that the many variations in official definitions through time and across countries make the global aggregate data extremely difficult to interpret. What is being counted?

Unofficial definitions

There are other definitions as well. For example, at its website (<http://www.projinf.org/fs/dp-day1.html#HIV>), Project Inform, a private non-profit organization concerned with AIDS, says that HIV is itself a disease:

HIV is a "spectrum" illness: all who are infected have the same disease, but there are many different stages to it. AIDS is the name given only to the most serious stage of HIV disease. In the least serious stage, people are HIV seropositive, meaning they have tested positive on the HIV antibody test but have no symptoms of illness.

If left untreated, most of those who are infected generally progress along the spectrum toward AIDS.

The Aegis website offers what is supposed to be a simplified version of CDC's official definition at <http://www.aegis.com/topics/definition.html>. It says a person has AIDS if he or she has a T-cell count below 200 or has at least one of the 25 'defining illnesses'. Curiously, there is no mention of HIV at all, except that one of the defining illnesses is 'wasting syndrome due to HIV'. There is no mention that HIV must be present for any of the other 24 illness or for low T-cell counts as a necessary condition for an AIDS diagnosis.

The Aegis list shows 25 'defining illnesses', while elsewhere (as in CDC's technical definition), there are 26. Apparently there are variations in the ways in which the diseases are grouped.

The definitions offered by private groups are not the official definitions. They do not serve as the foundation for official diagnoses and data collection. Therefore the analysis here will focus on the CDC definition, the highest level technical definition of AIDS that is currently available.

HIV implies AIDS or AIDS implies HIV?

The CDC definition says one looks only at those who are already determined to be HIV-infected. It takes HIV infection to be a prerequisite for a diagnosis of AIDS. The definition does not say how that HIV status is to be determined.

Similarly, in their 1994 *Revised Guidelines for the Performance of CD4+ T-Cell Determinations in Persons with Human Immunodeficiency Virus (HIV) Infections*, the CDC did not say how one is to decide whether an individual is HIV infected. The first paragraph simply asserts that HIV infection causes the depletion of T-cells.

According to the CDC definition, one begins by looking only at people that are HIV infected. If they also have some additional characteristic (e.g., a specific result on a blood test, or any of a list of diseases), they have AIDS. If AIDS is identified by marker A plus marker B, it is hardly sensible to suggest that this (A+B) is caused by A. HIV can be linked to AIDS as a causal factor, to be confirmed empirically, or it can be linked as a matter of definition. It is illogical to try to do both simultaneously.

CDC's summary definition, presented above, says 'An HIV-infected person receives a diagnosis of AIDS after developing one of the CDC-defined AIDS indicator illnesses'. This implies that one must be diagnosed as having HIV before one can be diagnosed as having AIDS. Yet a recent CDC surveillance report says 'AIDS incidence increasingly represents persons who were not diagnosed with HIV infection until they developed AIDS . . . (CDC 1998, p. 3).' This seems to say either (a) people who have AIDS can for that reason be assumed to have HIV, or (b) people who have AIDS may or may not have HIV; it is not a prerequisite, or (c) people who are diagnosed as having one of the 25 defining diseases may be described as having AIDS if they are then also shown to be HIV-infected. All three of these interpretations raise difficulties regarding the claim that HIV causes AIDS.

Disease or diseases?

A second major problem with CDC's definition is that it does not explain the commonality among the many different elements supposed to be involved in AIDS.

Parts (a) and (b) of the CDC's technical definition say that one has AIDS if one has a low T-cell count. Part (c) says that one has AIDS if one has any of an enumerated list of specific diseases, regardless of one's T-cell count. Thus, AIDS is not one thing, but several different things and, indeed, several different kinds of things. The linkages among them are not evident. What is there that warrants a common label?

Invasive cervical cancer is one of the three diseases mentioned in Part c of the CDC's technical definition of AIDS. It is remarkable that in three major overview studies of cervical cancer published in April 1999 in *The New England Journal of Medicine* (accessible via <http://www.nejm.org>), there is no mention of AIDS at all.

It appears that the only commonality in the diseases under study is that their incidence is presumably elevated in people who have compromised immune systems. The definition confounds the diseases that result from a weakened immune system, indicated by their distinctive symptoms, with the fact of a weakened immune system, indicated by low T-cell counts.

It is not clear whether HIV infection is to be regarded as a disease in itself, as a cause of disease, or as a predictor of disease.

It is not clear whether a low T-cell count is to be regarded as a disease in itself, as a cause of disease, or as a predictor of disease.

The relationship between HIV infection and low T-cell counts is not clear. Are they supposed to be definitionally linked or causally linked?

The CDC's surveillance reports are not very clear about the definitions and indicators used as the basis for surveil-

lance. They include 'Technical Notes' at the end referring to a series of back issues of the *Morbidity and Mortality Weekly Report*.

Although the purpose here is to explore the current meaning of AIDS, it may be useful to repeat the indicators for HIV specified in the mid-1998 surveillance report:

For this report, persons greater than 18 months of age were considered HIV infected if they had at least one positive Western blot or positive detection test (culture, antigen, or other detection test) or had a diagnosis of HIV infection documented by a physician. Before October 1994, children less than 15 months of age were considered HIV infected if they met the definition stated in the 1987 pediatric classification system for HIV infection (MMWR 1987;36:225-30, 235). Beginning October 1994, children less than 18 months of age are considered HIV infected if they meet the definition stated in the 1994 pediatric classification system for HIV infection (MMWR 1994; 43[no. RR-12]:1-10). This report also includes children who were diagnosed by a physician as HIV infected (CDC 1998, p. 38).

The tests explicitly named here have all been challenged. The specification "or other detection test" is so open-ended as to be meaningless. Under this definition it appears that HIV can be anything a physician says it is. There is no explanation in these technical notes of the definitional or clinical relationship between HIV and AIDS.

Accounting Practices

It has been argued that HIV infection has become the fourth leading cause of premature mortality in the United States (Selik 1997). Is there a new killer disease stalking the nation, or is this simply an artifact of accounting practices?

The argument leading to the conclusion that HIV is the fourth most important cause of death is based on the assumption that HIV causes AIDS. AIDS is, in essence, a collection of 26 previously known diseases. AIDS is not a disease, it is a collection of diseases. It may appear to be highly deadly because it counts together what previously had been counted separately. Is this an epidemic, or is this simply innovative accounting?

Consider an analogy. Acute respiratory infection is now listed as a leading killer of children worldwide. However, ARI is not a new highly dangerous disease. It is a collection of well-known diseases such as asthma, tuberculosis, and pneumonia. ARI is serious, but it is made to look more serious by the artifact of collecting together the mortality figures for several other diseases that previously had been viewed separately.

Several other accounting practices tend to make the numbers look more frightening. For example, the surveillance reports emphasize cumulative figures. The 1998 report (CDC 1998, p. 3) begins by saying that 'Through June 1998, 665,357 persons with AIDS have been reported to the CDC', without making it clear that this is a cumulative count beginning at some time (unspecified) in the 1980s, or maybe even earlier. (The surveillance reports refer to 'retrospective diagnoses' to cases in 1981 and earlier.) Also, once a person is diagnosed as having AIDS, it is retained forever, even if the original basis for the diagnosis disappears. Since AIDS is claimed to have a very long latency period, deaths may be attributed to AIDS with no sound clinical justification.

CDC's surveillance reports provide tables on 'deaths of persons with AIDS'. Understandably, some readers might think this means 'deaths of persons resulting from AIDS', but that is not what it says. The reports do not indicate any reason for assuming a causal connection. People who have

been diagnosed as having AIDS do eventually die, like everyone else. This does not necessarily mean they died as a result of AIDS. In the mid-year and year-end surveillance reports for 1997, the tables on 'AIDS Cases, Case-Fatality Rates, and Deaths' acknowledged in a footnote that 'Reported deaths are not necessarily caused by HIV-related diseases'. There is no table with this title in the mid-1998 report. The other deaths tables that are provided in the mid-1998 report have no such acknowledgment.

Some deaths associated with AIDS are 'iatrogenic', resulting not from the disease itself but from the medical treatment for it. The data do not provide any means for distinguishing these deaths.

Conclusion

The *MMWR Technical Notes* make claims about the completeness of the reports, but not about their reliability or validity. The technical definition of AIDS is impossibly difficult. It is hard to believe that the thousands of health care workers who diagnose AIDS or who fill out death certificates have a well-developed and common understanding of what AIDS means. It appears there are no simple, explicit, consistent, and widely accepted indicators for AIDS. Studies should be undertaken to compare health care providers' working definition of AIDS with the official definitions.

What can be done to escape from the convoluted and ambiguous set of concepts surrounding HIV/AIDS?

Since it can take so many different forms, if AIDS is to be used as a technical term, it would be very useful if every diagnosis of it were accompanied with an account of the type of AIDS under consideration. Otherwise, we can hardly know what is meant when someone says, 'this person has AIDS'.

However, the conceptual mess is so great, it requires far more radical treatment. It might be wise to rethink what the core issues are, and to formulate an entirely new terminology to discuss them. The need to revise the language is already foreshadowed by the efforts in some quarters to speak of HIV disease, rather than AIDS. However, I think there is a need for a clean and decisive break from the old, cumbersome language and its incomprehensible definitions.

On the cover of the *HIV/AIDS Surveillance Report* covering cases through 1997 (CDC 1997), the CDC says:

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).

It makes sense to say that AIDS is a group of diseases related to severe immunosuppression. But why does the CDC continue by saying it must be related to HIV? While many different kinds of diseases can result from severe immunosuppression, there is no apparent reason for making distinctions among those diseases depending on what caused the immunosuppression.

This insistence on a direct HIV-AIDS linkage has confused matters. It would be clearer if the CDC said something of this form:

AIDS refers to those illnesses that result from severe immunosuppression. There may be many different factors causing or contributing to severe immunosuppression. Among these are x, y, and z.

Since the term AIDS has now become so corrupted, it might be better to rewrite the first sentence simply as: 'There are many illnesses that can result from severe immunosuppression.'

Although I am not a physician, it appears to me that the

core issue in the HIV/AIDS discourse is the role of the immune system. The epidemiological data seem to show there has been a marked increase in the incidence of diseases resulting from severely compromised immune systems since the 1970s.

There could be multiple causes of this phenomenon. Immune systems may be weakened through their normal work of helping us to recover from disease, and they may also be vulnerable to various forms of stress or pathogens. The key thing we need to know, it seems, is what sort of insults to the immune system can bring it to the point of collapse so that it is no longer able to carry out its normal functions.

While we may have designated markers for measuring the degree of stress on immune systems, the crossover point, the threshold beyond which the immune system cannot recover, is likely to be different for different individuals. Thus, measuring the degree of stress on some standard scale (such as T-cell counts) may not help us to know when collapse is imminent. The strength of immune systems should somehow be assessed in terms of their distance from the collapse threshold for particular individuals. Collapse presumably would be defined as the condition in which the immune system can no longer carry out its normal functions, and is unable to recover on its own.

We need good scientific work to identify the likely causes, on one side, and the likely health consequences, on the other side, of immune system collapse. Presumably the strength or weakness of immune systems can be viewed as an intervening variable in the human biological system, mediating between inputs and outputs to that system, and serving as one among many useful indicators of health status.

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I would like to thank Nick Bennett, Lodewijk Bos, David Crowe, Roberto Giraldo, Todd Miller, and Jason Nussbaum for their helpful advice on earlier drafts of this essay.

Apology

In a news story in the last issue, *Continuum* mistakenly reported that Solgar Vitamins had been bought by Monsanto. We regret this error. Solgar Vitamins was bought by American Home Products. (see column this page)

No such thing as a free food supplement

Martin J. Walker

So concerned are many vitamin and food supplement companies about vulnerability during the present period of regulatory crack-downs in America and Europe that a number of them have jumped into bed with multinational pharmaceutical companies.

Buyer Beware!

Earlier this year Solgar was bought by American Home Products. AHP, despite its warm domestic name, is one of the world's biggest chemical and pharmaceutical product companies with net sales in the mid-1990s of almost nine billion US dollars. Originally a part of the Rockefeller empire, it is now interlocked with the giant Hearst media corporation. Like all large pharmaceutical companies, AHP has grown in leaps and bounds over the last ten years by absorbing other companies.

One such company was Wyeth-Ayerst, another pharmaceutical company which was originally part of the Rockefeller stable. Wyeth-Ayerst is now a biotechnology company which produces Hormone Replacement Therapies, vaccines and a range of infant formula preparations.

Another of AHP's acquisitions was Lederle, also an ex-Rockefeller company and again a biotechnology company which now produces a range of antibiotics.



In 1994, AHP purchased Cyanamid the American agrochemical business for US\$9.6 billion. With Cyanamid AHP gained a majority ownership in Immunex Corporation a leading biotechnology company which with Wyeth-Ayerst and Genetics Institute is now developing rhIL-12 an 'immune system modulator' for cancer patients and 'HIV sufferers'.

Buyer Beware!

Cyanamid also brought a range of herbi-

cides, insecticides and fungicides, as well as cattle anti-parasite and anti-bacterial treatments, together with what are referred to by AHP as 'medicated feed additives' and livestock 'productivity growth enhancers'.

Throughout the 1990's AHP had a number of what US business regulations call 'product liability lawsuits', especially against its product Norplant.

In the past Solgar could have been said to be part of the solution to future health care, producing high quality vitamins, food supplements and herbs. By joining with AHP Solgar have become part of the vicious circle which affects contemporary health in Europe and America and beyond. While one arm of a multinational produces health eroding chemicals which are introduced into the food chain and the environment, another arm holds out pharmaceuticals, vitamins, and food supplements to help ameliorate the damage.

Solgar have always marketed their vitamins and food supplements aggressively amongst natural and alternative health groups and paid generously to secure advertisements in their journals and magazines. When they were independent and seemingly committed to natural medicine, this patronage did not appear compromising; now some might consider that it is.

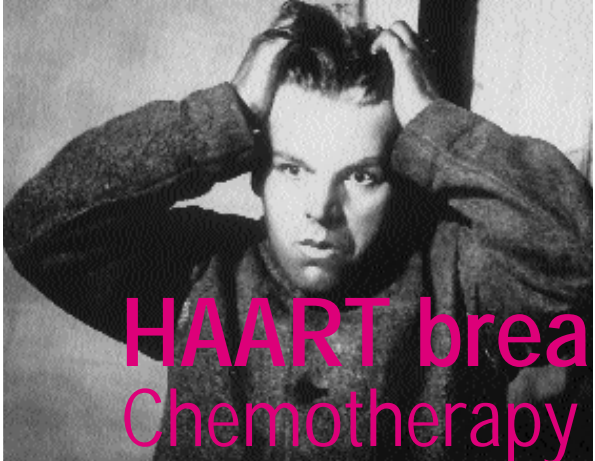


Photo : Favraux (Louis)



HAART break hotel Chemotherapy of AIDS Gordon Conference March 14-18, 1999

David Rasnick PhD is President of the 700 member US-based Group for the Scientific Reappraisal of AIDS

This year 105 people attended the 1999 Chemotherapy of AIDS Conference, with 40% coming from industry. Compared to the 1997 conference, this one was more subdued.

In 1997, virtually every presenter of new nucleoside analog inhibitors of reverse transcriptase characterized the compounds as DNA-chain terminators. This year not a single presenter mentioned the phrase DNA-chain terminators. Experimental controls were as absent as they were two years ago.

From my perspective the 4.5 day conference was largely a protracted yawn. However, William Cameron's talk Thursday morning made the entire trip worth while.

Cameron is on the faculty of the University of Ottawa. He is clearly an expert in designing and evaluating clinical trials. He told me that he consults for Canada's FDA.

While it was evident that Cameron fully accepts the HIV hypothesis of AIDS, nevertheless, he completely demolished the viral load surrogate marker as a substitute for morbidity and mortality end points in clinical trials. He said that people don't die of HIV viremia. He also stressed that viral load is ASSUMED to reflect quantitative effects. There was no basis for this assumption. I should point out that over the previous four days virtually every talk and poster (excluding mine of course) relied exclusively on viral load measurements to determine the effectiveness or failure of anti-HIV drug therapies.

Cameron illustrated with specific examples how easy it is to "engineer" a desired outcome in clinical trials using viral load surrogate endpoints. In order to guarantee a therapeutic effect one needs only to recruit relatively healthy patients and observe them only for a short period of time. This method works even for drugs that have no therapeutic benefit and are actually harmful to the patients. The explanation he gave (I couldn't have said it better myself) was that healthy people tolerate toxic drugs better than sick people.

He gave as a specific example the DDI clinical trial disaster. Over a short 12-week study, DDI showed efficacy based on viral load. But after 12 weeks, patients on DDI experienced severe toxicity. Robert Yarchoan of the National

Cancer Institute had discussed the severe toxicity of DDI just before Cameron's talk, which only emphasized the point.

Cameron also showed that the placebo arm of a surrogate marker clinical trial can also show a pronounced clinical benefit, indistinguishable from drug therapy, if only the studies were allowed to go longer. The end result is that there would be no difference between drug and placebo as long as the drug was not toxic.

It should be pointed out that to date all protease inhibitor clinical trials were terminated prematurely before it could be determined that people taking the drugs actually lived longer and better lives than those not taking the drugs.

Cameron suggested that any therapeutic benefits due to the HIV protease inhibitors may result from their anti-microbial activities since many pathogens have essential aspartyl proteases. (HIV protease inhibitors inhibit other aspartyl proteases.) However, he told me later that the people he'd seen on HAART looked like hell. They were wasting away to nothing among other problems. He was clearly not impressed with the drugs.

I was sitting at the back of the room during Cameron's talk. I had a good view of how he was being received. A number of people were noticeably uncomfortable, for example Martin Markowitz of David Ho's Aaron Diamond AIDS Research Center. About halfway through Cameron's talk, Markowitz grabbed a newspaper, turned toward the wall and pretended to read it. Cameron's lecture received only short, polite applause. It was the only time I applauded the whole week.

On to other topics. By and large the week was pretty boring. Nevertheless, there were a few scraps of information that some may find useful.

On Sunday, Angela McLean of the UK defined what is meant by acute HIV infection or acute illness. A person is acutely ill with HIV if he or she has a detectable viral load, i.e. the presence of HIV RNA, and does not have antibodies to HIV as determined by the ELISA antibody test.

This definition, of course, does not take into consideration those people who are false positive for the viral load and antibody tests or people who go back and forth.

McLean said that at the peak of acute illness with HIV that 6 new cells are infected with HIV by each previous HIV infected cell. (Peter Duesberg told me that in the laboratory one retroviral-infected cell will produce enough virions to infect 100 new cells.) She said that cytotoxic lymphocytes (CTL) kill wild-type HIV-infected cells in about 2 days. She went on to speculate that CTLs do not kill mutant HIV-infected cells, implying that this was the reason for the drug failures. McLean admitted during questioning that no other

'CASTRO AND MARKET. The bars have closed and I see a fare, a young man about 30. He has some trouble walking and uses a cane. "Franklin and Fell," he says, getting in. I ask him how it's going. "I don't know, really," he says. "I just had a heart attack and I'm trying to recover." I look at him in the rearview mirror and tell him he doesn't seem to be in the right age group for that. "I have AIDS and I'm taking protease inhibitors," he says. "One of the side effects that no one talks about is heart attacks. The pills make your heart weaker." Wow, I tell him, as if you don't already have enough to deal with. At his stop he says, "I'm getting better, but I don't know for how long." He gives me \$8 in paratransits and exits.'

The Night Cabbie appears every other Monday in *The Examiner*. You can write him c/o *The Examiner*, P.O. Box 7260, San Francisco 94120. Or send e-mail to cabbie@examiner.com

said that even a person with multiple inhibitor resistant mutant HIVs responds to the protease inhibitor combos as determined by a reduction in viral load in the first week. Furman did not explain this curious observation.

Later that morning, Jaap Goudsmit of Holland continued the drug resistance story. He began by contradicting the media reports that drug resistant mutant strains of HIV represent a growing threat. Goudsmit said that inhibitor resistant mutants are not transmitted from person to person. This was due to the very poor fitness of the mutant virions. In Holland, the appearance of mutant HIV resistant to reverse transcriptase inhibitors peaked in 1995, he said.

Goudsmit made the obvious point that with antibiotics, the appearance of drug resistant strains of bacteria, for example, increase with drug use. It puzzled him that with increased drug use the appearance of drug resistant mutants of HIV actually declined in Holland.

On Tuesday I had an interesting conversation with Che-Chung Tsai, a pathologist at the University of Washington, Seattle. I learned that T-cells pass through the entire lymph system, including all tissues, in 2 hours. At least 85% of T-cells reside in the gut. Because of this, he asks: why doesn't AIDS start in the gut?

Dr. Tsai works with monkeys in his AIDS research. He said that HIV grows 2-3 times as fast in monkey lymphocytes but monkeys don't get AIDS and do not incorporate HIV pro-viral DNA.

At the evening session on Tuesday the speakers tried to blame the metabolic

infectious agent had been put through her analysis. That means there is no way to judge the physiological significance of McLean's studies.

McLean made the curious statement that the better the anti-HIV drugs work, the more likely they will fail. Figure that one out. After a week of this stuff I think I know what she was getting at. Shortly after a person begins taking anti-HIV drugs his viral load drops. The greater the drop, the greater the supposed therapeutic effect. However, virtually everyone on the cocktails eventually shows a rise in viral load. This rise in viral load was interpreted by most at the meeting to reflect drug failure. However, there were a number of attendees who pointed out that a rise in viral load did not mean those patients were experiencing an increase in clinical symptoms.

Brendan Larder of Virco UK Limited began Monday's session on anti-HIV drug resistance. There are now 5 HIV protease inhibitors available. The ubiquitous viral load is the work horse of anti-HIV research and therapy. A rise in viral load in people taking the anti-HIV drugs is interpreted as drug failure due the appearance of drug resistant mutants. However, responding to a questioner, Larder stated that the presence or absence of mutations have nothing to do with "viral load resistance" seen in people. This was echoed Tuesday by Philip Furman of Triangle Pharmaceuticals in Durham, NC. Furman

abnormalities seen in people taking the protease inhibitor combos on HIV. I asked Kathleen Mulligan of UCSF why not treat a bunch of animals with HAART (PI combos) and see what happens? The moderator interrupted saying that my suggestion was irrelevant since the animals don't have HIV. That, of course, was precisely the point: to separate the effects of the drugs from HIV. Later a fellow in the audience told me that he was disappointed that my question was not answered. He clearly saw the simple logic behind the proposed experiment.

On Saint Patrick's Day our old friend Martin Markowitz of the Aaron Diamond reported on their on-going study of 27 people still on HAART. As in 1997, Markowitz didn't say a word about how those 27 people had been doing over the past 2 years on the drugs. Two years ago I asked Markowitz if his patients on HAART were doing better, the same, or worse while on the drugs. He didn't answer after asking the question three times. He knew I was in the audience, but this time I decided not to ask. If his patients had been doing well I'm sure he would have let us all know, especially me.

Wednesday included a discussion of long-term non-progressors: those folks who in spite of having either antibodies to HIV or HIV-RNA do not get sick after 20 years and longer. Eric Rosenberg of Massachusetts General Hospital said that viral load goes up and down in people whether they take the anti-HIV drugs or not. In people taking the drugs, the therapy is given credit for the reduction in viral load. In long-term non-progressors, the immune system is given the credit for low viral loads or reductions in viral load. Again, Rosenberg admitted without knowing it that the secret to long-term non-progression is not taking the anti-HIV drugs.

Thursday, Anthony Japour of Abbott Laboratories cited the 1998 paper by Palella *et al.* [Palella FJ, Delaney KM, Moorman AC, *et al.* Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. *The New England Journal of Medicine* (1998) 338(13): 853-860] as the best evidence that HAART was responsible for the decline in AIDS deaths. After his talk I pointed out that the paper by Palella was not a report of a clinical trial but was a retrospective survey. He acknowledged that fact. Then I asked him didn't he think it unusual that he used a survey and not a clinical trial as the best evidence that HAART was extending people's lives or at least improving their quality of life? To his credit, after the coffee break he acknowledged to the audience that his earlier reference had been to a survey and not to clinical trial data.

Japour made it clear that clinical endpoints are no longer used in clinical trials of anti-HIV drugs. The viral load surrogate is the sole basis for determining clinical efficacy. Drug toxicity is apparently the only clinical outcome that is noted. Current Phase III clinical trials are not even blinded; they are open labeled. Both the physician and the patient know whether they are on the drugs.

Robert Yarchoan of the NCI admitted that HAART has made the process of clinical trial drug evaluations very difficult. He recommends that we go back to extensive clinical trials of mono-therapy in drug naive people. The current process is so complicated that it is virtually impossible to

6/30/99 ABC (USA)
'20/20' TV program

Features LaGena Lookabill, a young model, poised for stardom, who is diagnosed with AIDS after a brief affair with star race car driver Tim Richmond who later died of AIDS. Excerpts from the program's transcript concerning an interaction between Dr. Joseph Jemsek, an AIDS specialist, and ABC's Sylvia Chase :

SYLVIA CHASE (VO) And another problem - protease inhibitors seem to stop working after a couple of years. And in addition, the drugs themselves could kill her by damaging her heart, liver, her pancreas.

DR JOSEPH JEMSEK The drugs aren't perfect. They cause side effects, which are cumulative and inexorable. Now I'm starting to see people die again.

SYLVIA CHASE (on camera) So people are actually dying of the side effects of these ...

DR JOSEPH JEMSEK Yes, you're ...

SYLVIA CHASE ... anti-viral drugs?

DR JOSEPH JEMSEK You're starting to see that.

Transcript freely available at ABC's website:
<http://www.abcnews.go.com/nair/2020/2020Index.html>

The AIDS Treatment Technical Assistance Council

NEW YORK, May 17
PRNewswire

'At the 12th World AIDS Conference in Geneva this past year the clinical necessity for immune reconstitution for patients living with HIV became a priority as the implications of viral resistance produced projections of almost universal failure of the present classes of antiretrovirals in the next few months for thousands of patients whose clinical options have been exhausted...'

Dangers of increased lipids in individuals using 'HIV' protease inhibitors.

Carr* *et al.* (1999) state: "Hyperlipidaemia at degrees associated with cardiovascular morbidity occurred in 74% of protease-inhibitor recipients. Our cut-offs may be conservative because cholesterol concentrations above 5.0 mmol/L and triglyceride concentrations above 1.6 mmol/L have been identified as clinically significant."

Carr A, Samaras K, Thorisdottir A, Kaufmann GR, Chisholm DJ, Cooper DA. *Diagnosis, prediction, and natural course of HIV-1 protease-inhibitor-associated lipodystrophy, hyperlipidaemia, and diabetes mellitus: a cohort study. Lancet* 1999 June 19;353(9170):2093-9.

*HIV Medicine Unit and Centre for Immunology, St Vincent's Hospital, Sydney, NSW, Australia. acarr@stvincents.com.au

AIDS virus may last 60 years in body

UPI Science News
WASHINGTON, April 26
Monday, BC cycle

'AIDS patients would have to take powerful drug cocktails for at least six decades ... suggests a disturbing new study. In another related report, scientists also found that these AIDS drugs, known as highly active anti-retroviral therapy (HAART), may weaken the body's own ability to fight the AIDS virus. HAART consists of drugs like AZT, combined with newer drugs known as protease inhibitors or non-nucleoside reverse transcriptase inhibitors.... Both studies are published in the May issue of the journal *Nature Medicine*.... This finding suggests that long-term strategies to fight AIDS will have to include programs in which patients periodically stop taking drugs, a sort of vacations from the therapies....'

conduct a clinical trial and interpret the results. In other words, we don't know what the clinical trials are telling us. The FDA representative in the audience said that the FDA supports mono-therapy on a case by case basis.

In addition to relating the fiasco of the DDI clinical trials discussed above, Yarchoan went into some detail about another tragedy: FIAU. FIAU was supposed to treat hepatitis B and was approved after a short clinical trial. However, after people were taking FIAU for periods just a little longer than the clinical trials, they began dying at alarming rates before the FDA finally pulled the drug off the market.

Yarchoan admits that the NCI is currently testing AIDS drugs that are "likely to have severe toxicity," e.g. F-ddA.

Jeffrey Murray of the FDA gave a talk on the design of Phase III clinical trials. By way of background, normal phase III clinical trials run from 1-4 years and cost \$30-50 million.

However, as of 1997, the FDA changed the rules for anti-HIV drug clinical trials. Murray said this change was based on a new knowledge of HIV pathogenesis. Maybe he was referring to David Ho's viral dynamics stuff.

Accelerated Approval Protocol is as follows: 24 week double-blind study; all patient should receive standard of care (he immediately then said this changes by the minute); report viral load proportion below assay limit; show that CD4 cell changes are consistent with viral load; report viral load vs proportion below 400. He said that relying on mean changes in viral load is too limiting.

Pediatric clinical trial: 48 weeks based on last patient entered; all should receive standard of care (i.e. AZT); report time to virologic failure (i.e. rise in viral load); report proportion below assay limit; show consistency between CD4 and clinical event.

Murray acknowledged that the FDA has not formally validated the HIV viral load assay. Nevertheless, he said that, "the time to loss of virologic response (i.e. how long it takes before a rise in viral load) is in a sense a clinical endpoint." He even said that "the FDA believes in viral load."

That statement gave me the shivers. The FDA should be in the business of evaluating evidence - not beliefs.

Murray said that failure is defined as viral load rebound. He also said that "active drugs do not arrest symptom progression and certainly does not return the patient to normal." This is probably why Martin Markowitz never talks about how well his 27 patients are doing after 2 years on HAART.

Regarding safety, Murray said that toxicity studies in humans should last 48 weeks with 300-600 people evaluated over 6 months and a smaller number over 1 year.

The FDA now asks for metabolism data for all trials. Jules Levin of NATAP (a gay activist group in New York) told Murray that the "Community" will be watching for the FDA to require metabolic abnormality measurements in clinical trials.

During the question period a guy in the audience proposed that the rise in viral load may not represent drug failure but actually immunological success. He based this twist of viral load interpretation on the rise in CD4 cells is the same patients.

Following Murray's talk, William Cameron tore to pieces the viral load mania as I described at the beginning.

David Ho's talk was Thursday evening, following the banquet. It was much ad about very little. He reported on 8 selected patients who had been on HAART for some time and had no detectable viral load. They took biopsies from a variety of tissues and

Ho said that "long-term non-progressors have something important to tell us."

examined 175 different tissue sections for the presence of replicating HIV. They found 13 sections

containing at grand total of 19 cells replicating HIV. I repeat: 19 cells in 8 people. Even if this were true and not an artifact, this number of cells is physiologically irrelevant. A guy in the audience asked Ho how significant were those 19 cells? Ho answered that when HAART was stopped that the viral load rebounded, implying that those few cells were responsible for the rebound. Concluding, Ho said that "long-term non-progressors have something important to tell us." They certainly do but not what he wants to hear. Finally, I presented a poster on Tuesday by Peter Duesberg and me on the Drugs-AIDS Hypothesis. Surprisingly, it went quite well. The 18 copies of the AIDS Dilemma paper by Duesberg and me were all taken during the poster session. I only took 18 because I thought hardly anyone there would want to be seen reading it. The 20 copies of my HIV kinetics paper were all gone in 30 min. That paper was certainly less threatening and could actually be of use to some of those folks. Some people even came up and asked questions. What amazed me the most was that instead of avoiding me at meal times (we all eat together at Gordon conferences) my table was almost always full even though I made a point of being the first to sit down. It just goes to show that things are hard to predict.

David Rasnick
1600 B Treat Ave. #2, San Francisco, CA 94110, USA
Phone/fax : +1-415-826-1241 email : rasnick@mindspring.com

REAPPRAISAL GROUP Newsletter:
<http://www.wwnet/~philpott.ReappraisingAIDS/>
THE GROUP, 7514 Girard Ave., No.1-331, La Jolla, CA92037, USA

Babies at risk

Michael Day

New Scientist, June 26, 1999

'EVIDENCE IS EMERGING that AIDS drugs can cause serious birth defects in a minority of babies born to HIV-positive mothers. Most specialists... say that larger studies are now needed to quantify the risks associated with taking AIDS drugs during pregnancy.

The concerns stem from a study led by Stéphane Blanche of the Necker Hospital in Paris. He has examined the cases of around a thousand pregnant women with HIV and found that eight gave birth to babies who, though HIV-negative, suffered from a neurodegenerative condition that kills its victims in infancy. The condition...is thought to be caused by abnormalities in mitochondria, the energy "factories" within our cells. The babies' mothers had all taken a combination of the drugs AZT and 3TC from week 32 of their pregnancy....

Concerns are being fuelled by a second study from a team led by Ofelina Olivero of the National Cancer Institute near Washington DC. In the journal *AIDS* (vol 13, p 919), the researchers report that AZT is incorporated into the DNA of white blood cells in people treated with the drug -including pregnant women and their babies...Olivero and her colleagues warn that the changes may increase the chance of developing cancer.

Experts say that neither study changes their advice to pregnant women who are HIV-positive...'



Photo: courtesy of the author

rights & policy

Michael U. Baumgartner
is Secretary General of the
International Forum for Accessible Science

It seems ambiguous to speak about human rights of people labelled with either 'hiv' and or 'aids' without addressing realities and consequences of these labels on peoples lives.

These realities do not discriminate against different people holding different views on 'hiv', the alleged virus suggested to cause aids. Hence, it does not matter whether you understand that the scientific evidence for 'hiv' as the cause of aids does even after over a decade not exist, which could be explained by the lack of a sound scientific isolation of 'hiv'. However, aids policies and legal practices do not discriminate on the bases of your knowledge. I have drawn up six scenarios - some of which already confirmed - to which someone living with the 'hiv'-label could be exposed to.

In order to protect themselves and others from these and other human rights violations, people living with a positive 'hiv-test result' have declared principles (GENEVA DECLARATION '98 Of Persons Living With A Positive 'hiv-antibody' Test Result). It was launched at last year's World-aids-conference in Geneva, Switzerland as The GENEVA DECLARATION '98 OF PERSONS LIVING WITH A POSITIVE 'hiv-antibody' TEST RESULT, and has since been up-dated.

Scenario 1

A journalist of a famous newspaper is fired from his job. An unidentified confidante of his put a faked obituary notice in the newspaper for his employer to find out about his 'hiv' label, leading to the premature termination of his employment. He has not been able to find employment in the field of journalism since, as he cannot give good reason for being laid off, without disclosing his 'hiv' label.

Scenario 2

A recipient of social welfare and health care benefits is at risk of losing her benefits because she refuses pharmaceutical products with well established detrimental effects. As she has been living with a positive 'hiv' test result for many years, waiting to die, she did not elaborate on finding employment. Her benefits are the only income. She is told

that by refusing treatment she 'admits' not to be ill. Hence, she 'should go back to work and be taken off her benefits', as if that were that simple after wasted years of unemployment.

Scenario 3

A drug addict in recovery is at risk of losing his place in a drug rehab program because he refuses to take so-called combination therapy against 'hiv', the alleged virus suggested to cause aids. His place is considered 'better used' for somebody 'willing to accept life-saving treatments' and not 'being part of a sect refusing to accept the overwhelming evidence of hiv's detrimental effect just like the flat earthers'.

Scenario 4

A young pregnant woman enters the hospital for what is considered routine testing for pregnant women, which now includes so called 'hiv testing'. The claimed test for 'hiv' shows up positive for no identified reason (infection through sex, syringes or blood products). The young couple - trying to cope with the death sentence put upon the wife by the aids-establishment tries to cope. They undergo 'hiv' counselling leading to an abortion. Several weeks after birth retesting of the women shows no trace of what is considered 'hiv'. Pregnancy itself can make a so called 'hiv antibody test' show up positive.

Scenario 5

Parents of a child suspected to be a carrier of 'hiv', the alleged virus suggested to cause aids, lose custody of their baby to the state authorities shortly after birth. After consulting scientific literature and experts the parents have made the informed choice not to give the new-born suggested treatment. Furthermore they concluded that breast-feeding the baby would be the healthiest form of nutritional supply for their infant. The state decided differently and orders the baby onto AZT, forbidding the mother to breastfeed her own child.

Scenario 6

A young gay man is admitted to the hospital with lasting headaches, nausea and increasing physical exhaustion. The clinical 'cause' of his deterioration is 'not found'. But because he identifies himself as gay, 'hiv', the alleged virus suggested to cause aids is 'identified'. The fact that he has been on arguably toxic 'prophylactic treatments' for over six months, is ignored. His deterioration continues resulting in his death. The cause of his death - despite lacking

clinical evidence - is considered 'hiv' the alleged virus suggested to cause aids. Investigation brings to surface that the medication he was put on in the hospital was too strong for an immune-compromised (weak) person. He died of kidney failure - not an aids- defining disease - yet is considered another aids death.

Scenario 7

In a hospital somewhere in an economically deprived area of this world an undernourished child - who is considered as having aids (an 'hiv' tests is not always needed to give an aids diagnosis and over 60 different other conditions can make a test considered to show the presence of 'hiv' turn positive) lies in a hospital with a malaria diagnosis. Her parents ask the doctor what treatment she needs, hoping that she would receive it in the hospital. The doctor explains to them: 'Because we know she will definitely die of aids, we have decided we cannot afford to give her and other hiv-positive patients malaria medication'. If the child had been considered as having malaria only, she would be given appropriate treatment against her clinical condition. The girl dies shortly after due to untreated malaria and will be another ill-identified aids-attributed death.

All scenarios did already or can occur easily based on the current well propagated views on both 'hiv' and aids as an all endangering, sexually transmitted and fatal disease. They are either viewed as "in the best interest of the patient", possible patient (individual as in Scenarios 2 - 7) or the group perceived as being affected by a labelled individual (social environment as in Scenario 1). It does not take much observation to realise, however, that all of these cases - as different as they might seem - are actually discriminatory and not in the interest of the persons living with a 'hiv' label.

Let us now going to link briefly the above mentioned scenarios with what I perceive as the most pertinent and inclusive human rights declaration which grew out of the above mentioned and other realities persons living with a positive 'hiv-test' result face. The GENEVA DECLARATION '98 OF PERSONS LIVING WITH A POSITIVE 'hiv-antibody' TEST RESULT.

Scenarios 1 and 2 relate to Art. 1/viii of the GD98 "right to work". Scenario 2 relates to 3/v of the GD '98 "right to assistance". All three scenarios are internationally declared human rights. Scenario 4 addresses the "right to information" GD '98 and also issued in the unaids-guidelines. Scenario 5 relates to art. 1/vi and 1/vii. The protection of the family again is an internationally declared human right. While art. 1/vii is a supplemented clause issued by people who experienced state interference because of a 'hiv' label. Scenarios 6 and 7 are crucial issues generally not addressed in international human rights. The first part (freedom of choice) belongs to the field of patient rights and as such to be addressed in declaration on patient rights and medical ethics. The second part (clinical condition priority) is especially relevant in dealing with 'hiv' and aids. I will address issues of patient rights and medical ethics at a later stage.

The GD '98 is based on the dissenting views on 'hiv/aids as well as on the mainstream ideas and is therefore unique. It is written in a matter to match international human rights language as it refers to and supplements internationally declared human rights either signed or endorsed by national governments. The two sources referred to in this declaration are the *UNIVERSAL DECLARATION OF HUMAN RIGHTS (UDHR)* of the *International Bill of Human Rights* adopted by the United Nations, and the *International Guidelines on HIV/AIDS And Human Rights* compiled by UNAIDS and endorsed by the United Nations.

Geneva Declaration '98

Of Persons Living With A Positive 'hiv-antibody' Test Result

We the people living with the label 'hiv' positive and/or aids, with our well-being affected by policies based on scientific findings acknowledge - whilst people appropriately and inappropriately are labelled with aids - the following:

I:1 Both 'hiv' and aids evolved in a multi-billion dollar industry full of commercial interests and bias.

I:2 Information generally available does not reflect all scientific opinions on 'hiv' and/or aids.

I:3 There are different views in the scientific establishment on what causes aids.

I:4 The scientific literature documents over 60 conditions (including, pregnancy, Malaria, TB etc.) which can cause a test for 'hiv' to be positive.

I:5 The discoverer of 'hiv', Prof. Luc Montagnier from the French Pasteur Institute, has admitted that he has never 'purified' (isolated) 'hiv'. Independent research has shown that there is no proof in the scientific literature of such isolation according to the Pasteur Protocol 1973.

I:6 All so-called 'hiv'-tests have therefore yet to be validated.

I:7 Public Health interests do not conflict with our rights (see *UNAIDS guidelines* 15/b)

We therefore request the following of local, national and international aids, health and human rights authorities:

II:1 People living with a positive 'hiv' diagnosis request the right to be part of all decision making processes involving 'hiv' and aids on local, national and international levels.

II:2 The results of our positive tests must be kept confidential at all times in order not to put us at risk of human rights abuses.

Furthermore:

1. Protection of the Rights of persons living with a positive 'hiv' antibody test result.

i) Right to life, liberty and security of person (Art. 3, UDHR)

ii) This includes the right to privacy and protection against any form of discrimination based on one's health status including the right to freedom of association.

iii) The right to freedom of movement; the right to travel or seek citizen-ship in any country of their choice free of discrimination based of their 'hiv' status.

iv) The right to freedom of opinion and expression

and the right to freely receive and impart information.

v) No person must be subject to forced testing and/or treatment or otherwise cruel or degrading treatment (see Art. 5, UDHR).

vi) People living with a positive 'hiv' diagnoses have the right to found a family, with their family being entitled to protection by society and the state (see Art. 16/3, UDHR).

vii) No child shall be removed from the custody of the mother because she is diagnosed as being 'hiv positive'. It has to be accepted as her decision if she sees breast-feeding in the best interest of her baby and herself and resists toxic treatments for herself and her new-born (see Art. 25/2, UDHR).

viii) Everyone, including persons living with a positive 'hiv' diagnosis has the right to work and participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits (see Art. 27/1, UDHR).

ix) Everyone, including persons living with a positive 'hiv' diagnosis, has the right to a social and international order in which the rights and freedoms set forth in this declaration and the Universal Declaration of Human Rights (UDHR) can be fully realised.

x) All, including persons living with a positive 'hiv' diagnosis, are equal before the law and are entitled without any discrimination to equal protection by the law (see Art. 7, UDHR).

2. Access to all information regarding 'hiv', aids and treatments

i) The right to education, especially about all aspect relevant to all conditions related to 'hiv' and/or aids.

ii) Publicly funded medical research into relevant fields must be free from commercial and/or otherwise inappropriate interests.

iii) Hence, the health of those living long term with a positive 'hiv' antibody diagnosis should be subject of publicly funded studies.

iv) All parties financially involved in a study and/or researcher and/or laboratory must be clearly and visibly stated in writing on the study.

v) All local, national and international policies on 'hiv' and/or aids must refer in writing to the scientific data which is taken in consideration as the basis for the intended intervention.

vi) The media's responsibility is to report accurately and without censorship all issues regarding 'hiv' and/or

aids and relevant treatments according to guideline 6/a of the International UN guidelines on hiv/aids and human rights¹. Where censorship can be demonstrated it must be challenged by media regulatory bodies.

3. Right to medical care and social welfare assistance according to our choices and needs.

i) The right to the highest attainable standard of physical and mental health.

ii) Non-toxic treatments and local resources (including natural medicines and traditional medical practices) should be given at least parity of availability and research with pharmaceutical treatments.

iii) It is the responsibility of each treating practitioner, if consulted, to access all potential treatments according to his/her practice, and reveal all information (including effects and adverse effects) regarding all treatment options to his/her client.

iv) People living with a positive 'hiv' diagnosis have the right to the treatments of their choice. Treating clinical conditions should be given priority.

v) People living with a positive 'hiv' diagnosis have furthermore the rights as outlined in Art. 25/1 UDHR especially the right to adequate standard of living, assistance, medical care and necessary social services, and the right to security in the event of unemployment according to their needs and their treatment choices.

Laws and/or regulations should be enacted to enable implementation of the policy of widespread provision of information about hiv/aids through the mass media. This information should be aimed to the general public as well as at various vulnerable groups that may have difficulty in accessing such audience and not be inappropriately subject to censorship or other broadcasting standards'

Furthermore we refer to the Universal Declaration of Human Rights and the Unaid guidelines on hiv/aids and human rights.

Breaching of any one or more of these requests must be viewed as putting our lives at unnecessary risk and may therefore be subject to legal prosecution.

Geneva, Switzerland, June 1998; revisions 1999

No matter what your level of knowledge on 'hiv' and aids is, the initially mentioned cases do not discriminate between those buying into mainstream ideas or dissenting knowledge on 'hiv/aids'. Hence, it must also be made very clear that no person living with a positive 'anti-hiv-antibody' test result will ever be safe as long as the 'hiv=aids=death-dogma' prevails. No policy will ever change as long as the pressure from people labelled and those concerned to reappraise the 'hiv'-aids-dogma is not successful. Informing oneself about the facts of 'hiv' and 'aids' might just be the first step to combat discrimination

based on fraudulent science and ill-advised politics.

It is one of the purposes of this regular column to educate about human rights issues and how to challenge discriminating practices on the basis of international human rights. This magazine in general and this column in particular shall provide important information to challenged authorities in their practices.

If you have concerns or information about human rights violations related to 'hiv' and aids, contact me through CONTINUUM.



Correction - references

It has been kindly pointed out that there were two errors in the references contained in the article *Virtual Viral Load Tests* by Michael Verney-Elliott in the last issue (*Continuum* Vol. 5 No.5). The references to the Roederer and Hel papers should read as follows: Roederer, M. 1998, *Nature Medicine* 4(2): 145-146

Hellerstein *et al*, 1999, *Nature Medicine* 5: 83
The author and *Continuum* apologise to John K. and anyone else who may have been inconvenienced by this loss of concentration. Incidentally, to date no-one has attempted to claim the f1000 bounty for pelleting down the alleged virus particles and photographing them.

Ukraine... Alternatives to Fear



Clair Walton, Manager, **The Quest Project**

Earlier this year the first of a series of alternative health seminars in Ukraine took place.

The seminars form part of a Ukraine project managed by Continuum under a European funded grant, offering alternative thinking and approaches to hiv and health including translating published works, many from Continuum magazine, into Russian.

It seemed fitting that the series should commence with

turned out to be extremely friendly, warm, optimistic and eager to join in discussion on the reality of life with an hiv label both from a Western and Ukraine perspective. We had been warned that as hiv testing was so recent in Ukraine, sufficient time had not elapsed for long term survivors to be counted. This was an opportunity for recently labelled to witness, to meet and talk to one healthy long term survivor. Hopefully counterbalancing the received wisdom that death was inevitable and pharmaceutical drugs being the only saving grace.

However, the Ukrainians seemed far more accepting of a broad range of views and solutions to ailments and less doomsayers about hiv. This, maybe, was brought about partly through necessity as pharmaceutical drugs have been less able to dominate, and maybe the stark reality of everyday life for many in a transitional and erratic economy where more immediate and very real needs are having to be met. One labelled person was shocked to hear that doctors had pronounced death sentences. 'Why would a doctor tell you you're going to die?' she said astonished. In fact, when we came to work with the medical professionals later in the week, I discovered they seemed to be far more in touch with the Hippocratic Oath, and with it the patient's welfare being paramount, than my own experience in Britain. The Ministry for Health Protection in Ukraine had organised the assembly of medical professionals from all over the country to attend the seminars and so we were fortunate to be working with not only doctors, nurses and psychologists but also doctors who teach in the medical schools.

It was, for me, a truly unique and rewarding experience. The combination of professional and life experience of Michael Baumgartner and myself respectively worked extremely well, and judging from the feedback from the participants, was well received. Similar workshops elsewhere could be possible and those interested should contact me at The Quest Project which has been established to deal specifically with long term survival and survivors (and those who want to be).

The Quest Project is the short name for The International Long Term Survivors Network of People Living with a Positive Hiv Test Result and where the questionnaire (survey for those living for seven years or more who have not taken anti-hiv pharmaceutical drugs) can be obtained. The project is raising awareness to the fact of long term survival, in particular healthy individuals and challenging human rights abuses (as recently at the United Nations), as well as, pushing for scientific debate on the increasing challenge to the hiv/aids hypothesis.

The more people who register as long term the more weight there is to the argument to challenge, and so I would encourage everyone to do so.

For further information please contact me;
Clair Walton
The Quest Project
4A Hollybush Place
London
E2 9QX
Tel: ++44 (0)20 7613 3013
Email : cw@thequestproject.demon.co.uk



Representative from Ukraine Health Ministry addresses healthworkers attending the seminar in Kiev

long term survival and the psychological impact of an hiv diagnosis. Michael Baumgartner in his professional capacity as a social worker and I, as a long term survivor, ran two workshops entitled 'Alternatives to Fear' in the first of the series to two distinct sets of participants; those living with an hiv label and medical professionals working in the hiv field.

The seminars took place in Kiev, the capital city of Ukraine, in early February. This former Soviet country was to be for me a new experience, and whilst I was aware that I would be sharing experiences amongst people on universal issues - fear and discrimination - I remained conscious of my lack of knowledge of the country and culture and my need to remain open to the experience ahead of me. The material divide between London and Kiev was expected and very much in evidence on arrival but I was to very quickly unite at a personal level with both labelled and professionals and to discover a far more enlightened approach to health than in the West.

The participants at the first seminar for labelled people



More Evidence in Favour of St. John's Wort

A cheap, common herb for tea wins trials

Krista Morien

A supplement to the journal *Pharmacopsychiatry* (Vol. 30, 1997) included two recent clinical trials and a review paper evaluating 12 earlier clinical studies on St. John's wort (*Hypericum perforatum* L., Clusiaceae).

The first of the recent trials, which compared a standardized St. John's wort extract to the tricyclic antidepressant imipramine, was the first to study patients with severe depression (Vorbach *et al.*, 1997). This study also employed dosages twice as high as those used in earlier studies. The two recent studies tested LI 160, a St. John's wort extract standardized to 0.3 percent total hypericins. In both trials, LI 160 demonstrated similar effectiveness and a better side effects profile compared with the standard treatments against which it was tested. (LI 160 is manufactured by Lichtwer Pharma of Berlin; it is marketed as Jarsin® in Germany and as Kira® in the United States.)

Until now, St. John's wort research has focused on subjects with mild-to-moderate depression. In the first of the two recent studies reported here, a randomized, double-blind, multicenter trial with 209 subjects, LI 160 was compared to imipramine in patients with severe depression. In this six-week study, subjects took either 1800 mg LI 160 or 150 mg imipramine daily. Earlier research has found St. John's wort as effective as tricyclics in mild-to-moderate depression, utilizing a daily dose of 900 mg St. John's wort extract standardized to 0.3% hypericin. According to the researchers, this was the first study comparing St. John's wort to imipramine in which subjects received adequate doses of imipramine (150 mg instead of 75 mg). Patients exhibiting severe psychotic or suicidal symptoms were excluded from the study.

At the end of the trial, 58 percent of the LI 160 group and 63 percent of those taking imipramine showed significant improvement on the Hamilton Depression Scale (HAMD). On the other hand, imipramine demonstrated more favorable results on the Clinical Global Impression (CGI) rating, with

70 percent of the drug group rating their improvement "very good" or "good" compared to 61 percent in the LI 160 group. The LI 160 group experienced far fewer side effects than the imipramine group, which is noteworthy considering that the dose of LI 160 was twice that used in previous studies. The most common side effects in the imipramine group included dry mouth, gastric distress, fatigue/sedation, and sweating. It was not ethical to include a placebo group in this study, due to the severely depressed state of the subjects.

The second St. John's wort study evaluated the efficacy of LI 160 versus amitriptyline (the most commonly prescribed sedating antidepressant) in 165 patients with mild-to-moderate depression (Wheatley, 1997). In this double-blind, randomized, multicenter, parallel group study, subjects took either 900 mg LI 160 or 75 mg amitriptyline over a six-week period.

At the end of the study, both treatments were equally successful in improving symptoms of depression, according to HAMD results. In addition, both groups demonstrated comparable scores on the CGI severity of illness and global improvement tests. The amitriptyline group did show an advantage in both of the secondary efficacy parameters (decreases in total HAMD and Montgomery-Asberg scores) and the HAMD sleep factor test. Again, LI 160 was clearly superior to amitriptyline in terms of adverse events. The author noted that a low dose of the tricyclic antidepressant may have been a limitation in this study.

This issue of *Pharmacopsychiatry* also contained a review article, reporting on positive results achieved with standardized St. John's wort extracts in 12 placebo-controlled trials with mildly-to-moderately depressed patients (Volz, 1997). All studies were previously published in peer-reviewed journals. In most of these studies, St. John's wort demonstrated greater effectiveness than placebo, often by the second week of treatment, with the greatest results evident by week four. The author noted several common methodological flaws in many of the studies, including short study periods and a lack of dose-finding research to pinpoint the most effective dosage. Nonetheless, the results of St. John's wort research have been impressive, offering the potential for greatly increased compliance among depressed patients. However, the investigators concluded, "Since most studies on hypericum have methodological flaws, further studies are warranted."

References

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- Vorbach EU, Amoldt KH, Hübner WD. Efficacy and tolerability of St. John's wort extract LI 160 versus imipramine in patients with severe depressive episodes according to ICD-10. *Pharmacopsychiatry*. 1997; 30 Suppl: 81-85.
- Wheatley D. LI 160, an extract of St. John's wort, versus amitriptyline in mildly to moderately depressed outpatients-a controlled 6-week clinical trial. *Pharmacopsychiatry*. 1997; 30 Suppl: 77-80.

Vaccine breakdown

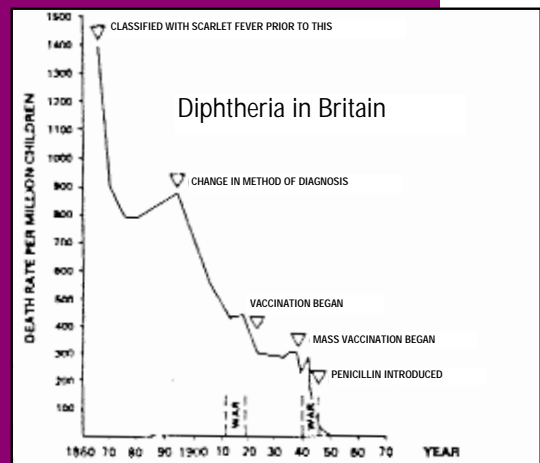
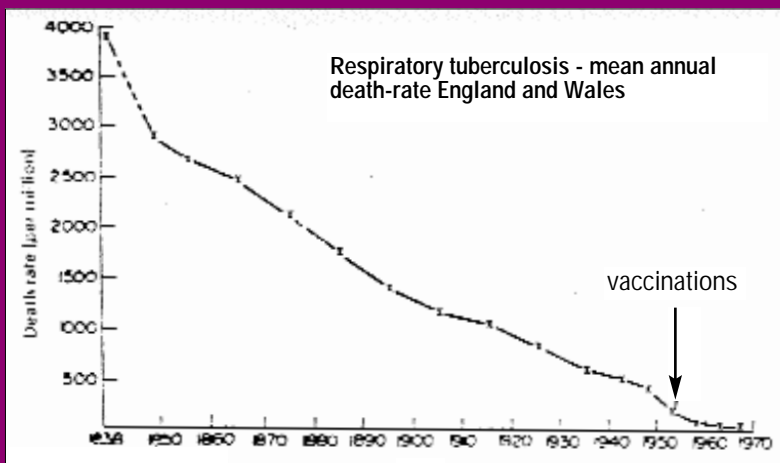
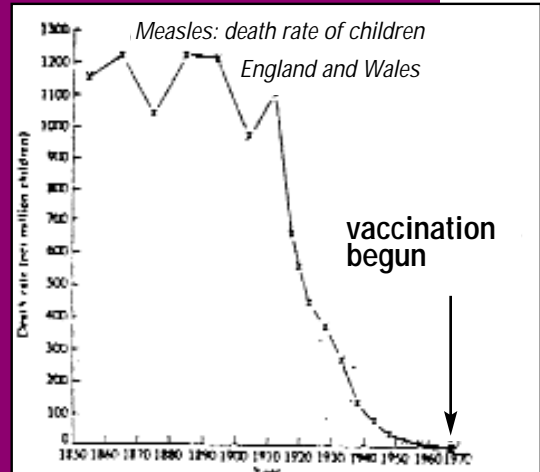
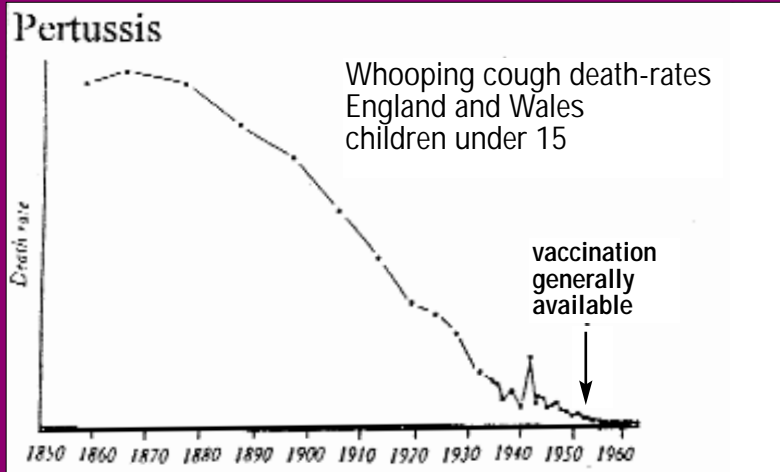
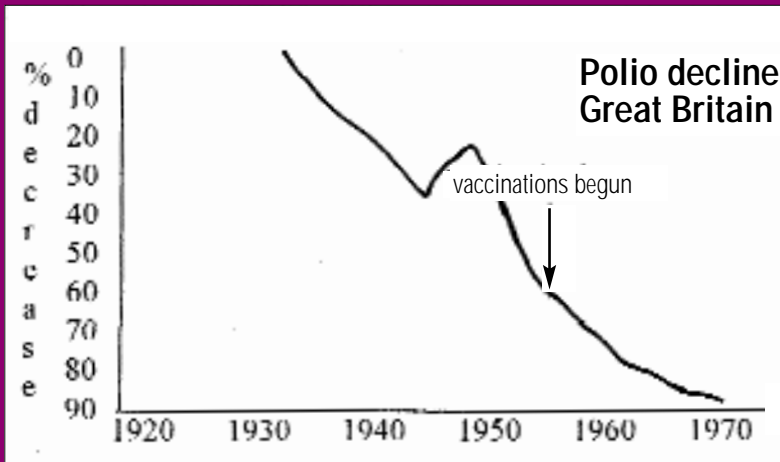
In five major illnesses in Britain, the introduction of vaccination had apparently no effect on the marked decline in death rates.

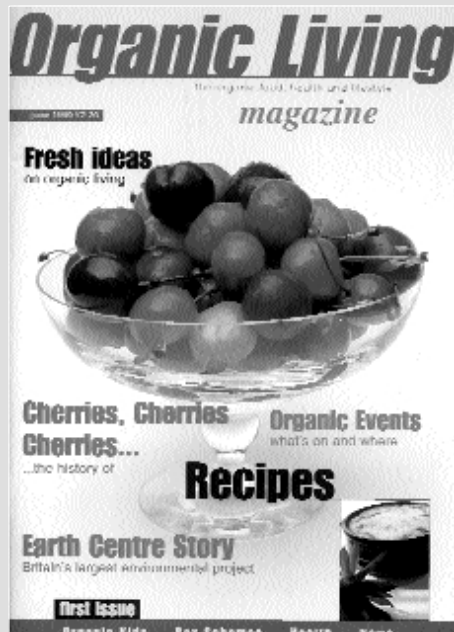
• **Photo top** : ACT UP San Francisco member Ronnie Burk gets out the message as part of a lockdown at the AIDS Research Consortium of Atlanta (ARCA) July 23 1999 to protest U.S. plans to export experimental HIV vaccines to Thailand and Africa.

• **Photo bottom** : ACT UP banner near busy Atlanta highway protests current AIDS vaccine experiments taking place in the U.S. and Thailand and planned for nations of Africa. (Human figure seated bottom left.)



Compiled by
Dr Hector Gildemeister
miscellaneous sources
hector@sfax.freemove.net





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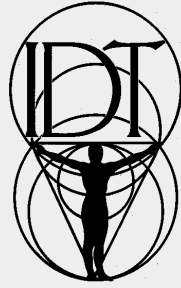
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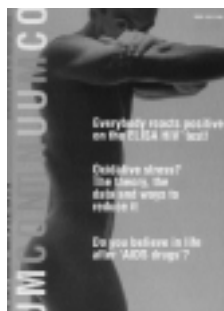
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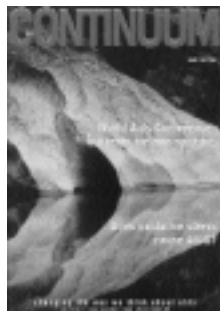
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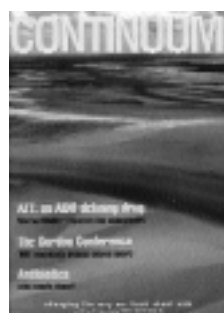
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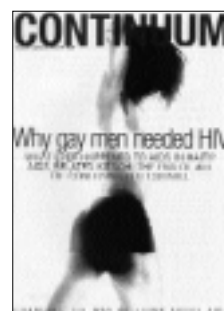
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Why CONTINUUM?

CONTINUUM, the *CONTINUUM* magazine, the other projects of the organisation and its international network were born out of the necessity for integrity, justice and healing around the death prognosis promoted throughout the AIDS-era.

The orthodox view on AIDS holds that it is caused by a retrovirus known as hiv that is transmitted through the exchange of body fluids. Once infected, a person will remain well for a time, though infectious to others, before going on to develop AIDS and dying. There is still no 'cure', just drug therapies said to slow the progress of the disease, and T-cell and 'viral load' counts to 'measure health'.

Fourteen years after the proposal of an hiv as the "probable cause of AIDS", toxic medication is still marketed and huge sums of money are spent on research with little verifiable hope for the future. Powerful pharmaceutical corporations have grown ever larger, capable in some ways of superseding the 'richest' nations on Earth. These corporations have substantial financial interests in controlling disease management, diagnostic

tests and so-called terminal illnesses.

Naive patients - mostly homosexuals, drug ab/users, black people, US Latinos, haemophiliacs, babies and the destitute - have become guinea pigs condemned to die young after being labelled with hiv. In contrast, the questioning of the hiv/AIDS-hypothesis through the images and voices of resistance of many analysts worldwide - including scientists, Nobel Laureates, medical doctors, researchers and health activists - has been generally disregarded by the mass media.

CONTINUUM magazine began as a newsletter encouraging those effected to become responsible and to participate consciously in their own healing process. An important function of the work is to generate and disseminate alternative information on AIDS and immunity, establishing networks with those dedicated to the analysis of scientific research and holistic models of health.

Assumptions run so deep among the medical establishment that only the unproved viral hypothesis has been promoted or funded in AIDS. Immunological investigations have

confirmed more than 60 conditions can trigger a positive 'hiv-antibody' test result. There is no scientific documentation proving the existence of hiv as a unique, exogenous retrovirus, much less one capable of precipitating some 29 diseases and death.

Among *CONTINUUM* readers are a good number of long-term diagnosed individuals not taking anti-retroviral drugs. Many are doing well after more than 13 years of being labelled with hiv. We work towards enabling alternative and immune enhancing studies that will help enable people maintain or regain their health.

CONTINUUM magazine is a unique forum for those in the scientific and health communities challenging the AIDS orthodoxy. *CONTINUUM* is a voluntary organisation dedicated to providing information we believe necessary for the fuller understanding of hiv/AIDS, immunity and health. We aim to encourage those whose lives have in some way been touched by the hiv-hypothesis to seek scientific proofs that an hiv has been isolated and exists, and that it causes AIDS. The organisation relies on subscriptions and donations to maintain its work. Your support in any way is greatly appreciated.