

# Reappraising

# AIDS

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## AZT for Pregnant HIV+ Women and Their Newborns

All HIV-positive pregnant women and their newborns should consume AZT, according to an article published in the November 28 issue of the *New England Journal of Medicine*. The study, sponsored by the National Institutes of Health and partially funded by AZT's manufacturer (Glaxo-Wellcome), was conducted by Rhoda Sperling of New York City's Mount Sinai School of Medicine, and MD professors at other universities around the country.

According to Agence France Presse (Nov. 27), Sperling's group was charged with "assessing the safety and effectiveness" of AZT on pregnant women and babies. The results: AZT administered to the mother through the second and third trimesters and continued for the infant's first six weeks resulted in a two-thirds reduction in HIV transmission: about 21% of the non-AZT babies were HIV-positive, compared with about 7% of the AZT babies, which is consistent with the results of previous similar studies.

What about safety? The eight-page report was stuffed with data and discussion concerning AZT's effect on HIV DNA, HIV RNA, T4 counts, and reverse transcriptase activity. But Sperling's report had nothing to say about the effects of AZT on the health of the babies. Compared with the AZT-free babies, what was the frequency of spontaneous abortions and birth defects among the AZT babies? Among the HIV-negative babies, was there a difference in short-term and long-term health between those who never consumed AZT and those who consumed it during their final six months as a fetus and first six weeks as an infant? What about the frequency of clinical symptoms in HIV-positive babies taking and not taking AZT?

Sperling's report addressed none of those questions, and mentioned nothing about evaluation of or concern with safety issues. (Eight attempts to contact Sperling at her Mount Sinai office were unsuccessful. She was usually there seeing patients, but never returned any of the phone calls.)

In 1995 three French physicians looked for birth defects among children born to HIV-positive women. The infants were administered AZT according to Sperling's protocol—second and third trimesters, first six weeks after birth—which they described as the official recommendation in the US and France. They found birth defects in 9% of the babies, but said nothing about other health effects (*Journal of AIDS* 9:2, p209).

A 1994 study of 104 HIV-positive pregnant women consum-

ing AZT produced similar data. Eight of the babies (7.7%) had birth defects, 8 of the fetuses spontaneously aborted, and 8 were therapeutically aborted (*Journal of AIDS* 7:10, p1034). In other words, 24% of the babies were killed or crippled while taking AZT.

Sperling's own data shows that if AZT is withheld, fewer than 24% will be born HIV-positive. So even if HIV *could* cause AIDS, and did so in every instance, does it make sense to prevent HIV transmission by possibly aborting or marring more fetuses than might otherwise become infected?

Yet Sperling failed even to acknowledge these alarming data in a report that explicitly recommended AZT for the fetuses and infants of all HIV-positive women.

Just as scandalous is that the NIH, which co-sponsored her investigation, has not objected to her conclusion. In February of 1995 the NIH halted the AZT arm of a study examining the effects of antiviral drugs on HIV-positive children. The study divided the children into three groups: those taking AZT alone, those taking ddI (an

AZT-like drug), and those taking both.

"An independent monitoring board examined the data in early February and determined that AZT caused sufficient problems that it should not continue to be tested," the UPI reported on February 13.

According to a *New York Times* article published the same day, "children taking AZT alone had more rapid rates of disease progression as measured by failure to grow, the appearance of any of the myriad infections that can be complications of AIDS, deterioration of neurological development and death."

The on-going study (ddI and ddI/AZT are still being tested) began "in August, 1991, involved 839 children initially aged 3 months to 18 years, who were treated in 62 hospitals," the *New York Times* said. "The study was intended to continue until the last child recruited had completed two years of therapy."

The *New York Times* article offered only one explanation for why the AZT kids were doing poorly: "AZT alone was unexpectedly proving to be the least effective of the three therapies."

### **ANOTHER MEDICAL DISASTER IN THE MAKING?**

**Inside: Protease Inhibitors  
CAUSE FOR CONCERN**

That explanation implies that all the problems—AIDS symptoms, death, arrested development—were due to HIV, not the drugs, and that AZT by itself was simply less effective at preventing these conditions than the other two treatments. But the UPI reported that the independent review panel suspected AZT of actually causing some of those problems, not just failing to prevent them.

The UPI, but not the *New York Times*, quoted Dr. Carol Baker of Baylor College of Medicine and co-chair of the study: "Children in the AZT alone group had more disease progression. The second part of the difference was in side effects."

In other words, she considered all the AIDS conditions to result from HIV, not the drugs, but did acknowledge that all the non-AIDS conditions resulted from the drugs.

Immediately following her statement the UPI article added, "Children who received AZT alone had many more blood and chemical abnormalities." Presumably these abnormalities indicated AZT toxicity, implicating AZT in some of the "problems" that predominated in the AZT-alone group.

To state her findings another way: among HIV-positive subjects taking AZT by itself, ddI itself, or both drugs simultaneously, she saw the most AIDS (immune suppression, weight loss, dementia, certain cancers) and non-AIDS (birth defects, arrested development, spontaneous abortions) pathologies in the group consuming AZT alone. She assumed that all of the AIDS pathologies resulted from HIV, and that AZT taken alone was simply less effective at *preventing* these conditions than the other two protocols. Meanwhile, she characterized the non-AIDS pathologies as drug side effects, and concluded that AZT taken by itself was more effective at *causing* these problems than the other two protocols.

There is an alternative explanation, one ignored by both press reports but advanced by scientists just as qualified as Dr. Baker. It is this: AZT and ddI both cause all of the pathologies she observed—even those under the AIDS heading—and that it is simply more toxic to consume AZT by itself than it is to consume either ddI by itself or both drugs simultaneously.

Since AZT and ddI are toxic to all growing human cells and carcinogenic as well, they are logical causes of the AIDS and non-AIDS conditions observed in the studies that looked for them.

Evidently ddI is not as effective as AZT at causing those

problems, says David Rasnick, a Berkeley biochemist who worked for 20 years designing protease inhibitors. Rasnick is not surprised that AZT plus ddI is less toxic than AZT alone. "Since AZT and ddI are chemical cousins, they compete for the same liver enzymes that render them usable by the body," Rasnick says. "The more ddI molecules you add, the more competition the AZT molecules will have for transformation by the liver enzymes. It is possible for toxic substances to be rendered less poisonous simply by adding similar molecules that are less toxic."

Rasnick says that what is missing from this study—and all studies of "anti-HIV" drugs—is a true placebo group. "The children faring the worst were those taking AZT alone," he said in a phone interview. "Those taking ddI or ddI plus AZT were doing better. I predict that a true placebo group, children taking no cancer drugs, would do the best of all."

Rasnick considers AZT-style drugs to be a cause of AIDS, and is convinced that HIV is harmless. Rasnick's view is based on the scientific method, a concept strangely missing from academic papers and press reports concerned with AIDS.

When the AZT arm of the NIH study was halted, Anthony Fauci, who heads the NIH's AIDS program, called for a reconsideration of AZT as a treatment in children and infants.

"Right now, the recommendation for children with AIDS is AZT," Fauci told the UPI in the same article announcing the study's termination. "This is certainly going to be relooked at." The *New York Times* article said that Fauci "would recommend that experts meet in a forum soon to discuss how to treat HIV-infected children. The uncertainty centers on whether pediatricians should...[use] ddI alone or in combination with AZT."

We have heard nothing else from the NIH regarding this matter, even now that a study it sponsored—one reportedly charged with evaluating AZT's safety—has unqualifyingly endorsed AZT as a prenatal and pediatric medication, without even mentioning the cautionary data discussed here.

Perhaps Sperling's group needed an independent monitoring board, one comprising scientists not funded by the manufacturer of the drug she was testing. We are left to wonder why such a board was constructed for one AZT study and not another, and why AZT toxicity was found in the study that did have an independent monitor, while no toxicity was reported in the study that had no independent monitor.

—Paul Philpott

## Rx WATCH

### IN SEARCH OF HIV

The British AIDS reappraisal magazine *Continuum* wants to mail a free sample issue to interested RA subscribers. The issue includes the lengthy scientific paper by Australian scientists Eleni Eleopulos-Papadopulos and Val Turner questioning the very existence of HIV. Peter Duesberg disagrees with them, insisting that HIV does exist. (Duesberg and the Aussies agree that AIDS is noninfectious and

caused by such factors as street drugs and pharmaceuticals.) This paper is one in a series of exchanges between them. Direct requests to RA or *Continuum* (see RA and *Continuum* contact boxes on back page).

### MAGIC UPDATE

Magic Johnson has been "freed from the chains of HIV," Detroit sports talk radio host Mike "Mega Man" Griffin announced on his Dec. 18, 1996 1200AM show. Grif-

fin says he called his "good friend" for a health status update, and Magic reported using a "powerful new combination of drugs called a cocktail." The last time the doctors checked, they could find no HIV in his blood, Griffin says Magic told him. If true, then Magic is taking AZT, the standard ingredient of those toxic treatments, although Griffin did not mention this.

—Paul Philpott

## PROTEASE INHIBITORS: *Cause for Concern*

Proponents of the HIV model say cocktail therapy—AZT and other cancer drugs combined with protease inhibitors—has real benefit, that consumption correlates not only with reduced HIV blood levels and increased T4 counts, but with improved clinical profiles. This, they say, represents a significant advance in both treating AIDS and demonstrating a causal role for HIV.

But does it? Are patients really getting better? Does the data really implicate HIV?

There are two reasons to think that patients are benefiting, neither of them good: press releases from corporate-sponsored researchers, and press accounts of patients who like their new drugs. Nowhere in the academic journals are the claims of clinical improvement documented.

"All we have are researchers talking to reporters about incomplete studies that haven't been scrutinized by the scientific review process," says protease inhibitor researcher David Rasnick. "And the scientists involved are funded by the companies that make the drugs in question."

"There is no justification for the claims coming from these sources," he says, "particularly when we've seen it all before." Ten years ago these same sources cheered AZT's arrival with flawed corporate studies showing dramatic increases in T4 counts. Spectacular tales of AZT causing miraculous recoveries appeared in the press but not in academic journals.

Today we know for certain that rather than helping AIDS patients, as those initial reports claimed, AZT actually causes AIDS symptoms. Given the nature of the claims in favor of the new protease inhibitors, Rasnick asks: "Why should we take them seriously?"

In the absence of properly documented clinical improvement, there's no basis for characterizing cocktail therapy as representing an advance in AIDS therapy.

The best substantiated claim responsible scientists can make on behalf of cocktail therapy at this point is that it boosts T4 counts and suppresses HIV viral load.

But do these data implicate HIV?

**Hardly.** For one thing, the PCR-based "viral load" test yields counts unrelated to the amount of virus actually present (*RA*, Oct., 1996), and T4 counting is a dubious indicator of health (*RA*, Sep., 1996). And without cell-killing activities or an appreciable presence in every patient (*RA*, Oct., 1996), HIV simply has neither the ability nor the opportunity to cause AIDS. Clear thinking scientists should have no reason to blame HIV for AIDS, regardless of the effects that a drug therapy might have on lab markers and even clinical outcome.

—Paul Philpott

### DO PROTEASE INHIBITORS BLOCK HEALTHY ENZYMES?

David Rasnick says yes, but not for the reason most people would think. Some reappraisers suppose that these drugs block HIV protease by blocking *all* proteases, including human proteases such as those that digest dietary proteins. If so, that would be a potent cause of toxic effects.

According to Rasnick, this is not the case. An inhibitor of one protease, in this case, the retroviral protease, is not a good inhibitor of other proteases. These drugs are very specific to retro-

viral protease, and are thousands of times less efficient at blocking other proteases—such as digestive enzymes necessary for human life.

However, the doses of protease inhibitors prescribed to patients are huge (2-7 grams per day), and the concentration is particularly high in the stomach, intestine, and liver, which process the drugs before they get diluted and dispersed throughout the body.

At high concentrations, even a drug that is very inefficient at blocking an enzyme can do so, just as 100 ordinary men working together can beat up Mike Tyson, whereas two or three could not.

Blockage of the human digestive aspartyl protease cathepsin D in the intestines may contribute to the diarrhea, nausea, and vomiting that has been reported in patients taking the protease inhibitors. Blockage of the detoxification enzymes that Rasnick describes in the article on page 4 may explain the liver toxicity.

So the situation is somewhat different than it is for the AZT-style drugs, which are toxic because they block human DNA production just as effectively as they block HIV DNA production.

—Paul Philpott

### Commentary

#### HYPE INTENSE AND UNQUESTIONED

Imagine if cancer patients told reporters that they'd experienced miraculous recoveries after beginning vitamin and herbal therapy. Doctors and medical scientists would dismiss these stories as mere "anecdotal evidence" in the absence of carefully controlled studies published in peer-reviewed academic journals.

The medical profession adopts a much different posture, though, when it comes to toxic substances prescribed to HIV-positive people.

You can hardly unfold a newspaper, open a magazine, or flip a channel without encountering miraculous claims for the new cocktail therapy, a combination of retroviral protease inhibitors and AZT-style chemotherapies prescribed as an anti-HIV treatment.

The *Wall Street Journal* (Nov. 8, 1996) ran a front page article by one of its features editors, David Sandford, an AIDS patient who relayed his personal story. "I was gaunt, tired and rather sure I was losing the battle" until he started cocktail therapy, which performed a "miracle."

Andrew Sullivan, the HIV-positive former editor of the *New Republic*, offered a personal tribute to protease inhibitors, "When AIDS Ends," which the *New York Times Magazine* afforded cover status. "People I had seen hobbling along," he writes, "their cheekbones poking out of their skin, their eyes deadened and looking down, were suddenly restored into some strange spectacle of health."

*Newsweek* (Dec. 2, 1996) devoted a cover story, "The End of AIDS?," to "I've been healed!" stories. A sample accounting of one patient's story: "He had to feed himself through an IV in his arm because he couldn't tolerate food... Then [he] began taking a cocktail of [protease inhibitors and] AZT... Within a few weeks he started feeling better."

*TIME* followed with a special double-issue (Dec. 30/Jan. 6)

proclaiming cocktail promoter David Ho its Man of the Year. It included an article, "Hope With An Asterisk," which focused on miracles attributed to protease inhibitors administered with AZT as cocktails.

Nowhere in these stories do the reporters mention that clinical recovery following cocktail therapy has not been documented in independent, peer-reviewed studies, hitherto the standard for medical claims.

—Paul Philpott

## ON SECOND THOUGHT...

# HIV Protease Inhibitors Don't Block AZT's Toxicity

In last March's *Reappraising AIDS*, I examined the spectacular claims made for protease inhibitors coming out of the January Retrovirology Conference in Washington, DC. The drugs were up for fast-track FDA approval, and hundreds of thousands of hopeful HIV-positive Americans were looking for a new product.

Scientists funded by the manufacturers of protease inhibitors stepped up to the lecterns and made bold announcements regarding the preliminary results from unpublished, on-going (which is to say incomplete) studies. When mixed with AZT and other cancer chemotherapies, these new drugs not only boosted T4 counts, they suppressed HIV "viral load."

The press eagerly published and broadcast these claims. A succession of protease inhibitors set new speed records for FDA approval. HIV-positive Americans rushed out to purchase them and began cocktail therapy.

In my examination, I noticed an interesting item mixed in with what little talk there was of protease inhibitor side effects: "When it [one of the protease inhibitors] reaches the liver, dozens of enzymes, called cytochromes, bind to [it]," Laurie Garrett wrote in her March 5, 1996 *Newsday* dispatch. "During that time other drugs that may be in a person's body cannot be properly metabolized."

I interpreted the term "not properly metabolized" to mean that protease inhibitors could prevent other drugs from being utilized. I posed the following question: "Could it be that some or all of the 'benefits' attributed to protease inhibitors might simply be due to their blocking the assimilation of the toxic AZT-style drugs [in the liver], rather than their blocking HIV replication?"

Then the next wave of media hype began. HIV-positive people with AIDS conditions were telling reporters that their

symptoms were subsiding—sometimes vanishing altogether—after beginning cocktail therapy. Although these scenarios even now have not been observed in independent studies published in medical journals, they came to dominate media coverage of HIV and AIDS.

I wondered about the people describing to the press miraculous recoveries. Could it be that prior to their taking protease inhibitors, they were taking AZT? If so, perhaps the AZT was making them

## Protease Inhibitors Probably Make AZT Even *More* Toxic!

sick in the first place, and when they added the protease inhibitors to form a cocktail, the protease inhibitors were blocking AZT's toxic effects. Were the new drugs in effect acting as an antidote to AZT? I asked David Rasnick, a designer of protease inhibitors and critic of the infectious AIDS model.

"You can never tell what is going to happen when you start mixing drugs together," he told me. "Sometimes, for unknown and unpredictable reasons, drugs taken together can be less toxic than when taken separately, and sometimes they can be more toxic."

Certainly, he said, my proposal was more likely than the proposal that protease inhibitors benefited patients by blocking the activities of HIV, which he considers to be benign and incapable of causing disease.

My new commentary on the protease inhibitor hype appeared in the December, 1996 issue of *RA*. Entitled, "Here We Go Again," it drew comparisons to the miraculous claims made for AZT when that drug was introduced ten years ago.

Revisiting my proposal that the protease inhibitors might be blocking AZT's

toxicity, I wrote: "David Rasnick, a PhD biochemist who designed protease inhibitors for twenty years...now thinks that this is a viable possibility."

Rasnick, however, does not stand behind that quote. He dismisses it as "pure speculation," and did not intend it for publication.

"Actually I believe protease inhibitors are likely to *increase* the toxicity of other drugs, including AZT," Rasnick said in a more recent interview. "My belief is based on the documented added risks of the Merck and Abbott protease inhibitors when used in combination with AZT and other drugs (Deeks, *JAMA* 277, 1997, p145).

This occurs because the drugs "inhibit the cytochrome p450 system in the liver, preventing the liver from detoxifying other drugs and substances—including AZT I'm sure—allowing them to build up to lethal levels. I expect similar complications will turn out to be true of the Roche drug as well."

This effect for the Abbott drug is "especially nasty" he says, and is "over and above the intrinsic toxicities of the HIV protease inhibitors themselves, which I consider to be considerable (see Commentary on page 3)."

So the cytochrome enzymes referred to by Laurie Garrett are responsible for detoxifying poisonous substances in the blood, not assimilating into the blood newly consumed drugs, as I originally thought. Since protease inhibitors attract and occupy those enzymes, the enzymes are not free to rid the body of AZT and other poisonous substances.

Rasnick has been firm all along that there is no good reason to think protease inhibitors might offer any benefits. His reluctance to accept the media hype appears well-founded and is the only responsible position to take.

—Paul Philpott

## NOTHING NEW ABOUT COCKTAIL THERAPY'S EFFECT ON VIRAL LOAD

*POZ*, the monthly high-gloss, pharmaceutical-sponsored magazine for HIV-positive people (and their much more numerous attendants, advocates, and educators) published an uncharacteristically thoughtful article titled, "The Morning After" (Feb., 1997).

The author, Mike Barr, considered the clinical relevance of the most celebrated effect attributed to protease inhibitors: reducing HIV "viral load" to undetectable levels. According to Barr, AZT has been achieving the same effects in some patients all along, but without resolving AIDS.

"In the European Delta study, fully 40% of participants became 'undetectable' on AZT/ddI; even 5% did so on AZT

monotherapy," Barr wrote. "Apparently we have been reducing patients' viral load to undetectable levels for a decade—but never knew it because the PCR technology [the basis of viral load readings] has only recently been acquired and commercialized. If becoming 'undetectable' on nucleoside combos hasn't prevented progression to disease and death, why is 'undetectable' on the protease combinations impervious to failure—except for the fact that we haven't followed patients long enough to see it?"

In other words, the dubious viral load test came along just when a new combination therapy—protease inhibitors mixed with AZT-style drugs—was being tested. Scientists funded by the protease inhibitor

manufacturers saw viral load levels drop to zero in many patients, and started crying "home run!"

They ignored similar results coming out of studies examining combination therapies that had been around for the past ten years, therapies that had failed to produce long-term clinical benefits.

*POZ* is committed to the HIV model, tirelessly promoting HIV hysteria and championing the distended federal AIDS budget. Its inclusion of this critical view could indicate a slight opening to honest, competent journalism. Or could it be their way of making sure tax payers don't perceive the AIDS War to be over and no longer in need of financial support.

—Paul Philpott

## AIDS: THE LEADING CAUSE OF UNJUSTIFIED HYSTERIA

by Charles Geshekter

"AIDS is now the leading cause of death among Americans aged 25-44." We hear this claim again and again from health officials, activists, professors, and, of course, the press corps. They expect us to respond with fear, deep concern, and (most of all) support for the enormous federal AIDS budget.

According to them, America's bedrock age group faces a significant and growing threat from AIDS, a condition now accounting for most deaths in this group.

This perception, despite its popularity, is refuted by the attending facts:

1. Sure AIDS is the leading cause of death among Americans aged 25-44. But of the roughly 170,000 deaths in this group for 1995, only 27,000—or 16%—died of AIDS. So most deaths in this group resulted from causes other than AIDS.
2. Accidental deaths (from car crashes, household mishaps, workplace tragedies, etc.) came in a very close second, at 15.7%. So in terms of mortality, AIDS hardly matters more than accidents for this group.
3. And the 27,000 AIDS deaths in 1995 were 18% fewer than the 33,000 in 1994. So AIDS is a decreasing, not an increasing, mortality factor.
4. Mortality itself is not a pressing concern for this age group. Of 82 million Americans aged 25-44, only about 170,000 died in 1995, for an annual mortality of only 0.2% (two-tenths of one percent). So for every 1,000 Americans in this group, only two die every year of any cause.

5. AIDS mortality is especially insignificant for this group. Since just 27,000 died of AIDS in 1995 out of 82 million Americans aged 25-44, the annual AIDS mortality was 0.03% (three one-hundredths of one percent)—and dropping! That means for every 10,000 Americans in this group, three die from AIDS each year.

6. Although most AIDS patients are in this age group, 89% of all American deaths occur among those older than 44.

7. The low annual AIDS mortality risk in this group—three out of 10,000—does not distribute equally across the population. Instead, annual AIDS mortality is much *lower* than three per 10,000 for the vast majority of Americans, and much higher than three per 10,000 for those in very special groups. Consider that approximately 94% of all American AIDS patients to date have consumed harsh street drugs, and another 3% were previously sick from hemophilia or from conditions requiring blood transfusions. Also consider that another unknown fraction developed AIDS only after taking AZT in response to a positive HIV-antibody test. Since AIDS is confined to very small subsets of the population, it follows that for Americans aged 25-44 who do not belong to one of those special groups, the annual risk of AIDS mortality is much less than the tiny three in 10,000 figure.

(Sources: CDC *Weekly Mortality and Morbidity Reports*; CDC *HIV/AIDS Surveillance Report*; US Census, 1990; "Health, United States, 1994," National Center for Health Statistics, 1995)

**HEAL-DENVER STARTED** Marty Fryer of HEAL-Seattle moved to Denver in December, and has started a chapter there. For more information on regular meetings, call (303) 634-4248.

**NUMBERS PERSPECTIVE** The AP reported that in 1995 there were about 1.5 million Americans in prison (*Detroit News*, Aug. 19). That's about twice the number of Americans who are HIV-posi-

tive (*RA*, July, 1996).

**HEAL ON TV** Turner Broadcasting Company (TBS) will air a news program focusing on HEAL-LA. Look for it Easter Sunday at 10pm Eastern, 7pm Pacific.

**TONY BROWN** One of the earliest supporters of the AIDS reappraisal movement was Tony Brown, a DC-based black conservative host of the weekly PBS talk show, *Tony Brown's Journal*. In 1992, Brown devoted six *Journal* programs to interviews with such reappraisers as Peter

Duesberg, John Lauritsen, Nathaniel Lehrman, and Robert Root-Bernstein.

Last year Brown published *White Lies, Black Lies*, a collection of essays on a variety of topics such as affirmative action (which he opposes) and AIDS. He titled his AIDS chapter "DAIDS: Drug Ac-

quired Immune Deficiency Syndrome" to emphasize his belief that AIDS in America results from the consumption of recreational and pharmaceutical drugs. The book was just released in paperback and is carried in major book stores.

—Paul Philpott

## SELF-CENSORSHIP

AIDS reappraisers aren't the only ones contending that the media declares some topics off-limits.

The Dec. 16 *USA Today* examined an ABC News *Prime Time* segment exposing a "dirty little secret in local news." In the segment, correspondent Chris Wallace reported that at the 1996 Investigative Reporters and Editors Convention, 29% of broadcasters said legitimate stories had been killed for fear of losing ads. "You can go after local government," Wallace observed. "You can go after the Pentagon, but don't touch local car dealers or grocery stores that advertise."

Wallace talked to reporters declaring on-record that they were pressured by editors to kill stories, and revealed that ABC executives pressured *him* not to run *this* story. "The worst kind of pressure is self-censorship," he warned.

Similar pressure might explain why HIV critics find it nearly impossible to get their studies and commentaries published in the major medical journals. Those publications rely on advertising dollars from the giant pharmaceutical companies, most of which are vested in an anti-viral approach to treating AIDS.

Pharmaceutical companies also advertise in newspapers and magazines, and on television, media which are just as unreceptive to HIV critiques as the medical journals. But pharmaceutical ads don't dominate those media as they do the medical journals.

### *Eye on the Media*

So financial considerations can only partially explain why the press doesn't scrutinize the infectious AIDS model. The full explanation probably involves social and political considerations. No media outlet can afford to be branded as "dangerous" or "irresponsible" by those who make up the enormous and pervasive HIV coalition: physicians, professors, scientists, health officials, and social activists.

Which leads us back to financial considerations. Perhaps the professions represented in the HIV coalition are, like journalists, influenced by the bottom line.

For AIDS, the bottom line is this: as long as Americans think that AIDS is infectious, they will employ a huge army of physicians, scientists, professors, graduate students, counselors, and educators to protect them.

Anybody who's studied this topic knows what happens when members of these professions criticize the infectious AIDS model: their peers and superiors treat them like a reporter who wants to investigate an advertiser.

—Paul Philpott

### CONTINUUM

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Continuum is a full-length magazine published every other month by British AIDS dissidents. Each issue covers scientific and social issues. For an annual subscription, send \$40 cash (US and Canada) to:

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