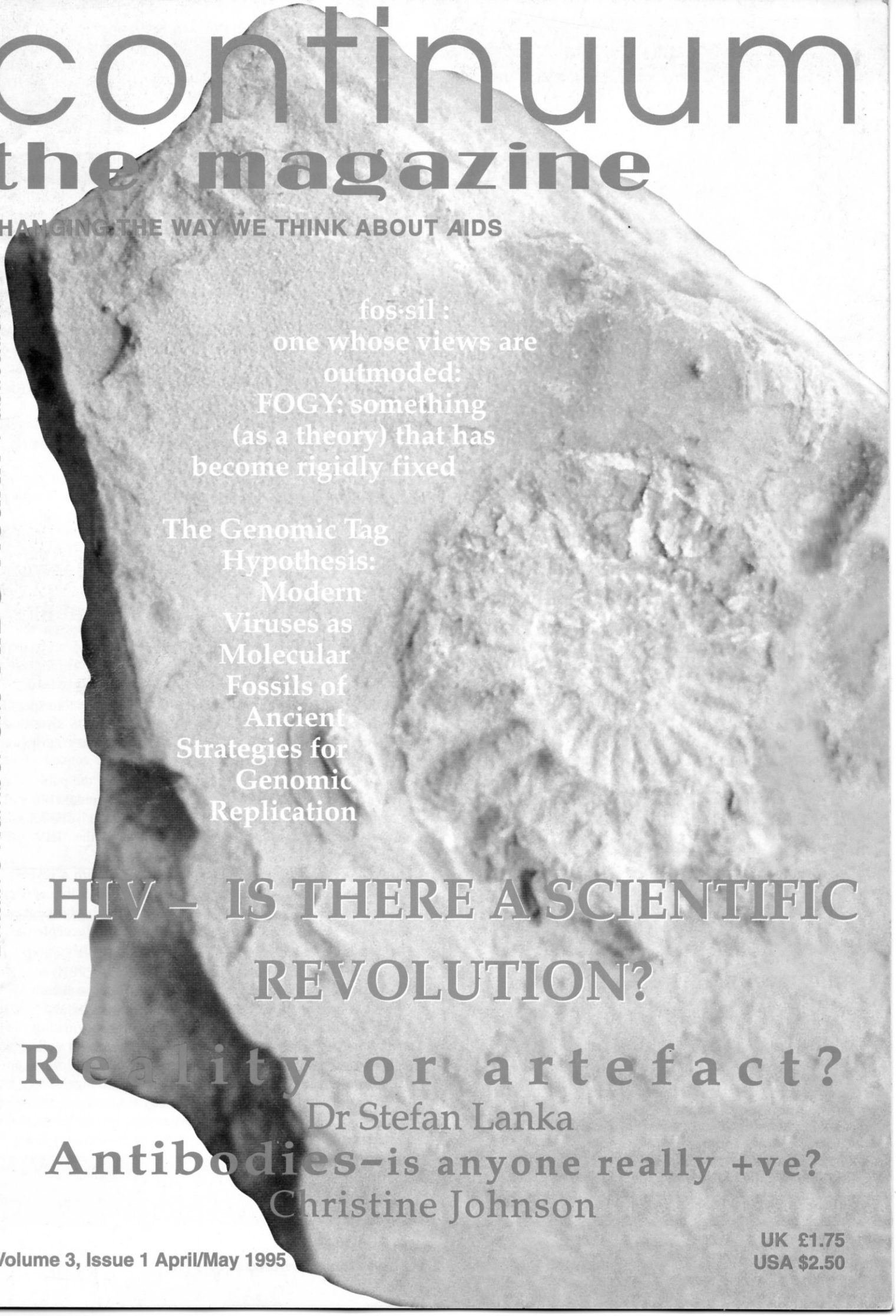
continuum
the magazine

CHANGING THE WAY WE THINK ABOUT AIDS

Britain's Number One *AIDS Health* Publication



fos·sil :
one whose views are outmoded:
FOGY: something (as a theory) that has become rigidly fixed

The Genomic Tag Hypothesis: Modern Viruses as Molecular Fossils of Ancient Strategies for Genomic Replication

HIV – IS THERE A SCIENTIFIC REVOLUTION?

Reality or artefact?
Dr Stefan Lanka

Antibodies–is anyone really +ve?
Christine Johnson

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In This Issue

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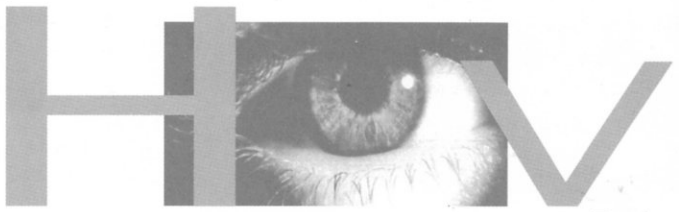

Something at once reassuring and provocative is happening with this issue of the magazine. Along with the informative and supportive content you would expect to find between these covers we are publishing, for the first time anywhere, a new paper by virologist Dr Stefan Lanka which is quite possibly the bottom line in HIV/AIDS research. It is an extraordinary paper which argues cogently and with ample references that the so-called human immuno-deficiency virus has never been isolated and does not exist. First reactions to this news will no doubt vary from derision to shock amongst AIDS officionados, but no response to the article will be valid unless the respondent has read and digested its content. We look forward to the developing revelations that this moment in health history will bring.

Dr Lanka is willing and ready to debate, discuss and elucidate his discoveries in a productive round table conference format here in London. The benefits of a full airing of the profound issues at stake here will be a movement towards a fuller and more specific understanding of how the disease situations of AIDS arise independently of a retrovirus and consequently how they may more purposefully be prevented or cured.

We look forward to the developing revelations that this moment in health history will bring.

Suggestions and inquiries about when and where the public conference will be held should be directed to the Continuum office.

In her compelling second article for Continuum Christine Johnson unravels the factual story behind the creation of the "HIV test", lifting the curse of the HIV diagnosis.

Molly Ratcliffe returns to the Women's Pages with a revealing examination of those recent additions to the AIDS list, cervical cancer and pelvic inflammatory disease. On the health page she uncovers connections between diet and herpes - accepted as a viral condition but which a balanced body can usually control.

Last September Jody Wells and Huw Christie attended the Nutrition and HIV/AIDS Conference held by the British McCarrison Society in Edinburgh, where they met up with some familiar faces including Cass Mann and former colleagues of his who now publish the AIDS periodical Equilibrium, plus delegates from as far afield as New York and Los Angeles.

During an informal discussion after Jody's speech on behalf of Continuum, an English biomedical researcher briefly left to check a reference book and reported back that the HIV antibody test was

Keeping an eye on HIV

listed as prognostic, not as he'd thought, diagnostic. He realised the significance of the distinction - rather than being the identification of disease, the test is expected to forecast future disease (AIDS), dependent largely on word games: AIDS is one or more of various diseases or conditions in the presence of HIV. Since a positive HIV test purports to indicate the presence of HIV, the prognosis for getting AIDS is 100% *if* you get one of the defining diseases or conditions. So the probability of getting one of the diseases is what should matter. But in the UK at least, Public Health Laboratory figures for the illness Pneumocystis Carinii Pneumonia (PCP) for example, are kept only when a PCP diagnosis is a patient's first "AIDS indicator disease"; that is, only for HIV positive people. Since PCP has been known for over fifty years in Europe (generally consequent on severe protein energy malnutrition - Leipzig study, 1973), and since there has never been HIV testing of the general population (heaven forbid), it isn't at all clear whether the current prognosis for getting PCP is

Public Health Laboratory figures for PCP are kept only for HIV positive people.

any better or worse if you're HIV positive or not! By dint of definition however, if you did test HIV positive and did get a PCP diagnosis, the test did accurately forecast AIDS! Like a stopped clock, it's right now and then, relatively.

Thus it turns out the prognostic HIV test becomes more accurate only as more diseases and conditions are added to the AIDS definition. If flu is ever included, expect claims of remarkable prognostic accuracy! Without adding more diseases, the cumulative figures for HIV without AIDS might climb well beyond their current 55%. Prognosis schmognsis! Certainly here at the office we heard of two HIV negative PCP diagnoses last year. Happily, it is now considered even in clinics to be a survivable condition. (Curiously, a leading London AIDS clinician recently informed us that having read the latest in-depth research paper of several hundred pages, it was not possible to conclude what PCP is.)

Huw Christie
Molly Ratcliffe

The Numbers Game

THE NUMBERS GAME By Bob Maver

According to the June 1994 CDC HIV/AIDS surveillance Report (11995, vol 6) the cumulative number of adult/adolescent heterosexual AIDS cases not involving drug abuse, haemophilia or transfusion was 10,632. This is an incidence of 1:20,000 in the corresponding adult U.S. heterosexual population over 11 years. Fully 40% (4,252) of these cases are a direct result of the CDC's 1993 change in the definition of AIDS. We are told that "everyone is at risk," but what we are not told is that that risk is trivial. In other words the general population is not at unusual risk at all.

Keeping an eye on HIV

The phone and fax lines to Continuum will remain open during the planned office reorganisation.

We are looking forward to monthly issues of the magazine later this year, and count on your interest and support to build a healthier more informed future for us all.

If you would like to help out with the distribution of the magazine, or perhaps some other aspect of the organisation, please let us know. A particular vacancy exists for an advertising worker. Call for an application form and meeting.

HIV reality or artefact?

Virologist Dr Stefan Lanka asks a number of searching questions: why, unlike other viruses, has HIV never been isolated? Is it possible to have an antibody test for a virus that cannot be isolated? Does HIV exist at all? His answers to these questions explain why AIDS research has no scientific base.

An error can never become true however many times you repeat it. The truth can never be wrong, even if no one ever hears about it.

Mahatma Gandhi.

For the past 10 years or so it has been the accepted wisdom that the human immuno-deficiency virus, HIV, causes AIDS. It supposedly occurs in many body fluids, and its transmission especially in semen and blood to a new host, triggers a slow but inexorable progression to AIDS and ultimately death. To infect another cell, HIV must at some stage in its life cycle exist as a separate and identifiable entity.

What has been ignored and kept from public awareness is, that there has never been a workable HIV test and that the definition of 'positive' has always changed according to the views of different organisations dealing with it, changed also according to the kind of tests used and changed from laboratory to laboratory performing the tests:

".. Its techniques have not been standardized, and the magnitude and consequences of interlaboratory variations have not been measured. Its results require interpretation, and the criteria for this interpretation vary not only from laboratory to laboratory but also from month to month .. " [1]

The dispute over who discovered HIV,[2] was a distraction from the question of whether the virus actually exists at all. The public was impressed that if a President and a Prime Minister[3] had to meet to resolve attribution, then the thing they were negotiating about must be real.

In 1993 a research group from Perth, Australia succeeded in publishing a paper on the HIV test.[4] Since then anybody could have read for him or herself that no AIDS test could ever work, because HIV has never been isolated nor even shown to exist. Since AIDS research and the media have largely ignored any critique of HIV=AIDS, especially the essential question of whether HIV really does exist, it is time to call again for a reappraisal of the whole HIV/AIDS hypothesis. In going back to the origins of HIV virology and telling the HIV story, a view will be presented which will make clear that HIV itself, the very object of this Manhattan Project of modern medicine, AIDS research, does not exist.[5]

A little virology

Viruses are essentially just packages of genetic information enclosed in a coat which consists of proteins. They can reproduce themselves only by infecting a suitable host cell and appropriating the chemical machinery they find there. The proteins making up the viruses are characteristic for each species of virus. Apart from enveloping and transporting the genetic information intact, the composition of proteins for a given virus results in a specific shape for the virus particle.

This much is generally known. Less well-known is the existence of other particles which look like viruses but aren't, and are nonchalantly referred to as "virus-like" particles. Such particles are far from rare, found, for example, always in placentas, and very frequently in the artificial environment of laboratory cell cultures. They have served to muddy the waters considerably as far as AIDS research is concerned, because particles just like these have been called HIV. To date, none of these has been characterised and shown to exist as an entity which one may justifiably call a virus.

One root of the belief in the AIDS virus

In classical theory DNA encodes the genetic material of heredity, which is then transcribed into messenger RNA which in turn specifies the assembly of amino-acids to construct the proteins of all living beings. In 1970 an enzyme (biological catalyst) was discovered in extracts of certain cells which was capable of converting a molecule of RNA into DNA. This was a revolutionary discovery, because it overturned a fundamental tenet of molecular genetics,

namely, that the flow of information was strictly one-way and never reversed. It had hitherto always been thought that DNA was transcribed (converted) into messenger RNA and that the reverse process from RNA to DNA was impossible. The enzyme responsible became known as reverse transcriptase[6] and a lot of new myths arose.

An error of the past: cancer caused by viruses.

It was believed that the new enzyme was a marker for a virus, because the cells in which it was detected, and which were used to study cancer,[7] were thought to have become cancerous through being infected by a virus. New to the idea of cancer viruses[8] was that nucleic acid, when in the form of RNA could be converted into DNA by the enzyme, thus providing a mechanism for viral nucleic acid to be inserted anywhere in the chromosome of the cells.[9] These "new" viruses became known as retroviruses.[10] The insertion of certain retroviral genes was thought to trigger cancer. The idea that these postulated viruses caused cancer quickly became "hot news" the world over, but did not survive investigation[11] and other explanations were sought.[12] The theory did not predict or explain the dramatic increase in cancer cases, cancer could not be shown to be transmissible, nor could it suggest any remedy in the form of a vaccine.[13] Interestingly, the spread of cancer viruses was blamed on homosexuals, prostitutes and black people, just as AIDS came to be 13 years later.[14]

Whenever and wherever reverse transcriptase activity was detected it was rashly assumed that retroviruses were at work. This turned out to be a grave error, because it was later found that the enzyme occurred in <u>all</u> living matter, proving that reverse transcriptase activity had nothing to do with retroviruses *per se*.[15]

Repetitive elements

Further research showed that at least 10% of mammalian DNA was composed of repetitive sequences which were referred to as "nonsense genes", parts of which, nonetheless, were described as "retroviral genes". They exist in their hundreds if not thousands. Some of them can even replicate independently and jump within and between chromosomes, and for this reason became known as retrotransposons. In the laboratory they can be made to migrate, and when this happens reverse transcriptase is invariably detected, which underlines the fact that reverse transcriptase activity has nothing to do with retroviruses as such.[16]

LAV, HTLV-III, HIV and all that

Because all this was already well known in 1983 it is incomprehensible that Françoise Barré-Sinoussi, a member of Montagnier's group, as well as Gallo's group itself in 1984, claimed to have discovered a new virus, when all they did was to demonstrate reverse transcriptase activity, and to publish photographs of cellular particles without proof that they were viruses. They could neither isolate them nor show that they were responsible for creating the observed reverse transcriptase activity, nor the tissue abnormalities in which they were observed.[17] They concluded: "the role of the virus in the aetiology of AIDS remains to be determined".[18]

What makes a virus new?

The isolation and purification of a real virus is a straightforward matter, because unlike cells, viruses of one species are always of the same size and shape, and can be readily separated from other cell components by standard techniques. A control experiment is to try an isolation with putative non-infected material in exactly the same way as the supposedly infected material. Nothing should be isolated in this case.

To identify a virus definitively, a first and simple step is to photograph isolated particles of it in an electron microscope, and they must look like the viral particles observed in cells, body fluids or cell cultures to distinguish them from other cellular particles which look like viruses, but are not. Proteins making up the viral coat must then be separated from each other and photographed. This produces a pattern which is characteristic of the species of virus. A similar separation and identification procedure must be gone through for the DNA or RNA of the virus. Only after the viral proteins and nucleic acid components have been properly identified is it legitimate to speak of a new virus.

No evidence for the existence of HIV

Such evidence has up till now never been produced for HIV. No photograph of an isolated HIV particle has ever been published nor of any of its proteins or nucleic acids. No control experiments as mentioned above have been published to date. What <u>has</u> been shown are photographs of virus-like particles in cell cultures, but none of isolated viruses, let alone of a structure within the human body having the shape ascribed to HIV. What the whole world has seen are <u>models</u> representing HIV with dish aerials, said to be receptors with which the virus attaches itself to cells.

The existence of HIV is inferred from an antibody test, but how this is supposed to work, when the virus has never been shown to exist and obtained free of cellular contaminants, remains a mystery.

The AIDS Test

Let us recall that the AIDS test is supposed to detect antibodies produced by the immune system in response to infection by the virus. This is routinely done by layering proteins ostensibly from the virus in the wells of a plastic rack and adding blood serum to be tested to each. If antibodies are present, they bind to the proteins, and when this happens sophisticated staining procedures can make this visible. But, because no proteins which are viral and free from contaminants have ever been obtained, one cannot be sure what the antibodies are that bind to the proteins.

This is the crux of the problem facing all HIV (AIDS) tests. The inability to isolate the virus, and to obtain proteins from it which are free from proteins derived from the cells in which the alleged virus is grown, reduces the evidence for the existence of HIV using antibodies to arguing in circles.

Why no HIV test is ever able to work

It is consequently quite illogical to claim that a positive test results from prior contact with the virus.[19] Because various ill-characterised proteins are involved, every test kit manufacturer applies his own arbitrary criteria, and no two kits ever give the same result. It makes no difference that learned committees set standards to decide which tests should be regarded as "positive" and which not, because this skirts round the problem, namely, to what are antibodies actually being detected in the AIDS test? It is of no help that nowadays "second" and "third" generation tests exist using synthetic proteins which give greater consistency and comparability, because only by an unscientific stretch of the imagination are they viral proteins!

Neither fudging the true identity of the proteins, nor advocating two kinds of test - reassuringly but mistakenly described as "search" and "confirmatory" tests - resolves this difficulty.

The ELISA test is used to screen for antibodies, which is "confirmed" by the more specific Western Blot. The dilemma cannot be stated more poignantly than by quoting from the leaflet accompanying one such test kit:

"The test for the existence of antibodies against AIDS-associated virus is not diagnostic for AIDS and AIDS-like diseases. Negative test results do not exclude the possibility of contact or infection with the AIDS-associated virus. Positive test results do not prove that someone has an AIDS or pre-AIDS disease status nor that he will acquire it".[20] *Quite*.

The direct proof of HIV

Some HIV researchers have tried to circumvent the problem by pointing to something called "direct" evidence for the virus. All that this meant, though, was arbitrarily selecting a protein of a certain size which happened to coincide with that shown in HIV models. The delusion of such "evidence" was illustrated when the protein later turned out to be of human origin![21]

How the genetic information of HIV was manufactured through...

Despite this deplorable state of affairs the majority of AIDS researchers still cling to the authenticity of HIV, because a genetic sequence for it has been published. Moreover, genetic procedures now exist, which, unlike antibody tests, attempt to identify the presence of HIV more or less immediately, instead of only weeks later when antibodies are formed. The fact that the genetic tests (PCR)[22] do not give the same results as the antibody tests is simply ignored.

Since no virus has been isolated, it follows that no nucleic acid has been isolated from it either. Complicated procedures are even so described in the literature, at the end of which something is produced which is called the nucleic acid of HIV.[23]

...a test tube

HIV and its DNA can allegedly be made by the "bucketful",[24] but under very surprising conditions which, *inter alia*, entail the use of extracts from plants and other oxidising chemicals, which could not possibly exist *in vivo*. Immortalised cell lines devised (and later patented) by the Montagnier and Gallo groups are co-cultured with extracts from human cells or the cells themselves. At the end of it all HIV itself is not actually obtained - only reverse transcriptase activity is shown to occur - which is taken to imply that the DNA that is found must have been viral in origin.

The real explanation of what happens is as follows. In the mixture of cell cultures and stressed human cells, RNA and reverse transcriptase come to be produced in large amounts, because the cells have been specially selected and treated to do this. The RNA is transcribed into DNA by reverse transcriptase, and long pieces of DNA are produced which are said to be viral DNA. In fact they are composed of unrelated pieces of expressed cellular RNA, transcribed into DNA and linked together by a process of "template switching" (a well-characterised property of reverse transcriptase).[25] This misleads ordinary researchers into believing that they have actually produced viral DNA.

It is said that this linear DNA is the free or the non-integrated form of HIV, which furthermore is said to be a unique feature of HIV because a lot of detectable free linear DNA has not been suggested in any other models of retroviruses.

...and a selecting process

The resulting pieces of DNA, are necessarily both shorter and longer than the "correct" length of HIV. Pieces corresponding to the "correct" length of HIV must be selected for size, because otherwise the purported DNA preparation would be a mixture of various lengths, which would violate a cardinal rule of virology that all nucleic acid of a particular virus be identical in size.

...and a detecting process

Having artificially prepared DNA pieces of uniform length, they are still not ready for presentation, because they consist of a mixture of all kinds of RNA fragments transcribed into DNA and thus cannot be shown to represent unique viral DNA. Accordingly, the mixture is subjected to a kind of lock-and-key detection process called hybridisation, whereby pieces of DNA are detected which complement more or less a probe of that which it is desired to be shown to have been prepared.

...and choosing a desired probe

Since no DNA from HIV existed to hybridise with the prepared DNA, Gallo and Montagnier simply used stretches of DNA from what they said was specific to HTLV-I, a retrovirus Gallo had earlier claimed to have discovered, and which they deemed suitable for this purpose. The DNA detected in this way was replicated and certain stretches of it cloned and declared to be the DNA of HTLV-III (later to be called HIV).

To summarise, the purpose of the exercise is to grow HIV, but it actually produces a mixture of different lengths of DNA, contrary to theory which says they should all be identical, and no virus at all. It is then claimed that the "correct" DNA has been prepared by finding certain strands in this heterogeneous mix by hybridising them with an HTLV-I DNA probe whose sequence is known and defined to be similar to HIV. However, non-hybridising strands of DNA should not be there at all, and the fact that they are, proves that a rag-bag of endogenous DNA from the pool of repetitive elements has been prepared, without any indication of what it is made up of.

It follows that "HIV" DNA must just be a laboratory artefact constructed to a pre-conceived idea of what retroviral DNA should be, and this assessment does not even raise the question why no virus can be obtained, whatever the experimental conditions.

Gallo and Montagnier's cloned HIV DNA

One cannot help asking why no-one had not long ago spotted the flaw in the techniques employed by the Gallo and Montagnier groups. After defining some segments of DNA to be "HIV"-specific, every researcher in the field worked exclusively with short cloned sequences (never the whole strand) on the reasonable assumption that the original characterisation had been correctly performed. From the isolation and identification procedure described above, it follows that the resultant sequences vary widely from one preparation to the next, which sequence analysts misinterpreted as the legendary capacity of HIV to mutate. A computer simulated phlyogenetic tree was constructed, which established precisely what its designer sought to prove.[26]

Some history

(I)

Perhaps one reason for this calamitous state of affairs is that HTLV-III was presented to the world as the cause of AIDS at a historic press conference on April 23, 1984 (a patent for an antibody test was applied for on the same day!), instead of making the evidence for it available beforehand, as correct science demands. The unholy hurry may be explained through the disagreement between the National Cancer Institute and the Centers for Disease Control (CDC) which favoured the French idea of the virus at the time. This opinion was published the very day before in a lengthy front page article in the New York Times in which the head of the CDC was quoted as saying that the French virus was the cause of AIDS.[27]

(II)

Even so, one must admire Gallo's audacity, because using a similar technique he claimed in 1975 to have discovered the first human retrovirus (HL23), but which turned out to be nothing more than pieces of DNA from three different sources of contamination.[28] Nowadays, even an undergraduate would know that if you added DNA to a cell culture, part of the DNA would be incorporated into the cells without any virus being involved.

What does the AIDS test actually test for?

Since "HIV" has been shown to be a laboratory artefact it must be assumed that, when not just cross-reacting with other known antibodies, the "AIDS" test detects antibodies against proteins produced in the procedure itself. They must be of human origin because the cells used originated from leukaemic patients. Test positivity, logically, results from immunological contact with them. However, since positivity actually correlates with otherwise unrelated factors such as rheumatism and sun bathing, no specificity can be ascribed to the test.[29] Whether antibody positivity really correlates with disease as is commonly supposed, remains to be determined by a critical re-evaluation of the data. Condoms, therefore, serve only to protect against venereal diseases and as contraceptives, and worse lull the user into a false sense of security by ignoring real dangers he may be exposing himself to.

Redirection of AIDS research

AIDS research is therefore back at square one and not at Basic Science as suggested elsewhere.[30] The main players have since 1993 begun to slink off, arguing that the virus having mutated so much is now no longer detectable. AIDS has therefore to be explained "in the absence of further whole virus".[31] Apart from the shortcomings of the antibody test, other misconceptions such as T-cell counting exist, which mean that the whole concept of AIDS needs to be completely revised.[32] It must be shown that there is any point in renaming a collection of known diseases as AIDS, just because someone is positive in the antibody or genetic (PCR) tests. Leaving HIV out of the picture explains why the epidemiological projections, which years ago had forecast a world-wide epidemic, have been a complete failure. Africa in 1986 was held up as a dire warning of what would befall the Western world. There AIDS is diagnosed by a combination of clinical conditions[33] such as chronic fevers, diarrhoeas, coughs and weight loss, all symptoms of the diseases of poverty, without testing for HIV antibodies.[34] It should hardly come as a surprise that an entirely different definition produces a different outcome.
Finally, the effect of a positive test result on mental and physical health needs to be considered and investigated.[35]

Anti-virals

Whatever happens, the use of AZT and other "anti-virals" which are supposed to target HIV replication, but actually kill cells indiscriminately (and ultimately the whole body), must be stopped immediately. It is especially distressing to note that AZT and its analogues preferentially attack those cells which divide most rapidly, namely, cells in the intestines causing diarrhoea and malabsorption of food, and in bone marrow, ironically, the primary production site for cells of the immune system.[36]

The people who need our help

The most important and delicate task is to convince antibody test positives that their result is not a death sentence, to be generally supportive of them, to assuage their anxiety, and to help them understand that with appropriate treatment of any specific disease, they have a good chance to retain or regain their health. The large number of long-term positives, whose condition cannot be explained by conventional AIDS theory, as well as the phenomonen of sero-reversion (return to negative test status), provide eloquent testimony to this. HIV/AIDS researchers and health officials are herewith called upon to debate the whole subject of HIV/AIDS openly and humanely, and to recognise the mistake of assuming that immune deficiency was acquired by an infectious agent.

The future

To address the many ills of our age, it is essential to regain over our bodies proper autonomy which we have ceded to misguided "experts".[37]
If we refuse to learn from what has happened in AIDS research and related developments, then worse is on the way, some of it is, indeed, here already.[38] An early genetics agenda dates back to the 1860s,[39] and in its comtemporary form is a primitive genetic determinism based on genetic sequence analysis, which holds out the prospect of manipulating, at least, defective genes. This is just wishful thinking:[40] all models of genetics and associated technologies, such as genome therapy, are based on a one-dimensional, static model which is an egregious over-simplification of the truth. The expectation of success in this field is based on the simplistic model devised by Gregor Mendel which even he could only make work by ingoring and discarding data which did not fit.[41]

Acknowledgements: This article is dedicated to Ivan Illich and Thomas McKeown: had their writings been taken more seriously the world would have been spared the AIDS panic as well as other perversions. I would also like to thank Volker Gildemeister (Meditel, London) for translation and constructive criticism, and of course, my family, Hans-Walter Wiegand and other friends too numerous to list for all their support.

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22 Just how little confidence is placed in the validity of such tests is revealed by the caveats in the leaflet accompanying one of them:
"The Amplicor HIV-I PCR test has been tested using whole blood specimens only. Performance with other specimens has not been evaluated and may result in false negative or false positive results...
"Detection of HIV-I may be dependent on the amount of proviral DNA in the specimen. This may be affected by specimen collection methods and patient factors such as age, disease status and risk factors etc. As in any diagnostic test, results from Amplicor HIV-I test should be interpreted with consideration of clinical and laboratory findings."
It will become clear later why whole blood rather than serum is used for this test, all the more so as the purpose of the test is to detect transmissable virus particles which should not have anything to do with the presence or absence of blood cells. This is all the more significant since a major form of HIV transmission is supposed to be via Factor VIII given to haemophiliacs, where blood cells are absent. The implication is that without blood cells no "viral" DNA would be detected!
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Health as a Virtue

Health designates a process of adaptation. It is not the result of instinct, but of an autonomous yet culturally shaped reaction to socially created reality. It designates the ability to adapt to changing environments, to growing up and to ageing, to healing when damaged, to suffering, and to the peaceful expectation of death. Health embraces the future as well, and therefore includes anguish and the inner resources to live with it.

Health designates a process by which each person is responsible, but only in part responsible to others. To be responsible may mean two things. A man is responsible for what he has done, and responsible to another person or group. Only when he feels subjectively responsible or answerable to another person will the consequences of his failure be not criticism, censure, or punishment but regret, remorse, and true repentance. The consequent states of grief and distress are marks of recovery and healing, and are phenomenologically something entirely different from guilt feelings. Health is a task, and as such is not comparable to the physiological balance of beasts. Success in this personal task is in large part the result of the self-awareness, self-discipline, and inner resources by which each person regulates his own daily rhythm and actions, his diet, and his sexual activity. Knowledge encompassing desirable activities, competent performance, the commitment to enhance health in others - these are all learned from the example of peers or elders. These personal activities are shaped and conditioned by the culture in which the individual grows up: patterns of work and leisure, of celebration and sleep, of production and preparation of food and drink, of family relations and politics. Long-tested health patterns that fit a geographic area and a certain technical situation depend to a large extent on long-lasting political autonomy. They depend on the spread of responsibility for health habits and for the socio-biological environment. That is, they depend on the dynamic stability of a culture.

The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population. This ability to cope can be enhanced but never replaced by medical intervention or by the hygienic characterisitcs of the environment. That society which can reduce professional intervention to the minimum will provide the best conditions for health. The greater the potential for autonomous adaptation to self, to others, and to the environment, the less management of adaptation will be needed or tolerated.

A world of optimal and widespread health is obviously a world of minimal and only occasional medical intervention. Healthy people are those who live in healthy homes on a healthy diet in an environment equally fit for birth, growth, work, healing, and dying; they are sustained by a culture that enhances the conscious acceptance of limits to population, of ageing, of incomplete recovery and ever-imminent death. Healthy people need minimal bureaucratic interference to mate, give birth, share the human condition, and die.

That society which can reduce professional intervention to the minimum will provide the best conditions for health

Man's consciously lived fragility, individuality, and relatedness make the experience of pain, of sickness, and of death an integral part of his life. The ability to cope with this trio autonomously is fundamental to his health. As he becomes dependent on the management of his intimacy, he renounces his autonomy and his health must decline. The true miracle of modern medicine is diabolical. It consists in making not only individuals but whole populations survive on inhumanly low levels of personal health. Medical nemesis is the negative feedback of a social organization that set out to improve and equalize the opportunity for each man to cope in autonomy and ended by destroying it.

from Limits to Medicine, by Ivan Illich
Penguin Books, 1990
(reproduced by permission Marion Boyars)

imprint

The latest publications dealing with health, nutrition, alternative treatments and HIV and AIDS issues.

We get so many requests for book lists that we have decided to re-publish this excellent and comprehensive list provided to subscribers of Reappraising AIDS, the American scientific and medical organisation which challenges the causitive link between HIV and AIDS. Should you wish to become a subscriber to Reappraising AIDS we have included the publisher's name and postal address.

Books

Adams, Jad
AIDS: The HIV myth. New York: St. Martin's Press, (1989).
One of the first and one of the best journalists to question the HIV hypothesis. Contains an excellent discussion on the immune system.

Badgley, Laurence. Healing AIDS Naturally. San Bruno, CA: Human Energy Press, 1987).
Dr. Badgley has been a vociferous critic of the HIV hypothesis since the early days of the epidemic. This practical book offers AIDS sufferers alternatives to the toxins typically prescribed and is also useful as a manual on how to stay healthy.

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Naessens's theory of disease, based largely on the idea of pleomorphism (micro-organisms that have many different forms), has never gained much favour, even though many of the most common pathogens (e. g. T. pallidum, the syphilis pathogen) are clearly pleomorphic. Naessens claims miraculous cures using formula 714-X, a camphor-derived product. He has been arrested and tried for his work, and 714-X is not approved for use in the U.S. (For more information on this product, phone 7 1 6/266 4630.)

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Modern medicine is rooted in pathology and the greatest pathology in AIDS, says Professor Caton, is to be found in the AIDS hypothesis itself, which has been fabricated by a runaway biomedical establishment that perpetuates itself by grounding itself in the viral theory of disease.

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This scholarly book explores fraud in science from Newton to Gallo. The author believes HIV to be the cause of AIDS; it would be interesting to see a revision of this book in the light of alternative theories.

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Lauritsen, one of the most indefatigable writers on the subject, states: "The AIDS epidemic is an epidemic of lies, through which hundreds of thousands of people have died and are dying unnecessarily, billions of dollars have gone down the drain, the Public Health Service has disgraced itself, and Science has plunged into whoredom." New York Native. Highly recommended.

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Kaposi's sarcoma is thought to be a separate phenomenon of the AIDS epidemic and to have a direct link with amyl and butyl nitrites ("poppers") used by gay men. Explores the poppers-AIDS connection. Most of the book consists of an annotated bibliography. Hank Wilson lives in San Francisco.

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The author amasses a wealth of evidence for the connection between undiagnosed or untreated syphilis and AIDS. Although the theory of syphilis as AIDS has largely been discredited, this book is included because of the dramatic empirical results Dr. Caiazza obtained from his antibiotic therapy. No one has yet adequately explained why antibiotics resulted in the attenuation of - and, in many cases, the complete disappearance of - KS lesions and other AIDS symptoms.

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Reason. June 1994.
Reason, December 1994. [letters received in response to the June article with the authors' response.]

Sources for further information:

ATRA (The Association to Reevaluate AIDS)
PO. Box 34233, San Diego, CA 92163
Phone (619) 491-2565 for recorded information. Package of material available for $4.

Christopher Street, NY
That New Magazine, Inc
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HEAL (Health, Education, AIDS Liaison - Old Chelsea Station)
Heal Bulletin, P.O. Box 1103, New York, NY 100024-4206, Phone: (800) 410-HEAL

Journal of International Health Research. Los Angeles, CA: People's International Health Project.
Monthly. 8033 Sunset Blvd., #2640, Los Angeles, CA 90046-2427. FAX:(213)857-0334. Phone:(213)857-0809.

The New York Native. N.Y.: That New Magazine, Inc.
Weekly. PO.Box 1475, Church Street Station, New York, N.Y. 10008.

Reappraising AIDS, La Jolla, CA: The Group for the Scientific Reappraisal of AIDS. Monthly.
c/o Charles A. Thomas, Jr., publisher.
7514 Girard Ave., #1-331, La Jolla, CA 92037. FAX: (619) 272-1621.

SPIN, New York, N.Y.
Monthly.
6 West 18th Street, New York, NY 10011.

WORLD WIDE WEB SITES

There is a Web Site on INTERNET maintained by Jason Vagner. Jason@asu.edu> This Web Site permits one to browse back issues of The Group's Newsletter and download as desired. Many people use the following sequence:
Iynx http: /ienuxsa.eas.asu.edu/- jvagner/aids

Another Web Site of great interest to The Group is one managed by Walter W. Stewart <stewartw@helix.nih.gov> Try:
iynx http://nyxlO.cs.du.edu:800l/ wstewart/

This Site contains the complete text of the Dingle Subcommittee Report on fraud and cover-up at the NIH.

THE REFLECTOR

The Group operates a news reflector on Internet. Address your e-mail to Professor Phillip E. Johnson at philjohn@garnet.berkeley.edu> This reflector is a source of relevant press on the HIV/AIDS issue as well as selected contributions of the membership. The Reflector is not open to everyone because it is unmonitored; any member can post messages to all. To be included on The Reflector's mailing list, please e-mail Professor Johnson.

Is anyone really positive?

Christine Johnson examines the methodology of Robert Gallo, inventor of the HIV test.

Well before 1984 (when HIV was announced to be the cause of AIDS), researchers had found evidence that antigen-antibody reactions were nonspecific for retroviruses. (This is true for regular viruses as well.) It is often believed that an antigen (a foreign invader which causes disease) and the antibody it elicits are 'soul-mates' and only react with each other. In reality, antigens (and antibodies) are not so selective and often cross-react with antibodies (and antigens) that they don't belong with. Since the principle of HIV tests is that HIV antigen present in the test kit will react with any HIV antibody that might be present in a person's blood sample, this is a crucial point.

Thus retrovirus antigens will react nonspecifically with multiple non-retroviral antibodies, retrovirus antibodies will cross-react with multiple non-retrovirus antigens, and antigens and antibodies to one retrovirus will cross-react with those of another. Considering this situation, it would be expected that the initial development of HIV antibody tests would have been done very cautiously, with insistence on verification by an independent method called a gold standard. This simply means that the reaction (a positive or negative test result) must be correlated with the presence or absence of the HIV in the body.

Robert Gallo, who developed the initial HIV antibody tests, never used a gold standard to confirm his ELISA test. His methodology entirely ignored the necessity of proving that his subjects were either infected or not infected by use of virus isolation, matching the virus isolation (VI) test results with antibody test results. If VI positivity matched antibody positivity, and if VI negativity matched antibody negativity in all cases, he would have had an ideal test. Instead, Gallo used a second antibody test, the Western Blot, to confirm his ELISA. It seems odd that the Western Blot, at that time (and even to this day) an entirely unproven test of unknown accuracy in this context, would be accepted without question as adequate verification of Gallo's ELISA, yet such was the case.

This wasn't the only thing wrong with Gallo's study. He used a group of AIDS patients in his sensitivity determinations and random blood donors for his specificity determinations (sensitivity is the extent to which a test will be positive in patients with the disease in question [HIV infection], and specificity is the extent to which a test will be negative in patients without the disease).

To begin with, Gallo simply assumed that his AIDS patients were all infected with HIV. After all, HIV caused AIDS, and therefore they must be infected. Conversely, he assumed that all the random blood donors were not infected. Since they were healthy and didn't have AIDS, they must not be infected. The idea was that any negative test results in AIDS patients must be false negatives, and any positive results in the random blood donors must be false positives. Using these figures, determinations of sensitivity and specificity were made.

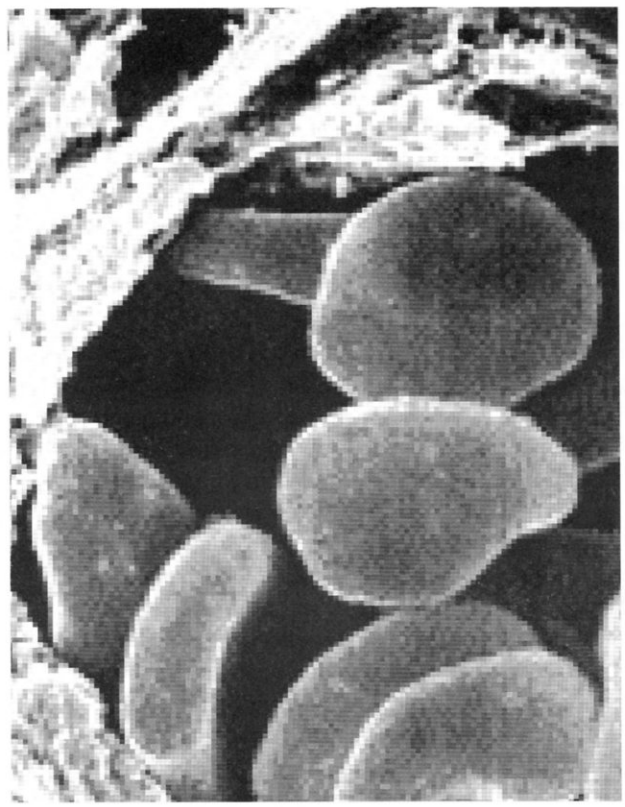
Perhaps Gallo had been to one of those positive thinking seminars where you are instructed to keep affirming that something is true, even if it isn't, in the hope that your belief will make it so. The reality is that he didn't know if his Western Blot was accurate, he didn't know if AIDS patients were really infected, he didn't know if the random blood donors were not infected, and more to the point, he didn't know if HIV caused AIDS. There was an awful lot of assuming going on in Gallo's study, and in subsequent years, no one else made any different assumptions when they were attempting to verify the accuracy of their HIV antibody test kits, using

essentially the same methods as Gallo did.

In any case, Gallo's methodology was utterly without scientific merit and it was invalid for him to conclude that his ELISA test was "both highly sensitive and specific and should be considered a reliable initial screening test for the presence of antibodies, and hence exposure, to [HIV]".[1] ELISAs eventually became notorious for their high rate of false positives (which is why they are always supposed to be 'confirmed' with Western Blot), yet much of the developing ideology concerning AIDS was based on data provided by these early tests.

Let's imagine for a minute that Gallo had been a true scientist and was not willing to assume anything. Therefore, not assuming that HIV caused AIDS, he might have asked himself, "Since we noticed that almost all AIDS patients were positive on this test, and almost all blood donors were negative, there must be a reason for this pattern. What do these reactions mean in each of these unrelated groups of people? In AIDS patients, what is our test reacting with? Is it reacting with antibodies to a specific infectious agent that might or might not cause AIDS, or is it reacting to something else?"

The obvious answer to this question has eluded the AIDS research establishment simply because they continue to assume that a positive HIV antibody test in a person with AIDS is without question a true positive. This reasoning has also been extended to anyone in a risk group. Certainly no-one spends one iota of energy wondering if a positive result in a gay male, intravenous drug user (IVDU), haemophiliac, or a blood transfusion recipient is a false positive. In fact, all these groups have something important in common and therein lies the answer to the mystery.



Every one of these risk groups has been exposed to a plethora of foreign antigens and infectious agents and thus they have numerous antibodies to many non-HIV antigens. Many of these antibodies have the potential to nonspecifically cross-react with the antigens in the HIV test kits.

For instance, haemophiliacs, who routinely administer clotting factor, pick up whatever is in the blood plasma of 20,000-30,000 people used to make one vial of Factor VIII. Needle-sharing and multiple sexually transmitted diseases among IVDUs lead to a similar state. According to the comparative charts in Robert Root-Bernstein's book "Rethinking AIDS", gay males have "the highest disease load of any North American or European risk group",[2] even greater than that of haemophiliacs (and comparable to the microbe burden of Africans).

They have been repeatedly exposed to, and thus have antibodies to, a range of diseases and microbes, including cytomegalovirus, Epstein-Barr, herpes simplex I and II, hepatitis A and B, HTLV I and II, Giardia, amebiasis, toxoplasmosis, Chlamydia, syphilis, gonorrhea, mycobacteria and other bacteria. Anal intercourse plays a key role in this situation, and in addition, semen absorbed through the rectal mucosa can lead to production of anti-sperm antibodies, which also can cross-react with the HIV antibody test.

Over the years, a lengthy list of diseases and conditions have been well-documented to produce false positives on HIV antibody tests. In particular, false positives have been noted in persons who have been exposed to hepatitis B (the same is true for people who have been vaccinated for hepatitis B). This disease is common among AIDS risk groups in the United States and Europe, but not in the general population. Many gay men and almost all haemophiliacs have been infected. Interestingly, hepatitis B is present at endemic levels in the general population of Asian countries as well. According to Bryan Ellison, co-author of "Why We Will Never Win the War on AIDS", 99% of all people in the Far East are born infected with the hepatitis B virus, where it is transmitted perinatally and exists predominantly as a latent infection.

Cross-reactions are such a problem in the risk groups that Eleopulos et al. have stated, "It is to be expected that cross-reactivity with HIV antigens would be the rule, not the exception, in these groups".[3] Lee et al. and Moore et al. have stated findings of "a high rate of false positives"[4] and "very high false-positive rates for HIV"[5] in the high-risk groups.

Therefore, there is no reason to assume that a positive HIV antibody test result in a member of a risk group is a true positive. It is quite likely that the opposite is true.

The situation is even worse in Africa. Mainstream AIDS researchers have commented from time to time that HIV antibody tests may not be specific for HIV in African populations, that is, the false positive problem is so extensive that most or even all positive results are false. In 1985, Hunsman et al. stated "...African sera yield a high prevalence of false-positive reactions with the ELISA for [HIV]".[6] Labius Mutanda, a Uganda scientist, commented that "ELISA and Western Blot assays may not always be able to reliably ascertain HIV infections in many African individuals".[7] Mutanda told me that he had observed Africa blood samples to be positive when tested with the kits of one manufacturer, whereas the same samples would be negative with the test kits from another company. He noted this with both ELISA and Western Blot. Even Gallo conceded that for African populations that did not compare to those he studied, the ELISA test might need to be supplemented with a confirmatory test.

A recent study by Max Essex, a well-known AIDS researcher, reported high levels of false positives in persons with leprosy, as well as their contacts. It was proposed that these cross-reactions occurred not only to Mycobacterium leprae (the microbe associated with leprosy) but to other Mycobacteria species as well, and that "ELISA and Western Blot may not be sufficient for HIV diagnosis in AIDS-endemic areas of Central Africa where the presence of mycobaterial diseases is quite high".[8]

The implications of this are obvious. Tuberculosis (caused by Mycobacterium tuberculosis) is a fairly prevalent AIDS indicator disease all over the world, especially in IVDUs. In many areas of the world, especially those with 'new, rapidly spreading AIDS epidemics', tuberculosis is a common, endemic disease. Half of the world's reported tuberculosis cases (as opposed to estimates) occur

in South East Asia. It is particularly widespread in Africa and is estimated to kill over a million people a year there. Another member of the Mycobacterium genus is M. avium, involved in Mycobacterium avium complex (MAC), which is the most common systemic bacterial infection in American AIDS patients.

Another disease which has been implicated in false positive HIV antibody tests is malaria, which may help explain why HIV appears to be transmitted predominantly via heterosexual intercourse in Africa and Asia, but not in the United States and Europe (where AIDS and HIV still affect mostly males). Mosquitoes do not practice gender discrimination and anti-malaria antibodies are common in men and women alike in malaria-endemic countries. Similarly, tuberculosis affects each gender equally.

Traditionally, AIDS and HIV have been quite rare in Asia but now we hear, mostly from the World Health Organisation (WHO), the alarming news that HIV is spreading out of control in this region. According to the Los Angeles Times, "the global AIDS epidemic is now spreading in Asia faster than anywhere else in the world",[9] possibly soon to eclipse even the alleged monumental 'heterosexual spread' of HIV in Africa. However, when looking at WHO's map of world-wide malaria prevalence zones, it is interesting to note that the malaria belt and the AIDS belt coincide almost exactly. The countries mentioned in the Times article (Thailand, India and Vietnam), as well as sub-Saharan Africa, all lie neatly within the malaria belt. There are high correlations between the AIDS belt and regions where tuberculosis is endemic as well.

Is it possible that the 'heterosexual spread of HIV' in these areas is mainly due to the spread of HIV antibody testing programs?

In 1991, over three million cases of malaria were reported in Southeast Asia and over 20 million in Africa. WHO estimates that 300-500 million clinical cases occur each year, with countries in tropical Africa accounting for more than 90% of them. Southeast Asia reported 373,000 (though WHO's estimates are much higher for Africa). About half of the AIDS patients in Africa suffer from tuberculosis.[10]

In addition, mass immunisation programs against hepatitis B have been carried out in Asian countries in recent years, Thailand in particular, with over two million people having been vaccinated. This, coupled with the endemic levels of hepatitis B outside risk groups, creates a large potential for false positives in the general population of Asian countries which is not present in the United States or Europe. Here, very few people outside the risk groups either are exposed to hepatitis B or feel the need to be vaccinated for it.

In view of all the above, is it possible that the 'heterosexual spread of HIV' in these areas is mainly due to the spread of HIV antibody testing programs?

Now, how about people in the general population of America and Europe, who are not exposed to many microbes and who have relatively low levels of antibodies? What does a positive test mean in this group? Not very many people from the general population test positive, and from the days of Gallo onward, it has been usually considered that a positive test result in any member of a low-prevalence population is almost certainly a false positive. Langedijk states that in both ELISA and WB "[almost] all reactions, especially in low-risk populations, represent false-positive results".[11] According to Lepine[12], in low-risk groups, the majority of positive ELISAs will fail to be confirmed by Western Blot. Even in cases where the ELISA has subsequently been 'confirmed' by a positive Western Blot, the person is not likely to be HIV infected in the absence of clinical or epidemiological information to the contrary.

It is a classical principle of diagnostic test interpretation that when a person has no logical reason to have the disease being tested for, the test result is most likely a false positive. As Griner states, "When the likelihood of disease is low, a normal result tends to exclude but an unexpectedly positive result is not particularly helpful in confirming the disease".[13] However, it is obvious that this precept is ignored on a regular basis, as one anomalous transmission case after the other crops up in the media. People in no risk groups, practising no risk behaviour, who have absolutely no reason to be HIV infected, have blamed their 'HIV infections' on such diverse and absurd sources as dentists, oral polio vaccine and surgeons somehow picking up HIV from one patient and transmitting it to another during sequential surgical procedures.

If most or all positive results in any group are false positives, then, as a practical matter, how should one respond to a positive HIV antibody test? Rejoice and throw all caution to the wind? Unfortunately, the situation isn't that simple and the answer depends on whether you belong to a risk group or not.

In low- or no-risk groups, a positive test is of no concern unless there is a logical reason for the person to be infected, a reason which makes sense without having to stretch the imagination to incorporate bizarre theories such as dental transmission and so on. Even on the rare occasion when a positive might possibly be a true positive, one still has to grapple with the issue of whether HIV infection has any relevance to the development of AIDS whatsoever.

On the other hand, in high-risk groups, a positive test can serve as a surrogate marker for AIDS risk - not AIDS, not HIV infection, not certain death and doom, but simply an indication that the person has been exposed to certain pathological conditions that might possibly lead to AIDS or other illnesses. For these people a positive HIV antibody test should be viewed as a signal that it is necessary to assess their life-style for possible health risks.

The cross-reactions which produce false positives can occur as a result of many conditions, both pathological and non-pathological, so it is wise not to jump to any conclusions but rather correlate test results with factors such as symptoms, medical history, life-style, drug use, risk behaviour and so forth. In any event, a positive test result certainly cannot be used to justify a diagnosis of HIV infection or so-called antiviral therapies such as AZT.

In spite of their possible limited applications, HIV antibody tests have probably caused much more human misery and tragedy than any possible benefit they might provide as nonspecific markers of AIDS risk factors. I most vehemently beg to differ with Gallo's statement that his antibody test "has by now saved countless lives" and recommend that its use be entirely discontinued. AIDS should be diagnosed on the basis of clinical symptoms alone.

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continuum woman

by
Molly Ratcliffe

If you have queries or comments to make, don't hesitate to pick up a pen and write to Molly, care of the Continuum office.
PO Box 2754, London NW10 8UF

In the 12 years since 1982, 787 women have been diagnosed with AIDS in the UK and 445 have died. But what are these women actually dying of, that is what I would like to know? In this article, I take a look at two AIDS-defining conditions - Pelvic Inflammatory Disease and cervical cancer.

In the beginning of 1993 the CDC (Centers for Disease Control, USA) changed the definition of AIDS to include two conditions specific to women.[1] This was not the first time the AIDS definition has been altered. This happened in 1985 when HIV antibody presence was first included, and then in 1987 when other conditions were added. It seems like hardly a year goes by without something else being included or removed from the list of AIDS-defining conditions. At present the list contains 24 conditions, including P.I.D. (Pelvic Inflammatory Disease) and Invasive Cervical Cancer - both specific to women. Interestingly, in the year from March 1993 to March 1994,[2] just after the AIDS definition was changed, there was a 44% increase in the number of women diagnosed with AIDS in the UK. Could this be as a result of the two conditions newly added which occur only in women?

Both P.I.D. and Cervical Cancer occur in women that are not HIV+ as well as in women that are. The same is true for all the other diseases making up the AIDS definition. All of them occur with or without HIV antibodies, or so-called HIV antibodies. Eleni Papadopulos-Eleopulos has shown in her 1993 paper[3] that HIV tests are so inaccurate and non-specific to HIV that you cannot be sure who is HIV positive, and it's not possible to say if anyone has live HIV, the retrovirus itself, in them.

Cervical Cancer

The inclusion of cervical cancer in the Acquired Immune Deficiency Syndrome definition seems particularly strange since neither it, nor any other kind of cancer, has previously been associated with immune depression or suppression. Many things have been linked to cancers and suggested as causes but there are as yet no clear answers. Robert Gallo, who found fame and fortune in 1984 as the discoverer of HIV (a claim later proved to be false), had previously linked retroviruses to Leukemia, breast cancer and cervical cancer. None of these theories were ever proven and have since been dropped by him, due to a lack of evidence. In December 1994 I spoke to the Imperial Cancer Research Fund and the Cancer Research Campaign asking for their views on the inclusion of cervical cancer in the AIDS definition. Both organisations were shocked and amazed at this news and could not think of sensible reasons as to why this should be. In fact, they told me that since 1950 the incidence of death from cervical cancer in England and Wales has been dropping by approximately 100 a year.[4] In 1958 there were 130.5 deaths per million, and in 1990 there were 67.4 deaths per million as a consequence of cervical cancer - in 1991 a total of 1880 deaths. So HIV has not caused an increase in cervical cancer since they started testing for it in 1982.

As for what the causes of cervical cancer might be, statistics show that smoking doubles your likelihood of getting it, while the HPV (Human Papilloma Virus, causing genital warts) and Herpes virus are also possible causative factors. Poorer women also have a higher incidence of the disease.

So is there evidence that HIV causes cervical cancer? To put it succinctly: no. It has been suggested that HIV+ women are 10 times more likely to develop abnormal cells[5] than those not HIV+. This is an alarming statement, and closer examination shows the logic to be flawed. If a women has HPV or has been exposed to it she is likely to have HPV antibodies in her bloodstream. If she then has an HIV antibody test the HPV antibodies may well cause her to test false positive, since HIV tests are not specific to HIV antibodies. It is entirely possible that women who have tested HIV+ and have cervical cancer or abnormal cervical cells have

tested HIV+ because of the presence of HPV antibodies in their bloodstream. The same applies to herpes. If herpes is found in association with cervical cancer, and you test HIV+, you cannot know if it is the herpes virus antibodies or the HIV antibodies giving you the positive result.

Remember, deaths from cervical cancer have been dropping every year since 1950. The discovery of HIV and AIDS has not changed this trend. 93% of women with abnormal cervical cells don't go on to develop cervical cancer - the cervix simply returns to normal. And if you do have abnormal cervical cells or cancerous cells you don't have to resort to surgery or medical intervention. Women have healed themselves using homoeopathy, Chinese herbs and acupuncture, and by making positive changes in their lives and as a result have become healthier and wiser.[6]

Pelvic Inflammatory Disease

P.I.D. also newly included in the AIDS definition in 1993, is not a single disease but refers to any infection and inflammation of the pelvic organs which is caused by bacteria or viruses.[7] It can affect the fallopian tubes, ovaries or ligaments of the pelvic area. The main agents causing P.I.D. are chlamydia and gonorrhea, both of which are sexually transmitted bacteria, although there are up to 40 other sources of infection including tuberculosis, CMV and herpes. The infection may occur as a result of infection, or by a blood-borne agent such as tuberculosis. If PID isn't treated it can result in blocking of the fallopian tubes and infertility. It is also a factor contributing to ectopic pregnancy. The agents causing PID often occur in the normal body environment and do no harm, unless the healthy balance of the internal environment is disturbed. This might be through stress, poor diet or chemical agents, especially antibacterials or antibiotics. If this happens certain bacteria will grow abnormally and cause damage to the pelvic area. This is a similar situation to what occurs when antibiotics disturb the fungus/bacteria balance of the gut or vagina and it results in thrush (candida albicans) overgrowth.

I don't know the statistics for PID in this country. It's not a fatal condition but it can be chronic and very painful, as well as damaging to the body. Nor do I know how many women that have tested HIV antibody positive or developed AIDS have PID. No-one seems to be collecting or publishing these figures. What I do know is that some of the agents responsible for PID, particularly CMV, tuberculosis and herpes, but also gonorrhea and chlamydia, could cause you to test false positive to HIV - as the Eleopulos paper shows.

So to conclude, in both cervical cancer and PID the conditions themselves could cause you to test positive for HIV antibodies, and this could account for the conditions being included in the AIDS definition, since they seem to be appearing in the presence of HIV. As a result of the new AIDS definition, the number of women being diagnosed with AIDS is rising, More women are being told that they should take toxic medications and that they have a fatal disease, and that HIV is the cause of their misfortune. It's not HIV, but the misinformation that surrounds it, that is the problem.

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Preventing Herpes

by Molly Ratcliffe

About 3 years ago I discovered I had herpes. I didn't give it much thought until a year later I had a painful attack that began slowly, reaching a crescendo at 2 weeks, at which point I decided something had to be done. I found a book in the local library on the relationship between Herpes and diet and have never had a herpes attack since. This is what I discovered:

Herpes Simplex Virus is very common in the population. Herpes Simplex I usually affects the mouth causing cold sores, and Herpes Simplex II usually affects the genitals and anus causing blisters and sores there. It's easily contracted via direct skin contact with someone who has active herpes, i.e. blisters or sores. Most people who contract herpes have an attack after the initial infection but don't go on to have a second attack. You can be exposed to the herpes virus and not become infected. This seems to be dependent on how healthy you are at the time and perhaps also due to immunity built up by previous exposure to the virus. A minority of people with herpes do get successive attacks, but there are things you can do to minimise the possibility of having another attack, and also ways to relieve suffering and lessen the severity of an attack, without resorting to pharmaceutical drugs.

It is believed that the herpes virus enters the body through the thin membranes of the vagina, penis, anus or mouth; whatever the place of direct contact with someone having an attack is, 2-14 days after the virus entering the body small blisters appear on the surface. They can be painful, tingly or itchy. They fill up with a clear liquid which turns yellowish, then the tops come off to reveal painful ulcers which will gradually dry up within a couple of weeks. Having entered the body, the virus travels up the nerve fibres until it ends up in the nerve root. It seems that the virus will stay there for the rest of the person's life. Sometimes it will reactivate the sores, yet in many cases it will cause no further problems.

Preventing a Herpes Attack.

Several factors contribute to the likelihood of you having another attack of herpes once you have been infected. It is the immune system that deals with invaders such as the herpes virus. If you are under stress, are over-tired or have a diet that fails to supply you with all the nutrients you require for good health, your body will be having difficulty functioning properly. This will make it harder for your immune system to keep the virus under control. Reducing stress and having a balanced diet are important ways of enabling your body to function well. Cutting down on your intake of stimulants, including coffee, tobacco and alcohol, and foods containing concentrated sugars will also allow your immune system to do its job better, rather than it having to fight the negative effects of such substances.

Lysine and Arginine.

In the 1950s it was discovered that two amino-acids affect the herpes virus. Lysine was found to deter herpes growth and arginine was found to promote herpes growth. [These are 2 of the 22 amino acids found in the proteins of all living cells. Amino acids are the building blocks of proteins.] Lysine and arginine are found mostly in high-protein foods. The important thing to remember if you want to avoid a herpes attack is to increase lysine intake and decrease arginine intake.

Some of the foods that contain a large amount of lysine are also high in fats (eg. cheese and eggs) which makes it difficult for the body to absorb the lysine, so it's necessary when eating lysine-high foods to remove fat where possible and not to add extra fat by frying etc. Animal foods high in lysine include fish, red meat, milk and poultry. Vegetable foods high in lysine include soya beans, butter beans and mung beans. While it's important to eat foods high in lysine it's also important to decrease your intake of foods high in arginine, especially nuts, seeds and chocolate. Grains, particularly buckwheat, rice and wheat contain small amounts of excess arginine. Low protein foods such as vegetables and fruit have little if any amino acids and therefore no lysine or arginine.

Refer to the tables to see foods that will inhibit herpes [high lysine] table 1, and foods that provoke herpes [high arginine] table 2. Bear in mind that if you eat foods high in lysine they will inhibit arginine and vice versa. So if you ate a tuna fish salad followed by a peanut butter sandwich, the sandwich would negate the anti-herpes effect of the lysine in the fish.

This doesn't mean that you can never eat arginine rich foods. If you are having a herpes attack it would be a good idea to cut out excess arginine foods like chocolate and nuts and have small amounts of grains while eating plenty of fish, goats milk, butter-beans etc. You can eat vegetables and fruit as you like since they contain neither of the amino acids. It's a sensible idea to note your intake of lysine and arginine foods at times when you are more likely to have a herpes attack, ie. when you are under stress or over-worked, and for women around the time of menstruation, which puts the body under a lot of stress.

Supplementation

If you find it difficult to obtain adequate amounts of lysine in your diet, or you don't want to eat fish etc., you can use a supplement of lysine in tablet form. It is called L-lysine and usually comes in about 500mg tablets. They should be taken on an empty stomach (as opposed to vitamins which are best taken with or after food) to allow greater absorption. To keep a high level of lysine in the bloodstream take it 3 times a day. Fat and sugar interfere with lysine absorption. The amount that you need to take depends on the amounts of lysine and arginine in your diet and the severity of herpes attacks. Your general health and stress levels also need to be considered.

Some people take 1000mg-3000mg as a preventative, and 3000mg-8000mg during an attack, spread over a day. Personally I prefer to get the balance from my diet rather than use concentrated amounts. You must decide which you prefer. No side effects have been noticed at these levels. However, both lysine and arginine are essential for the body to function properly. Arginine is essential for the formation of white blood cells and immunity so you need to beware of inhibiting arginine completely by the use of too much excess lysine.

Vitamins and Minerals

Since herpes is caused by a virus, anything that strengthens the body's ability to defend itself against viruses will help to lessen the occurrence of a herpes attack. Vitamin A, E and B complex enhance the body's ability to produce antibodies and white blood cells, and may decrease the incidence of infections.

Vitamin C improves the body's immune response. Vitamin C taken with Bioflavinoids (substances occurring with vitamin C naturally in foods) speeds up the healing process of sores. Iron and Zinc are important for proper immune functioning.

Other Natural Ways of Treating Herpes.

- Bathing sores in salt water is a very effective and cheap way of reducing pain and drying up the sores. Use 1 tsp. of salt, preferably sea salt, to a pint of tepid water and bathe the affected area twice a day.
- Melissa [lemon-balm] as an ointment or diluted essential oil has an antiviral effect and can be used to treat sores on the mouth or genitals. You can also drink lemon balm tea made from the loose herb. A tsp. of herb to a cup of boiling water infused for 5 minutes will calm the pain from the sores and help your body to fight the infection.
-Echinacea purpurea is a herb that is antiviral (notably effective against herpes and influenza). In addition it is slightly antibiotic and promotes wound healing. It enhances the body's natural immunity and stimulates T and B lymphocytes. It should be taken as soon as symptoms appear, either as a tincture, or by making tea from the loose herb - 3 tsps. to a 1/2 pt. water, simmered for 10 minutes and drunk at intervals during the day.
- The seaweed Dulse and Licorice root are also effective against herpes virus, as are chlorella and wild blue-green algae.

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Table 1 - High Lysine foods - Foods to eat

Portion	*Food*	*mg Excess L-lysine*
4 oz (115g)	fresh fish	+930
4 oz (115g)	shark	+880
4 oz (115g)	tinned fish	+810
4 oz (115g)	chicken	+740
4 oz (115g)	beef	+720
8 fl oz (230 ml)	goat's milk	+520
8 fl oz (230 ml)	cow's milk	+420
4 oz (115g)	lamb	+420
4 oz (115g)	mung beans	+410
4 oz (115g)	pork	+380
1 oz (30g)	cheese	+280
4 oz (115g)	beans, cooked	+270
4 oz (115g)	butter beans	+240
4 oz (115g)	cottage cheese, dry	+220
4 oz (115g)	mung bean sprouts	+210
1 tablet	yeast, brewer's	+190
4 oz (115g)	crustaceans (crab, etc)	+170
4 oz (115g)	soyabeans, cooked	+130
8 fl oz (230 ml)	milk, human	+100
3 oz (85g)	green beans	+30
3 oz (85g)	dates	+20
4 oz (115g)	spinach	+20
4 oz (115g)	asparagus	+20
1	peach	+20
4 oz (115g)	aubergine	+10

Table 2 - High Arginine foods - Foods to avoid

Portion	*Food*	*mg L-lysine Deficiency*
3 oz (85g)	hazelnuts	-2250
3 oz (85g)	Brazil nuts	-2110
3 oz (85g)	peanuts	-2060
3 oz (85g)	walnuts	-810
3 oz (85g)	almonds	-710
3 oz (85g)	cocoa powder (chocolate)	-650
2 tablespoonsful	peanut butter	-510
3 oz (85g)	sesame seeds	-450
3 oz (85g)	cashews	-420
3 oz (85g)	carob powder	-310
3 oz (85g)	coconut	-290
3 oz (85g)	pistachio nuts	-240
4 oz (115g)	buckwheat flour	-230
4 oz (115g)	chickpeas	-210
4 oz (115g)	brown rice	-190
3 oz (85g)	pecans	-180
4 oz (115g)	oatmeal, cooked	-130
3 oz (85g)	sunflower seeds	-120
4 oz (115g)	corn	-80
2 slices	wholemeal bread	-80
2 oz (55g)	wheat bran	-80
4 oz (115g)	millet	-60
1	yam	-60
1	banana	-30
2 slices	rye bread	-30
2 oz (55g)	cabbage	-30
4 oz (115g)	lentils	-20
3 oz (85g)	grapes	-20
3 oz (85g)	raisins	-20
1	cucumber	-20
1	tangerine	-10

Open letter to Continuum readers from the publishers of PRAXIS

PRAXIS has been forced to suspend publication indefinitely, mostly due to a lack of financial support.

In the past three years, in the pages of PRAXIS, we've tried our best to tell the truth about AIDS, and as people dealing with HIV and AIDS, to share our 'journey in consciousness', and so to help facilitate the healing process. Though I have consistently wished we might reach more people, I feel we have at least been true to our vision and accomplished many of the above aims.

I'd like to take this opportunity to thank all our British readers, especially readers of CONTINUUM who have been amongst our most consistent and loyal supporters.

In particular, I'd like thank Jody Wells whose encouragement and generosity has helped keep our work alive and relevant over the last three years.

Sincerely,
Jerry Terranova,
Publisher, PRAXIS.

PS Our PO Box is still in operation, If any of you would like to communicate with me or order back issues of PRAXIS, drop us a line - CURENOW/PRAXIS, PO Box 29386, Los Angeles, CA 90029.

See previous page for Nutri Centre discount vouchers

In the next June/July issue of continuum

Interview: Joan Shenton, Director of the award-winning production company Meditel speaks out on how mainstream TV backed away from the truth about AIDS

Buenos Aires: Airing the alternatives. An inside report on the April Alternative International AIDS Conference in Argentina

History of AIDS: Activist Michael Baumgartner's revealing resumé of the turning points in AIDS history

plus **Health issues, Amoroli, AIDS and Infants, a Questionnaire, and more!**

Dear Continuum...

Dear Continuum,

Thank you for your personalised letter. It did not make me feel like I was a number on a list for you, but a person.

Please allow me to express my feelings, something which I wanted to share with you all for a long time. Firstly, I wish to show my sincere gratitude to "Continuum", especially to Jody, who met me in my desperation of being HIV+ at such a young age. It was he who taught me about positive attitudes, the importance of nutrition and to keep away from medicines. He showed me that I would die the day I gave up struggling, when I would stop taking care of myself, or if I wanted it to happen. Thanks to you all, I rediscovered myself, my position in nature around me, I even re-explored God. Surely, you were amongst the first who helped me accept the fact that I was HIV+, and change it to my best, towards my own benefit.

Yes, being HIV+ has developed my sensitivity, my appreciation of simple daily life pleasure: a flower or a sunset. Being HIV+ has enabled me to search for an inner peace, which to an extent with your help I have achieved. Certainly "Continuum" made me feel BIG again, proud of being who I am, capable of challenging myself to become a better person.

In spite of my health status and the fact that I live on a 'tiny' island where even the mention of condoms is a mortal sin, due to our strong Roman Catholic influence, I now have one more year to finish my university degree, with exciting opportunities even to work in foreign countries. It was "Continuum" that taught me never to give up. Whichever decision I shall make, it will contribute to my mental and spiritual growth.

I am now twenty-four years old, with a mere experience of two years that I live with the virus. There is a lot of work to be done in my country regarding the issue of safer sex, HIV and AIDS. But I am limited to share my personal experiences. The only way I can reach out to the Maltese public is by sharing "Continuum" copies, answering to written interviews and writing articles. This is mainly due to the enormous social stigma attached to the matter and the fact that Malta is so small. I am bound to bump into people I know every five minutes.

However, my future fascinates me. I feel I have so much to offer to others. I feel that my character has been sculpted through this experience of being HIV+, so that I can care for others. I want to dedicate some of my life towards the welfare of others who maybe need my help. I also feel that I am greatly needed here in my country to assist those who maybe did not have the wonderful opportunity I had in gaining beneficial knowledge on HIV and AIDS. I am even planning of spending some time working in organisations like yours, or maybe dealing on a twinning agreement, so that people in my country too, will find hope and meaning in their lives.

I admit my strong personality, my assertiveness in HIV education is partly merit of Jody Wells and "Continuum". I will pray for you all that God gives you strength to continue your hard work. Keep it up. You are really doing a fantastic job.

Yours sincerely,

Guzeppi, Malta.

Dear Continuum,

Firstly, let me say what a first class magazine you continue to produce. I look forward to each issue.

I'm writing to ask for some information. Whilst I was recently in California, I was watching a tv programme, introduced by a doctor Alex Duarte, who owns a company called Mega Systems. The company produces, trials and tests different types of herbal medicines. He mentioned "Shark Cartlege", and its effects, but also mentioned "Ozone Therapy". He has written a book called "Ozone Therapy and the Immune System", which I have ordered, but it will be at least 8 weeks before I receive it. He claims that out of 600 people that have trialled this therapy (all of which were HIV positive) now nearly half of them are now testing HIV negative.

Dr. Duarte went on to explain that the FDA would not allow his company to sell the therapy, unless he is prepared to put up US$220,000,000 and carry out research for 10 years. As the laws in the USA are changing, similar to laws in the UK, regarding homoeopathic medicine, he is trying to patent his therapy before the laws are introduced.

Have you ever heard of ozone therapy, and if you have, could you let me know where I could get this information from?
With many thanks,

(Name and address withheld on request)

Dear Continuum,

I have read of Continuum in Nexus magazine (Australia) where an article was reprinted from "What Doctors Don't tell You", Vol. 5, No. 4, 1994.

I am HIV positive - was diagnosed in mid 1991. I have been treated with AZT (2 years) and ddC (6 months). Now I am doing much better (i.e. returned to normal health) since discontinuing all drug treatment and radically changing aspects of living. I believe I am an HIV survivor. Please send info on your magazine.
Love and light, let's provide some hope!
Kind regards,

Jan, Australia.
(46 year old mother of 2 teenage sons)

Dear Continuum,

I have just sent you a subscription renewal for one more year of the magazine. I get a lot from being a member in terms of information, advice and huge discounts on the vitamins I buy.

However, I would like to see the magazine write more about how people affected by the virus could benefit by giving up smoking. Tiny studies have shown that smoking hugely increases the chances of getting very sick (what a surprise!) and while it's well and good saying that we know someone who smokes 40 per day and is fine, for the majority smoking is very unhealthy - this is especially true if you have a 'weakness' in the lung, eg. asthma or hayfever.

Smoking is similar to AZT in a way - some people, the minority, seem to take it into their systems with impunity. But this doesn't stop us from crying out for the others it kills. The same should be for smoking cigarettes. Let's get honest and let's get real.

If you care about your health and have taken the nutrition message on board, what the hell are you smoking for?

As a member of Continuum, I applaud the campaigning stance against toxic drugs. Let's move into a new year with a new target for our energies - the tobacco companies, whose profits at the cost of lives and health, make of the 8,000 who have 'died of AIDS' pale in comparison to the 100,000 who die each year from tobacco-related illnesses.
Good luck with '95.

Marcel Weil,
London.

Dear Continuum,

I am ending a cheque on behalf of a friend for a further 12 months subscription to Continuum.

Your publication means so much to both of us - thanks for keeping us all in touch with the REAL world.

Best wishes,

(name and address supplied)

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Leon K. Chaitow ND DO, responds to the review of his new book *"You Don't Have to Die - unravelling the AIDS myth"*, which appeared in the last issue of Continuum.

The review of my new book 'You Don't Have to Die - unravelling the AIDS myth' is deserving of a brief response.

Your reviewer takes exception to the apparent confusion my co-author and I display in our references to 'HIV-disease' and says, "either HIV exists and leads to AIDS or it doesn't."

Let's be clear, 'HIV-disease' is the name now given to AIDS in many official circles and our 'Message to the Reader' makes clear that we are using conventionally acceptable terms and phrases because this is still the current mindset. We make our position crystal clear and I reject the accusation of 'chickening out' and indeed find it somewhat insulting. We have taken a clear position, and are addressing an audience which is not as 'enlightened' as your reviewer, and based on reviews elsewhere which have focused on the positive message we offer and have not dwelt excessively on this one semantic issue, I believe that Continuum has performed an uncharacteristic disservice to its readers via this review.

In answer to your reviewer's query, HIV may exist and be a part of a complex set of interactions which would allow AIDS to evolve, something which could well happen even if HIV were not present; or HIV may be an idle bystander in that process rather than a participant in the process; or HIV may actually be a necessary part of the process - I simply do not know nor am I able to accept that anyone knows.

What I do know and what I say over and again in this book is that HIV alone cannot cause AIDS, that AIDS can and has been reversed, that AIDS is apparently possible without HIV ['apparently' because the testing is so inaccurate that certainty is impossible].

To have the entire review gabbling on about this issue seems distinctly unfair since the major thrust of the book is not towards that debate but towards providing evidence of safe and effective alternative approaches, none of which were even mentioned in the review.

As to not discussing the Eleopulos review, we were indeed remiss, but nevertheless clearly stated our doubts about all forms of current testing on pages 50, 51, 52 and ended by saying, "The degree of false testing is impossible to estimate, but there is no doubt that it led to needless confusion and heartbreak on more than one occasion since one of the criteria for being labelled as having AIDS is a positive HIV test result".

Many thanks for the excellent interview with Neville Hodgkinson, and for the fine work you are doing through Continuum.

With best wishes,
Leon Chaitow.

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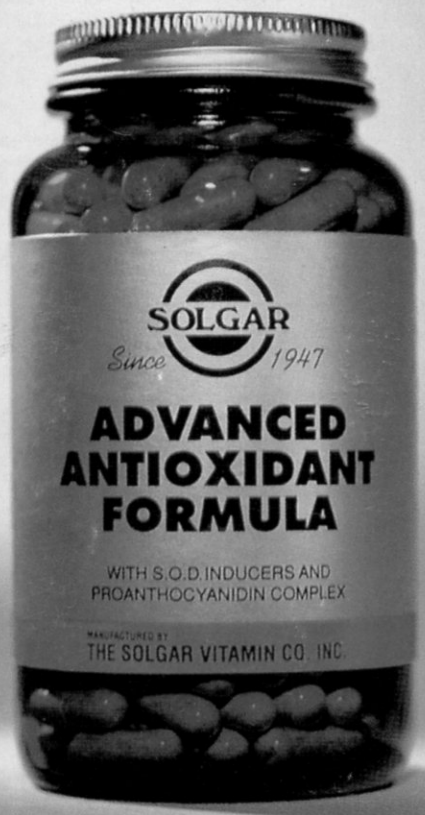

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