

Rethinking

AIDS

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THE HIV GAP IN NATIONAL AIDS STATISTICS

The HIV-AIDS hypothesis rests on the assertion that all AIDS cases are associated with HIV (*Confronting AIDS-Update* 1988, Natl. Acad. Sci. Press, Wash., D.C.; Blattner, W., et al., 1988, *Science* 241, 514-515; Weiss, R. and Jaffe, H., 1990, *Nature* 345, 659-660; Duesberg, P.H., 1992, *Pharmacol. Ther.* 55, 201-277). Therefore, the Centers for Disease Control (CDC) groups American AIDS cases in its *HIV/AIDS Surveillance* into "exposure (to HIV) categories." However, there are no national AIDS statistics that document the natural coincidence between AIDS diseases and HIV. Contrary to its title, the *HIV/AIDS Surveillance* of the CDC does not report HIV tests. Correlations between HIV and AIDS can only be determined from individual studies and from those CDC AIDS case report forms that include HIV tests.

But most "HIV tests" measure antibodies against HIV rather than the virus itself. And antibodies are not unambiguous evidence for the presence of a virus, nor are they rational predictors for viral disease. Instead antibodies neutralize HIV and restrict the virus to latency. This is the

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AIDS—THE GREAT NUMBERS GAME

The AIDS epidemic has presented a unique opportunity for special interest groups to manipulate numbers. Furthermore, although there are few people interested in downplaying the epidemic, there are many who would like to exaggerate its impact. Some want to use it as an excuse to discourage non-marital sex. Medical researchers want more AIDS research funding. Public health officials don't want to risk being accused of complacency about a major infectious disease that has quite properly attracted worldwide attention: Gay activists want people to feel that it is everyone's disease—not just a gay problem, so that more funding will be available. Politicians realize that they can't lose by engaging in the "politically correct" business of promoting "AIDS awareness" and "AIDS prevention."

Finally, the media understands that the public will read any story about AIDS, particularly if it has numbers that get attention. Because few in the media really understand the numbers, the special interest groups are able to manipulate the data to put the epidemic in its worst light. Here are some of the tricks used in "the great numbers game":

"*We are all at risk!*" True enough. But the risk varies—from very high for the IV drug user who shares needles with his sick friends, to too remote to be of concern for most of us. In fact, for most people, the risk is so low that worrying about it may cause more harm than good because of the extra stress that results.

"*The sky is falling!*" Nearly all of the estimates of HIV+ people and projections of future AIDS cases made by public health officials have turned out to be too high. This is partly because of a lack of understanding of the nature of the epidemic; but it also occurs because (1) no one wants to appear complacent; (2) the worse the epidemic is projected to be, the more money will be made available for public health work; and (3) when the numbers turn out to be lower, the officials can take credit for having done a good job of AIDS education.

Use of cumulative numbers. A headline reported that one group had a "70% increase in AIDS cases in the past two years." Actually, the number of new cases was less than two

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AIDS—THE GREAT NUMBERS GAME

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years earlier—but the cumulative number of cases since the epidemic started was up 70%. (Using this logic, every disease is on the increase.) Unfortunately, this technique of presenting AIDS data is all too common, and frequently misleads even the better reporters.

Use of percentage increases for small groups. If the number of cases of a disease goes from 1000 to 1500 for one group of people, and from 10 to 20 for another group, as a public health matter it would seem that the first group needed the most attention. Yet frequently we hear that the second group "had the highest rate of increase in cases," because it had a 100% increase, while the first group had only a 50% increase.

"Russian Roulette" and other fallacies. How often have we heard that "engaging in unprotected sex is like playing Russian Roulette?" Yet with Russian Roulette there is a one chance in six of taking the fatal bullet, whereas for most people, there is only a remote chance of sexual contact with an HIV-positive person, and only a very small chance of infection even if one's partner is infected, because HIV is so extremely difficult to transmit by penile-vaginal sex. Thus those who use the "Russian Roulette" warning are equating a one-in-six risk with a risk of "one-in-a-million" or less.

"When you have sex with someone, you're having sex with all of his partners, and his partner's partners, and their partners, etc." The implication is that if any of these previous generations of sexual partners was HIV-positive, you'll become infected.

The statement implies a near-100% efficiency of transmission of HIV by penile-vaginal sex. Many articles and warnings have implicitly assumed that sexual contact with an HIV+ person automatically means that the partner will become infected, and polls indicate that most people believe that sexual contact with an infected person is likely to result in HIV infection. In fact, it is so difficult to transmit HIV in this manner that one's prior heterosexual partners rarely ever matter for heterosexuals. (However, they do make a difference for homosexuals, because of the greater efficiency of transmission of HIV by anal sex.)

Failure to put numbers in perspective. Another headline said "AIDS has become the fifth leading cause of death for people ages 15-40." Sounds serious—until one realizes that (1) overall death rates are very low at the younger ages, and (2) most of the deaths that do occur are concentrated in the top four causes.

Overemphasis on isolated, "freak" occurrences of HIV transmission. The transmission of HIV by a Florida dentist to five patients was an aberration, caused by either a major failure to observe normal dental procedures, or a deliberate act of murder. Yet the media treated it as if it represented a new—and possibly common—means of transmission, and millions of people began to fear a trip to the dentist.

"Save the Children!" We all want to protect our young

people from harm. The AIDS epidemic has given the special interest groups the chance to use this desire to push for greater prevention efforts. We constantly hear about the "exploding AIDS epidemic" among teenagers. Yet the number of AIDS cases reported to the CDC for ages 13-19 declined from 170 in 1990 to 159 in 1992. For ages 20-24 (representing people who probably became infected with HIV while teenagers), the decline was from 1626 cases in 1990 to 1446 in 1992.

For ages 13-24, AIDS cases attributed to heterosexual contact have increased somewhat, from 243 in 1990 to 295 in 1992. This was 7% of the total of 4,114 AIDS cases reported as arising from heterosexual contact in 1992 for all ages combined.

"I was protected—I was wearing a condom!" There was the drug addict who was warned not to share needles, because he might get AIDS. He responded that it was okay because he was wearing a condom. Yet, how many times have we heard total numbers of AIDS cases quoted, particularly for teenagers, and then used as a reason for AIDS education campaigns aimed at prevention of heterosexual transmission?

And finally, there are simple *mistakes in numbers*. These can happen in any article, but happen more often with AIDS (and are more apt to be believed by the reader) because it is such a complicated disease. This author has discovered many such errors, including in such distinguished publications as the *Journal of the American Medical Association*, where an article overstated a rate of HIV infection by a factor of 100 because of confusion over the mathematics of percentages, and the headline of a table in the 1991 issue of the *World Almanac and Book of Facts* which claims that the table lists "U.S. Metropolitan Areas with AIDS Rates of 25% or more." The actual list is for cities with rates of 25 per 100,000 or more, not 25 per 100.

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WHY HIV WILL ALWAYS BE ONE STEP AHEAD

Contrary to widespread belief HIV is not mysterious. It is also neither insidious nor even clever. These obviously are properties of the virologist not the virus. And that this patently ordinary retrovirus, with a genetic complexity of only 10,000, which has already consumed more than 10 million dollars per nucleotide, continues to remain mysterious to the smartest, most clever and determined of scientific assaults, ought to make us reflect a moment on this trivial point of grammar. Before yet more effort and money are committed it might be a good idea to at least consider another trivial grammatical point. How a virus that doesn't cause AIDS causes AIDS is, and always will be, a deep mystery indeed.

Harvey Bialy

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reason that leading AIDS researchers have had notorious difficulties in isolating HIV, even in people dying from AIDS (Weiss, R., 1991, *Nature* 349, 374; Cohen, J., 1993, *Science* 259, 168-170).

Moreover, antibody tests generate false-positive results if an epitope is shared between different organisms. According to a recent review entitled "HIV testing: State of the Art," "depending on the population tested, 20 to 70% of...two successive positive ELISAs (enzyme-linked immunosorbent assay) are confirmed by Western blot (an alternative antibody assay)." (Sloand, E.M., et al., 1991, *JAMA* 266, 2861-2866)

In a population with a low probability of infection, the false-positive rate is high. According to the widely cited study of applicants to the U.S. Army by Burke et al., 83% of all initially positive ELISAs (10,000/12,000) were false-positives (*New Eng. J. Med.* 319, 961-964, 1988).

In a population with a high incidence of infection, however, the false-positive rate is expected to be low. Therefore the CDC assumes that "the tiny proportion of possibly false-positive screening tests in persons with AIDS-indicative diseases is of little consequence" (*Confronting AIDS-Update* 1988). But this is not observed.

For example, one study documented 131 repeatedly ELISA-positive homosexual men with negative Western blots in a cohort of 4,994 homosexuals of which 37% were HIV-positive (Phair, J., et al., 1992, *J. AIDS* 5, 988-992). Another study "found HIV-I infection in only 4 (12.5%) of 32 high-risk cases" with repeatedly positive ELISAs (Cehim, C., et al., 1991, *J. Infect. Dis.* 164, 656-664). HIV infection was negative by Western blot, provirus amplification with the polymerase chain reaction (PCR), and virus isolation tests. Another study identified 33 ELISA-positive and even Western blot-positive subjects who were HIV-negative based on the PCR test for HIV DNA (Schechter, M., et al., 1991, *AIDS* 5, 373-379). These subjects were from a group of 316 homosexuals of which 158 (50%) were PCR-positive.

The relatively high incidence of false-positive HIV antibody tests in these HIV risk groups probably reflects the presence of antibodies to other viruses

and microbes that may cross-react with HIV. For example, 7 out of 10 blood donors treated with an influenza virus vaccine in 1991 became HIV ELISA-positive. Each of these proved to be false-positives upon confirmation with a Western blot (Mac Kenzie, W.R., et al., 1992, *JAMA* 268, 1015-1017). Since the CDC "...accepts a reactive screening test for HIV antibody without confirmation by a supplemental test..." (*Confronting AIDS-Update* 1988) and does not request a repeatedly positive antibody test in its "AIDS adult con-

TABLE 1: HIV-free AIDS-defining diseases and immunodeficiencies

Risk Group	U.S./Canada/	Europe	Africa	References
Homosexuals	722	37		1-22/23-26, 74
Intravenous (IV) drug users	251	335		18-20, 27-35, 75/36-39, 74
Infants of IV drug users	55	11		40-43, 44, 45
Hemophiliacs	256	78		46-58/57-61
None/unreported	307	14	2555	16-21, 62-67/21, 68/26, 69-73
TOTALS	1591	475	2555	
SUM TOTAL	4521			

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fidential case report" forms, it includes false-positives in its *HIV/AIDS Surveillance*.

In fact, the CDC even includes AIDS cases in its *HIV/AIDS Surveillance* "without laboratory evidence regarding HIV infection" (*Confronting AIDS-Update* 1988). Upon request, the CDC's director of the HIV/AIDS division, Harold Jaffe, stated that the HIV status of 43,606 out of the 253,448 American AIDS cases recorded by the end of 1992 was "not tested" (per. com., 1993). However this figure seems to be an understatement. Obviously, all 10,360 American AIDS cases diagnosed before the HIV antibody test, i.e., before 1985, were not tested (*HIV/AIDS Surveillance*, February 1993). In addition, the CDC published that "Approximately one third of AIDS patients in the United States have been from New York and San Francisco, where, since 1985, <7% have been reported with HIV-antibody test results, compared with 60% in other areas" (*Confronting AIDS-Update* 1988). Thus, between 1985 and 1987, 58% (93% x 1/3 + 40% x 2/3) of the 56,807 AIDS cases recorded in that period, or 32,948, have not been tested. For 1988, the CDC reported that 27% or 9,039 of the 33,480 AIDS cases recorded for that year were not tested for HIV (Selik, R. M., et al., 1990, *J. AIDS* 3, 73-82). According to the CDC's Technical Information Activity, 3682 AIDS cases without an HIV-test were recorded in 1989, 2888 in 1990, 1960 in 1991, and 1395 in 1992 (per. com., 1993). Thus, at least 62,272, or 18,666 more than Jaffe reports, were not tested.

Determination of the HIV-AIDS correlation is further obscured because HIV-free AIDS cases are not recorded in the CDC's *HIV/AIDS Surveillance*. By 1993, at least 4621 HIV-free AIDS cases had been documented in the S., Europe, and Africa with the clinical AIDS definition (Table 1). Even Jaffe, again upon request, reported 89 HIV-free AIDS cases (per. com., 1993). The cases recorded in Table 1 suffered from one or more of the over 25 heterogeneous AIDS-defining diseases and from AIDS-defining immunodeficiencies without diseases. Some of these proved to be HIV-free even by PCR amplification of viral RNA and DNA.

Table 1 includes some American and European immunodeficiencies that may not exactly fit the current definition of AIDS defining immunodeficiency without disease, which is <200 T-cells per microliter (CDC, 1992, *MMWR* 41, RR 17, 1-19), as for example, HIV-free male homosexuals on various recreational drugs with "X cells per cubic millimeter" (Table 1, ref. 14) or HIV-negative hemophiliacs with T4/T8 cell ratios of about 1 or <1 (Table 1, refs. 46-61). But even if not all of these cases fit the current definition of AIDS-defining immunodeficiency exactly, they do so prospectively. This is because their T-cells typically continue to decline either because of risk behavior, such as the consumption of recreational drugs, or because of clinical AIDS risks, such as chronic transfusion of foreign proteins as prophylaxis against hemophilia (Duesberg, P.H., 1992, op. cit.).

Since a clinical definition is used in Africa, statistics from

this continent are not biased against HIV-free AIDS. For example, 2215 out of 4383 (50.0%) African AIDS patients from Abidjan, Ivory Coast, Lusaka, Zambia, and Kinshasa, Zaire, were HIV-antibody negative (Table 1, ref. 70, 71). Another study using antibody tests and supplementary PCR tests for HIV reports 135 (59%) HIV-free AIDS patients from Ghana out of 227 suffering from weight loss, diarrhea, chronic fever, tuberculosis, and neurological diseases (Table 1, ref. 72). Only 37 (30%) of a group of 122 African tuberculosis patients were HIV-positive, according to a study published in 1993 (Table 1, ref. 73). An earlier study documents 116 HIV-negatives among 424 African patients, and Montagnier et al. diagnosed HIV in four out of eight (Table 1, ref. 26, 69). It follows that about 50% of the African AIDS cases, or 65,000 of the 129,000 diagnosed by 1992 (Duesberg, P.H., 1992, op. cit.), may be HIV-free and thus not caused by HIV.

Instead of considering the potential usefulness of HIV-free AIDS cases in the search for the cause of AIDS, the CDC and the NIH's director for AIDS hid in 1992 the then rapidly growing numbers of HIV-free AIDS cases (Duesberg, P.H., 1992, op. cit.) under a new name, "idiopathic CD4 lymphocytopenia" or ICL. Indeed, the new name has sent HIV-free AIDS cases into obscurity. But efforts to set apart HIV-free from HIV-positive AIDS cases by the new term are not based on clinical or scientific arguments. According to an editorial by Anthony Fauci, HIV-free AIDS or ICL cases are unlike the HIV-positive cases because (1) "Given the heterogeneity of the [ICL] syndrome, it is highly likely that there is no common cause," and because (2) "Approximately one-third of the patients are women, as compared with 11% among those with HIV...[in America]" (Fauci, A., 1993, *New Eng. J. Med.* 328, 429-431). Yet proponents of the HIV hypothesis, including Fauci, insist that HIV is the common cause of the more than 25 heterogeneous AIDS diseases and that HIV causes African AIDS, although about 50% of the African patients are women (Duesberg, P.H., 1992, op. cit.).

In view of the above, I submit that the natural coincidence between HIV and AIDS in America and Europe remains unknown, and is certainly less than perfect. Thus arguments for the etiological role of HIV in AIDS, which assume a perfect correlation, are fundamentally flawed.

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RETHINKING AIDS congratulates Kary Mullis, Ph.D., recipient of the 1993 Nobel Prize for Chemistry. Inquiries and kudos to the following address: 6767 Neptune Place, #4, La Jolla, CA 92037 (fax 619-456-0639). Mullis, an early signer and contributor to the Group, is an outspoken opponent of the HIV-causes-AIDS theory and is strongly against the use of AZT as therapy. Once his busy schedule permits, we hope to feature him in a future issue.

Please use the enclosed return envelope to subscribe or donate. Your contribution matters.

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STATEMENT

The Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis came into existence as a result of our efforts to get the following four sentence letter published in a number of prominent scientific journals. All have refused to do so.

"It is widely believed by the general public that a retrovirus called HIV causes the group of diseases called AIDS. Many biomedical scientists now question this hypothesis. We propose that a thorough reappraisal of the existing evidence for and against this hypothesis be conducted by a suitable independent group. We further propose that critical epidemiological studies be devised and undertaken."

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