continuum
the magazine

CHANGING THE WAY WE THINK ABOUT *AIDS*

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Volume 3, Issue 2

JOAN SHENTON
SPEAKS OUT

STEFAN LANKA ANSWERS BACK

AMAROLI THE AMBER FLUID

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in this issue

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editorial

"Come mothers and fathers throughout the land,
Don't criticise what you don't understand..
For your sons and your daughters are beyond your command...
The times, they are a-changing."

Bob Dylan, songwriter, 1966

We shirk change too easily. Perhaps because an HIV diagnosis is meant to herald, as Dr. Steven B. Harris would have it, "an implacable decline", many AIDS-concerned people unconsciously arrest developments that don't seem to conform to their intentions. But some events are inescapably beyond our control. In the fortnight that **Continuum** goes to press, London's oldest weekly gay paper, **Capital Gay**, has closed down, the future of the **Pink Paper's** monthly HIV/AIDS supplement **Positive Times** is uncertain because of an editorial resignation, and conversely **Meditel Productions** received a letter of interest in a documentary about Dr. Lanka, and Eleni Papadopulos-Eleopulos et al. Our common-or-garden ways of finding out who's discovering what are being reorganised. Our visions of our lives can change significantly depending on the news we receive.

Joan Shenton's years of work making television about the deep questions within AIDS have given her a unique insight into events and how reporting of them is controlled. That she found time to talk exclusively to **Continuum** is typical of her concern and generosity - what she has to say reveals why media on the whole tell only an arbitrarily "correct" version of AIDS. It's important we know how the official version of events became so lacking in truth.

Change at **Continuum** is focused on unravelling the web of HIV and AIDS. Of course we are not alone in the media, as an item in **HIV Watch** shows. At the highest levels statements of changing expectations regarding HIV and AIDS are being given.

We are again making space for Dr. Stefan Lanka's views. His paper **HIV - Reality or Artefact** published in the last issue elicited a detailed response from physician Steven B. Harris, of Salt Lake City, Utah, whose disparagement of "HIV sceptics" on the Internet and in a lengthy article published last year in a US magazine (which has been absorbed by London's Kobler Centre staff in recent months), has made him a clarion exponent of AIDS. We publish his dismissal of Dr. Lanka, and Dr. Lanka's illuminating reply. Open-minded readers can begin to form their own opinions. Last issue's **HIV - Reality or Artefact** also caused a long letter of protest to arrive at **Continuum**-funders CRUSAID from the UK Coalition of People Living with HIV and AIDS (see **Continuum,** Vol. 2, No. 3). If the "coalition" would only address us directly, we could publish their views.

Don't imagine we've neglected our health. Rising numbers of people do amaroli, and not only because it's free, though that may explain why it's rare in the health industry. Real benefits can quickly follow its use, which in some societies is as traditional as the land. Nor have we stopped there. If your dietary intake is good, you want it absorbed in a healthy digestive tract. Consider, if you will, the complexities of the colon.

The editors wish you a resourceful read! ■

"The past has never been a reliable guide to the future...all we can say with certainty is that tomorrow's world will be different. That somehow frightens me - but, like everyone else, I'd give anything to see it."

Professor Stephen Hawking, July 1995

HIV watch

MONTAGNIER SPREADS THE GOOD NEWS

Luc Montagnier, the 'discoverer' of HIV has let the cat out of the bag. In the *Sunday Telegraph (June 18th, 1995)* he said that there was no 'explosion' of AIDS in Northern Europe and that it was wrong to frighten the general public into thinking that there was a high risk of catching the syndrome. Sounds like good news, though some would disagree. Nick Partridge of the Terrence Higgins Trust being one of them. His comment was that "we cannot let people run away with the idea that AIDS in the UK is not having a significant impact". Significant impact on what - the employment figures for doctors, perhaps?

A NEW CO-FACTOR

This intriguing notice was sent in by a **Continuum** reader. He found it on the wall in a south London pub. We're wondering if it will be incorporated into safer sex campaigns. It certainly seems to identify an as yet ignored 'high-risk' activity. Hopefully 'listening to assholes' will become a new category occurring on those indepth questionnaires GUM clinics are so fond of issuing these days.

SPECIAL NOTICE

MEDICAL AUTHORITIES HAVE ANNOUNCED THAT AIDS CAN BE CONTRACTED THROUGH THE EARS BY LISTENING TO ASSHOLES

USE EXTREME CAUTION AROUND HERE

A FALSE CONVERT

A former Catholic priest was awarded **$4.1 million in damages** recently after having been mistakenly diagnosed HIV+. Raymond Mackesney, 57, had undergone nearly seven years of experimental drug treatments after he tested positive on two separate occasions in 1985. The damages were awarded by a federal jury in the District of Columbia (USA). How they know they were false positives is anyone's guess, since there is no accurate way to test for HIV antibodies or 'live virus'. We're looking forward to the day that everyone who has supposedly 'tested HIV+' and been told it's a marker for progression to AIDS will get some financial recompense for their suffering. If each of the 16,000 or so HIV+'s alive in the UK were to get a similar sum we'd be talking about a payout in the region of £32,000,000,000. The thought of having to kiss goodbye to a sum like that might be a powerful deterrent for those concerned from exposing the truth.

RUSH HOUR

A new book recently published by Cassell, called *The Stonewall Experiment: A Gay Psychohistory,* has come to our attention. Written by Ian Young, also a poet, it's reported to be a fascinating and illuminating examination of gay culture. It includes an excellent history of the use and misuse of 'poppers' and an insightful view of the HIV/AIDS debate. We'll be including a full review of the book next issue.

ANYONE FOR AN EPIDEMIC?

Feeling up for a stimulating evening, two of the **Continuum** team went along to see **Larry Kramer** (founder of ACT UP) and **Simon Watney** (AIDS theorist) in conversation at the Conway Hall, organised as part of Pride week.

There was a disappointing turnout, but the invocation "To thine own self be true" written in gold over the proscenium arch seemed to give hope to the proceedings. However, after having heard the word 'epidemic' at least seven times in the first 15 minutes, our brave duo began to wilt, and eventually left after half an hour of nothing much. An epidemic of what, they wondered? Inaccurate medical tests, AIDS activists, or simply an epidemic of people who don't know the meaning of the word? Epidemic comes from the Greek and means the widespread occurrence of a disease in a community at a particular time. You could hardly call 10,304 AIDS cases out of a population of 56 million in 12 years an epidemic. You can **call** it an epidemic, but there's no reason why anyone should believe you.

SAFETY IN NUMBERS

Pride '95 was in Victoria Park, London and we were there in the CRUSAID health tent with piles of magazines and welcoming smiles. It was a bit odd, though. It seems the only health issue to affect gay people is AIDS. The overwhelming majority of organisations were of the HIV=AIDS variety, with a few exceptions, notably Equilibrium and the Helios Centre. If only it was as simple as the majority of organisations would have us believe, i.e. wear a condom, use clean needles and you'll be fine. As it is, life is complex, as is the human body, and maintaining health is a many-faceted endeavour encompassing a whole range of variables. Trouble is, that kind of message just doesn't easily condense into a single catch phrase. Oh well!

AUTHOR DIES

The extraordinary **Robert E. Willner,** MD has died of a heart attack, aged 65. Author of *Deadly Deception: The Proof that Sex and HIV Absolutely Do Not Cause AIDS,* he stunned Spain by inoculating himself with blood from an 'HIV+' haemophiliac to demonstrate his commitment to these views. Despite being widely reported on TV and in newspapers throughout Spain, most of the world took no notice. Willner said of his dramatic action, "I do this to put a stop to the greatest murderous fraud in medical history". Though having 30 years' experience in medicine, it took him four years before he suspected there was something wrong with the AIDS hypothesis and another five years to arrive at what he considered to be the truth. Robert Willner has been as inspiring voice in the AIDS debate and the news of his death saddened us all at **Continuum.**

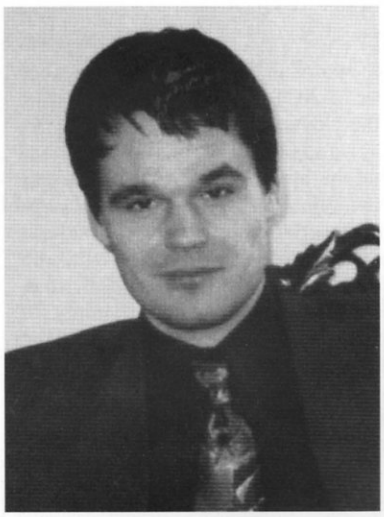
GALLO ON THE MOVE

Robert Gallo, the virologist who first claimed to have discovered HIV, is now leaving the N.C.I. (National Cancer Institute), part of the N.I.H. (National Institute of Health, USA), having been advised to do so by those 'higher up'. Rumours that he would leave began in 1994 after the Clinton administration agreed to give the Pasteur Institute of Paris the majority of patent royalties from the American HIV tests, thereby acknowledging French claims that Gallo misappropriated cell cultures.

Gallo had worked at N.C.I. as part of their 25-year 'war on cancer' which, despite billions of dollars, provided few, if any, insights to the disease. Now he's relocating to Baltimore where he intends to "get into this [AIDS] up to my elbows". Perhaps a reference to a possible side career as a dish-washer! ■

HIV debate

Dr. Stefan Lanka answers critic Steven B. Harris M.D.'s rejoinder to his paper we published in the last issue. After Dr. Lanka's introduction we print their comments side by side.



Stefan Lanka:

Dr. Steven B. Harris will no doubt consider it an impertinence even to respond to his "rebuttal" of the thesis I put forward in my article on HIV in the capacity of a "purported" virologist, striking as it does at the very bedrock of his credo. I console myself that while I make no claims to infallibility, I have no doubt that I **am** a virologist, moreover, one motivated by altruism, and untroubled by any worries that I may have dispatched any friend or patient to an entirely unnecessary and painful death, through craven obeisance to an ill-thought out medical theory concocted by a French mediocrity who, right from the start, doubted the validity of a virus-only theory of AIDS causation and only last week unleashed a new wave of doubt; and an American scientific gangster who had committed so many crass, self-aggrandising blunders in the previous decade, that only a knave would trust him to tell the time correctly.

Nor have I forgotten the First Commandment of my profession: *primum non nocere.*

It is, of course, only supposition on my part to think that elementary cell biology forms any part of the curriculum of medical training of American doctors. If so, it is astonishing that Dr. Harris has either forgotten it all or is willfully ignoring it, for reasons best known to himself.

That said, I must compliment my critic on his courage and relative erudition, for it is not often that, in my admittedly still limited experience of life, a mere doctor knowingly crosses swords with a molecular biologist/virologist on the latter's home ground. Physicians are normally more at ease in the miasma of epidemiology than engaging in disputation with the practitioner of an exact science.

Dr. Harris's simple mistake is to have ignored well-known intracellular structural particles common to all metabolically active cells, of which there are many. Harris clearly would have benefited hugely looking down an electron microscope more often, and allowing himself to be enchanted by the multiplicity of such "Harris" viruses, more widely known as coated vesicles. This would have made him realise that their very ubiquity in healthy tissues meant they could not be responsible for any pathogenicity.

This is hardly a pardonable error, since basic prudence on his part should have led him to study fairly closely the characteristics of electron micrographs of microsomes in general, and coated vesicles in particular, with or without the help of a specialist in this field - it did after all form one of the cornerstones of my article. Neither virus particles nor cellular particles are rarities in the literature. Contrary to Harris's little jibe, I have spent an enormous amount of time in libraries, far too much of it wasted trying to make sense of the mile upon mile of bookshelf devoted to the riddle of "cancer-causing" viruses.

Harris's strategy appears to be to launch a shut-out bid by declaring HIV to be a lentivirus, implying that this explains everything. Yet lentiviruses are an even worse case of virological muddle than HIV, in that they, too, have never been isolated nor proven to do what is alleged of them. Fiddling around with them has been going on for 20 years at least - to no effect - whereas with HIV it has only been 10! A very important difference, though, between the two situations is that lentiviruses have at worst affected only a handful of animals with so little consequence, that most scientists would be hard pressed to say anything about them, whereas HIV has spawned one of the worst mistakes in the annals of medicine, a veritable nightmare for those affected, and a significant impairment of the quality of life of those who just live in dread of it.

Whether lentivirus or not, it is a nullity *ab initio* to seek to prove anything in science by arguing only by analogy. That is the negation of the scientific method. Whatever may be true of FLeV, FIV, SIV etc. has no bearing on the existence or function of HIV. Points of visual similarity do not constitute proof of identity or function. To assert otherwise means either that he has never looked at electron micrographs, or more likely that he deludes himself or deliberately wishes to delude others.

The fatuity of his reasoning is highlighted (quite fortuitously) by the recent "discovery" that HIV is most definitely not a lentivirus. Lenti- means *slow* - it makes no reference to shapes or anything else. Since January 1995 we have it on the highest authority that HIV replicates very rapidly, at a rate of 1000 million particles a day, every day, for an average of 10 years. Anybody with an ounce of common sense must have realised that a virus cannot have been barely active for the first 10 years of its existence, then suddenly turn out to be "hyperactive".

Steven B. Harris

Here are some more complete remarks on the long paper *HIV, Reality or Artefact*, the product of a purported virologist, one "Stefan Lanka, Ph.D." Excerpts from Lanka's paper are below, and my comments follow.

Lanka: *"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."*

Comment: Strangely enough, Lanka does not explain what we're seeing in all those electron micrographs.

Lentiviruses (the viral family to which HIV belongs) are not just blobs, but are highly complex and stylised structures which are difficult to misinterpret when seen. They are spherical membrane-covered viruses of about 100mm diameter, with glycoprotein knobs which easily shear off. When they bud from cells (a picture one can see in any AIDS text), the nuclear material in them forms a crescent shaped structure around the outer limb of

Stefan Lanka

reply begins next page

Harris

the bud, as it does in the HTLV viruses. Unlike HTLV viruses, however, mature lentiviruses (with the exception of non-lymphotrophic lentiviruses like visna/OLV/MVV) have an eccentric nucleoid containing RNA, which lies at one end of a truncated-cone shaped viral core, much like type D retroviruses. At either side of the core are dense lateral bodies, which D retroviruses lack (the D types bud differently also). For a primer on lentivirus structure, contrasting it with other retrovirus structures, I recommend *AIDS 5:617-638, 1991*. Lymphotropic lentiviruses are visually unique, and readily identifiable.

These visually identical lymphocyte-infecting lentivirus retroviruses EIAV, BIV, FIV, and SIV, infect cows, horses, cats, and monkeys respectively *(sic)*, and these infections have all been done experimentally. The results for the last three viruses are immunocompromise, CD4 cell loss, lymph tumours, opportunistic infection, brain infection, wasting, and death. A review of these studies (plus pictures of the viruses) can be seen in my article in this quarter's *SKEPTIC* magazine, on your newsstand now *(SKEPTIC, vol 3. no. 2, 1995)*.

1. HIV-l and HIV-2, the two viruses isolated from human AIDS patients, are identical in appearance to the other viruses in this class. They share protein antigens, and they share genetic organisation. They are infectious, and cell-free preparations of them are capable of killing cells in placque assay, which is a time-honoured standard for presence of a virus. They have been molecularly cloned, and the clone DNA, when added to cell culture, produces viruses of identical appearance, which can again be separated from cells, and which show the typical morphologic characteristics of lentiviruses *(Virology 189:695- 714, 1992)*, as well as their typical proteins and enzyme activities. It is even possible to grow this virus in the presence of an inhibitor of an enzyme which cleaves proteins for the core of this virus, and show that the resulting viruses which are produced from cells have defective-looking cores which mark them clearly as abnormal lentiviruses *(AIDS Res. Hum. Retro. 10:735-743, 1994)*. Such studies are now routine.

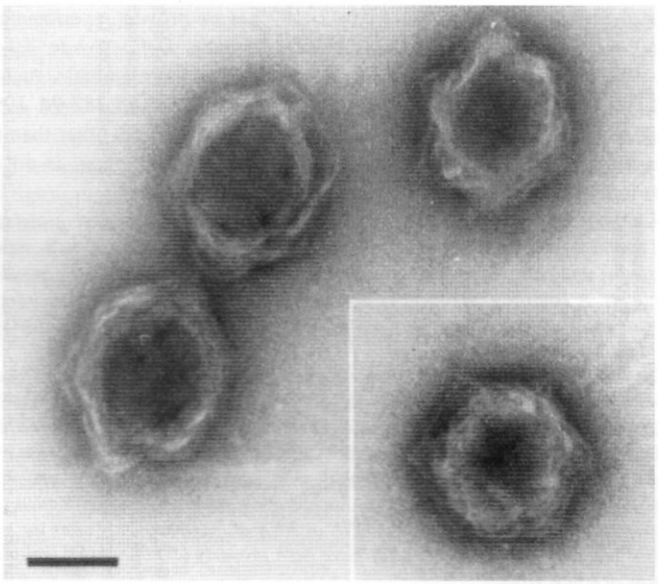
Dr. Lanka states: *"Less well-known is the existence of other particles which look like viruses but aren't, and are nonchalantly referred to as "virus-like" particles. Such particles are far from rare, found, for example, always in placentas, and very frequently in the artificial environment of laboratory 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."*

Comment: But here, it is Dr. Lanka who is muddying the waters. There are existent studies in which less than perfect-looking particles have been called HIV, and assumed to be HIV, but some of these studies have no doubt also seen cellular debris or other retrovirus which can be mistaken for HIV or other lentiviruses if not all identifying features are present (for instance, see the overcited *Hum. Path. 19:545-549, 1988* for some particles which could be anything). However, there are quite enough studies in which all the lentivirus characteristics noted above **are** present in EM photographs, and morphology is considerably more clear. In these studies, the viruses in the electron micrographs are clearly either EIAV, FIV, SIV, or HIV-l, or HIV-2.

2. Lanka goes on to expose an "error" of the past: *"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, were thought to have become cancerous through being infected by a virus. New to the idea of cancer viruses 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. These "new" viruses became known as retroviruses. 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 and other explanations were sought. 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."*

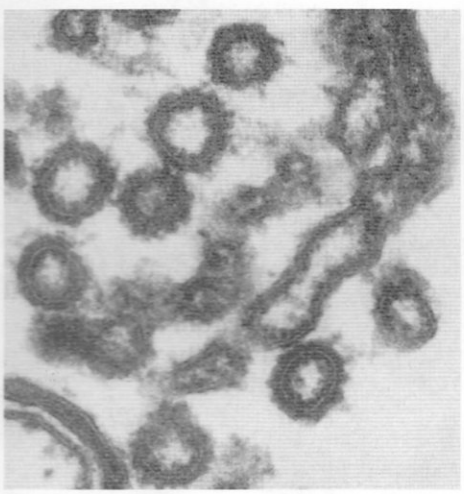
Comment: This is, in general, untrue. Not all cancers were blamed on viruses. Many viruses, such as FLeV, FIV, SIV, and even DNA viruses with reverse transcriptase activity, like hepadnaviruses in woodchucks

Lanka



Electron micrograph of correct isolation of Ectocarpus Siliculosus Virus.
(Klein et al. *Virology 206:1, 1995*)

1. I despair; where is the proof of isolation of HIV-1, to say nothing of HIV-2. Dr. Harris seems to have suffered a blackout at this juncture - the whole point of my paper was that HIV has not been isolated. If it had been, there would have been no case for him to answer.



Normal cellular coated vesicles with abundant protein spikes.
(A-level Biology text)

2. It would be a considerable help if Dr. Harris stopped pulling the wool over people's eyes about fundamental matters he rightly finds acutely embarrassing. Which cancers were thought of as being due to viruses and which not? It is pointless to waffle excuses now about the mass failure by the scientific community in the '70s and '80s and to wax lyrical about some detail about HIV which he finds "elegant". The fact of the matter is that then, in respect of cancer as now of HIV, the fundamental science is wrong, and no amount of epidemiological soft soap "isn't it funny that ..." can rectify it.

The War on Cancer declared by President Nixon on 23/12/1961, based on the notion that viruses cause cancer, implied that all cancers are caused by viruses. Those researchers who did not accept this were ignored and defunded. It is a gross deception, like everything to do with HIV and AIDS is in our time, to deny that it was never alleged that all cancers were caused by viruses. Then as now unwarranted extrapolations are made from what

Harris

(Gastroenterol. Jpn. 25, Suppl 2:38-42, 1990) were proven experimentally to cause cancer in lab animals *(J. Acquir. Immune. Defic. Syndr. 4:547-557, 1991)* and even in random source animals (pet store animals, such as cats) brought to the lab and given virus *(J. Vet. Med . Sci. 55:387-94, 1993; J. Infect. Dis. 170:543-52, 1994)*. The idea that retroviruses other than the Rous virus, and in particular lentiviruses could cause cancer, is not an error; rather it has been proven in multiple experiments.

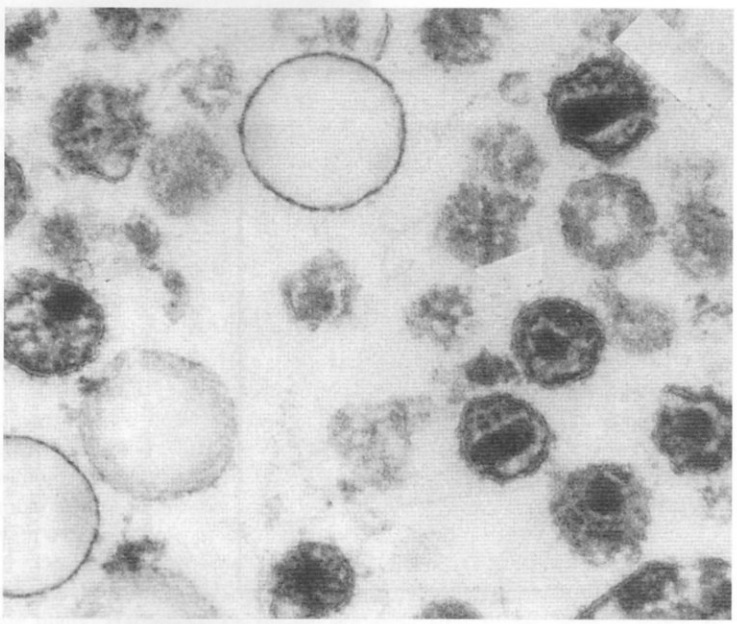
Lanka goes on: *"The isolation and purification of a real virus is a straightforward matter, because unlike cells, viruses of one species are always of the same size and shape, and can be readily separated from other cell components by standard techniques. A control experiment is to try an isolation 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."

Comment: All this has been done for HIV. Lanka's problem is that he has not spent enough time in the library.

3. He says: *"Such evidence has up till now never been produced for HIV. No photograph of an isolated HIV particle has ever been published..."*

Comment: see *Virology 189:695-714 (1992)*, particularly p. 700 where some nice photographs of isolated HIV particles are published, with all lentiviral morphology clearly seen.



"...ultrathin sections of co-sedimented HIV and latex spheres...along with membranous and macromolecular debris...some HIV particles clearly showed envelope knobs."
(Layne et al. *Virology 189:695-714, 1992, p. 700*)

4. Lanka: *"nor of any of its proteins or nucleic acids."*

Comment: This is not clear: he wants photographs of proteins and nucleic acids? For proteins from the virus to be separated and photographed as spots on gels is easy, and these do produce characteristic patterns for HIV. For instance, Cohen et al. *(J. Virology 64:3097-3099, 1990)* in the course of looking for a vpr gene protein in HIV, separated HIV particles and banded them on a sucrose density gradient, where reverse transcriptase activity was detected in just the fractions expected for a retrovirus. These same fractions (but not others) gave the characteristic multiple protein bands of HIV on radiolabeled SDS-PAGE electrophoresis, as well as the vpr protein product. Here are all the components of the virus, banding in packages where the virus itself should band. This repeats the classic Barré-Sinoussi work. Yuan et al *(AIDS Research and Human Retroviruses 6:1265-1271, 1990)* repeats and extends this same work: it is real. For an interesting variation see Ratner, et al., *(AIDS Res. and Hum. Retrovir. 7:287-294, 1991)* in which various clones of HIV with gene deletions for

Lanka

can be made to happen in a test-tube to what happens *in vivo*. I cannot recommend too strongly the paper by Peyton Rous (the father of retrovirology) especially his comment that "the first tendency will be to regard the self-perpetuating agent active in this sarcoma of the fowl as a minute parasitic organism. Analogy with several infectious diseases of man and the lower animals, caused by ultramicroscopic organisms, gives support to this view of the findings, and at present work is being directed to its experimental verification. But an agency of another sort is not out of the question. It is conceivable that a chemical stimulant, elaborated by the neoplastic cells, might cause the tumour in another host and bring about in consequence a further production of the same stimulant" *(J. Exp. Med., 13:397-411, 1911: Sarcoma of the fowl transmissible by an agent separable from the tumor cells)*.

The ludicrous situation, into which contemporary cancer research has manoeuvred itself, is described by Gerald B. Dermer, who provides the evidence that cancer *in vitro* and cancer *in vivo* have nothing to do with each other.

3. But look long and hard at Harris's pride and joy, the paper he repeatedly cites, because it supposedly describes the isolation of HIV, with photographs, to prove it. It is called *"Factors underlying spontaneous inactivation and susceptibility to neutralisation of Human Immuno-deficiency Virus"*, a somewhat unfortunate title under the circumstances, don't you think, Steve? On page 700 one sees instead of documentary proof of a virus, a preparation of the above mentioned cellular particles, which are of different sizes and shapes, and, as the caption clearly states, are contaminated with "membranous residues" and "macromolecular fragments". This is not what an isolated virus preparation should look like. What they should look like can be seen in any virology textbook. When real viruses are isolated, they do not need "fixing", which means embedding them in a resin to stop them from falling apart, nor interspersed with latex balls (!) to cushion the various particles from each other, nor slicing into ultra-thin sections to reveal some particles from within the preparations, only then being in a fit state to be photographed in an electron microscope. Isolated virus preparations contain no visible impurities, and after staining in one piece to give contrast, are photographed. All particles look alike. All known viruses that are real have been isolated and photographed in this way. To see what a virus should look like the reader, open-minded AIDS researchers and especially Dr. Harris could do worse than read about a virus in whose isolation and characterisation I myself was involved. (See Klein et al. *Virology 206:1, 1995*)

4. What is wanted are photographs of the native gels of the proteins and of the nucleic acid.

Harris claims that the missing proteins of HIV are found in the paper by Cohen et al. But what we actually see is more fiddling and tinkering with the evidence. We see the result of "radiolabelled SDS (detergent) polyacrylic amide gel electrophoresis (PAGE)". One needs to see the proteins on the SDS gel **before** antibodies to it were added, which then bind to certain proteins and are made visible by means of radiolabelling. If you have something to show, and above all if you want to prove that the proteins of a virus have been isolated and separated according to size, then the native gel has to be shown before further experiments are conducted. This is standard procedure - except, of course, in the case of HIV where it really matters! If you attempted this with HIV isolations you would find that many proteins wouldn't fit in with the conventional HIV model. To get round this problem, only photos of antibodies when bound to selected proteins are shown, and the presence of other proteins, which remain unboun

Harris

gp envelope proteins are shown to all produce p24 activity which segregates at the proper sucrose density of 1.12-1.14. This p24 protein at this band is protected by trypsin by something, and that something is obviously a lipid membrane, which is disrupted by Triton detergent. Here again are lipid covered p24 protein particles which have the proper lipid density and are infectious (this paper also contains EMs of lentiviruses budding from cells when the clones are added to them).

5. Lanka: *"No control experiments as mentioned above have been published to date."*

Comment: That depends on what one wants for a control. There are many papers in which it is shown that when replication is interfered with in HIV, the virus product in culture is either missing or defective. Again, see *AIDS Res. and Hum. Retroviruses 10:735-743, 1994.*

6. Lanka: *"What has 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."*

Comment: First, I have quoted a paper above in which the virus is isolated from cells in culture *(Virology 189:695-714, 1992).* It's not clear why isolated viruses should be needed here; so long as the virus is not connected to the cell, what more isolation is needed? It is known that HIV can be totally isolated from cells (see *Virology* paper above) so why do this every time, when the separation is known to damage some virions and sometimes give worse quality photos? (Although the paper cited above manages to have isolated virions with excellent photos, it isn't easy). Once again, these are not "virus-like" particles in cell cultures, these are particles with as clear morphologic characteristics as are needed, and as Lanka demands for identification of viruses.

7. I know of no really good photos of HIV isolated directly from humans, but the virus is present in low concentrations outside cells in humans, and contamination is great. What is wrong with culturing it first?

8. Lanka: *"What the whole world has seen are models representing HIV with dish aerials, said to be receptors with which the virus attaches itself to cells."*

Comment: These glycoprotein knobs can be seen directly in electron micrographs of some isolated viruses in *Virology 189:700,1992.* What more is needed? If Dr. Lanka needs a good primer (as it appears he does) on lentivirus structure, as opposed to the other retrovirus structures, I again recommend *AIDS 5:617-638, 1991.*

9. The evidence that these knobs attach HIV to cells is massive, and it is ridiculous that Lanka refers to it as "said to be." One can construct HIV with the gene for these knobs deleted, and show that HIV is produced (as seen by its isolation on sucrose gradient) but not infective. However, if another plasmid for this protein is added to cells making HIV, the HIV produced has the attachment protein available and **is** infective. One can even add attachment protein from a mouse virus, and produce HIV which will infect mouse cells. Infection itself can be shown by making the virus carry yet another gene for antibiotic resistance, to allow cells it infects to survive in special media. For an elegant set of such experiments done with this "nonexistent" virus, I suggest the Ratner paper above, or looking up Page et al, *J. Virol. 64:5270-5276, 1990.*

10. Lanka: *"This is the crux of the problem facing all HIV (AIDS) tests. The inability to isolate a viral entity, and to obtain proteins from it which are free from proteins derived from the cells in which the alleged virus is grown, reduces the evi-*

Lanka

by antibodies, is not revealed. Only selected proteins are made visible by binding to antibodies, because only pre-selected proteins are used to inoculate experimental animals which are used to produce those antibodies, with which these proteins are detected. The same applies to humans in whom only antibodies to proteins are produced with which they had previously been in immunological contact, i.e. inoculated with (except rheumatism and autoimmune diseases). It is quite a difficult argument to follow which will leave many a head spinning, but that is how AIDS "science" works. Dr. Harris has clearly been taken in by it though.

Variations of an original error (Ratner et al.) may enchant Harris, but remain an error just the same. They show once again that something has been obtained from a cell preparation, not from viruses.

5. The only valid control experiment for a viral isolation is the mock experiment. Infected and uninfected cell cultures must be treated alike in every way before isolation is begun. A parallel isolation is then attempted using precisely the same procedures. *Ad hoc* variations for reasons of experimental expediency void the whole experiment. If a virus exists, it has always been possible to detect bands of virus particles from an infected organism, appearing at the right density in an ultracentrifugation experiment, without visible contaminants. In the control experiment nothing should be detectable at that density. If something is detected, it must be assumed that what was previously detected were not viruses, or they were contaminated by something else, in which case the isolation was only partially successful at best. This is all very elementary virology.

Controls for this purpose have never been performed. They would turn out to be "positive" in the same fraction of cases as infected people, but be called "culture false positives".

6. It is becoming clearer why Dr. Harris is so complacent about the present muddled and circular argumentation: strange as it seems, he does not seem to understand how the ELISA and WB tests are supposed to work. If you cannot even **once** isolate proteins belonging **only** to HIV (without any cellular proteins present) how can you be sure that the antibodies are to HIV and not to other proteins? None of the tests for HIV depends on the **appearance** (shape) of the virus, but on the nature of the proteins of it and it alone. What an appalling blunder to introduce morphology. It is the use to which these proteins are put that matters. As if you could characterise a complicated biological structure just by looking at it!

How can it be that Dr. Harris has (conveniently) forgotten that all antibody tests are based on the **patented** proteins concocted by Gallo and Montagnier? It has long been a criticism of their use (notably by Duesberg) that these proteins originally decreed to be from HIV in 1984 are still ostensibly capable of detecting current strains of HIV antibodies, when the virus allegedly mutates so rapidly; remember Steven, HIV is supposed to mutate like mad. (Mutate means change.)

7. Of course you don't, because there aren't any. You cannot culture them first without ending up with proteins from the cells in which you "cultured" HIV.

8. Have a good look at the photographs. You will find knobs galore, which have got nothing to do with HIV, in the healthiest of normal cells.

9. The evidence of 100,000 papers on HIV and AIDS is indeed massive; unfortunately (or rather, mercifully) not one of them contains any evidence for the existence of HIV or of its components. What is required is a standard isolation experiment under standard conditions, not something fanciful like sprinkling cloned DNA onto cell cultures and seeing what happens. That one can throw any old mouse genes into cell cultures and produce something mouse-specific, is just modern alchemy. That resistance to antibiotics has also been bred in, transgresses against all scientific decencies, paid for by us, the taxpayers. Such misuse of public money is quite appalling. How can it be justified?

It is scientifically unacceptable to dream up explanations of what went wrong and proceed as if nothing of significance had happened, as is usual in AIDS "science".

10. Something that co-purifies with something else is of no interest to any-

continued on page 27

The Amber Fluid

Amaroli, or urine therapy, has been practised in many ancient cultures and survives in India and among those who know of its healing potential. Swami Pragyamurti, a yoga practitioner well versed in its uses, talks to Molly Ratcliffe about its many benefits, ranging from increased energy to boosting the immune system and helping to clear up Kaposi's Sarcoma.

"The main thing about Amaroli is that if you're dealing with a positive diagnosis, whatever that means, and you're trying to adjust your life along more caring, respecting-yourself lines, the urine therapy can help you on several different levels. No-one's claiming miracles, but I think combined with our efforts to live more constructively, to look after our body, mind, emotions, spirit: definitely amaroli can be part of that." *Swami Pragyamurti.*

Amaroli (amari is an ancient Indian word for urine) is the practice of drinking, washing in, rubbing into the skin or using poultices of your own urine as a safe and effective therapy. Its use goes back as far as mankind. There are traces of it in many ancient cultures. It is mentioned in some of the classical yoga texts such as Hatha Yoga Pradipika (6th century AD) from India where it is referred to as a profound spiritual practice as well as being cleansing. Even the Bible recommends "drink the waters out of thine own cistern" (Proverbs V). People have told me stories of soldiers pee-ing in their boots during wars to avoid infections, or of their grandmothers urging them to put a urine dressing on a cut.

Many people's first reaction to the concept of even touching their own urine is one of horror. "It's waste, it's dirty, it smells!" - a sad reflection of how distrustful of our own bodies we have become. In fact urine is a totally sterile liquid. As Pragyamurti says, "You can think of it as much purified blood, surplus to the immediate needs of the body. It's not waste in the sense that faeces is waste. It's very pure stuff."

Toxins are removed from blood in the liver and then it is filtered by the kidneys before it is passed out as urine. It is approximately 95% water and the remaining 5% consists of tiny amounts of various minerals, vitamins, enzymes, hormones, etc., all of these substances being personal to the individual; your own homoeopathic dose of what is going round your body, which, when re-introduced, stimulates the body's healing processes.

A way to understand the logic of using your own urine is to think of nature. A tree sheds its leaves and as they decompose on the surrounding ground they provide the perfect nourishment for new growth. It seems that amaroli works in a similar way. As J.W. Armstrong, author of the book 'The Waters of Life' says, "within Man himself is to be found the substance to cure his disease".

Pragyamurti has been drinking her own urine and washing in it daily for about 8 years as part of her yogic practices. Since she found it so beneficial she's been passing on her knowledge to people going to her to learn yoga at the centre she runs. She told me, "I noticed certain benefits to myself fairly quickly. It seemed to strengthen my immune system and the first winter I practiced I didn't pick up every single passing cold or cough. The only thing I could tie it down to was amaroli. I experimented going off it for a few days, say during menstruation, and I would feel I might get a cold, so I'd whack up the amaroli again. About 5 years ago I'd started teaching yoga to people that were 'HIV+' or had 'AIDS' and it seemed obvious that amaroli could help, especially for all kinds of skin conditions. I'd read the books and knew all the theories but I experimented quite a bit on myself before I felt I could talk about it."

A good way to begin with amaroli is to apply it externally. Once you get over any initial aversion you might have to the substance you can experiment taking it internally. It's best to use the first urine you pass in the morning as it's more potent. Try to take only the mid-flow as it is purer than the beginning and end flow...and it's good for your urethra muscles to start and stop the flow!

To use it on your skin, take a little in your hands and rub it on until it dries. It's beneficial to apply it to the head, neck, chest and arms, but all over the body is even better. Let it dry in the air and leave it. Some people recommend washing it off after an hour. For more severe conditions you could re-apply it every few hours or however often you feel it necessary. What is amazing is that you don't end up smelling like a urinal! It's only when it's wet and warm, as in babies' nappies, that it smells. Fresh urine is almost odourless. For very severe skin conditions it's suggested that you use urine that's a few days old. Pragyamurti's opinion is "experiment - it's up to each individual.

It's important that people don't feel 'uurrghh' about using urine, so start easily. Old urine has a stronger smell so you may feel more conscious of it, but I've never had any complaints."

When you begin drinking it, you should start with a small amount, (again, first of the day, mid-flow) say a few fluid ounces, and gradually increase it. That's because taking in the urine has a detoxifying effect and if you take too much too soon the process can be over-dramatic. Common detoxifying reactions as the body rids itself of poisons can be spots, rashes, nausea, headaches or diarrhoea. Having these reactions is a positive sign that the body is expelling what it doesn't need; it's part of the healing process. Going through it will enable your body to function more fully.

The benefits of using this free, daily available therapy are many. First of all, people report an increase in energy and more youthful-looking skin, which is great for self-confidence: it improves how you feel. Also, for what it's worth, people who go to have their T-cells counted have reported a definite and stable rise in them since using amaroli. Pragyamurti has assisted students with many of the common 'AIDS-defining' conditions such as K.S., fungal infections, candida, herpes as well as eczema, psoriasis, athletes foot, or just simply, greasy or dry complexions. Some students only use it externally, while others have become more enthusiastic and use it internally also. On K.S. lesions it has been applied throughout the day causing the lesions to be much reduced in size. For candida of the throat she has successfully recommended drinking half of the amaroli and gargling with the remainder.

Interestingly, many skin-product manufacturers buy urine from sewage plants and use extracts of it in their products, though they are not keen for this to be known. Cow's urine is also used (See Koes van der Krones' book, due out in the UK in the autumn.) In ancient Rome, there was a tax levied on urine collected in public reservoirs.

During pregnancy is another good time to practice amaroli. It's important not to take too much too quickly as the mother's body is closely connected with that of the foetus, and it wouldn't be useful to go through severe detoxification. But taking a small amount can help balance the effects of pregnancy, particularly morning sickness.

Something that you soon become aware of when using amaroli is that

Within man himself is to be found the substance to cure his disease

whatever you eat and drink will affect the quality of your urine. Eating meat or dairy products, processed foods, sugar or alcohol etc. will tend to make the urine darker and give it a bitter taste. Conversely, eating fresh, mostly vegetarian foods produces urine lighter in colour and taste, therefore easier to use. The darker urine is still good stuff and beneficial, but what often happens is that being aware of the effects of diet on the urine quality will encourage more balanced, wholesome nutrition, which in turn will improve how you feel and function - a process of biofeedback. As you continue to drink your urine, it will become progressively purer day by day.

Perhaps the most crucial observation Pragyamurti has made concerning the use of Amaroli is this: "Somebody who's HIV+ has been given to believe by much of the world that his or her bodily fluids are the most lethal thing on earth. Now, if you've been given this piece of 'information' about yourself and you can take a wine glass of your own urine and smilingly swig it down it's a most amazing transformation that takes place; a very profound spiritual healing. Then healing can take place on whatever level and towards whatever ultimate end. It's a deep self-acceptance. It gives people a lot more than good physical health. Nothing can change the point at which we all have to go, but it can do something to your spirit and how you feel about yourself."

If you're taking medication, drinking your own urine will bring about some recycling of that and you need to be careful. Dr. Lincoln Pauls, an osteopath with a lot of experience using amaroli with his clients, suggests that when taking medication you only drink a little amaroli a day; 1 or 2 fluid oz. You'll get the benefit without too much recycling going on. Pragyamurti has had students on AZT, for instance, who've done this and found themselves feeling better. They've then cut down on the AZT and eventually stopped it, meanwhile increasing the amount of amaroli they take, with very positive results.

(It may surprise you to know that when taking allopathic, i.e. conventional, medications having opposite effects to the symptoms, some of what you take, or by-products of it, will be passed out in urine. "A drug acts like a shot from a shot gun - some shot lands on target but the rest does not", explains Peter Parish, writer on the effects of medications.

The liver and kidneys are involved in processing and eliminating drugs taken into the body. In the liver they are broken down by enzymes into inactive **or** active compounds which are then excreted in urine or bile. The kidneys, while filtering the blood and removing excess substances also remove drugs and their products, which then leave the body in urine.)

There are no contra-indications for amaroli. Even when people are in the terminal stages of disease and their urine might be thick and unpleasant to taste, it's still recommended that they take it, and the outcomes have been amazing, from what I've read. A whole other area of amaroli is urine fasts. It is used in cases of very serious illness. The patient will be advised

It's a deep self-acceptance. It gives people a lot more than good physical health

to drink only their own urine and water and to rub the whole body several times a day in it, for as long as is necessary. Reversals of extreme conditions are reported to have occurred. Pragyamurti herself has limited experience in this area and feels that one should be careful about such a procedure and that one would need to do it under the supervision of someone with experience.

So where is the scientific research to show what the effects of Amaroli can be? Answer, there isn't any. And why should that be? Could it be that no-one can ever make any money to speak of from a therapy that doesn't cost anything? There are some books written about amaroli (see below) containing countless personal testimonies - doctors who've used it in leprosy and malaria hospitals in India and Africa, or for people with cancers and leukemia and all sorts of serious conditions. News of its efficiency travels by word of mouth. If you want to know if it works, try it and see, or talk to someone who is doing so. Only experience can really tell you if it's a good thing or not. And remember: it's free. So what do you have to lose?

"Hippocrates, the great priest of medicine, advised the physicians to accept the help of the laity in the treatment of disease, but his advice has seldom been followed.
Like the kingdom of heaven, the kingdom of health has to be taken by storm."

J.W. Armstrong in "The Waters of Life", 1944.

[Swami Pragyamurti runs the Satyananda Yoga Centre in Balham, London. She can be contacted there for further advice and information on amaroli and other yoga practices.
Molly Ratcliffe has been practising amaroli for nearly 2 years.]

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Useful Publications:

J.W. Armstrong: The Waters of Life; 1944, pub. Rupa, India.
Dr. Beatrice Barnett: Urine Therapy; 1992.
Miracles of Urine Therapy; 1987.
Martha Christie: Your Own Perfect Medicine; 1994, pub. Future Medicine.
Dr. Paragji D. Desai: Shirambu Cure, pub. Narbharat Sahitya Mandir.
Dr. Arthur Lincoln Pauls: Shirambu Kalpa; 1978.
R.V. Karlekar: Auto-Urine Cure.
Dr. Swami Shakardereananda: Amaroli; 1978, pub. Bihar School of Yoga Saraswati.
Koes van der Krone: The Water of Life; pub. Amethyst Books, Autumn 1995 ■

A letter from Gil Gutknecht, U.S. Congress Representative to Dr. Anthony Fauci of the National Institute of Health, dated 24th March 1995:

As a freshman Representative who sits on the Government Reform and Oversight and Science Committees of the 104th Congress, one of my concerns is the AIDS policy of the U.S. government. Twelve years, $35 billion and 270,000 deaths since the beginning of the AIDS crisis in America there is still no cure, no vaccine, and no effective treatment for the disease.

Considering the social and financial costs involved so far, I would like to request your responses to a series of questions:

1. *I am told that:*
   a) there is not a single documented case of a health care worker (without any other AIDS risk) who contracted AIDS from the over 401,749 American AIDS patients in 10 years;
   b) the partner of AIDS patient Rock Hudson, the wife and 8-year old daughter of late AIDS patient Arthur Ashe, as well as the husband of the late AIDS patient Elizabeth Glaser are HIV- and AIDS-free;
   What is the scientific proof that AIDS is contagious?
2. *Is there any study showing that HIV-positive American men or women - who are not on recreational drugs, or AZT, or received transfusions - ever got AIDS from HIV? Are there any documented cases of tertiary heterosexual AIDS transmission: AIDS transmitted to a non-risk group heterosexual who in turn transmits AIDS to another non-risk group heterosexual?*
3. *After more than ten years of intensive research and over 100,000 papers published on HIV/AIDS, is there a study that **proves** that HIV is the cause of AIDS?*
4. *How do you explain HIV-free AIDS cases (I am told there are over 4,621 on record) beyond renaming them 'ICL'*?*
5. *If infectious HIV is the cause of AIDS, why is Kaposi's Sarcoma - the signal disease of AIDS - exclusively observed in male homosexuals?*
6. *Why are there long-term survivors (12-15 years) of HIV? (Is there medical precedent for a fatal virus with such a long latency period?) Are long-term survivors generally people who do not use recreational drugs and AZT?*
7. *How does the medical community explain the fact that the median life expectancy of American haemophiliacs has increased from 11 in 1972 to 27 in 1987, although 75% were infected by HIV in the decade before 1984?*
8. *Can federal efforts ignore the theory that recreational drugs and AZT cause AIDS considering that 30% of all American AIDS patients are intravenous drug users, and that nearly all others are users of oral recreational drugs and/or AZT, ddI or ddC?*
9. *Considering that there is little scientific proof of the exact linkage of HIV and AIDS, is it ethical to prescribe AZT, a toxic chain terminator of DNA developed 30 years ago as cancer chemotherapy, to 150,000 Americans - among them pregnant women and newborn babies - as an anti-HIV drug?*
10. *Is there any scientific precedent of a virus causing an autoimmune disease? What do Kaposi's sarcoma, lymphoma, dementia, cervical cancer, and wasting disease have to do with immune deficiency? If HIV never claims more than one out of 1,000 cells every other day and the body replaces at least 30 out of 1,000 during the same period, how does HIV damage the immune system?*
11. *In how many American AIDS cases was HIV actually found? How many presumptive diagnoses of HIV have been recorded? Do HIV antibody tests cross-react with other microbes, viruses, vaccines or other natural or artificial substances?*
12. *Considering the history of the HIV=AIDS hypothesis and its inability to come up with a cure, vaccine or effective treatment for AIDS in the past ten years, how much money has been spent by government agencies on alternative-hypothesis AIDS research (ie. Duesberg, Root-Bernstein, Lo)?*

Advancement in medicine depends entirely upon experimentation, objectivity, testing all hypotheses, and most importantly, debate, in order to find the truth. Consider this initial inquiry my contribution to this important debate. I eagerly await your response to the above questions.

**ICL= Idiopathic CD4 Lymphocytopenia*

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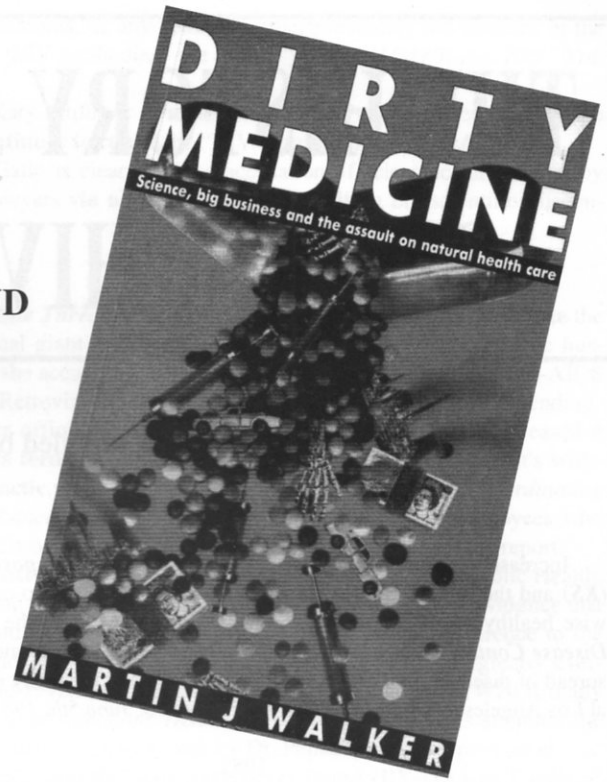


DIRTY MEDICINE: SCIENCE, BIG BUSINESS AND THE ASSAULT ON NATURAL HEALTH CARE

by Martin J. Walker, Slingshot Publications, 1994, £15, revised edition; Slingshot Publications, BM BOX 8314, London, WC1N 3XX. ISBN 0 9519646 07.

Reviewed by Alex Russell

"*Dirty Medicine* is a frightening story of the free market at war with the powerless. It exposes how, under the guise of government regulation, big business, science and medical orthodoxy defended their products and profits from competition." So concludes the back-cover-blurb of Martin J. Walker's polymorphous tome, *Dirty Medicine*.

Walker's probe into the relentless power struggles between competing medico-scientific discourses/paradigms often reads more like a detective novel where Walker takes on the role of investigative journalist turned private detective. Walker states: "...in writing *Dirty Medicine* I was most concerned to highlight the historical struggle between natural and orthodox medicine and chart the ascendancy of professional power within medicine. The power of the drug companies and medical practitioners aligned with high technology science, the desperate and disgusting scramble for profits over diseased bodies and the consistent and corrupt assault upon natural treatments, in Britain and America, are important ingredients of a contemporary story. The object of my book was from the beginning general and political: it sought to defend those whose choices were being eroded...." *Dirty Medicine* is not a book with a linear message since it deals with very divergent areas of health practice including the American origins of scientific medicine, the Bristol Cancer Help Centre, AIDS:the plague that made millions and Wellcome & AZT.

Dirty Medicine is divided into five parts; part one looks at the growth of scientific medicine and the history of health-fraud campaigns in America. Part two examines the early training and practices of some of the therapists who were 'attacked' by the health-fraud campaign in Britain.

It would take more than a whole issue of ***Continuum*** *to do justice to Walker's complex and encyclopaedic investigations*

Part three looks at the British science lobby and its relationship to industry. Part four traces the historical conflict between orthodox and complementary medicine in Britain - included in this section is an analysis of the Wellcome Foundation & Trust emphasising the licensing, manufacture and sale of AZT. Part five picks up on the stories of those practitioners whose work was discussed in Part two.

It would take more than a whole issue of **Continuum** to fully critique *Dirty Medicine* and do justice to Walker's complex and encyclopeadic investigations so this review will focus on journalist Duncan Campbell's attacks on critics of the HIV hypothesis.

Since the first printing of *Dirty Medicine* in 1993, its distribution had faced considerable opposition - almost exclusively coming from Campbell who threatened anyone who distributed or wrote about the book with libel actions. Campbell, a well-known advocate of AZT and the HIV/AIDS hypothesis campaigned to marginalise those that critiqued both 'anti-viral' therapy and the HIV/AIDS hypothesis: such as Jad Adams, writer of *The HIV Myth*, Cass Mann of Positively Healthy and Prof. Peter Duesberg, HIV-sceptic - all who appear in Walker's book.

A chapter on 'Jad Adams and The HIV Myth' focuses upon the dead lock-impasse that exists between the so-called AIDS establishment and a counter-AIDS establishment (often crudely nominated as 'dissidents' or 'heretics'). In 1989, Jad Adams launched his book, *AIDS - The HIV Myth* at a meeting at the London School of Economics with Campbell among others. Adams suggested a debate with Campbell yet what resulted "was a hectoring harangue, for the most part personal rather than scientific or academic". Critical open dialogue is impossible when competing language games are used as totalising truth claims, or as 'beliefs' (as the HIV/AIDS hypothesis has become for some). It is paradoxical that someone with Campbell's investigative rigour should take such a naïve and uncritical view of the HIV/AIDS hypothesis and AZT. Campbell told the audience that if you have AIDS you must have HIV and if you have HIV you must have AIDS and if you do not have HIV you will not get AIDS; i.e. that HIV led inexorably to AIDS and that AZT was their only salvation. At this 'debate' Campbell also expressed seething contempt for Cass Mann and Peter Duesberg. Walker argues that Campbell believed in a conspiracy of 'dissidents', 'charlatans' and 'quacks' who were exploiting AIDS patients: this is as simplistic as stating that there is a conspiracy by the pharmaceutical giants to poison patients.

This leads me to my only criticism of Walker's polemic. While I believe he is right to deconstruct the myth of the neutral scientist which arises out of the long-discredited Baconian view of the scientist as a disinterested seeker of truth cleansed of prejudices, preconceptions and private interests, his own leaning towards conspiracy theory as 'acceptable post-modern ways of recounting late twentieth century history' is too simplistic. Paradoxically, in writing this book, Walker rightly demolishes Campbell's own use of fantasy-conspiracy-theory. We are all imbricated within power; we cannot reduce everything to the binary logic of 'them' and 'us', 'perpetrators' and 'victims', 'establishment' and 'heretics'. Power relations are more complex, intersubjective, nebulous and subtle.

Walker's book concludes with an excellent list of health care, self-help, campaign and pressure groups in the UK and Europe. It is time *Dirty Medicine* was debated, not censored.

About the author*: Martin Walker, a socialist investigative journalist, chaired the AZT ON TRIAL Conference held in London in June 1993, whose speakers included Peter Duesberg, John Lauritsen and Celia Farber. After finishing his book,* Dirty Medicine, *(the first book published in the UK to critique Wellcome's chemotherapy drug AZT) Walker initiated and chaired the Standing Committee Against AZT Malpractice (SCAM) - the AZT protest group that challenged the legality, ethicacy and toxicity of the drug.* ■

THE HISTORY AND CONSEQUENCES OF THE "HIV/AIDS"-HYPOTHESIS

Compiled by Michael Urs Baumgartner

1981

Increased clinical frequency of the skin neoplasm ***Kaposi's Sarcoma (KS)*** and the pneumonia ***Pneumocystis Carinii (PCP)*** in so called "otherwise healthy" male homosexuals in the USA reported to the ***Centers for Disease Control (CDC)***, a U.S. government health authority monitoring the spread of diseases, by Dr. Michael Gottlieb, of the University of California at Los Angeles (UCLA) *(MMWR No. 21/Vol. 30, June 5th, 1981).*

1982

The CDC announces this new phenomenon as ***Acquired Immune Deficiency Syndrome ("AIDS")*** *(MMWR No 37/Vol 31, September 24th, 1982)* despite the fact that ***KS*** is **not** due to an "immune deficiency" a.k.a. low T-cell count.

1983

(1) ***Dr. Luc Montagnier*** microbiologist et al. at the Pasteur Institute, Paris "isolate", from the lymphnode of a male homosexual **without** AIDS, "retrovirus particles" he terms ***Lymphodenopathy Associated Virus (LAV)*** which later will be called "Human Immuno-deficiency Virus" ("HIV") *(Science, Vol. 220, May 20th, 1983)*

(2) ***Dr. Robert Gallo***, cancer researcher at the National Cancer institute (NCI) in Bethesda, USA, **revises** a paper written by **Dr. Montagnier** and **adds** in the introduction the suggestion that **"LAV"** is associated with the so-called ***Human T-cell Leukemia Virus*** family ***("HTLVs")*** *(Science, Vol. 220, May 20th, 1983)* - a type of virus he claimed credit for in the beginning of the 80's despite its having been first "identified" in Japan in the mid 70's *(John Crewdson, Chicago Tribune, November 19, 1989).* Gallo proposed ***"HTLV I"*** caused T-cell Leukemia, a rare form of cancer in adults, by infecting the T-cells (a type of immune cell which fights disease in the body), causing them to multiply uncontrollably. In AIDS-patients ***"HTLV III"*** is **claimed to do quite the opposite**, to destroy these very T-cells. **Both hypotheses have since been proven wrong**. Morphologically "HTLV I" and "II" are so different from "HTLV III" that they can hardly be considered the same family to begin with. The French make therefore a clear distinction between their virus "LAV" and the "HTLVs" *(Steve Connor, New Scientist, February 12th, 1987).*

(3) Dr. Gallo receives ***"LAV"-sample*** from Dr. Montagnier with **patent right** claim for future **test kits** based on "LAV". Dr. Gallo states his lab is **unable** to grow "LAV". *(Steve Connor, New Scientist, 12th February 1987)*

1984

(1) Dr. Robert Gallo et al. continue to claim **"HTLV III"** causes AIDS by killing T-cells. At the same time **he takes patent** on the mass-production of "HTLV III" in **immortal** T-cell lines (the same kind of cells that he claims simultaneously, are **killed** by "HTLV III/HIV") *(Science, Vol. 224, May 4th, 1984).*

(2) Dr. Gallo publishes **"pictures"** of **"his"** "HTLV III" which **turn out to be** pictures of the French "LAV" which later will be called "HIV". *(Science, Vol. 224, May 4th, 1984/ Steve Connor, New Scientist, February 12th, 1987).*

(3) ***"HTLV III infection"*** is declared the **"probable cause of AIDS"** by Dr. Gallo at a press conference called by Dr. Margret Heckler, Secretary of Health and Human Services under the Reagan administration, despite there not being any scientific paper published to back up such a claim, nor any scientific debate prior to the statement. The fact that ***"HTLV III-antibody presence"*** was detected **at best** only in 85 % of "AIDS-patients" was not mentioned *(L.K. Altman, New York Times, 24th April 1984).*

(4) The ***National Institute of Health (NIH)*** on behalf of the US government **takes worldwide patent** for the "HTLV III antibody test", known as the "AIDS-test", with Dr. Gallo getting shares *(Steve Connor, New Scientist, 12th February 1987).*

1985

DNA analysis **proves** Montagnier's **"LAV"** and Gallo's **"HTLV III"** to be **identical**. One of Dr. Gallo's samples has been **"contaminated"** with "LAV" accidentally or deliberately, as also happened in the case of the "Human Leukemia Virus 23" ("HL23"), which Dr. Gallo also claimed credit for in 1975, but which turned out to be a cocktail of two monkey viruses *(Steve Connor, New Scientist 12th February 1987).*

1986

(1) The International Committee for the Taxonomy of Viruses names the disputed "virus" ***Human Immuno-Deficiency Virus*** **("HIV")** *(Coffin et al. Science, Vol. 232, May 9th, 1986).*

(2) The ***French Government*** brings a **patent infringement** case against the ***U.S. Government***, claiming that Dr. Montagnier is the discoverer of "HIV" and **not** Dr. Gallo. Dr. Gallo testifies he did **not** believe the French "LAV" was the cause of "AIDS" **before** he applied for his own "HTLV III" **antibody-test-kit patent**.

(3) The American ***Phase II Study*** starts, to prove the therapeutic **antiviral** effect of the toxic early-60's **anti-cancer** drug ***AZT*** in people with "AIDS" - and is prematurely terminated because it's claimed to "prolong life" and "improve quality of life" and must thus be available. This study is considered fraudulent by several scientists *(John Lauritsen, The AZT Story: Poison by Prescription; Asklepios, New York, 1990).*

1987

Dr. Peter H. Duesberg, molecular biologist at the University of California in Berkeley, **questions** the destruction of T-cells by "HIV" in humans (*in vivo*) and states **"no direct killing"** of CD4-cells (T-cells) *(Cancer Research, Vol. 47, 1987).*

1988

(1) Dr. Gallo **retracts** his hypothesis about "direct killing" of CD4-cells by "HIV" but continues to support his **unproven theory** that "HIV" **causes** "AIDS". He now suggests "indirect mechanisms" triggered by "HIV" as being responsible for the decline of CD4-T-cells *(Journal of Acquired Immune Deficiency Syndromes, No. 6/Vol. 1, 1988).*

(2) The ***Concorde Trial***, a large Anglo-French study, starts in co-operation with the manufacturer of AZT, ***Wellcome***, to test the **prophylactic effect** of AZT as an **"antiviral"** on "HIV-antibody" positive individuals who have **no** "AIDS-symptoms". Up till now AZT was given to people **"at risk"** from "AIDS" in the western world.

1989

The US-recruit study terminates. From October 15, 1985 to March 31, 1989 1,141,164 US-recruits under the age of 20 were monitored for "HIV-

antibodies". Only 393 tested "positive" over a period of 3 ½ years, that is **less than 0.035%** *(JAMA, No. 15/Vol. 263, April 18, 1990).*

1990

Dr. Montagnier presents his findings that "HIV" itself does not kill T-cells at a press-conference in San Francisco.

By **1991**, ten years after the "new syndrome" was "identified", the "HIV/AIDS" connection is ever more tenuous and questionable. Since there was never an isolation of what is called "HIV", there is no proof of a "new retrovirus". All there seems to be are antibodies that, perversely and uniquely for medical history, are now an indicator of an early death due to about 29 old diseases under a new umbrella term, not to dwell on toxic treatment with an old drug and an increasing number of new ones.

The hypothesis of direct cell destruction by "HIV" has been disproven, yet other hypotheses are and will be created with little reasonable foundation. By now there is strong evidence that "HIV" is an unexceptional "viral particle" like all so-called retroviruses and no danger to the human cell.

Despite the establishment's blindness the number of "HIV/AIDS"-critics is growing fast. Towards the end of the eighties there is an increasing number of agencies and publications in the USA, England, Germany, Switzerland etc. addressing facts on "AIDS" rather than promoting the false and deadly "HIV=AIDS=death" hypothesis.

1992

(1) ***Dr. Kary Mullis***, an American biochemist and inventor of the ***Polymerase Chain Reaction (PCR)***, to date the most precise way of testing for viral DNA, states "PCR has made it easier to see HIV. But human beings are full of retroviruses, and neither HIV nor any other retrovirus by itself poses any kind of threat, which is not to say that there is no such thing as AIDS - only that HIV does not cause it" *(Newsweek, August 1992).*

(2) ***The Committee of Research Integrity***, a scientific body of the National Institute of Health, declares Dr. Gallo **guilty** of scientific misconduct on different occasions relating to the "establishing" of the "AIDS-virus" *(John Crewdson, Chicago Tribune, November 19, 1989).*

(3) Senior scientists and physicians from around the world, forming the publishing group ***"Reappraising AIDS"*** propose professional re-evaluation of the "HIV=AIDS-Death"-hypothesis.

1993

(1) Evidence that the **majority** of people in the "Western world" diagnosed "HIV-antibody" positive are **not** getting AIDS, fifteen years after the assumed introduction of this "retrovirus". US numbers by mid-1994 claim more that one million "HIV-positive" individuals with around 350,000 "AIDS-cases"; European figures reveal 0.5 million "HIV-positive" with between 50,000 and 100,000 "AIDS-cases" including the dead *(WER, WHO report No. 27, 1993).*

(2) The first intervention *An urgent appeal for action: On the effect of the unproven "HIV=AIDS"-hypothesis and its effect on human lives* is made by ***People's International Health Project*** in conjunction with ***International Educational Development*** at the ***United Nations*** in Geneva, Switzerland *(Press Release HR 3358, Children's Issues, Agenda Item 24 and HR 3360, Science and Technology, Agenda Item 14).*

(3) The termination of the Concorde Trial of AZT shows **no observation** of the hypothesised prophylactic effect, but a **higher mortality** in the AZT-group than the placebo-group. Still, the manufacturer Wellcome publicly reaffirms the drug's efficacy citing a previously discredited Australian study and several Scandinavian studies which were too small to be significant *(Lancet, Vol. 341, April 3rd, 1993).*

(4) ***Dr. Eleni Papadopulos-Eleopulos***, medical physicist from the Royal Perth Hospital, Australia, et al. demonstrate the **inaccuracy of all "HIV-tests"** - ELISA, Western Blot antibody tests and PCR viral detection. Their research shows that other conditions unrelated to "HIV", such as TB, malaria, leprosy, vaccination against Hepatitis B, even the common 'flu, or a 'flu vaccination can trigger a positive "HIV-antibody" test result *(Biotechnology Vol. 11, June 1993).*

(5) There are 4,621 **documented** "AIDS cases" clinically diagnosed - meaning from a "risk group" and with an "AIDS-disease" - **without** any indication of "HIV", at least 1,500 of them in the USA *(BioTechnology Vol. 11, August 1992).*

(6) The CDC again **adds** more elements to the "AIDS definition". Now 200 T-cells per micro-litre of blood or less, cervical cancer, recurring bacterial pneumonia, or any of the 25 other previously old diseases in the presence of "HIV-antibodies" are called "AIDS" *(MMWR No. RR17/Vol. 41, 1993).*

(7) Dr. Kary Mullis is **awarded the Nobel Prize** for chemistry for the PCR and **continues to refute** the "HIV" causation theory of AIDS.

(8) Dr. Gallo is cleared of the accusation of scientific misconduct by a panel of lawyers **via alteration of the definition** of "scientific misconduct".

1994

(1) ***Mrs Sue Threakell*** accesses ***Legal aid*** in England to **prosecute** the pharmaceutical giant Wellcome over the death of her haemophiliac husband, which she accuses was caused by Wellcome's best selling "anti-AIDS drug" AZT (Retrovir) and not by his "HIV-condition". The case is pending.

(2) Fuller official data from the Concorde Trial is finally released **a year after its termination** and confirms the initial findings that it's **without prophylactic value** and **increases mortality** *(Concorde Co-ordinating Committee, Lancet, vol 343, April 9th, 1994).* Wellcome employees who were on the Co-ordinating Committee are told not to endorse the report.

(3) ***Dr. Max Essex***, of the Harvard University School of Public Health, et al., a leading originator of the "HIV=AIDS" theory publish **evidence** that **"HIV-antibody" testing is non-specific**, with particular reference to the purported epidemic in Africa, where the numbers have been greatly overestimated and revised by the World Health Organisation (WHO) many times *(Journal of Infectious Diseases Vol. 169, 1994).* This supports the published yet widely ignored work by Dr. Papadopulos-Eleopulos et al.

(4) Dr. Gallo **admits "...we have never found HIV-DNA in T-cells..."** at a meeting sponsored by the National Institute on Drug Abuse, May 23/24, in Washington DC *(Lauritsen, New York Native, June 13, 1994).*

(5) Finally Dr. Montagnier gets **sole credit** for the discovery of "HIV" *(Newsweek, July 1994).*

(6) A study carried out at the ***Royal Free Hospital, London*** claims that 25% of "HIV infected" haemophiliacs will **remain** "AIDS free" over a period of 20 years and 15% will remain "AIDS free" over a period of 25 years *(British Medical Journal, Vol. 309, 1994).*

(7) The Inspector General's office of the US Department of Health and Human Services reports "...there was **no evidence** to support Dr. Gallo's claim of having independently discovered the virus or created the AIDS-test...". "The claim that HTLV 3B (Gallo's HIV infected T-cell line) was contaminated by LAV comes into question since there appears to be **no evidence** there ever was a 3B to be contaminated" *(Ostrom, New York Native, Vol. 585, July 94).*

(8) ***Dr. Stefan Lanka***, molecular biologist at the University of Konstanz, Germany, states that the existence of what has been called "HIV" has **not** been proven. **There has not been an isolated entity which may be called "HIV"**, only cellular proteins, among them an enzyme named Reverse Transcriptase (RT). It had been claimed RT was specific to so-called "retroviruses", but as early as 1983/4 the enzyme could be detected in all living cells. Lanka claims what has been shown at the genetic level, instead of "HIV", is human endogenous (i.e. from within the cell) genetic material out of the pool of the as yet 90% undecoded so-called repetitive elements of the chromosomes present in everybody.

This stresses the **worthlessness** of the "AIDS-tests" and indicates these tests may only point out contact by one individual with human proteins from others, most likely from white blood cells, because the "HIV-antibody test" is only made out of proteins from (patent) white leukemic blood cells produced in the lab: if someone has immunological contact with foreign human proteins and then produces antibodies, these are read as "HIV-antibodies" *(Fehldiagnose AIDS, Wechselwirkung, Dec. 94).*

1995

(1) Dr. Eleopulos et al. publish evidence that there is **little or no** likelihood of "HIV" being in *Factor VIII* (missing clotting factor prescribed to haemophiliacs) and in the unlikely event of few particles surviving the Factor VIII manufacturing process they could not possibly be viable infectious particles *(Genetica, 1995:51 - 70).*

(2) Prof. Duesberg publishes evidence that the immune suppression found in haemophiliacs is **directly increased** by the contamination proteins found in clotting factors, which constitute 99% of the product. **The immunosuppression is directly age and dosage related** *(Genetica, 1995: 51 - 70).*

(3) After Holland, Switzerland, England, Spain and Italy the next

AIDS-Dissident Conference was held in Argentina.

(4) The first AIDS-dissident feature movie is in progress in London, England.

(5) The UN-action *An urgent appeal for action* continues in Geneva, Switzerland by *International Educational Development*.

At the tenth International AIDS Conference in Yokohama, Japan scientists now **claim** AIDS to be an "autoimmune disease" - the immune system turning against its own organism - yet another new hypothesis with little scientific back up. It is commonly known that most known autoimmune diseases are due to toxins rather than viruses.

Meanwhile the prescription of AZT and other so called "antiviral therapies" equally dangerous, continues to around 200,000 both asymptomatic "HIV-antibody" positive individuals and people with "AIDS" in the "western world", despite its **1000 times higher toxicity than initially claimed**. A **deadly treatment** that actually **mimics** the disease *(Project A.I.D.S. International, Public Information Dossier, March 15th, 1993)*. Soon AZT under another brandname will be available in the so called "third world".

Today it is in trend to give "cocktails" of labelled "anti-HIV-drugs". The treatment gets as diffuse as the diagnosis and deadly. **Healthy** individuals get treated with **highly toxic** substances based on a T-cell count of 200 or less despite the fact that these counts are not reliable markers for disease or early death *(J.P. Aboukler et al., Lancet, April 1993/Celia Farber, SPIN magazine, spring 1994)*. The so-called "side-effects" of those drugs (DNA-chain terminators), some 50 in number, include the wasting, nausea, immune suppression, anaemia, disability and death common to medically perceived "AIDS".

After **tens of billions** of US dollars and ten years of "HIV" research and the claimed "world AIDS epidemic", there are **still people dying** of an erratic hypothesis summarised as "Acquired Immuno-deficiency Syndrome", despite the fact that 40% of the "AIDS-diseases" are **not** due to "immunodeficiency", including KS, one of the two initial "AIDS-defining" diseases *(Serge Lang, HIV/AIDS: have we been misled?, Yale Scientist, Fall 1994)*.

How much do we really know about "AIDS"? Studies and many experienced AIDS-professionals state **intoxication** through combinations of factors such as intravenous and/or oral and/or nasal recreational drugs like heroin and/or cocaine and/or ecstacy and/or crack and/or poppers and/or MDA etc. often in combination with alcohol, and/or medical drugs like AZT and/or ddI and/or D4T etc., and/or prophylactic and/or excessive use of Septrin and/or antibiotics, etc., and/or extended malnourishment and/or poor hygiene and/or excessive foreign proteins and/or misdiagnosis along with coercion and statistical zeal, cause what we call "AIDS".

The scenario closely mimics the 1970's Japanese SMON health scandal where the anti-diarrhoea drug *Clioquinol* (brandnames *Entero-Vioform* and *Mexaform*) manufactured by Ciba-Geigy, and not the hypothesised *"Inoui Virus"*, caused thousands of human deaths *(Channel 4 publication: Drug injury and what to do about it; The story of SMON, by Joan Shenton)*.

The consequences of ignoring these aspects of history are massive with catastrophic dimensions for individual human life and the reputation of medical science and practice.

With credits to People's International Health Project, Los Angeles; Meditel, London; Prof. Peter Duesberg, Berkeley; Huw Christie, London; Dr. Heinrich Kremer and Dr. Stefan Lanka, Germany. ■

A visit to Berlin, before and after

Professor **Peter Duesberg** encounters mixed blessings on a recent European visit

by Dr. Volker Gildemeister

My once strong interest in AIDS had by December 1994 all but evaporated. I had realised over the years that there was only slender reason to believe (and certainly no proof), that HIV was the cause of AIDS. What is described as "overwhelming evidence" is just a very large number of publications examining the question of **how** HIV causes AIDS (on the assumption that it does), bolstered by a consensus amongst professionals in the field saying that it does. Furthermore, AIDS was not the one-off "derailment" of due process in medicine, as I had once heard it described - it was the norm. What is more, I felt I understood how these habitual cock-ups occurred. They stemmed directly from the habit of "medics" of picking on a convenient correlation, and declaring it to be the causation, when nothing could be further from the truth. A correlation could never decide between the chicken and the egg, and as a rule, they got it wrong.

Despite the best efforts of Duesberg and a few others over the years, nothing appeared to shake the **faith** of those who believed in HIV's role, even though many a believer must have asked himself before now how come nothing worth having ever came of it all.

My attitude of resignation, even contempt for those who "believed" in HIV, was changed overnight with Stefan Lanka's paper showing that HIV didn't even exist - that it didn't do anything had been clear for ages. The great value of Lanka's paper was that it explained a number of technical

At a stroke, some minor oddities in the HIV "heresy" fell into place

matters in virology, which by their nature, all non-virologists have to take on trust, namely, not only why the ELISA and WB tests could not work in the way one had been led to believe they did (antibodies to what protein?), but also a number of other virological procedures which, at best, amounted to convoluted illogicalities (what did Gallo prepare; hybridisation), at worst, a barely forgivable lack of oversight by experts of their subject (role of reverse transcriptase; applicability of PCR).

That nothing in the official HIV/AIDS story was credible, riddled as it was with internal contradictions and permanently inexplicable phenomena, was a given, but that a good deal of virology, in particular its implications in antibody function and testing, and T-cell counting, flew on little more than a wing and a prayer, was shattering.

At a stroke, some minor oddities in the HIV "heresy" fell into place. If HIV did not exist, then self-evidently there could be no antibodies to it, nor could it be transmitted, not even "with difficulty", as both sides agreed was the case. So, what would Duesberg think about all this? First considerations were: well, he'd be somewhat embarrassed, since it would invalidate much of his pre-AIDS work on retroviruses, and render a good deal of his subsequent analysis of AIDS incidence and antibody studies pointless. But why wonder what he **would** think, why had he not been thinking already? The substance of Lanka's bombshell had been in the public domain since 1993 in the form of Eleni Papadopulos-Eleopulos's *BioTechnology* paper, which, so rumour had it, he had even refereed.

So off it would have to be, to sit down with him round a table, where there would be plenty of time and paper napkins to draw things on. That opportunity would arise in the Moncef Restaurant, in the Budapester Strasse, when Duesberg came to lecture in Berlin on 15th May.

The moment finally arrived. "Well", he said, "it would be funny if it were true, and I am not necessarily saying it isn't, but four independent, competing groups would hardly come up with the same sequence for a virus that didn't exist." Damn, I thought, trust a clever sod like him immediately to pick on the one aspect of all this AIDS-ology I have always wanted to swat up on.

I thought I couldn't trust my ears: here was the excruciatingly precise Peter Duesberg doing what his opponents always loved best - not answering the question. He once flared up in exasperation on being asked something that would have required detailed knowledge of Kimberley Bergalis's sex-life: "you will be asking me next to explain the sacrament of the Immaculate Conception."

Question: what did sequence analysis have to do with proof of existence of the virus? Did the four groups really agree? If they all fell victim to the same initial error, they might very well all agree; Lanka had explained how that came about with the hoary business of "hybridisation", but no matter, let's see what a greater brain would come up with.

"What does it matter whether it exists or not, it doesn't do anything anyway", he continued. Later on he shaded this a little to "Of course, the more the others claim for their little darling, the more they will be hoist by their own petard", but all in all a rather disappointing performance by Peter the Great.

It became clear that he had not thought about this matter much, if at all, even though he had been "on notice" over the last few months by the odd remark on the telephone. He had not properly read and/or understood Eleni's paper, and there he was in bad company, for nor, until recently, had I. Strange that, from one Prussian regarding the Greek heroine from Down Under, who in print could easily pass for a Prussian herself.

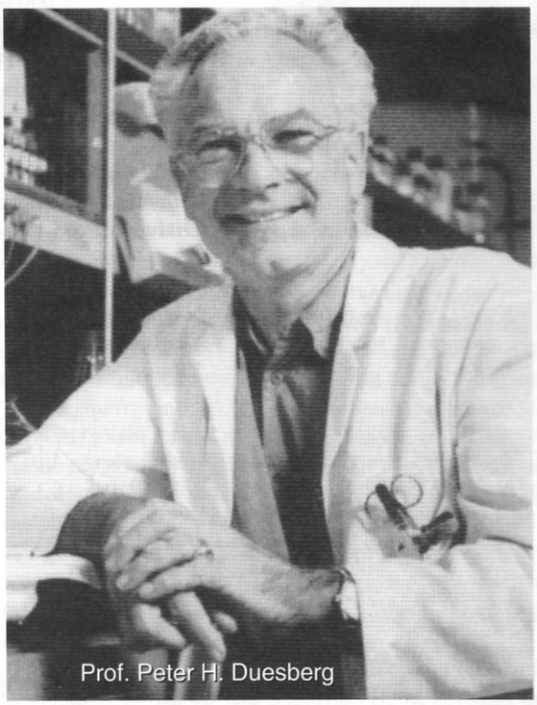
Conclusion: we may be entering a post-Duesbergian world, unless he puts his thinking cap on. Surely he realises that it knocks out the other side's case completely, stuck as they are with only one thing: "what about the poor blood and blood products recipients? Studies have shown that...." yawn, yawn, yawn. Don'tcha just get sick of it: how were the data authenticated, what factors were controlled for? Did they move points on a graph around a bit to make it look better, or were they honest? Who'd know or care much if they weren't? *(see: Science, December 9, 1994: "The Duesberg Phenomenon").*

The Lecture

The omens were not good as a single carload of dissidents pulled up at the university in Dahlem where Berlin's famous Free University campus sprawls. What ugly run down concrete boxes from a bygone era, I thought, as we picked our way along weed-cracked footpaths towards our goal, Lecture Hall 2. We had already been told that no publicity for the lecture had been carried by any local newspaper despite the best efforts of the organiser, Peter Schmidt. So that left just word of mouth and some torn down posters to announce the event. Perhaps all it would attract would be two carloads and a stretch limo for the famous "fatties" (Kawi Schneider and Peter Schmidt) of Berlin cable TV who had made Berlin something of

a thorn in the side of Germany's $1 million a year AIDS doctors, in an otherwise compliant country (yep, that's how much one of those gets for wondering whether AZT plus a bit of ddI, before, later or with a cup of tea, is better or not than something else that couldn't conceivably work anyway). No Joan Shenton or Neville Hodgkinson there, to disseminate their "criminally irresponsible" views into millions of homes.

Inside the building proper, we find just a few people assembled, but we can't be sure whether they are prospective participants or remnants from some other function, and in any case, they hardly outnumbered a group of 10 or so young men with rifles who look like the university army cadet corps on a bad day. They turn out to be Berlin policemen. Berlin students have a long tradition of trouble making. They were at it long before it became fashionable elsewhere in 1968. At the centre of a little group I stumble on Duesberg being harangued by a young gay activist. Someone was berating Peter about a "study" showing XYZ. God, how I hate that word now. Prior to AIDS I had always thought of it as a noble word; nowadays, it so often seems to be shorthand for a collection of statistics, compiled by doctors bored with looking after average people, preferring instead to delve into the sex-life and problems of others, and doling out experimental drugs.


Prof. Peter H. Duesberg

Since Peter was, as usual, one against the rest, I decided to relieve the pressure on him by joining the fray. After a while, Peter and most of the others had slipped away into a locked adjacent lecture hall, it seemed. Only two young women and a smirking youth were guarding the entrance. They disapproved of a crackpot like Duesberg being allowed to trot out his irresponsible nonsense. They were nurses, and really knew what it was really like to have AIDS. They also disapproved of the shameless profiteering by the organiser for charging an entrance fee - what a nerve. That he had to pay for Duesberg's flight and other expenses for staging the lecture did not concern them.

Finally, I find an open door on an upper floor and am amazed. A large, tiered lecture hall, chock-a-block full, with Peter hardly visible, wedged in a corner in front of a lectern. Where did the 600 people all suddenly come from? Quite a boisterous gathering even at this stage, mostly, but not all, students, somewhat intimidating, but not overly so. Peter Schmidt ambles to the microphone and gives off rather too many platitudes for comfort. Good acoustics, I noted. Then it's the turn of the great man himself. An expectant hush quickly settles over the hall, when from right at the back, high up, a group of punk-types start bellowing slogans to the accompaniment of a ghetto-blaster, or so it looks from my vantage point. Peter smiles and steps back for the hubbub to die down. It takes ages. This will be fun, I thought, I have never been to a happening before. A semblance of silence again, Peter resumes, a new outburst of longer duration, members of the audience start protesting and counter-haranguing; talk of academic freedom, disgraceful. In the end Schmidt must have threatened to stomp up to the protesters and sit on them; anyway, they settle down and Duesberg gets going. The atmosphere remains rather tense with a steady stream of interjections, often disapproving of the rather curt replies that Peter tended to dole out.

After one such incident, the microphones seem to go haywire, horrible feedback pierces the eardrums. From where I sit it looks as if one of the microphones has come into alignment with the loudspeakers. Schmidt heaves himself up and endless fiddling ensues, Duesberg resumes, more squealing, more fiddling. As I **think** I can see what the trouble is, I walk down to him to disentangle him from his neck-microphone. But others had already noticed there was something else afoot. The original protesters, having slipped away, had occupied the PA control room and turfed out the technician. Now they were having fun fiddling with the volume controls, to good effect. It seems like the end. The audience had grown very restless, and I ask Peter if he wants to take some fresh air outside, because it had by now become really rather hot and sticky. He thinks it not a good idea, it might make people think he's chickening out.

The matter is finally resolved. The army cadets, a.k.a. the police, had evicted the occupiers, and the lecture resumes, and is allowed to finish with only minor interruptions. The applause is interminable, more reminiscent of ovations Mrs Thatcher used to get after addressing the party faithful than for someone right-thinking people loved to hate. I was surprised, he appeared to have turned the audience, or else they were applauding his guts for sticking to his guns. As the infamous Verney-Elliott opined, "they came to jeer, and left to cheer".

The one-hour lecture took more like 2 ½ hours, and the whole show lasted nearly four. At the end of the lecture Peter found himself imprisoned in a thick cordon of supplicants, for what seemed like an eternity.

I still think Peter needs a strategy. It might have seemed a good idea 2 - 3 years ago to enlist the help of gays in overturning the orthodoxy, but it hasn't worked, has it? How about becoming a full-time politician or else returning to the quiet world of academe, and a bit more sequencing? Or better still, embracing the HIV non-existence theory properly, and completely knocking the ground from under the other side with their endless, pointless antibody studies. What's so great about being the king of retroviruses, when none of them do anything? Is the chair of Tibetan prayer wheels at Harvard more appealing? I hazard a guess that there won't be much mileage in "poppers" on nude mice at UCLA Irvine.

There are really weighty issues still to be addressed by a scientist of his calibre: what really influences immune competence? What about the psychological effects of the HIV death sentence for starters? Don't people really get herpes outbreaks when under stress, or in sunlight? Don't they get shingles likewise? Aren't colds and flus more common in winter? **How** do improvements in nutrition, hygiene and sanitation bolster the immune system? Are Koch's Postulates really all that Peter cracks them up to be, when Koch was sometimes rather economical with the truth? (And as for Pasteur, little better than Gallo at fiddling his results, one now discovers more than a century later.)

"AIDS research turned upside down" (*Nature, 26 September 1991*). Did Peter not notice or read this hagiography? Did he not think there was something "funny" about:

(i) mice developing antibodies to proteins characteristic of "HIV" (i.e. gpl20 and p24), when exposed to T-lymphocytes from another mouse that had never been anywhere near HIV?

(ii) 3 out of 4 macaques developing antibodies to SIV in T-cell carriers, but so did 2 out of 4 controls without "SIV", i.e. just antibodies to the T-cells? [Just fancy that, exclaimed Mrs Huggett, another cup of tea, dear? Now I come to think about it, shouldn't all 8 have developed antibodies to what we now know were the T-cells, not SIV at all?]

No doubt a Jesuit could conjure up other explanations, but common sense says:

(i) the identification of gpl20 and p24 seems to be something of a hit and miss affair, to put it kindly. These results were published in *PNAS* and *NATURE,* not a pop magazine or samizdat!

(ii) they cannot tell the difference between antibodies to the lowest form of life, SIV, and a **human** T-cell;

(iii) the quantification of antibody titres must be somewhat dodgy, if infected cells produce 10 times as much as the uninfected cells;

(iv) why do the SIV need human T-cell carriers, anyway?

Why did Peter not smell a rat four years ago, and roll his sleeves up to look into this antibody mess, instead of trying always to answer his critics using such unreliable data? Knowing now that HIV does not even exist, there is less reason than ever to shilly-shally around.

It is not as if everybody, and most of all me, isn't, or shouldn't be, deeply grateful to him for having unswervingly and at huge personal cost, resisted almost single-handed the official dogma. It has been very helpful to consider that most AIDS is caused by drug abuse, and that AZT is absolute madness. But that's it. The whys and wherefores of drug taking are (presumably, but who knows) beyond even his expertise, and for others to work out. There are genuine problems in the here and now for the abilities of Peter Duesberg to get stuck into. ■

The debate goes on

Two now famous papers by Ho and Wei published on 12th January 1995 in NATURE on the dynamics of "HIV infection" *in vivo* have convinced the AIDS establishment that a constant titanic struggle between HIV replication and the human immune system continues throughout the period of an individual's "infection".

Professor Peter Duesberg and Dr. Harvey Bialy have addressed this extraordinary theory in the following letter published in NATURE 18th May 1995:

Sir, In an editorial in the 19th January issue of NATURE, John Maddox invited "Duesberg and his associates" to comment on the "HIV-I dynamics" papers published the previous week, indicating that these new results should prove an embarrassment to us. Although we do not think that a scientist should be embarrassed for pointing out inconsistences and paradoxes in a hypothesis that have only been reportedly resolved ten years later, we nonetheless prepared a fully referenced, approximately 2,000 word critique of the Ho et al. and Wei et al. papers that we believed met the criteria of "not being longer than it needs to be, and pertaining to the papers at hand" that Maddox set out in his widely read challenge.
Unfortunately, he did not share our view and agreed to publish only a radically shortened version, and only after he had personally "gone over it with a fine-tooth comb" to remove our perceived misrepresentations of the issues. We found these new conditions so totally at variance with the spirit of free and fair scientific debate that we could not agree to them.
Readers of NATURE who are interested in these questions, and feel that they do not need to be protected by Maddox from our ill-conceived logic, can find the complete text of our commentary in the monograph supplement to the most recent issue of GENETICA. Here we would point out only that the central claim of the Ho et al. and Wei et al. papers - that 10^5 HIV virions per ml plasma can be detected in AIDS patients with various nucleic-acid amplification assays - is misleading. The senior author of the Wei et al. paper has previously claimed that the PCR method they used overestimates by at least 60,000 times the real titre of infectious HIV: 100,000 divided by 60,000 is 1.7 infectious HIVs per ml, hardly the "virological mayhem" alluded to by Wain-Hobson. Further, Ho and a different group of collaborators have just shown that more than 10,000 "plasma virions", detected by the branched DNA amplification assay used in their NATURE paper, correspond to less than 1 (!) infectious virus per ml. And infectious units, after all, are the clinically relevant criteria for a viral pathogen.
Finally, in view of Wain-Hobson's statement that the "concordance of their (Wei and Ho's) data is remarkable" note that Loveday et al. report the use of a PCR-based assay and find only 200 HIV "virion RNAs" per ml of serum of AIDS patients - 1,000 times less than Ho and Wei. So much for the "remarkable concordance".

Peter Duesberg, Dept. of Molecular and Cellular Biology, University of California, Berkeley.
Harvey Bialy, BioTechnology, New York.

References available on request.

In the beginning the CDC said...

You can perhaps understand why the Centers for Disease Control (CDC - the US agency in charge of AIDS) did not accompany by a fanfare the release of the following fact sheet when you apply its import to the preparation of Factor VIII for Haemophiliacs. Even so you might wonder why free channels of information barely trickle with the implications of this news.

Thus, without further overture, the CDC in 1994: **"In order to obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus...the amount of virus studied is not found in human species or anyplace else in nature...it does not spread or maintain infectiousness outside its host. Although these unnatural concentrations of HIV can be kept alive under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the number of infectious viruses by 90 to 99% within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other body specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to that which has been observed - essentially zero."**

Factor VIII has been supplied as a freeze-dried powder since the '70s. Therefore, as the CDC information confirms, there could be no HIV in Factor VIII, so it could not be HIV causing their immune suppression. Around half of all haemophiliacs in the USA are "HIV-antibody" positive or have a classical AIDS diagnosis. Will the CDC repeal the antibody and PCR tests from hell and get real about the multifactorial influences on human susceptibility to disease?

interview

Joan Shenton

in camera

Her London-based television production company, Meditel, has earned seven broadcasting awards including the Royal Television Society Journalism Award for the pioneering documentary AIDS - THE UNHEARD VOICES, and the British Medical Association's Certificate of Educational Merit for AZT - CAUSE FOR CONCERN, but JOAN SHENTON is in The Dominican Republic (the nation that shares a small Carribean island with the world's "poorest" country, AIDS-stigmatised Haiti) writing a widely-awaited book of her particular journey as a documentary maker through the AIDS decade. Meditel's distinguished AIDS programmes are currently avoided by the major broadcasters in Britain. Raised, praised and erased - why?
Between moving flats and making travel arrangements, she spoke over tea to Molly Ratcliffe and Huw Christie about the realities of programme making, before bidding London "hasta mañana".

Why did you enter the field of broadcasting in the first place?

I really went into television because I'm a showoff at heart and I wanted to perform. I tried to get into television and ended up working for the World Service Radio first, then something called THIS WEEK IN BRITAIN that was sent out by the Central Office of Information. It was a weekly film about Britain which went to Latin America every week in Spanish, which is where I was born. I went to Anglia Television for three years and then Nationwide's first three years as a reporter.

In 1972 I was very ill, and had systemic lupus erethematosis - called "drug induced" lupus. I'd had non-specific diarrhoea, if there is such a thing, like they couldn't work out why I had it so badly. I travelled to Spain and got worse and worse. They thought I had cholera. So they said, "Give her everything you've got." I was given massive doses of penicillin into the thigh - that big!- and then I was given chloramphenicol which is withdrawn here and banned because of its side effects. It is still a mystery as to why the lupus syndrome occurred, it is an autoimmune condition. Luckily my kidneys weren't affected. So I was flown back to England, I had three months in Westminster Hospital, and I did nearly die. I went down to four and a half stone, then I had a series of convulsions. They thought that I was going. I can remember looking out of the window and saying, "I'm 29, I've done the concert under the motorway and my old people's programme so maybe it's alright to go." They gave me massive doses of cortisone that night to try to rally me...and it was like a miracle cure - I came back to life the next day. Then they saw the rashes starting to emerge - I had five weeks of consecutive rashes, just what's called total body inflammation.

Eventually the corticosteroids started to damp down the inflammation but caused massive fluid retention, oedema, of the whole body. I couldn't walk really because my legs were just all fluid and finally they controlled that with diuretics and I did actually improve very well. I was able to go home as a very fat person which was another whole change of identity. I think people are nice to fat people, they don't see it as a threat.

I had almost a year off, lost my job on Nationwide as a presenter, and that's when I went to Thames where - to come to this business of being a medical reporter - I got a job at Thames Television as presenter of a consumers' programme which went nine years. It was Tony Bastible and me, and that had a very good following. During the course of that I started to get the problem with my hip which was a side effect of the high corticosteroids. I walked with a stick for four years and I had my first hip replacement in 1975 I think it was. I had it redone in '83. But that was very successful. In the course of all of that I wanted to do medical reporting and I persuaded the producer Mary Macanally, and she said, "Well, consumer...I don't know, medical?!" People weren't doing it then! Of course they let me. That's when I started looking at drug injury. My first set of programmes were about SMON. There was a court case going through Britain at the time which was the first **ever** drug injury case that **went** to court. All the others were settled, like thalidomide.

SMON?

Sub-acute myeloptic neuropathy is the damage to the nervous system - in actual fact the complete breaking of the connection between the nerve cells - by a drug called enteroviaform. The chemical is called clioquinol, it's actually anhalogenated hydroxyquinolin and these were given as antidiarrhoeals.

We all had them in South America but we never had them for more than two days or three, but in Japan they were being given prophylactically in hospitals for a month before surgery and then for the rest of their lives. Little by little it paralyses from the waist down, and affects the optic nerve and you go blind. I went to Japan and met many young people and it was just shattering to see lives completely destroyed. Many died. And! That was what they **tried** to blame on a virus. They called it the Inoui Virus. However, the Japanese didn't want to lose the Olympic Games publicity they were going to get so they very wisely put a lot of money into a multidisciplinary committee to look into it. And multidisciplinary is the important factor because in AIDS the virologists have never really had scrutiny from a multidisciplinary group. A good piece of detective work occurred and Professor Tobaki noticed that everyone that had SMON had green chelate on the tongue, green urine; he found the cluster where there were

most cases, he then found that that hospital had one drug that they had given all of these patients, and high doses - it was pure detective work. They found that this drug that Ciba-Geigy had always said could **not** be absorbed through the gut, and therefore just came straight out, **was** absorbed through the gut, did cause irretrievable damage and could kill.

Ciba-Geigy had to pay £203 million in compensation. There was a nine year court case with something like 37 lawyers, and our adviser Etsuro Totsuko, the Japanese human rights lawyer who is often in our office, was one of the kingpins in it all. He fought for nine years. So, God! Drug injury led to a speciality then, and Channel Four was just starting up, and commissioned us. We offered a series called KILL OR CURE, and Meditel was formed...well, Meditel had been formed actually in 1979 to make videos of hip replacement techniques teaching surgeons how it's done.

So the first AIDS programme you made, coming out of that sort of work, would have been 1986?

When the AIDS story...story?!...situation, began to emerge, I left it alone because I thought look, I'm interested in looking behind the scenes, and this seems so clear cut, you know, this awful virus was killing these young people, and **everybody** was making programmes about it, so why was Meditel going to jump on a bandwagon? Meditel only had brief to do things other people couldn't easily get hold of. We had huge tracts of inside information on things like drug injury, and information about pharmaceutical companies; that's what made people commission us. But when AIDS came I thought, "Right, I'm not going to compete there." You know, because it's been done, and very well done I thought.

Until...

Until Michael Verney-Elliot came on the scene. He joined me with a suitcase full of literally two years of research. And he said: "There's something wrong, there's something wrong. This business of HIV being sexually transmitted like this, it must be in the blood, its gotta be in the blood. And why are gay men being penalised or blamed? Why this Haiti business? How does it all fit in?" I mean it was endless. So at that point I thought, "God, he may have something about this bad blood, that it's being brought in illegally from third world countries, via Canada, under orange bottle labels." And this is blood for plasma and for blood transfusions and haemophiliacs.

Orange bottles?

Oh yeah. It was being illegally exported from Brazil to Canada in orange bottles. This was going to be our story. We went to Channel Four, and David Lloyd said: "Very interesting, I'll give you development money." Jad [Adams] and Michael went to Canada and America to check this story but they found that it would be very difficult to prove because we couldn't get hold of the **actual** bottles or any real evidence as to **who** had been injected with so-called dirty blood. While they were out there Jad heard about Peter Duesberg, and he read the *[Journal of] Cancer Research* paper, and he got fascinated by it. And so did Michael. They read that paper very carefully. It was a difficult paper to understand at that point - it is extremely technical. It's his first you see, before the *Proceedings of the National Academy of Sciences* ones.

Pharmacology and Therapeutics?

That was his manifesto, after four years of papers, first in *Cancer Research*, then two or three in *Proceedings of the National Academy of Sciences* - that was a huge struggle, they tried to stop publication - but those put him into the forefront of the scientific literature. They had to take notice of him.

So when they came back from the States they'd read the papers and came back talking about them?

Well no, Jad, actually, being the good journalist that he is - he was actually young journalist of the year - said, "Look, there's two things we can do. We can do BAD BLOOD, or do this story." And obviously, I could tell, he wanted to do that story. I thought it was totally fascinating and said, "Let's go for that". We went to David Lloyd, who said yes, which was brilliant, and we were funded to do the story. Off they went to film it, and Peter Duesberg, in '87. I was back at base. I went into Soho to view the rushes - because in those days we were on 16mm film - I remember sitting there with Alan Ballard the editor, and I said: "This is **dynamite**." I mean, it was the most incredible interview with Peter. The film got made, and it won the Royal Television Society Award, and as you know it fell into a pool of silence...as I always say. Nobody commented on it. It was in the DISPATCHES slot. As I said, we thought it would change the world..

Do you have any idea why?

Yeah. There are all these reasons. That AIDS involves a kind of death-worship cult, so people are so involved in it that they want to think they know the cause. If you take the cause away from them it's like taking the rug from under their feet. People like things in boxes: "This is the cause.." Also, medical journalists were very committed to HIV and to changing the world through their journalism. They felt useful.

Telling people how to live.

How to live. And they felt, "At last I have some reason for being a medical journalist." We challenged an orthodoxy, but it was more than that. We challenged a group of journalists who felt that they were being very useful.

Are these journalists still in their jobs today?

They're all there. I mean, even Neville [Hodgkinson] will admit to you that in the early days of AIDS **he** was...and people like Steve Connor and even a few like Nick Nuttal from the *Times*. He did comment on one of them, and he found it very interesting, but since then, he says, "Oh Joan, I don't really know enough about this to follow on."

The second programme that you made followed how soon after?

In '89 I went to California to meet Peter Duesberg and see him in situ and we started talking about THE AIDS CATCH.

What was driving you at that point, given that you'd met a well of silence with the first programme?

Oh, the drip drip effect. After our first programme people were contacting us. Jad had written his book, AIDS: THE HIV MYTH. We were getting a lot of flack after Jad's book from Duncan Campbell and from the Terrence Higgins Trust and people like that. The hostility was such that Michael and I met every day. He came to the office. And we just talked about AIDS every day, the two of us. Literally for about 18 months or two years.

Were you getting a satisfactory flow of information to fuel this discussion?

Yes, yes. Through Peter. Now, that's a very good point, and I have never thought of that before. Peter was feeding us a lot of stuff. Everything in fact he was giving. All his wrangles that he was having with the establishment I have documented here which is why I'm writing the book because I've got incredible documentation. That made me talk to Jad and Michael and we said, "Let's try for another one". I rang Peter and said:

"Has anything changed your mind since you made the last film with us?" and he said: "Absolutely nothing, in fact I'm more convinced than ever that HIV cannot possibly cause AIDS. Not only that," he said, "I actually think AIDS is obviously not infectious." So that became our working title - AIDS: INFECTIOUS OR NOT?

And did you have support from a TV company?

Yes. David Lloyd again. He said, "Yes, let's have that one." I remember ringing him one day and saying: "David, I want to ride the horse on this one. The orthodoxy has now had from '83 til 1990 its own way. Right through. Hundreds and thousands of articles, hundreds of television programmes. I want to actually take it from Duesberg's angle. I don't want on-the-this-hand-and-on-the-other. I'm just going to really go through the middle and carry this." And David Lloyd said: "Fine." Because in television we are allowed to do that at times. So we did it. We were **pilloried** for what people called misrepresentation, at the Broadcasting Complaints Commission. Because, you see, when I interviewed someone at length who was a member of the orthodoxy, and because of the knowledge we had, I could trip them up..and when I say "When I interviewed", that's very naughty, Michael Verney-Elliot did the interviewing. We would work it all out, and we'd say, "That's the weak point, let's go for that," and we would make them dig their own hole, then that was the bit I used. With Montagnier, I said in the preface, "Montagnier's still sure that HIV causes AIDS, however, he now says" - and then we used the quotes: "HIV on its own cannot possibly cause AIDS". He was **shifting** position. And **we** were found guilty of misrepresenting him, if you please, by the Broadcasting Complaints Commission. He never complained! Duncan Campbell complained "on his behalf". **That's** no longer allowed by the way.

What I'm talking about is technical: it's what's called Due Impartiality in a Television Programme. They introduced that recently. You always had to show balance, now you have to have Due Impartiality. However, there always has been a case whereby you could, if you signposted it properly, say, "We are going to argue from this point of view," and within a series. David Lloyd always argued, because we were the only dissenting voice, why should our brief little programme, one in something like 400, have to be duly impartial: ours was actually challenging the other 400? So what we did was we signposted it: "In this programme we shall argue that HIV is not the cause of AIDS and AIDS is not infectious."

And it was Positively Women, and Terrence Higgins Trust and Duncan Campbell that took you to the Broadcasting Complaints Commission?

And WelIcome. We were found guilty of being "unfair" in our treatment of AIDS and guilty on 9 out of 11 counts. They threw two counts out. But to my astonishment, within the nine was being unfair to Montagnier.

That had been a direct quote of his that you'd used?

Oh yes! We had actually prefaced it with, "He believes HIV causes AIDS," so there was no way we were trying to make him look a dissident. But a lot of people you see in that film, by putting them in they thought - just the mere fact they were in it - that we were manipulating the public into making them think those members of the orthodoxy were dissidents. It was all very complex. And several other interviewees complained. One of them complained to Duncan Campbell, so he did take on some people's complaints. But actually, Duncan went looking for them! I mean, he saw the film and he rang them all up and he said, "How do you feel?" But I must tell you a story.. you know what, when we did AZT - CAUSE FOR CONCERN, I had this wonderful guy who did the study at Duke University - the famous [Veterans' Administration] AZT study that said it made no difference in mortality, in time of death - Professor John Hamilton. He knew what had happened to us - and he wrote to me with a copy of correspondence that he had received from an AIDS doctor...do you remember the young man who died who was on the RIGHT TO REPLY programme? The guy who used to work at the Kobler? He apparently wrote to all the people we'd interviewed on AZT - CAUSE FOR CONCERN, and said, "We're going to put a complaint into the BCC," but it was phrased prettily nastily: "This company has been found guilty before of misrepresentation. Do you feel misrepresented?" Professor Hamilton sent me the letter. I sent that straight to the BCC and said, "This is the kind of pressure our interviewees are put under." Because John Hamilton was outraged by it! He said, "No, I'm very happy with the way Meditel Productions treated my interview."

What did the BCC say about that?

Nothing! You know. Ph! But something very current is that although we were found guilty and it did affect us - I hoped it wouldn't, and I'd like to talk a bit more about that in a minute - what's happened now is that those complaints would **not** be entertained today: they've **changed** the basis for the BCC to receive complaints. There's a precedent now, just been set - I can't remember what the subject was - which says that a pressure group cannot complain on behalf of anyone, if they were not in the film. You see, what was happening was that pressure groups were starting to complain. Although we had filmed individuals, a pressure group had taken it upon themselves to make complaints on their behalf. You're now not allowed to do that.

Did it get more difficult to persuade people of the appropriateness of making programmes?

Everyone except David Lloyd, yes. We went on to make AZT [- CAUSE FOR CONCERN], then [AIDS IN] AFRICA, so you have to take your hat off to him.

AIDS IN AFRICA was also under the auspices of David Lloyd?

All. Well - I did some later on for SKY news. AZT BABIES, AIDS DISSIDENTS IN EUROPE, AMSTERDAM ALTERNATIVE AIDS CONFERENCE and DIARY OF AN AIDS DISSIDENT for SKY News.

Peter Duesberg doesn't discuss Africa much.

It was a great relief in Africa because when we could speak to the doctors whom we had been led to by Ricardo Leschot - Dr Ricardo Leschot had already been in advance, and I said to him, "Ricardo, whatever you do and find, come back and give us an account", and if it hadn't been for him laying the groundwork I wouldn't have had these contacts. It was really important - and he came back and mentioned all of these people that I contacted - to my amazement they were all saying the same kind of thing as Duesberg. They'd read Duesberg too which was fascinating. And I'd not had that in England at all. Except for Professor Gordon Stewart here there wasn't anyone in the orthodoxy I could talk to. He's the ex-Professor of Public Health at Glasgow University and very much into how the figures have been wrong. He predicted the correct figures long ago, and the government wouldn't take any notice of him. Nobody would publish him. He was proved absolutely right. He kept within the high risk parameters.

Sky News, Channel 4 - why are you not making another programme for either of them?

SKY NEWS has changed a lot. Quite honestly, I haven't offered a lot to SKY recently because they couldn't pay you, they paid you in kind. But it was great to get something on.

It doesn't sustain a production company.

No, it doesn't. Secondly, Channel 4, David Lloyd, simply has gently kept us hanging on but a month ago he said, "Sorry, there's no way you can get either your haemophilia story or your poppers story or the latest *Nature* argument with Duesberg in this run," which is up to June, and since we were relying on it since last Autumn to do one in this run, we've petered out of money.

Why did he say it wasn't possible to get them on?

His excuse is that he's got too many medical stories already in the run. But the real reason I think is, and he once did say this to me, until something really big happens, until a major science journal says, "Duesberg is right, HIV doesn't cause AIDS", and everyone starts turning round, he's not going to go for it. Well, it's not going to happen that way, is it?

The National Council for One Parent Families challenged the BBC's PANORAMA programme over BABIES ON BENEFIT, aspects of which did not agree with NCOPF views, by taking their complaints to the BCC. The BCC found in favour of the NCOPF on certain points, and PANORAMA replied with a case in the High Court. The High Court ruled that the interpretation of the Broadcasting Act 1990's stipulations that to have complaints upheld by the BCC the plaintiff must have appeared in or have a direct interest in the programme in question, and have been affected by it, did not include a representative lobby group that did not contribute to the programme.

It's going to happen gradually.

Do you feel there's a general attitude that the kind of programmes you've made about AIDS are somehow safer kept off the air?

Yes. First of all, when THIS WEEK - the sort of flagship current affairs programme for Thames Television - said they were going to commission one based on Amsterdam [Alternative AIDS Conference, 1991], they pulled out at the last minute because someone went to the Terrence Higgins Trust - without me - and the THT poisoned them against us, and said we'd been found guilty by the BCC. They pulled out. I sued Thames Television. I threatened litigation and they paid up. Very quickly because they were committed on contract. But they got frightened of using me and Meditel as independents. You remember that those programmes are usually done in-house, so it's very rare they go out, and to go out and have someone they suddenly heard the BCC had found guilty...there's a lot of suspicion of independents. And jealousy. But also...this is too detailed for you...I was given a producer in-house who was trying to control us. He's the one that went to everyone else behind our backs and said, "What are these people really like?" You can't work with somebody like that. And then he wrote a shitty report to the editor saying, "We mustn't make this programme." He was very politically correct. He just loved the THT. He thought that Nick Partridge was the bee's knees.

There are certainly such people!

He was in awe of the establishment. The AIDS gay establishment. Our credibility has relied greatly on the help and co-operation we've had from groups in the gay community like Positively Healthy, Continuum and HEAL, London, because without that of course we are just working in isolation. Peter always said, "Nothing will change until the gay community supports this look at the hypothesis, because the gay community has the political power."

You must have been through a range of feelings about the sorts of people that really control the media debate in this country.

I went to the BBC. I went to Horizon, Panorama, Panorama, Horizon, Panorama. Forget it. They treated us very badly.

Do you think there was anything to be learned from the BCC's criticizers?

No. David Lloyd, after the adjudication said, "It's like going into a football match, winning nine nil and being told you've lost." They're just politically correct. They wanted to be nice to the Terrence Higgins Trust which was supporting young men who were dying. They didn't know anything about the science, and they kept saying, "We're not here to discuss the science." And I said, "Yes we are."

There is a perception that Professor Duesberg is homophobic.

He's only accused of that by one or two strange people. He is absolutely not homophobic at all.

It was one of the standard things that was used against him in the beginning, wasn't it?

Gallo was suggesting Peter was gay! It was something like he wears leather jackets and goes around with his cronies who are...! You know, you can't trust him because..

Gallo must be homophobic!

Peter Duesberg worked with Gallo and he realised early on that HIV didn't have the capacity to be pathogenic and when he heard Gallo announce it he simply said, "It cannot do it." That is how Duesberg started. Forget homophobia, all that. I thought; "Oh, BCC, nobody takes much notice of that." But it was used against us in many different ways. As I say, THIS WEEK pulled out effectively because of that. I have a recorded interview with the producer who said so; and what the THT had said. But secondly, whenever there was a little bubble of interest in Duesberg's work, the barons of science at the Medical Research Council like [Professor Sir Ian] Klugg and [Professor Max] Perruz, both Nobel Prizewinners, and also various other people involved in a lot of MRC HIV research would write in to the *Independent* etc. and would say, "How dare you allow this view to surface? After all it has already been put forward by the discredited company Meditel Productions who were found guilty by the BCC." This came up in the first paragraph. Wellcome used it against us, all the time. Little by little we then were seen as partisan and my peers, now in very senior commissioning positions, even though I get on very well with them and they like me, they say, "Joan, I can't get you through the Controller of BBC 1 or 2. You are seen as partisan. You are now a pressure group." I have tried to get the Great AIDS Debate off the ground, either as HIV ON TRIAL, or as THE GREAT AIDS DEBATE with people on one side, people on the other, call in the top scientists and make them fight it out. No way. They won't let us do it. Of course little Meditel needs programmes to survive, but they won't commission us to do it. They commission another company to do it and we're just another guest on the show. Fine. Great. But it's not work.

And also they're **not** doing it because there isn't the will there anywhere else. You know, you need a driving force to actually get that on air. A colleague of mine called Nick Fraser said, "You know something, you are not going to get any more programmes on air until you claim your territory in a book." I mean he's a book writer, I'm not, so I laughed. Then I went away and thought about it. And actually, he's probably right. It is the only thing to do now, for the moment. Because if you could see the file of our rejections. It's **this** thick with outlines for Poppers, terribly important to do that programme, AZT again, Penta, you know...

As you say, Nature's *not going to put on the cover, "HIV Not The Cause Of AIDS". If they want to wash their hands of it it'll be by not mentioning it.*

Yes. And maybe in a few years time they'll all say, "Oh well, the HIV test, well, it was a useful marker, but it's not relevant. It's just an indicator. We still do it."

Peter Duesberg could be suggested as the prime proponent of HIV dissidence. There must be others, your reference points..

0h, Harvey Bialy. Peter and Harvey are key, because they will always listen and have a considered view. And Charlie Thomas, who started the Group for the Scientific Reappraisal of AIDS, he's always been very powerful. And then of course Frank Bounakis and Michael Ellner, and Professor Gordon Stewart has always been very helpful but he skeeters off in other directions and chastises us.

Chastises you for what?

For being rash, and supporting Peter unthinkingly. But he's always been very good. He's a friend and an ally. And my contacts to do with Africa who are African doctors who have really stuck their necks out to help.

Your book is not going to be only about the HIV/AIDS issue?

Yes! Oh yes, it's not a sort of skip through medical mistakes! "You must claim your territory," he said, meaning the dissident debate. I'm still commissioned in other areas a bit, but this was the bulk of our work for seven years. One DISPATCHES could keep Meditel alive for a year.

Do you have a title for the book?

The word dissident is a problem, you see, to a lot of people. People who are outside this debate, who are, say, political journalists, they say, "Don't have the word dissident in, because you'll be marginalised. It'll be considered just a mini argument."

Don't you think you're moving through a land of Lilliputians? Alexander Solzhenitsin was a dissident.

I know. And... samizdat!* Listen, I must mention Professor Alfred Hässig. Dear Alfred's not very well. He's in hospital at the moment. And he has been a tremendous help. Not only that, he helped us financially too, to keep going for a few months when we had absolutely no money at all. He was great, and he always said, "Joan, make it. Make it samizdat! It doesn't matter. It'll be shown one day." This was DIARY OF AN AIDS DISSIDENT. He and an old friend of mine from South America, family friend who's a banker, gave us enough money to be able to go to Berlin and film. And at that stage I thought, "It'll never be shown, it doesn't matter, we're going to do it!" And it's to be given the courage to do it samizdat! Just a few pounds - enough to get there with your little high8 camera and do it. And we did it. Then it exploded outwards, because that was when Gallo and Weller were there and we caught them in the press conference, and even then I thought, "Oh well, this may never hit the air," then SKY NEWS put out a half hour version.

Did it not get seen in the United States as well?

Yes! Unfortunately, the one-hour version has never been shown yet.

[* Russian : self-publication - underground political works banned or censored by the Soviet authorities which were distributed usually in typewritten form. Radizdat is the broadcasting of samizdat works.] ■

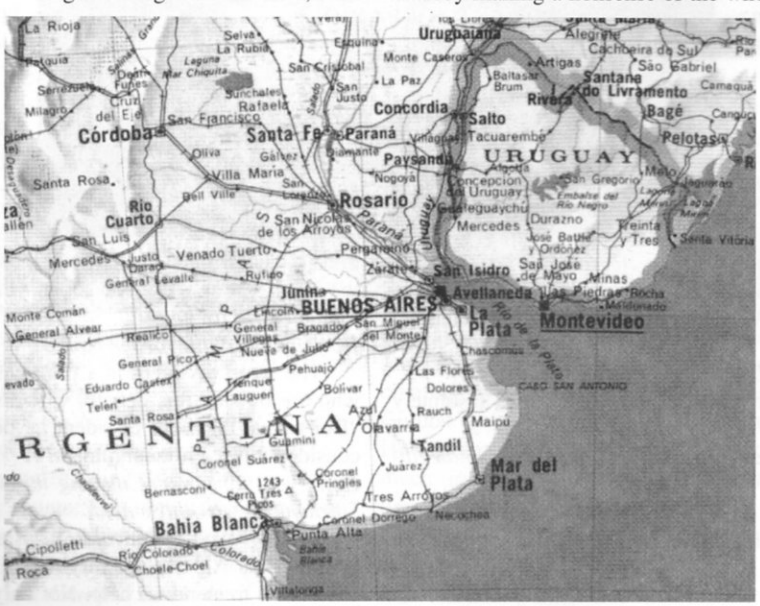
THE FOURTH INTERNATIONAL ALTERNATIVE AIDS CONFERENCE.

Michael Verney-Elliott reports

This is not a word for word account of the proceedings, as I did not sit through some of the presentations, merely my impressions as a veteran of four such conferences - Amsterdam, Barcelona, Bologna and now Buenos Aires.

The symposium was organised by Dr. Ricardo Leschot, a member of The Group for the Reappraisal of the HIV/AIDS Hypothesis, based in San Diego, California. Ricardo attended the first conference in Amsterdam in 1992, and had always dreamed of offering an alternative view of AIDS to his fellow South Americans. As a result, some of the world's leading AIDS sceptics assembled in Argentina at the beginning of April to discuss the latest developments in AIDS research. We were united in our belief that the HIV=AIDS=DEATH scenario, foisted on a gullible public by the phalanx of failed cancer researchers, ambitious experts and opportunistic vets who comprise the AIDS orthodoxy, is totally wrong. As a result, billions have been spent, millions are in a state of terror, tens of thousands have died from orthodox 'treatments', and we are still no nearer to defeating AIDS. Every orthodox strategy has failed, not one life has been saved by it, and an HIV vaccine is still a mirage. The conference was a chance to point out the latest absurdities of the orthodoxy, offer new strategies for AIDS treatment, and to try to persuade a reasonable audience that an HIV+ diagnosis is not a death sentence.

I attended as part of the Meditel contingent along with the boss, Joan Shenton, and scientist Hector Gildemeister. Extracts from three of the TV documentaries we made challenging the AIDS orthodoxy were to be shown, and we were there to answer questions. My own agenda was to try to warn against the use of the lethal nucleoside analogue drugs like AZT to treat AIDS; and recreational drugs, including poppers, which I am convinced are damaging to the immune system, and can initiate the bodily decline we call 'AIDS'. The 'Virus from Hell' scenario may be expedient and politically correct, but is all too literally fatally flawed.



The proceedings were held in the large General San Martin Cultural Centre, and it was obvious from the initial Press conference on April 7th that there would be a lively divergence of opinion even amongst the dissidents. Stefan Lanka stated his radical view that HIV, the 'AIDS virus', is merely a laboratory artefact, and that no true isolate has ever been achieved. Harvey Bialy, Science Editor of BioTechnology, vehemently denied this, taking the line that the virus does indeed exist, but as a dormant, orthodox retrovirus it does not and cannot cause AIDS.

Harvey's talk, to an attentive audience of some three hundred delegates from South and North America and Europe, was entitled 'One Hundred Thousand Papers and No Proof.' He pointed out that the huge volume of scientific literature published on AIDS since 1984 cannot show one single paper that proves, clearly and unequivocally, that HIV causes AIDS. No mechanism has been shown by which a dormant retrovirus, restricted to latency by antibodies, and frequently untraceable in PWAs even using the PCR amplification technique, can cause the devastating syndrome known as AIDS. Whilst taking the view that the retrovirus known as HIV does exist as an entity, he used the memorable image of the virus being in a 'coma'. Hold that thought. Can a virus in a coma cause a disease? His talk brought out all the arguments familiar to AIDS dissidents who have read Peter Duesberg's views on HIV, and although Peter could not attend the conference due to commitments at Berkeley, Harvey cogently and forcefully reiterated Duesberg's principal objections to HIV being the cause of AIDS, perhaps well known to many readers of **Continuum**. Moreover, he was particularly scathing about attempts to 'blame' Africa for the origins of AIDS, and told of his observations that in the tourist centres of Africa, AIDS is found in conjunction with the rise of drug addiction, especially amongst prostitute women. This would seem to mirror the situation in Europe and Thailand.

Frank Buianouckas, a Professor of Mathematics and founder member of HEAL, New York, chaired a panel on 'How to Interpret a Positive Western Blot Test'. Nothing said will come as any surprise to those who read the last **Continuum** and Christine Johnson's brilliant distillation of the work of Eleni Papadopulos-Eleopulos and her colleagues in Perth, who pointed out that just as there is no established international gold standard for ELISA testing, Western blotting is equally prone to error in terms of confirmation of viral infection. The general consensus at the conference was that the tests are so flawed as to be worthless.

It may be worth remembering that AIDS is the first 'disease' in which antibodies to the supposed causative agent are used as a prognosis of death, thereby making a nonsense of the whole concept of vaccination at a stroke. If you are only initially diagnosed as being HIV infected by antibodies to it, as Duesberg observed very early on - "The show is over for the virus" - you are already vaccinated against it. Despite early efforts by the orthodoxy to dispel this paradox by claiming that the antibodies are non-neutralising, this is obviously not the case, as evidenced by the consistently undetectable viral titre in the peripheral blood of PWAs in the presence of supposedly anti-HIV-specific antibodies.

John Lauritsen gave a talk entitled 'The Risk-AIDS Hypothesis', perhaps the most courageous offering of the conference. With his customary measured delivery, objectivity and meticulous attention to the facts, he argued: i) there is no such thing as 'AIDS'; ii) HIV is not harmful; and iii) an AIDS diagnosis is the result of group-specific risk behaviour. It was obvious from his presentation that he holds as little truck as I do with 'political correctness' - true science cannot be constrained by such tacky expedients - and got right down to the nitty gritty.

He argued that AIDS "is a phoney construct". By way of illustration, he cited Peter Duesberg's often quoted summation of AIDS as defined by the Centers For Disease Control:

INDICATOR DISEASE + HIV = AIDS i.e., in conjunction with HIV, an "AIDS-indicator disease" becomes AIDS. In the absence of HIV, the AIDS-indicator disease is called by its old name. Thus, INDICATOR DISEASE - HIV = INDICATOR DISEASE.

e.g. TB + HIV = AIDS
TB - HIV = TB
or: DEMENTIA + HIV = AIDS
DEMENTIA - HIV = CRAZY.

John then reminded us of the reasons why HIV is merely a harmless

passenger virus, before moving on to his most politically contentious argument - that 'AIDS' is the outcome of specific health risks in the lives of the major risk groups.

He merely pointed out that the members of all the so-called risk groups have a logical reason to be immuno-compromised, something that most of us have maybe been aware of from the outset, but were hesitant to admit, either through fear of political incorrectness, misplaced gay indignation or other personal reasons for denial of the obvious. John had no such qualms and asked not, "Why have these people developed AIDS?" but rather, "Why are these people sick?" He then dealt with each of the risk groups in turn.

Starting with drug addicts, he reminded us that for at least a hundred years it has been recognised "that the classic profile of a chronic heroin user has been emaciation and lung disease." Not only is heroin damaging to the immune system, it also suppresses the respiratory system. "The consequences are tuberculosis or one or another form of pneumonia: emaciation and lung disease."

Moving on to gay men, John is worth quoting at length:

"The following profile fits most gay men who developed 'AIDS': In the decade preceding their diagnosis they contracted venereal diseases (VD) many times, treated with ever stronger doses of antibiotics; they took antibiotics prophylactically, to avoid getting VD again. They drank too much, they used "recreational" drugs, they smoked heavily. They experienced terror, owing to a war waged against gay men by the Moral Majority (an American coalition of fundamentalist Christians); they experienced loneliness, alienation, and depression; they experienced shame and self-hatred, which, in a vicious circle, they acted out in ways that degraded themselves - and as the epidemic developed, they experienced grief; they were in perpetual mourning, their hearts broken by the loss of their closest friends." .... "It would appear that this subset of gay men became sick primarily because of drugs, both medical and 'recreational'. At any rate, there were abundant health risks in their lives, and it would have been surprising if any of them had remained healthy."

John did not deal at length with AIDS related to blood transfusion or haemophilia, for reasons of time, but pointed out that they account for less than 10% of America's AIDS cases. John did however go on to condemn the use of AZT and other nucleoside analogue drugs, which he regards as lethal, and the chief cause of 'iatrogenic AIDS' (AIDS caused by medical treatment). Papers by Peter Duesberg and Eleni Papadopulos-Eleopulos subsequently published in the most recent edition of *Genetica* amplify this point, and finally lay to rest the myths surrounding haemophilia and transfusion 'AIDS'. With more and more haemophilia specialists admitting that AIDS in their patients, previously assumed to be due to an infectious agent in their clotting factor, is age and dose related, the infectious agent theory collapses, as does the '*post hoc, propter hoc*' cliché. As with all other cases of AIDS, haemophilia cases are the result of excessive intake of alloantigens and toxins, not of an exposure to a single infectious agent. Iatrogenic AIDS, in fact.

John's 'program of recovery' will be familiar to readers of **Continuum** based as it is on common sense and logic: "Illness is usually multifactorial in origin, and good health is always multifactorial. Good health doesn't depend on any one panacea, but a number of elements: freedom from toxins; nutritious food (in moderation); vigorous exercise; pure water, pure air; freedom from hostile stress, including noise; satisfying friendships; satisfying sex; satisfying work; an intellectual life; and sleep and rest."

John also questioned the wisdom of alternative and complementary health carers who subscribe to the official explanation of AIDS, the whole HIV=AIDS bundle, and try to tinker with the immune system on that basis. As he believes the whole of the official line on AIDS is wrong, such treatments seem misplaced. He also said that many alternative therapists seem anxious only to push their own speciality whether it be appropriate or not in rebuilding the immune system. He sees such behaviour as merely seeking to "reinforce the (official) paradigm from the alternative health camp". No wonder that, in the carefully engineered prevailing atmosphere of terror surrounding AIDS, charlatans abound. His strongest condemnation was of three alternative therapists, all with books in print, who recommend the use of AZT, describing them as "traitors to the ideal of holistic health". One of these writers, who suggests warm baths to counter the side-effects of AZT, invoked the most withering contempt. John's presentation gave his audience a great deal of food for thought.

The alternative medical approach to treating AIDS was well represented by Michael Ellner of HEAL, New York, Gareth James of HEAL, London and Alfredo Embid of Madrid. The delegates listened with great attention to the therapies suggested by these speakers, and were impressed by Michael's description of AIDS terror as 'bone pointing', the infliction of a psychological AIDS=DEATH mindset by an incompetent medical profession. I have since come across an official medical name for this 'condition' - epinosis, a psychic illness brought on by a previous malady. Gareth and Alfredo listed the many therapies being offered for alternative treatments for AIDS, which in their opinion seem to be beneficial. My own impression was that by far the most important treatment on offer was to instill into the patient a positive and hopeful outlook. How about a T-shirt with the slogan "Accentuate The Positive" sold with a copy of the classic Andrews Sisters' record to promote awareness of this vital message on Pride Day? It makes more sense to me than the doomy, designer-accessory red ribbons which have come to symbolise the designer 'disease' of the century.

As an illustration of the lengths to which the orthodoxy will go in pursuance of their conception about the 'cause' of AIDS, Dr. Fabio Franchi from Trieste, Italy, raised a much needed laugh when he pointed out that the official line in Italy is that plumbers are dissuaded from donating blood, as they are notoriously susceptible to the charms of their housewife customers and consequently have a lot of extramarital sex. This is particularly ironic since the promised heterosexual epidemic of sexually transmitted AIDS in Europe has never materialised. Hold this thought - What would happen if they threw a sexually transmitted epidemic and nobody came?

"Illness is usually multifactorial in origin, and good health is always multifactorial"

Fabio also believes that the search for an AIDS vaccine is in a quagmire, but one speaker's ideas rendered the whole idea of a vaccine superfluous:

Stefan Lanka gave a brilliantly theatrical exposition of his belief that HIV does not, in fact, exist and is merely a laboratory artefact. Readers of **Continuum** have already had a chance to read his radical views, and I must say I found him very persuasive. He too was drawing on the implications inherent in Eleni Papadopulos-Eleopulos's work. When I suggested to Peter Duesberg that Lanka might be on to something, in Berlin recently, he conceded, "Anything is possible in science." However, before throwing the HIV baby out with the bathwater, I think it should be considered whether the best way to defeat the unproductive, orthodox view of HIV as the 'cause' of AIDS may still be to argue in terms of the conventional wisdom.

The media coverage of the AIDS debate was represented by Joan Shenton, and Celia Farber of Spin Magazine. Of the documentaries made by Joan's company, Meditel, for Channel 4 Television, sections of 'AIDS and Africa' and 'AZT - Cause for Concern' were shown, as well as the whole of the 1990 programme 'The AIDS Catch'. In the discussion after this programme, I pointed out to the audience that AIDS survivor Ron Webeck, who featured in the show as a gay man with AIDS, had seroreverted, and no longer had HIV, verified by PCR tests. He refused some two years later to appear in our show about the dangers of AZT. He told me his doctor had persuaded him to take AZT 'in case the HIV came back'. Within a year, he was dead.

The next day, Joan showed her film on 'AIDS and Africa', and the audience was amazed by the state of affairs she found there. Her film showed with great clarity that what is being called AIDS in Africa is merely the resurgence of endemic fatal diseases on a terrifying scale, due to poverty, malnutrition, rotten sanitation, demographic changes inherent in civil wars, and the collapse of the medical infrastructure. Condoms cannot prevent malaria, TB or any of the other endemic diseases Africa is prey to, and tiny national health budgets are being used on campaigns instilling sexual terror, and, consequently, limiting the birthrate. Such medico-economic colonialism is in keeping with the racism which tried to claim that AIDS came from Africa in the first place.

On the last day, commenting on the 'AZT - Cause for Concern' extract, I reminded the audience that since 1992, when it was transmitted, despite vigorous legal attempts by Wellcome to suppress it at the last moment, nothing has been shown to contradict anything we said, and indeed several subsequently published trials showed no benefit from taking AZT in terms of survival, delaying disease onset, or quality of life. Depending on how one interprets the data, it is possible to state that AZT actually accelerates

the onset of AIDS symptoms. I reminded them of the finding that taking AZT for any length of time, assuming survival, patients were shown to have a 46.4% chance of developing non-Hodgkin's lymphoma. The relevant paper was co-authored by Samuel Broder, the chief proponent of the use of AZT. Despite the manufacturer's claim that the side effects of the drug are reversible, no-one has ever succeeded in 'reversing' lymphoma. To try to warn against this toxic drug, I reminded them that Harvey Bialy believes HIV to be a virus in a coma; that Stefan Lanka thinks HIV is no more than a ghost summoned up by technology. Whichever they believed, I pointed out you cannot kill a comatose ghost with a hand-grenade like AZT, you merely kill the patient.

It was Celia Farber, in her talk on 'AZT in Pregnant Women', who gave the most telling example of the selectivity of the medical followers of the AIDS orthodoxy. She had followed a trial involving 41 pregnant women given AZT during their pregnancy to see if it would lessen the risk of passing HIV on to their babies. Several of the babies were born with physical abnormalities, including two with extra fingers and/or toes. When asked about this, it was explained that the two women came from families with a congenital history of this condition, or polydactyly, as it is known. The Oxford Textbook of Medicine describes this condition as 'very rare', and includes it in the section on 'Disorders of uncertain aetiology', yet we are asked to believe that out of a mere 41 participants, two happen to have been co-opted with a family history of this 'very rare' condition, and the suspicion that the birth deformities in these and the other infants were due to the use of AZT was not entertained. Has thalidomide been forgotten, or is this another case of belief in coincidences, which seems to litter the path of AIDS orthodoxy? That scientists should be economical with truth is understandable. If you are a frustrated cancer researcher, or perhaps a vet with a wife who has a black belt in shopping, it could be tempting to ride first class on the AIDS gravy train, all expenses paid. Every man has his price - and woman too. However, I am still naïve enough to expect better of the medical profession.

As usual at these do's, the informal chat at the end of the day's proceedings was very informative, and many ideas and hypotheses were swapped and chewed over. Ho and Wei, who claimed in separate papers to have found a titanic struggle waged between HIV and the immune system, received very short shrift. According to Frank, who is, after all, a mathematician, the mathematical model was rubbish, a typical 'GIGO' - Garbage In, Garbage Out. Others pointed out that Kary Mullis has declared 'Quantitative PCR is an oxymoron', and he should know, he got the Nobel for inventing it. For readers unfamiliar with these much-hyped 'proofs' of how HIV causes AIDS, they purport to show that during the 'incubation period' between infection with HIV and the onset of symptoms of AIDS, the cells are churning out billions of viral particles daily. These are dealt with by a corresponding daily increase in the numbers of T4 cells. However, the mechanism whereby cells and viral particles cancel each other out, without leaving any trace, was not hypothesised. This is akin to supposing that the battle of the Somme could be fought in a wheatfield for ten years without anyone suspecting it was happening, and without leaving any telltale debris or so much as a broken wheat stalk. Battles are a bloody business, never that neat and tidy. In twelve years, no trace of this 'monumental struggle' has ever been seen, despite the fact that HIV is the most intensively studied virus in history. Needless to say, this 'virological mayhem' has been uncritically and eagerly accepted into the received wisdom as gospel, and is widely quoted as the 'proof' that HIV causes AIDS.

When the official AIDS edifice begins to totter, it must be shored up with increasingly baroque and fantastical buttressing. The AIDS 'research' gravy train has come to a halt in a deserted siding, and all the highly-paid researchers can do is pull down the blinds, pretend the train is still moving, and tell tall tales to keep up their spirits and grant funding. Wishful thinking is no substitute for scientific competence. It is of little satisfaction that I was right in 1987, when I said: "Congratulations! The team that did not bring you the answer to cancer has now not brought you the answer to AIDS." Plus ça change.... ■

Dear Continuum...

Having read the Congressman's letter (page 10), why not write to your M.P. outlinging what you think is wrong with the official line on HIV and AIDS?
Request your M.P. to get some asnwers from the All Party Parliamentary Committee on AIDS.
Remember to include your address and ask for a reply, to ensure that your letter will be considered.
And keep the letters to **Continuum** flowing. We love to read your views on the services we offer; whether it be praise or criticism, we need to hear it.

Dear Continuum,

On Thurs, 25 May 1995, I wrote to Val Turner of the Royal Perth Hospital, Western Australia:

"Dear Dr. Turner,
The question: If the tests can cross-react with other antigens in the blood, how do we verify that a result is indeed a false positive? Is there another series of tests run using ELISA and WB or are there separate tests used that can somehow confirm the results as being indeed false positive? Is this question answerable at all? I hope that you can help me. It seems to me that virus isolation is not the answer to this question...yet what else could confirm a false positive?"

Val Turner responded:

"Dear Sean,
The answer is in our BioTechnology paper. For us, all positives are false positives. There is no data to the contrary. From between 17-80% of AIDS patients HIV cannot be isolated yet they are antibody positive. The tests must be non-specific. Even if some AIDS patients have HIV and positive antibody tests how can you tell that the non-HIV causes which operate to make the tests non-specific do not operate in AIDS patients with HIV? You can't, and under such circumstances you can't tell a person they are infected with a lethal human retrovirus.
If you want to decide whether HIV could be one of the causes of HIV infection then you have to look at HIV and HIV isolation itself and make up your mind about all the data that's used to define the existence of HIV. If you do all that you will find that the phenomena used to define HIV are all non-specific, including the HIV proteins which are defined, not by taking apart an HIV particle, but by the same antibody reactions used to determine HIV infection. In other words HIV proteins are defined circularly. There is no new information when you get down to looking at HIV. You end up with proving HIV=antibody reactions and antibody reactions=HIV.
I know this may be hard to see but that is how it is. That's why we are the most radical of all HIV dissidents and that's why no-one believes us. You can only prove the existence of HIV by isolating it and that is not achieved by the demonstration of antibody reactions. Re-read the Gallo paper and BioTechnology and it will soon fall into place.
Best wishes, Val."

I thought this might be of interest to some of your readers.

Yours,

Sean Current

Dear Continuum,

I would just like to thank you for talking through my doubts about Septrin with me when I called the office and also for sending me a few issues of the magazine which showed me that there is a much more positive way of dealing with my situation than that which was offered by my doctor. The Septrin's in the bin, I've bought a load of vitamins and, most importantly, I'm not scared out of my wits anymore. For that alone I can't thank you enough.

I look forward to the next issue.

Martin, Greater Manchester

Dear Continuum,

I so look forward to your magazine, the only one I've seen on HIV issues which I really wanted. I have Vol. 2, No. 5 & 6, and I thought it was so fantastic, educational and thought provoking, and just what us "rebel long-term survivors" need to give us encouragement.

My count drifts down to my doctor's obvious discomfort in view of what he terms "my obvious good health". "I've never seen you looking so well," he says, as he scratches his head.

One of my sons said to me, "And Mum, you enjoy every minute of it don't you!" Boy, I sure do and I love to hear of others and the more noise we all make and the more doctors we keep confused, the better it will be for everyone.

Don't get me wrong, I haven't always been so well - I was on AZT and then ddC and so ill I can remember the nightmare only too well. I still have nerve damage from the ddC (numb toes), but I have really turned everything else around - yes, I love every minute of everything!

God bless you all.

(Name and address supplied)

Do you want to meet someone in your local area?

Here is an extract from a letter received in the **Continuum** office recently:

"I've just been reading the April/May copy of Continuum magazine, it's the only one I've seen but have filled in the subscription form so hopefully I shall see more. It is very refreshing to see people challenging the standard view of AIDS and HIV put forward by the medical profession. I am also wondering if you can put me in touch with any like-minded individuals or organisations; the usual ones...are very good in their way, but they are still all about dying from AIDS and that makes them, to me, very negative in outlook. Continuum is the first organisation I have come across with a truly positive approach. Keep it up!"

We have had a number of such requests for more information about groups or other like-minded people in your local areas and we have decided to start a service of putting you in touch with others near you whom you may want to meet, talk to, exchange ideas/experiences, or just socialise with.

So please, if you would like be a part of a network of Continuum readers, contact us on 0181-961 1170, and we'll see what we can do.

You and Your Colon - Partners in Health

by Boo Armstrong

The bowel is probably the most laughed at organ of our bodies, yet it carries out essential eliminations from the body and can create an internal environment which is either healthy and supportive or dangerously poisonous. The colon is the part of the bowel which is most likely to harbour disease-causing bacteria. The digestive system is essentially one long tube which digests and absorbs nutrients from everything that enters through the mouth. The colon begins where the small intestine ends in the lower right hand side of the abdomen. It travels up as far as the ribs, moves across the width of the body and travels down the left hand side where it loops across to the middle and joins the rectum and anus.

It is here, in the depths of our digestive system, that billions of non-human organisms make their home. 'Bowel flora' is the collective name given to the four hundred-odd species of bacteria that live in our bowels. A healthy colon contains about one and a half kilos of E. Coli, Salmonella, Streptococcus, Poliovirus, Pseudomonas, Trichomonas, Entamoeba, Bifidus, Bacteroides, Clostridium, Lactobacilli and Candida. These are the family names of microorganisms which live together in a healthy colon in perfect harmony. Some of these microorganisms are potential creators, when out of balance, of serious diseases while others are beneficial to the human host.

In the depths of our digestive systems billions of organisms make their home

Friendly bacteria survive best in a fibrous, alkaline environment where waste material moves along steadily. They help keep us alive by completing digestion, producing B vitamins and controlling the growth rate of the harmful bacteria, viruses, fungi, yeasts, amoeba and worms. Disease causing 'unfriendly' organisms thrive in an acid environment of stagnant, rotting foods.

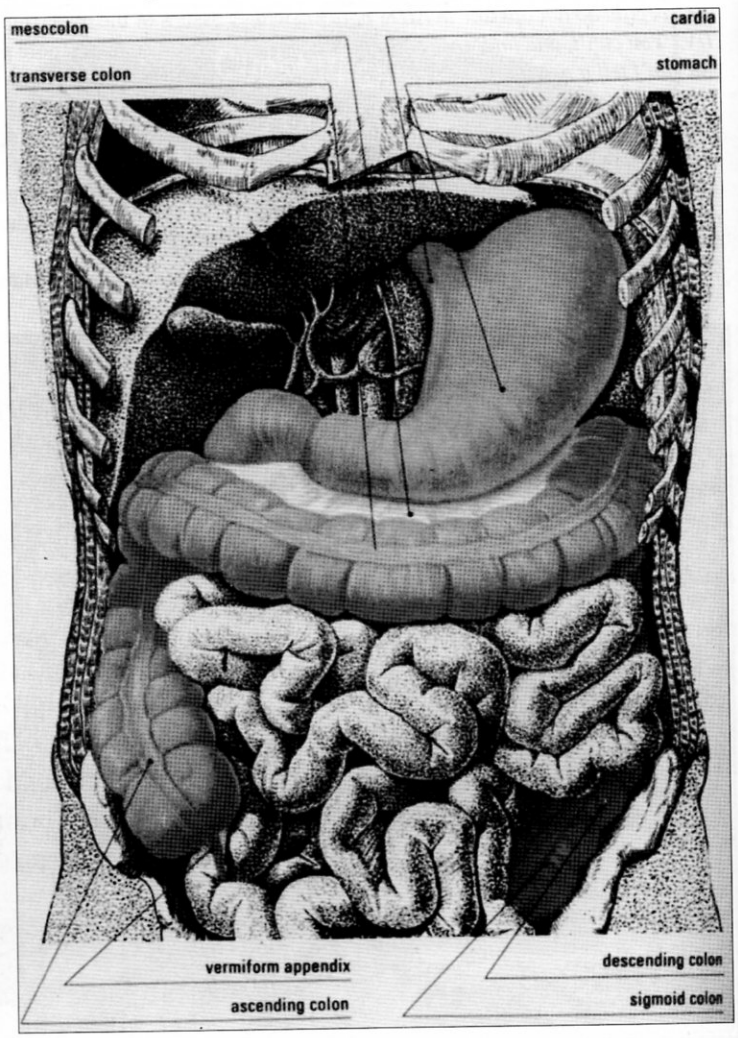
What can be done to encourage friendly bacteria to settle in and get rid of the pathogenic ones? Vegetables and whole grains will help to create the right environment and acid forming foods should be avoided. These are animal produce, sugars, salt and refined carbohydrate, so a meal consisting of a meat or cheese sandwich on white bread and a sugary drink will wreak havoc in your intestinal garden. Many pharmaceutical drugs are also dangerously acid forming.

Antibiotics are a specific type of drug that have a disastrous effect on the bowel flora, in a different way. They indiscriminately kill bacteria, good and bad, the amount killed depending on the spectrum or range of the antibiotic. This will leave an ecological vacuum which will be filled with pathogenic bacteria unless you take in the friendly kind.

The most efficient way of doing this is by supplementing with Acidophilus or superdophilus and creating an environment in which they can take root which means eating fibrous foods such as vegetables, whole grains, pulses and fruits and avoiding mucous forming foods and those which stick to your gut wall. Most people have old undigested foods lining their gut wall. Colons removed in autopsy have been found to weigh more than forty pounds. It is not uncommon when people cleanse their colon to find in their faeces undigested food which they ate months ago. Whole peanuts have been found in people who have not eaten peanuts for six months.

These days in our fast food, stress filled lives two serious problems are occurring in our bowels: our flora are out of balance and toxic waste materials are not being eliminated. Everybody knows that you need to eat fibre to keep the contents of your bowel moving along, but not so many people know what slows the process down. Mucous forming foods are hard for the body to move through the colon because of the sticky nature of mucous.

The most mucous forming foods are dairy products from cows milk, flesh foods and soya products. The best way to see for yourself if what you are eating produces lots of mucous in your body is to look at your stools and see how much mucous they contain after eating different foods. Vegetables and fruit hardly form any mucous apart from gas-ripened bananas and sulphered fruit.



Some foods have a tendency to stick to the bowel wall for other reasons. Wheat is one of these foods because of gluten, a gluey protein it contains. Gluten is hard to digest and has a tendency to stick to the lining of your intestines, especially when it is combined with mucous. Together they form a hard, impervious layer with the consistency of car tyre rubber. Nutrients which would normally be absorbed through the bowel wall into the blood and lymph (the two circulating liquids in your body) are prevented from doing so by the layer of mucousy, glutinous foods.

As this layer builds up, attracting and producing disease, the passageway through the bowels gets narrower and narrower with more waste products getting trapped in the sticky mass and the owner of the gut will usually start to reabsorb toxins, resulting in one of the longest lists of symptoms ever. Mental conditions such as depression, fatigue, poor memory and mood swings are common. Physically someone with a toxic colon could have allergies (food and chemicals), diarrhoea, muscle and joint pain,

The difference that you'll see and feel will astound you

menstrual cramps, distorted vision, impotence, drowsiness, indigestion, bad breath, wind and rashes to name a few. Rashes are interesting because they usually occur on your skin which is an external reflection of the digestive tract. If you think of the wall of the digestive tract as a second skin it is clear that they play similar roles in protecting us from things trying to get into our bodies.

The good news is that cleaning up your toxic colon can reverse this situation and the difference that you will see and feel will astound you. During a colon cleanse the immune system needs to be nutritionally and emotionally supported to help the body deal with toxins which are being released. The colon can be unblocked by controlling mucous (diet), loosening old faeces (herbs and enemas) and then removing the loosened material with enemas and colonic irrigation, food supplements, herbs, yoga, kinesiology and so on.

Whichever combination of treatments are used to clean the colon it is essential to drink plenty of purified water (friendly bacteria cannot stand the chlorine), eat good food, maybe drink aloe vera juice if you can afford the cold-pressed, organic type. Cabbage juice is really food for encouraging Acidophilus to grow. Other organic vegetable juices are good news as well, especially to someone with a poor appetite because you can concentrate all the enzymes, minerals and vitamins in an easy to digest form which will help your body to eliminate toxins. It is also a good idea to supplement your diet with friendly bowel flora such as Bifidophilus and Acidophilus. Your local health food shop should be able to tell you which is the best kind to buy - beware, some are cultured in milk which is mucous forming and some are of such bad quality that most of the bacteria are dead by the time you get them, or they are destroyed easily by your bodily defence systems.

There are lots of books on the subjects of bowel cleansing, bowel flora and candida and many are worth reading and a health care practitioner can talk you through an individual diet and supplement programme along with any other treatment. Considering that an estimated 80% of diseases are related in some way to poor bowel health it may well be time to start looking after yours.

Bibliography:

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'The Colon Health Handbook', Robert Gray.
'Probiotics', Leon Chaitow and Natasha Trenev.

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continued from page 7

HIV debate

Harris

dence for the existence of HIV using antibodies to arguing in circles....It is consequently quite illogical to claim that a positive test results from prior contact with the virus....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!"

Comment: These are the same proteins which are coded for by the viral genome, and which co-purify with the infectious virus on sucrose gradient, as noted above. Why does it take a stretch of imagination to imagine that they are viral proteins?

11. Lanka: *"The dilemma cannot be stated more poignantly than 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."*

What's the problem with that? Not everybody with HIV has AIDS. This is elementary.

12. Lanka: *"Negative test results do not exclude the possibility of contact or infection with the AIDS-associated virus."*

No, since it does take from 2 to 6 months for antibodies to show up. So?

13. Lanka: *"Positive test results do not prove that someone has an AIDS or pre-AIDS disease status nor that he will acquire it."*

Again, since all people with HIV don't get AIDS (maybe 90% do). Again, so what?

14. Lanka: *"Quite."*

Quite what? Here one has a test of good prognostic value. It's so good that insurance companies are not allowed to use it. If it showed nothing

Lanka

one. Individual proteins should have a density that is entirely different to complete viruses, and should for that reason **not** band at the same density as viruses! It seems that these researchers have never even learned the ground rules of cell biology and virology. The quality of evidence that convinces Harris is frightening.

To try once more, second and third generation tests use **synthetic** proteins, clearly therefore they are not viral. How can something that is synthesised be viral? A virus is a creation of nature. They are used to improve reproducibility, which would be justified if one knew what they represented. Is that really so difficult to understand?

11. Of course, not everybody with HIV has AIDS. But aren't they all supposed to get it? Are you sending me up?

12. Is there anybody anywhere so obtuse that they do not appreciate that no test could possibly work during the period between infection and the manifestation of antibodies and/or symptoms? The import of the leaflet's message is that the manufacturer disclaims any confidence as to what might be shown up on a positive test, for good reason, as I have been at pains to try to explain.

13. Since when has it become "official" that HIV is not inevitably fatal? I suppose some people's T-cells, for as yet unknown reasons, are not destroyed. Since when is this so, and in Dr. Harris's own words, please, an explanation of this yet other, novel property of HIV?

14. The insurance angle brought in by Harris is incomprehensible in a European context. Dr. Harris seems to be saying that American insurance companies have to take on anybody irrespective of risk. For all I know that

Harris

useful about a person's future, insurance companies would want to save their money.

15. Lanka: *"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!"*

Comment: Neither gp-160, nor the viral reverse transcriptase of HIV (which is magnesium dependent, unlike any in your cells), are of "human origin". You will find none in any human cell uninfected with HIV. Both are coded in the genome of HIV.

There follows a sorry theory in which Lanka theorises how the genome of HIV, now fully sequenced and cloned (and found to be very much like previously known lentiviruses), was supposedly "manufactured".

16. Lanka: *"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."*

This is baloney. Cells produce no magnesium dependent reverse transcriptase, no matter how you stress them.

17. There follows a fantasy that the HIV genome, so similar in structure to the 9-gene genome of other lentiviruses, was produced by mixing up and producing random cell DNA, and fishing out the "right" retroviral like sequences with HTLV sequence probes.

18. Lanka: *"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)."*

Comment: A nice scenario, except for a couple of small problems. HIV looks like a lentivirus, it doesn't look like HTLV visually at all. Furthermore, HIV has no antigenic similarities to HTLV-I, something that caused Gallo real problems until he got a sample of Montagnier's LAV virus (the real HIV). Instead, HIV antisera cross reacts to EIAV (equine infectious anaemia virus) which really is a lentivirus (one that infects horses' lymphocytes).

19. So to get a lentivirus from DNA already in human cells, we must posit, at the very least, that Montagnier used EIAV probes, and managed to "make" a human lentivirus (which kills and buds from human cells!) out of normal cell DNA, fishing it out with horse virus DNA probes (!).

20. Lanka: *"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."*

Comment: No, it actually produces fine looking viruses - lentiviruses in fact, in good form. Again see all the papers I quote above, particularly the *Virology 189:695-714, 1992*.

21. Lanka: *"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 just a rag-bag of endogenous DNA from the pool of repetitive elements has been prepared."*

Comment: Wrong. If this were so, DNA PCR hybridisation would "get" HIV DNA out of any human cell. But there have been many studies

Lanka

is true, unbelievable as it sounds. But then it it is known that American politics can be bizarre. I have a question: are US insurance companies also obliged to insure every drunken driver, or forbidden to weight the premium against someone like that - are you pulling my leg?

15. p24 is the direct evidence for HIV as far as most HIV researchers are concerned. Harris tries to divert attention by using reverse transcriptase and gpl60, which have never been considered in this context. gpl60 is just a cellular precursor protein, and the famous reverse transcriptase is not even correctly demonstrated, because the RNA template used for this is readily converted into DNA by cellular DNA polymerases. The magnesium ion argument is therefore just another dud.

If reverse transcriptase were really proven, which is questionable given the lamentable state of AIDS research, then it would have to be encoded in the special lines needed to make HIV. Where's the problem?

16. Again, I find it embarrassing to have to point out to Harris that in the method he mentions, DNA polymerase activity is detected, not reverse transcriptase activity. This is indeed dependent on magnesium. What is the difference between one *-ase* or another, between friends?

17. Unlike Harris, who has clearly not read or considered any of my references, I have chased up some of his. So template switching is too difficult a concept for him to deal with, or does it not exist? In one of his favourite papers (*AIDS, 1991, 5, p. 619*) about HIV structure he will find that HIV has only three genes. Does that mean it is not a lentivirus after all, or that Gelderblom is wrong? I think this has gotten all too complicated for Harris, who can only make visual and epidemiological judgments.

18. Please, Dr. Harris, spare me! So poor Robert Gallo had problems, did he? I thought he never got viable sample(s) of Montagnier's LAV, wasn't that the whole problem why President Reagan and Premier Chirac had to meet? What a nerve to rebut one non-existent virus with another non-existent virus. Do you really think Gallo didn't prepare HTLV-III but **did** HTLV-I? It must be obvious to a blind man with a stick by now, that Gallo has never done anything right in his life. Have you not read the Crewdson Report in the *Chicago Tribune*; are you unaware of the Office of Research Integrity's findings; are you not aware that he has finally got the push from the NCI? And you have the nerve to bother people with some problem he may have had cooking the books. What an insult of an answer waffling on about cross-reacting sera. If one does not know the answer to a problem, the correct intellectual position is to say, "I don't know". No-one is required to adjudge a technical problem on a highly specialised subject not in his field. 'Flu vaccines, hepatitis B and malaria (which you may have heard of) all cross-react with HIV tests. What does a horse virus nobody has heard of and cares about less, have to do with the price of tea in China?

It is perfectly understandable that Harris may have difficulty in rebutting the template switching and hybridisation arguments put forward in my paper. I am a virologist, and this is pure virology. Do you think I woke up one morning and say to myself, "Let's play silly buggers, and put it about that HIV doesn't really exist."? Of course not. No physician could possibly rebut it without the help of a top-rate virologist. If a Duesberg tried, I'd pay attention, but talk of sera and antigens, God help us!

19. I refer the honourable doctor to my preceding answer.

20. I again refer the honourable doctor to the answer I gave above.

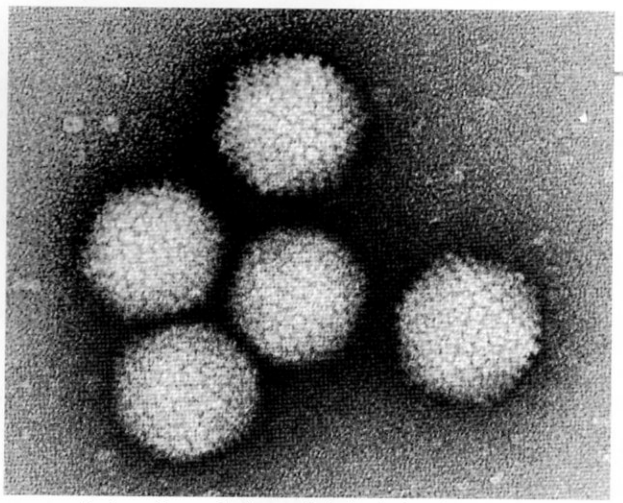
21. It is my humble opinion that the sequences are endogenous and anybody can prove it. Not only in man, of course, but also in the special cell cultures that always have to be used to make HIV. But here's the rub, dear Dr. Harris! That is how HT23 (the first human retrovirus) was discovered in 1975, but which Gallo very soon thereafter had to withdraw from the "market", because vociferous ape virologists staked an earlier claim to it. This also explains why Gallo and Montagnier published almost identical sequences, because he had purloined them as endogenous sequences from

Harris

of HIV infected people, along with HIV-negative controls, and the PCR or viral culture is negative on the controls. No "HIV" DNA is there. See for instance *N. Engl. J. Med. 326:1385-1391, 1992; N. Engl. J. Med. 321:1621-5, 1989; AIDS 6:373-377, 1992; AIDS 8:895-900, 1994.*

Lanka: *"One cannot help asking why no-one had not long ago spotted the flaw in the techniques employed by the Gallo and Montagnier groups."*

Comment: Actually, one cannot help asking why nobody has spotted the flaw in Lanka's argument, which suggests that "HIV DNA" must be in every normal cell, since HIV as a separate entity does not exist, and therefore no DNA PCR test can ever be "negative" on anyone. Yet these tests routinely find no HIV DNA in HIV negative people.



Electron micrograph of correctly isolated adenovirus type 2

22. Lanka: *"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 sunbathing, no specificity can be ascribed to the test."*

Comment: Then why does a positive test give you a 50% chance of dying of immuno-deficiency in 10 years? That's a harsh punishment from rheumatology and sunbathing. And why do positive antibody tests correlate so well (both positively and negatively) with viral culture tests (which measure a protein) or with direct PCR (which measures DNA).

23. If there's no virus to explain all this, how does Lanka explain it? Remember, one must explain not only why people who test positive for "HIV" antibodies almost always test positive by culture and PCR (which don't test for antibodies), but also why people who test negative for antibodies test "negative" by culture and PCR (see last set of four papers quoted).

24. Lanka: *"Whether antibody positivity really correlates with disease as is commonly supposed, remains to be determined by a critical re-evaluation of the data."*

Comment: Is the claim made that it was done wrong the first time? Showing how (the burden of proof) is on Lanka before more are conducted. HIV is the only variable which independently correlates with AIDS risk in all AIDS groups. None other has been found.

Lanka

Montagnier; only illicit collusion could have produced the concordance that was obtained. Not only these two, but also Robin involving Weiss, although the Pasteur Institute has up till now not sued him for patent infringement. The evidence is available for all to see at the Patent Office in London.

One reason why, in the so-called PCR controls, nothing is found, is that the human cells used to act as controls, are not stimulated (stressed) in the same way as those in which one wants to detect HIV, i.e. they don't compare like with like. The RNA detected in PCR tests is not expressed under normal conditions, because they do not belong to the normal repertoire of the lifecycle. The RNA detected is formed in response to stress when cells in short-term cultures begin dying, or are treated in such a way that cellular activity is disturbed, and "retroviral sequences" are expressed which are not formed (transcribed) otherwise.

PCR only detects very short stretches of DNA that in this case are supposed to be components of the genetic material of viruses. If one succeeds in this, it is immediately described as "PCR positive", implying that the remainder of the genetic material ascribed to HIV is found somewhere else. This is pure guesswork!

On careful reading of Harris's references on PCR and many others, one discovers that a number of PCR tests for viral RNA use **chromosomal** DNA as controls! As every genetics student would object immediately, this can't be done. Transcription into RNA changes the gene sequence, i.e. the RNA is "edited"; on reverse transcription back into DNA it is no longer the original DNA. Starter molecules needed for this edited DNA are now prepared which fit this DNA, but not the original. Herein lies the wizardry! A wonderful piece of deception, and available for all to see! All recounted history! Regrettably, with terrible consequences. The argument is tricky, and if Harris can't, or is reluctant to, grasp it, then so be it. I have never claimed that HIV DNA is present in every human being for the obvious reason that it doesn't exist, except as a lab construct.

22. I presume Harris means "have a 50% chance of dying of AIDS", not immuno-deficiency. Or does he not know that they are not synonymous? 39% of AIDS cases have nothing to do with immuno-deficiency. It appears to be all the same to Harris. HIV kills off T4 cells, therefore 10% of people get Kaposi's Sarcoma, 6% develop dementia, 3% develop lymphomas and 19% waste away. Or is this the point at which the "fiendishly clever" effect of HIV comes in, whereby it causes these totally disparate diseases "indirectly", by molecular mimicry, by apoptosis, by autoimmunity, by protein toxicity?

By the way, is there another slip up in Harris's "have a 50% chance of dying"? Is this now official policy - only half the HIV positives develop full-blown AIDS? Since when, and why, but see also 27 below.

23. I suppose I do have to spell it out, superfluous as it seems. It is not disputed that "HIV positives" are in some way at risk. The question is how, and of what.

I strongly urge readers to study carefully the papers cited by Harris to understand why in HIV negatives PCR is also apparently negative. It is quite simply because they never compare like with like, and play a trick on top of it all. The first HIV PCR studies gave no concordance at all between antibody and PCR tests. Nowadays, this is glossed over, and in those cases where this can't be done, it is claimed that HIV is present only in the mutated, defective or non-integrated form. In summer 1993 (see my earlier paper) they invented the concept of molecular mimicry to explain the inexplicable: it says that the virus had mutated so much that in effect it has mutated itself out of existence.

24. I am aware of Harris's dismissal of the alternative drug intoxication theory. I assume he is relying on the Winkelstein et al. paper, and no doubt assumes that is the end of the matter. I can only rejoin that if he is so naïve as to rely in any way on the accuracy of self-reported drug use - just as an aside, who the hell knows what people really take in when shooting up, swallowing or sniffing adulterated illegal drugs prepared in back street labs. Has he never been in an organic chemistry lab, and noted that side reactions always occur, what nasty reagents are used to make new compounds? If so, he would assuredly be less cock-sure.

The other - oh, so hard to quantify, so let's forget all about it - factor is the effect of a psychological death sentence of a positive diagnosis. As a virologist I cannot quantify it either, but as a human being I know it to be extant, and I cannot just forget about it as Harris seems to with such insouciance. Has he never heard of psycho-neuro-immunology?

Harris

25. Lanka: *"AIDS research is therefore back at square one and not at Basic Science as suggested elsewhere. The main players have since 1993 begun to slink off, arguing that the virus having mutated so much is now no longer detectable."*

Comment: Utter nonsense. References?

26. Lanka: *"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."*

Comment: There is no evidence that these drugs produce deficits in the cell-mediated immune system which are important clinically. There is no evidence that they produce AIDS (as Lanka may be trying to suggest here) and a great deal of evidence they don't (the *Concorde* trials).

27. Lanka: *"The most important and delicate task is to convince antibody test positives that their result is not a death sentence."*

Comment: Nobody said it was. At least 10% of newly infected people today will still be well and healthy in 15 years, even if medicine does not improve, and only 75% will be dead. For haemophiliacs, that may be as low as 50%. And, of course, things will not get that bad, because medical treatment will improve drastically in the next 15 years. So there is real hope.

28. Lanka: *"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."*

Comment: That depends entirely upon the state of the destruction of their immune system. It is unrealistic to tell someone with no CD4 cells and 100 CD8 cells, for example, that they have a "good chance" to regain their health. Some people don't like to be lied to by their doctors.

29. Lanka: *"The large number of long-term positives, whose condition cannot be explained by conventional AIDS theory,"*

Comment: There are not a "large number" of long term positives - it is a small percent (10%). And "theory" has nothing to say about their existence either way. That is simply a cheap shot by Lanka at the establishment.

30. Lanka: *"as well as the phenomenon 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."*

Comment: Sure we will. Just as soon as Dr. Lanka can tell us how it is that when people got AIDS after a blood transfusion, their donors were found more likely to be high risk gay men, than the donors were for people who got the identical amount of blood from the same bank, but didn't get sick. When the "lifestyle" of a stranger donor statistically predicts disease ($p < .01$) in the transfusion recipient, perhaps Dr. Lanka can explain this without resort to an infections agent? Please read *New England Journal of Medicine 310:69-75, 1984.* It's as good an article now as it was then, and as frightening. ■

Lanka

A propos "..independently correlates with AIDS risks in all AIDS groups", what does Dr. Harris make of the recent CDC announcement (see page 17 of this issue) that there cannot have been any HIV in Factor VIII given to haemophiliacs since drying of blood products reduces the risk of infection to "zero"? Are they not suddenly a risk group, who have AIDS without HIV? Awkward, isn't it?

25. See references 30, 31 in my original paper. I can only urge him and others who might want to establish a half-way decent overview of much of modern virology and genetics to take the trouble to read more widely. My references have not just been plucked out of thin air, and I have read and, hopefully, understood them, which is more than can be said of some people!

26. Dr. Harris is pretending that the immune system is properly understood. I hazard a guess that at most 1% of what it really comprises is known, hardly a proper basis for dogmatism. Least understood is the significance, if any, of T-cell counting. Dr. Harrids would get the most up-to-date crtical review of current knowledge on this troubled subject by reading Eleni Papadopulos-Eleopulos et al. in *Genetica* 1995. And when he has doen that he would benefit by swatting up on the whole murky topic of antibody testing and the PCR in *BioTechnology* 1993 by the same authors. He will become a wiser man.

I know someone who has for several years had only 3 T-4 cells, which he named after his dead friends. He himself is well. Dr. Felix Konotey-Ahulu of the famous Cromwell Hospital, London, has described a healthy tribe in Ghana whose mean T-cell count is 100 (*sic*). Also, why can an individual have twice as many T-cells in the morning as in the evening? Is this also "just baloney"? Certainly not, it is all well documented. These arguments of Harris's are all little more than conjecture, and only tangential to the case of whether HIV exists or not, and how it was "manufactured"; dealing with them thoroughly would open up a whole new can of worms, beyond the scope of this response.

27. Since when is it "official" that 10% of positives will be alive after 15 years? I thought you said it was 50% (see section 22), or is that to be understood as meaning 40% die in years 10 to 15? In German we have a saying "Lügen haben kurze Beine" (lies have short legs, i.e. they don't get you very far). Stop making policy on the hoof, it won't work. Long-term survivors have only been officially recognised for the past 2 years, now you claim they are recognised to constitute 10-50%.

28. Destruction of the immune system, eh? Dementia, cachexia, lymphomas and Kaposi's sarcoma? And now cervical cancer, no less. Remember, "Lugen haben kurze Beine."

29. In case you have forgotten, official theory states that **all** positives die. It goes on to state that admittedly "precisely" how this happens is not known, but the evidence that they do is "overwhelming". What are you trying on here, Steven?

30. Thank you, I might just do that one day. That will have to be such a boring day as can never be. To waste my time reading about yet another flawed transfusion study with a frightening scenario that turned out to be wrong (see Dr. Steven B. Harris in *SKEPTIC 1995, vol. 3, no. 2, p.76*) is all I need.

I would like to pay tribute to Dr. Harris for his spirited attempt at a rebuttal. Its complacency and self-delusion are astounding, but he gets full marks for trying to answer the problem to the best of his abilities. In this respect it contrasts sharply with the usual attitude of the establishment whose reluctance to enter public discussion is utterly reprehensible. ■

We would like to express our sincere thanks to Alastair and David of PrintKings for their invaluble assistance and co-operation especially in the preparation of both this and the last issue of the Continuum magazine.

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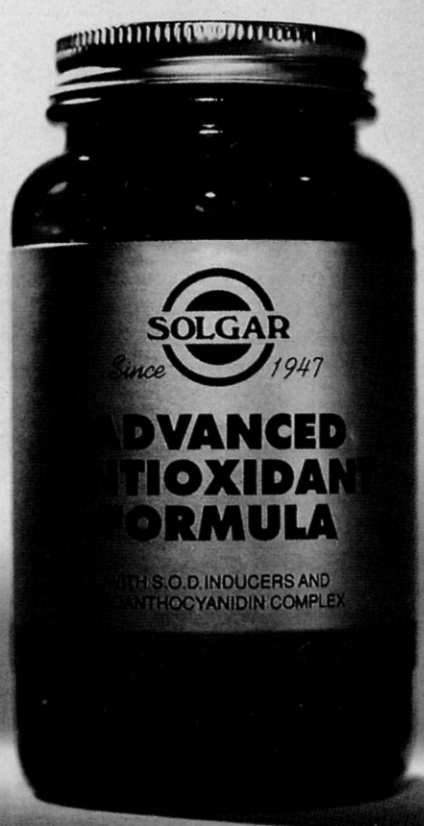

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