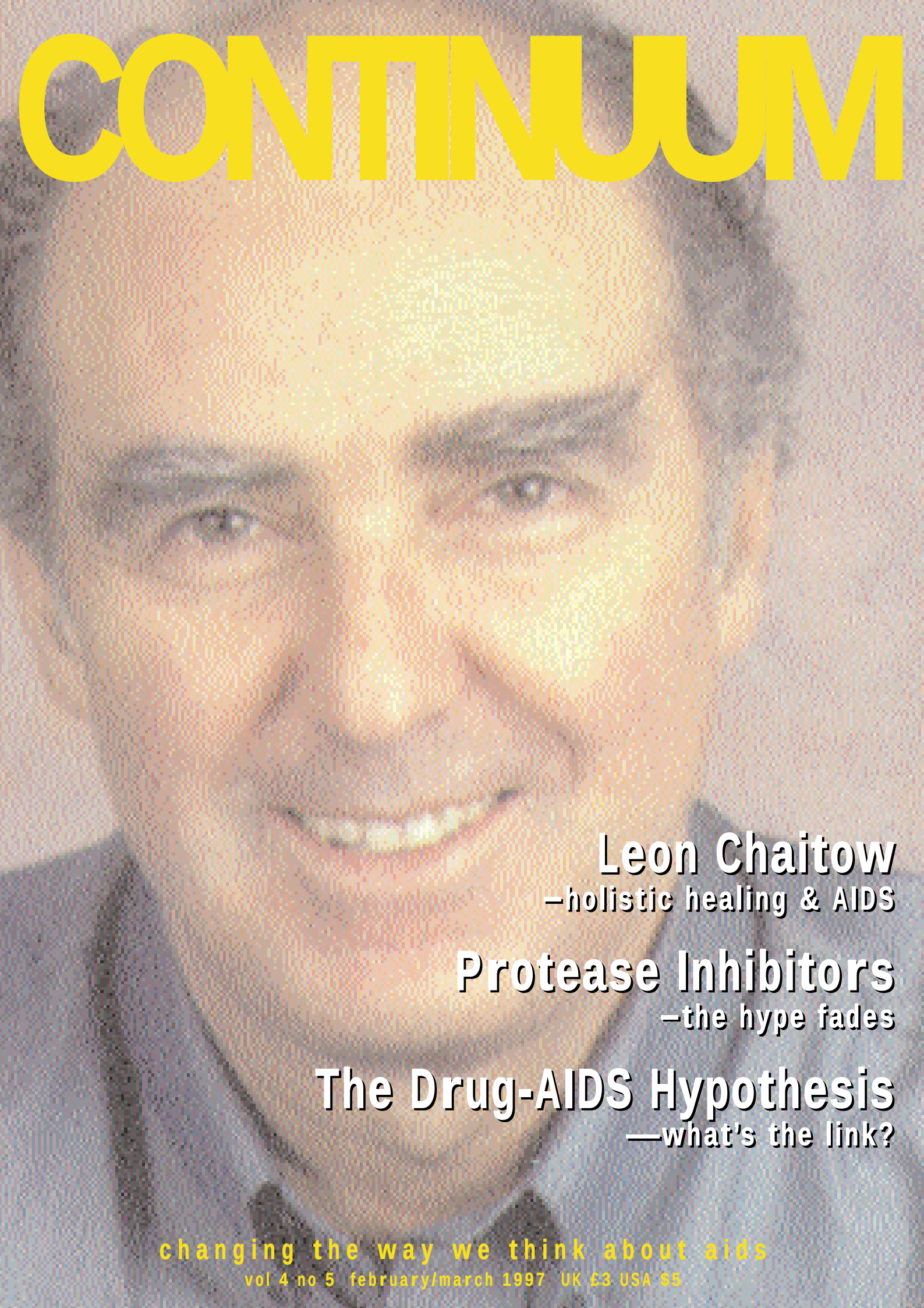
CONTINUUM



Leon Chaitow
—holistic healing & AIDS

Protease Inhibitors
—the hype fades

The Drug-AIDS Hypothesis
—what's the link?

changing the way we think about aids
vol 4 no 5 february/march 1997 UK £3 USA $5

CONTINUUM

a magazine by the living for the living

vol 4, no 5
february/march 1997

why CONTINUUM?

The orthodox view on AIDS holds that it is caused by a virus known as HIV that is transmitted through the exchange of body fluids. Once infected, a person will remain well for a time, though infectious to others, before going on to develop AIDS and dying.

Despite the huge sums of money spent on medical research, there is still no cure, just drug therapies said to slow the progress of the disease, and regular T-cell counts to measure health.

A whole industry has evolved around AIDS, on which many careers and businesses depend, but which offers little hope to those affected. It works on the premise that HIV=AIDS=DEATH.

CONTINUUM began as a newsletter encouraging those effected to empower themselves to make care and treatment choices. As we look further, anomalies in the orthodox view continue to appear.

Are you aware, for example, that the link between HIV and AIDS has never been more than hypothetical? That a growing body of scientists and doctors throughout the world doubt that HIV causes AIDS?

At the onset of the "epidemic", the hysteria that resulted from the linking of sex, death and an infectious virus created a climate where to question the "facts" was considered reprehensible. Many of those who dared to do so were silenced or ridiculed. Since the growth of the ortho-doxy, those who question have also had to contend with the weight of vested interests.

Twelve years after HIV was first associated with AIDS many predictions based on the viral hypothesis are failing to materialise. **CONTINUUM** is a unique forum for those in the scientific community challenging the orthodoxy and those whose lives have in some way been touched by the hypothesis.

CONTINUUM is a voluntary organisation dedicated to providing information we believe is necessary for the fuller understanding of HIV, AIDS and immunity. All our workers are unpaid and the organisation relies on subscriptions and donations to maintain its work. Your support in any way is greatly appreciated.

focus

features

supplement 20

PHOTO: Martin Langer, 1986

Doing Time – news may travel relatively fast, but is it always accurate?
(see pp. 4-7 etc)

news

regulars

changing the way we think about aids

Rising confidence

The annual Health Monitor survey of 10,000 people found that the number of 18 to 20 year olds risking 'unsafe sex' has doubled in the past 12 months. Among all adults, the number expressing "strong concern" about developing 'AIDS' has fallen. "A lot of people have come to the conclusion that they are not at risk from HIV", said Anne Weyman, chief exec of the Family Planning Association.

The Guardian 14 Feb 97

Falling figures

The annual number of 'AIDS' deaths has fallen by half, new figures show. Researchers hope this means the worst phase of the 'epidemic' is ending. Dr Tony Fauci, of the NIH, said he expects more such results from around the USA. Hospitals in Los Angeles are announcing similar dramatic falls. London's Chelsea and Westminster hospital has closed down one of its 'AIDS' wards due to lack of demand, as has Sydney's Royal North Shore Hospital.

THUD, 21 Feb 97

Sydney Star Observer 30 Jan 97

Testing rejected

The *British Medical Journal* rejected compulsory 'HIV' testing for doctors as callers jammed helplines at three hospitals that employed an 'HIV diagnosed' junior doctor who died last month. Rosemary Geller, Shropshire's Director of Public Health, said: "We have never had a case in this country of HIV or AIDS being transferred from a health care worker to a patient". The cause of Dr Olukayode Fasawe's death has not been established.

The Guardian 20 Feb 97

Dirty Water

Dwindling UK water supplies have led to an outbreak of human infections with water-borne parasite *cryptosporidium,* that produces sudden explosive diarrhoea. In immune-compromised people infection can occasionally be life-threatening. 300,000 north London and Hertfordshire households have been told to boil all water for consumption.

The Times 4 Mar 97

New Genes

Genetically engineered food will be banned from sale in Australia until cleared by food and health authorities and specially labelled, under the country's first proposals to control transgenic produce. Products containing less than 5% of an approved genetically modified food will escape labelling.

The Australian Jan 97

UN Network hunts for HIV

The World Health Organisation Network for HIV Isolation and Characterisation (WHO-NHIC) has been placed under the auspices of the recently created programme United Nations-AIDS (UN-AIDS) so efforts since 1989 to identify HIV can continue.

Says Dr Eva Maria Fenyo of the Karolinska Institute, Stockholm, a Principal Investigator who has acted as co-ordinator of the programme, the ongoing attempt to characterise HIV has been "a fantastic experience". The Network involves laboratories in at least 11 countries, and its goals include "to facilitate the international collaborative research addressing critical questions" and "evaluation, validation and standardisation of modern laboratory technologies for hiv isolation and characterisation" in "effective partnership" with "scientists, institutions, organisations and the pharmaceutical industry."

Dr Fenyo stated, "There is very much more to learn about HIV," but claimed "proper isolation of the virus has been achieved". Dr Saladin Osmanoff of UN-AIDS' Department of Policy, Strategy and Research in Geneva said research with material from different parts of the world has produced "variations in the structure of HIV" of as much as 30%.

Dr Fenyo revealed the Network's current preferred criteria for isolation of HIV are either: (1) detection of a "virus-specific enzyme", reverse transcriptase, which she claimed has been known to be retrovirus-specific since 1970, though this enzyme has been frequently reported by other scientists in non-viral genetic activity in contexts as diverse as insects, yeast, maize and humans. In yeast reverse transcription can be found "precisely mimicking the early stages of infection by a retrovirus" according to a British secondary school biology text; or (2), detection of a "virus-specific antigen", a protein known as p24. Long-running disagreement exists between "discoverers of HIV" Luc Montagnier, who claims p24 is the most specific protein of HIV, and Robert Gallo, who claims p41 is the most specific HIV protein. Montagnier claims on the contrary p41 is a common cellular protein. Today, oddly, WHO minimum criteria for a positive result on the HIV Western blot antibody test do not require inclusion of the Network's p24.

Pressed for undisputed evidence of structural isolation of a complete HIV, Fenyo cited electron micrographs produced by Dr Hans Gelderblom of Germany. This scientist however acknowledged the particles he photographed were not separated from other cellular particles and proteins (i.e. in reality isolated); and they were not banded at the density gradient of 1.16g/ml, which conventional science has defined for retroviruses.

He cautions that the "knobs" of glyco-protein 120 (gp120) which are essential for the idealised model of HIV he proposed in 1987 to be infectious are seen only in "immature (budding) particles" which are "very rarely observed" and are seen only "on metabolically impaired cells". He estimated the average number of these essential infectious knobs seen is 0.5 (sic), and cautioned that even these could represent false postive readings.

The UN-AIDS programme, structured in 1996, is sponsored by six organisations including the World Bank and UNICEF, with an annual core budget of US$120 million. The Network for Isolation and Characterisation of HIV is allocated between US$200,000-400,000 per year which is used for co-ordination, and seed funding for laboratories in developing countries. Dr. Osmanoff estimates that the actual amount expended by participating laboratories attempting isolation and characterisation in USA, Europe and Africa is ten times this figure.

"HIV" doctor freed

A medical doctor accused of 14 cases of HIV-associated murder and 5,800 cases of HIV-associated attempted murder has been set free in Goettingen, Germany. After pressure from health and human rights organisation regimed, the world's first AIDS-murder-trial ended with the court dropping murder charges related to allegations of "inaccurate testing" against Günter Ekkert in August 1996; three of 14 antibody positive transfusion patients had died of unreported causes.

The accused was set free on the 24th February 1997 after it was proved that the county's Minister of Justice and the German government knew there are no data to sustain claims on "HIV" and "AIDS" and no "AIDS"-scientist willing to testify under oath on a causative relationship. The policies of the German health authorities are thus under judical pressure. Chancellor Kohl has become personally involved in the "AIDS" scenario which came into existence during his near record tenure. Whistle-blowers are now airing the possibility that Germany will soon abandon the US-dominated AIDS-policy.

Contrary to the CDC-definition of "HIV" and "AIDS", the decision of the German High Court is that "HIV" is neither a deadly nor dangerous virus, but merely "something" which does harm. It is thought to be now a matter of time till the courts acknowledge they have dealt with a phantom.

Recent trials of politicans and especially judges of the former East Germany have created an atmosphere in which courts place the right to life above other, particularly political, issues.

PHOTO: Flash Press

Red ribbon bash – hardly a lapel was without one at movie star Elizabeth Taylor's 65th birthday party on February 16 at the Pantages Theatre, Hollywood. Tickets cost US$1,000, with proceeds benefitting the star's personal AIDS Foundation. Taylor entered hospital the following day for brain surgery.

Threat to natural choice

A campaign for global standardisation of dietary supplements is being mounted by German pharmaceutical giants Hoechst, Bayer and BASF – three companies formed when IG Farben was dismantled after the Nuremberg War Trials for their role in making poison gas for NAZI concentration camps.

The German government is proposing to European partners, to the WHO and the FDA (US) that higher-range dietary supplements should be regulated, enabling the medical industry to control this world market. The World Trade Organisation will meet again in 1998 to set up guidelines for prophylactic and therapeutic vitamins, herbs, amino acids and minerals. If agreed, higher-range dietary supplements will be classed as medicinal, requiring expensive pharmaceutical licensing procedures prior to marketing.

The German cartel's proposal threatens to become the International Reference Standard under both the General Agreement on Tariffs and Trade (GATT) and the North American Free Trade Agreement (NAFTA). Nations that do not comply may face economic sanctions. In Spain, a ban on advertising of natural products which have not undergone the drug approval process has already been implemented. France says that a distinction should be made between toxicology and nutrition when safety limits are considered.

The European umbrella organisation Consumers for Health Choice, and the US Life Extension Foundation are fighting the plans stating research has shown long-term benefits of taking higher dosage vitamins and minerals, which are becoming scarce through modern farming methods. They claim an enforced Recommendation of Daily Allowance (RDA) will curtail access to desirable supplements, since reclassification as pharmaceutical drugs will force vitamin manufacturers to take their products off the market or put prices up several-fold. According to Lord Baldwin of Britain's Parliamentary Group on Complementary and Alternative Medicine, "They are refining the distinction between supplements and medicines... I do think it's an artificial distinction".

Contacts:
Sarah Winterton, Administrator, CHC Ltd, Tel: (0)171 222 4182.
Pat Stern, Life Extension Foundation website at http://www.lef.org

More old monkey business

A hundred chimpanzees, many deliberately "infected with HIV", are being rehoused in a retirement complex in California after not one of them developed AIDS. The move follows a campaign by pro-animal rights activists led by People for the Ethical Treatment of Animals (PETA).

Chimps used for such research cannot be put down, according to the research industry's code of practice, so they may live a normal lifespan of 60 years.

The new facility, Waystation, cost US$1 million. PETA wants the US Congress to pay $10 million for other homes, arguing this is a fraction of the sum drug companies spend on animal research. Says Martine Colette, founder of the refuge, "Chimps don't owe humans anything. But humans owe chimpanzees a lot."

Among those to be rehoused is "Booie", over 40 years old and famous for his ability to use sign language. Keepers have not ruled out teaching him to sign "HIV does not cause AIDS".

Gulf chemicals

Two teams of US researchers have linked the range of symptoms experienced in the Gulf War to chemical exposure, in particular organo-phosphates. The teams reported an increase in neurological injuries. Symptoms reported by Gulf war veterans included insomia, anxiety, memory and reasoning failings, fatigue, asthma, bronchitis and post traumatic stress disorder.

British Medical Journal 18 Jan 97

Herbal problem

Trade in herbal teas and medicines is threatening some plants with extinction, says a new study claiming 18 species are in urgent need of protection. World sales of herbal remedies are increasing by more than 10% per year. World Wide Fund for Nature said trade in herbal medicines isn't always bad for the environment: "Many plants have been sustainably harvested for a long time."

New Scientist 15 Feb 97

Old wounds

Will 'AIDS' tattoos become mandatory? The *British Medical Journal*'s letters page contained several criticisms of Bernard Rabinowitz's suggestion that 'HIV' testing should be obligatory before surgery. Registrar Paul Walker wrote: "Do we tattoo people with the letters AIDS, isolate them in a ghetto, or eventually transport all those infected into separate camps? What would be the next step?"

British Medical Journal 18 Jan 97

KS research

A protein extracted from the urine of pregnant women may help in treatment of KS, claims Robert Gallo. Researchers grew KS cells in mice with poor immune systems. Most animals were overwhelmed and died. The survivors were female mice that became pregnant. Subsequent research with the human pregnancy hormone chorionic gonadotropin and human KS are reported as promising.

New Scientist 22 Feb 1997

Elusive diagnosis

Former *New Republic* editor Andrew Sullivan elucidates the non-existence of 'HIV' in a feature entitled *When Plagues End*: "The diagnosis was so confoundingly elusive. I felt no sickness. I had no symptoms. There was nothing tangible against which I could fight – no perceptible, physical ailment that medicine could treat. So it seemed less like an illness than like some amorphous condition of life..."

Independent on Sunday 16 Feb 97

COMMENT

From Fritz Lang's pioneering film Metropolis and Charlie Chaplain's Great Dictator to Tina Turner's Steel Claw, free-spirited commentators have represented the machine-like oppression of industrial society.

What's the role of a citizen? (What's the role of an artist?) Who can dictate their own terms any more?

It may be best that humans and their communities learn to negotiate terms with each other. At least at the scale on which we affect the planet, and the radical nature of some of the effects we could have – nuclear snarl-ups, for example – it matters that respect for the rights of others be nurtured.

Continuum is a voluntary organisation. This edition of the magazine, the first of the year, is a bit delayed, because we are not a relentless machine. When one of us is unwell, as Tony has been, we know we can adapt, and put wellbeing first. I think you'll agree, Tony's layout of this issue is now the best ever. And he is making his recovery.

The worst crime of the HIV/AIDS hypothesis is the curse that decline is inevitable. There are abundant examples of people who have reversed immune dysfunction, overcome specific illnesses, and survived as long as it's possible with the antibody diagnosis – i.e. since the terrible tests came into use. But the popular message is still one of a downhill trend. This is clearly not inevitable. Recovery is the goal, and can be the reality, time after time.

This issue carries a range of information and insight to help people achieve that goal. William Shakespeare wrote, "Our remedies oft in ourselves do lie, Which we ascribe to heaven." There's something true about that. We all have a higher self which knows more than our conscious mind. Sometimes in dreams, or in stillness, and even in unlikely moments when we least expect it, the wisdom of wellness speaks to us. Having the pieces of the puzzle in your mind is the first step to making a whole picture.

Published bi-monthly by:

CONTINUUM

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Continuum is grateful for support received from the Study Group on Nutrition and Immunity, Bern, Switzerland

Affiliated to the Harrow Association of Voluntary Service,
The Lodge, 64 Pinner Road, Harrow HA1 4HZ. Regd. Charity No: 294136

Printed by: Calvert's Press Workers Co-operative,
31–39 Redchurch Road, London, E2 7DJ. Tel: 0171 739 1474

diss

There was a time when we tortured and burnt witches. It was not possible, of course, to prove that someone was a witch, but our ancestors got round that little legal problem by simply dispensing with the need for evidence. An unsupported accusation that whipped up public hysteria was quite sufficient to send hundreds of men and women to their deaths. A community justified its actions by claiming it was carrying out God's work.

Today, in our more sophisticated society, we no longer persecute witches. We hunt out and prosecute paedophiles instead. Unlike witches, paedophiles undoubtedly do exist and we are right to arrest them, even if the debate remains necessary over precisely where to set the age of consent. And we are morally at liberty to condemn anyone who sexually violates another person against their will. But, if we are to distance ourselves from the lynch-mob tactics of our witch-hunting ancestors, we should ensure that we only root out and punish sex offenders using honest and fair laws. We should not dispense with the need for evidence, no matter how hard it may be to prove paedophile or other sex offences, and we should certainly not send people to prison on the basis of an unsupported accusation.

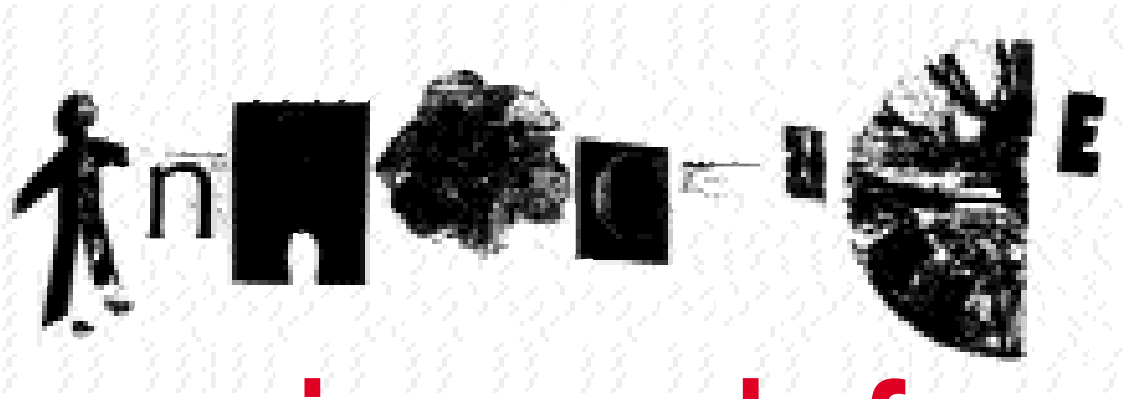
In September 1995, a 16-year-old youth called Nathan was arrested by the police in his home town of Malvern, Worcestershire, and charged with ten burglaries at the homes of old people living on their own, with another 48 similar offences to be taken into consideration. He was remanded in custody to Gloucester Prison to await sentence by the court. He was warned that, because of the unusual quantity and seriousness of his offences, he faced a Section 53 sentence – a sentence longer than the maximum two years usually imposed on a 16-year-old. Inside the prison he was also badly bullied. It was his first time in jail.

One day, soon after going inside, he telephoned his mother. Sobbing, he made an allegation to her that I had sexually abused him on a number of occasions three years before. His mother reported the conversation to Nathan's social worker and the police. An investigation was started, although I knew nothing about any of this until eight months later when I was arrested.

Nathan, however, reaped some immediate benefits from his allegations against me. His social worker wrote to the prison and got him moved away from the bullies, on the grounds that he was helping police with their inquiries into a sex abuse case, which would make him a target for bullies. A favourable pre-sentence report was written, urging leniency from the court, on the grounds that he had only committed his crimes because he had been sexually abused. So he was given just 22 months, of which he served only eleven.

While still in prison, Nathan was interviewed by the police on two occasions, making a statement each time. In the first, he alleged that I had indecently assaulted him by getting him drunk at my home, then, after he had gone to bed in the spare room, that I had gone in and forced him to give me a blow job. In the second statement, a couple of months later, he now added two accusations of buggery. He claimed these three incidents had happened in the Autumn of 1992, after he had been on a camping holiday to France with me and three of our friends.

I was blissfully unaware of all this until Saturday 18 May, 1996, when seven plain-clothed police officers forced their way into my house in Malvern and arrested me. I was still in bed at 8:30 a.m.



is no defence

Continuum chairman **NIGEL EDWARDS** has just been jailed for serious sexual offences on a 13-year-old boy. He has consistently denied the allegations and claims he is a victim of a miscarriage of justice and bad law. Here he tells his story which, he believes, spotlights a serious threat to vulnerable gay men and lesbians and raises some important issues.

having only returned home from London for the weekend at 5:00 a.m. I was told I was being arrested on suspicion of committing buggery on Nathan when he was aged 13. My response was: "This is absolutely ridiculous." And it was. Although I am openly gay, and have even been deputy editor and acting editor of the Pink Paper, Britain's national lesbian and gay newspaper, I have never indulged in penetrative anal sex, either way. It is just not my style, and all my friends know that. I never have, and I never could have buggered Nathan. I did, however, have quite a lot to do with him in 1992, but I never laid a finger on him sexually, nor was I attempting or planning to.

I was questioned for two hours by the police and gave the fullest possible answers to their questions. I was amazed when, after all this, and despite them having no evidence whatsoever other than Nathan's word, they charged me with one indecent assault and two buggeries. I was released on police bail, on condition that I did not contact any prosecution witnesses.

The case took another eight months to come to trial. In August, after Nathan was released from prison, I began to hear on the grapevine that he was trying to withdraw the allegations. Of course, I thought. They no longer serve him any purpose, and he was afraid of having to follow through what he had started, with the risk of being shown up as a liar in the witness box at my trial. The police, however, scenting a high-profile case against a leading member of the gay community, and someone who was also well known as a BBC newsreader and journalist (my pre-Pink employment), refused to let him pull out. They interpreted his reluctance as the fear of having to undergo the trauma of facing me in court and reliving his painful memories. Despite the fact that Nathan would be 18, they began to apply for him to give his evidence via a video link, or at least, behind a screen. All this was calculated to impress upon a jury his bravery, and the trauma he was alleged to have suffered at my hands.

I was confident before the trial that, as an innocent man, the truth was on my side. There was, of course, absolutely no supporting evidence. I was not denying my friendship with Nathan, or that he often joined me and my friends at weekends. In fact, it was my two friends, Gerard and Jason, that he was really friends with. They were in a relationship, and came to stay at my house every weekend from February 1992, when they first met, until September that year. Nathan only ever came around when they were there. He was fully aware that they were in a gay relationship and, although I never discussed it with him, he was fully aware of my orientation. Nathan, who identified as straight, was entirely comfortable with us, and clearly did not feel threatened by me or any of my various gay friends who visited at weekends.

My first major shock, in preparing for the trial, came when my solicitor told me that because the Conservative government has changed the law to make it easier for the police to prosecute child sex cases, they had no need to support the case with corroborative evidence. Nathan's allegation was quite sufficient for a conviction. Since there was no other evidence, the jury would be forced to make its decision by judging Nathan's word against mine. The only defence available to me was a weak blanket denial – "it never happened". The dates were drawn too widely, encompassing several months, so I could not even provide an alibi to say I was elsewhere, or doing something else at the time. Nathan did not even have to prove that anyone had ever buggered him. At least with a murder, there is a body, and so someone must have done it, even if it was not the accused. That is the question now being raised following the release of those convicted of murdering the newspaper boy Carl Bridgewater. And the same is true of most crimes. Someone must have done it. But under child sex laws, it is not even necessary to prove that anything happened in the first place. Nathan was free to invent both crime and perpetrator.

All hopes that Nathan might pull out were dashed when the police personally collected him and took him to Hereford Crown Court for the opening day of my trial on 21 January. So my hopes now lay in Rachel Brand, my barrister, breaking him down in the witness box to show him up as a liar. The proceedings began with the judge, with great fairness, ordering social services to disclose those papers in Nathan's file relating to his being bullied in prison, the serious charges he faced, and the benefits he received by his allegations. Clearly the judge thought them relevant.

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Dissenting View *Continued from page 5*

To my great relief, Nathan's evidence – given without any video link or screen, on account of his age – was greatly at odds with what he had said in his statement 12 months bef5ore. He was of course having to recall incidents he had invented, rather than real events which stick clearly in the mind. He contradicted himself in several significant particulars. In court, he now said that all the incidents happened before the trip to France. When challenged, he had no explanation. Rachel Brand said: "Surely you would have known when you went to France whether you had something to fear from this man or not. You would have remembered your feelings about him?" The indecent assault and the first buggery now got telescoped together either side of a Saturday night. In his statement, he claimed nothing had happened the next morning, nothing was said, and he just went home. He denied trying to blame me for his crimes to get himself out of prison – and had no explanation when it was pointed out to him for why he had made precisely that allegation in his statement. He could not explain why he kept going back to my house, or why he never told anyone for three years. He even suddenly came up with a previously unmentioned fourth incident. Considerable doubt was cast on his descriptions of the buggery positions, my barrister pointing out that as he described it, the act was physically impossible.

Gerard and Jason both gave evidence to show that they must have been staying at my house when Nathan alleged he was there on his own.

My own full and frank evidence in the witness box, in which I fully admitted being gay, was dismissed by the prosecutor as "dangerously smooth talking" whereas Nathan's stumbling and shifting was "an act of bravery".

I was stunned when after three hours the jury of nine men and three women returned a guilty verdict on all three counts. The judge, I believe, was equally surprised. My solicitor says his four and a half year sentence, being so light for the somewhat savage and inhuman acts I was supposed to have committed, was very light. I am told that I have no grounds for appeal, unless there is new evidence. So here I now write, in an extremely spartan cell, enduring the rigid regime of Gloucester prison. I am also forced to go on Rule 43 – segregation from the mainstream prisoners – for my own protection. Everyone here knows about me – I was described as "evil" in the News of the World.

Here I sit and brood on the injustice that has sent an innocent man to jail. Innocence is no defence. The jury, I believe, was homophobic. Despite all the obvious contradictions, they chose to believe Nathan's word against mine: queer, therefore he must be a child molester. I condemn a law that enables someone like Nathan to manipulate the police and the courts to his own selfish ends. But I brood particularly on this sinister thought: the gay community has rightly been worried in recent years about increasing use of a legal ploy known as the Portsmouth Defence, where a man accused of murder gets the charge reduced to manslaughter by claiming he "understandably" lost his temper when the victim made a homosexual advance on him – something he does not need to prove. He therefore escapes with a few years in prison instead of a life sentence.

Nathan appears to have made use of a subtle development of the Portsmouth defence, one that could be copied by any young criminal who wishes to win leniency from the court by claiming (without having to prove it) that he only committed his crimes because he had been sexually abused. All he has to do is polish up his story and point the finger at some convenient and vulnerable gay man. Like the witch-hunters of yore, he is helped by a law which allows him the unique luxury of not having to prove his allegations. And, like the witch-hunters of yore, he can rely on public hysteria against paedophiles to convince a jury that anyone who's gay must most likely be also a child molester. They too will often justify their actions as doing God's work.

I suppose I should at least be grateful that, for the time being, we have no death penalty in this country. But this miscarriage of justice will scar me for the rest of my life.

• Letters can be sent to Nigel Edwards at: KD1492 Edwards, HMP Gloucester, Barrack Square, Gloucester GL1 2JN, UK.

TIME BANDITS

Volker Gildemeister
with Huw Christie

The more things change, the more they stay the same. Of course, mainstream press coverage of AIDS has always been abysmal, oscillating between alarmist plaguism, divine retribution for the dark deeds committed by gays, and weepy compassion – hopes always being invoked (if less and less believed) that the pharmaceutical industry will come galloping to the rescue – and always dashed. When ring-leader Time promoted physicist-turned-whizz-kid-AIDS-reseacher Dr David ("It's the virus, stupid!") Ho of the Aaron Diamond AIDS Research Centre, New York, as its 1996 Man of the Year last December "for pioneering the treatment that might, just might, lead to a cure", it proved again Barnum's dictum that no-one goes broke underestimating the intelligence of the American public. Or perverting it.

> *"Time magazine's recent diagnosis of homosexuality as a 'pernicious sickness' like influenza or opposing the war in Vietnam"*
>
> – Gore Vidal, *Pornography* 1966

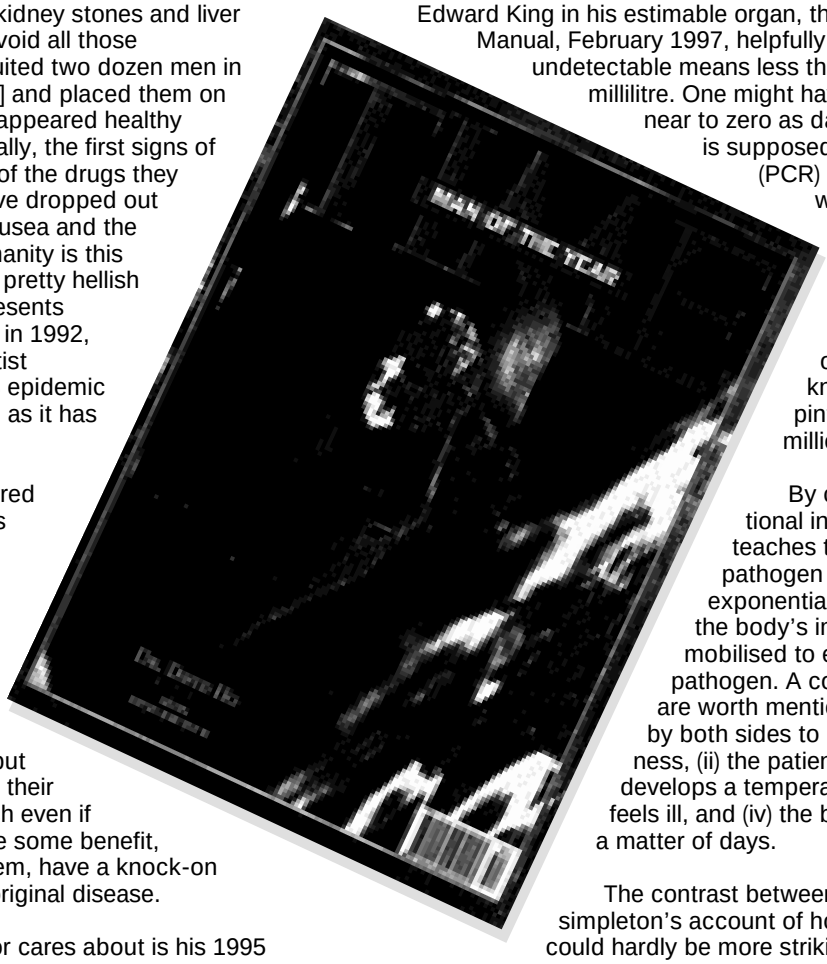
Time's first issue appeared in 1923, founded by Henry Luce, born in China the son of a Christian missionary. Its historically fairminded treatment of issues relating to gays is evident in, for example, descriptions of gay playwright Tennessee Williams as "basically negative" and "sterile" – code words for homosexual – and, rather contradictorally, his work as a "fetid swamp". A cover story on gay English poet W H Auden was killed off when the managing editor of the day learned of Auden's sexuality. Time Inc merged with Warner Communications, forming Time Warner Inc, in 1989. Current distribution of the magazine is around 5.4 million copies worldwide per week.

The highly visible promotion of Ho is at least predictable. Flashes of extravagance routinely pepper the murk of AIDS-misinformation. First, there was the mind-numbing, cell-killing AZT. It managed to hog the limelight as a solo turn for about five years, even though a half-awake chemistry student could have cast serious doubt on the rationale for its use. Later, when Concorde proved AZT worse than useless, it was cocktail time with AZT analogues, ddI and ddC. In the not so distant past, mercury was administered to kill off harmful germs, which was obviously not without its problems, so someone had the bright idea of giving arsenic instead. The wonder is that no one thought of adding a pinch of strychnine, such was the intellectual poverty of medicine then, and is now of AIDS research/AIDS journalism. The promulgated reasoning was: HIV mutates rapidly, hence develops the means to neutralise AZT; administering the double whammy of ddI and ddC surpasses HIV's mutational capacity to survive and it dies. Pure fantasy, of course, plucked out of thin air. Apparently, the stuff that international newsmagazines can be made of – see AIDS: Fighting the Scourge [scourge – a thing regarded as a bringer of punishment!], May 1987.

And now Time has come for the protease inhibitors (PI) of "stellar scientist" Ho – not by themselves, mind you, but again in conjunction with AZT, as if that wretched stuff had not wreaked

International news magazine fakes a hero

enough havoc already. Time describes the human face of the PI cocktails thus: "Chances are that people will have to stay on combination therapy the rest of their lives – assuming they can tolerate the often excruciating side effects, which range from diarrheoa and fatigue to spasms, kidney stones and liver damage... But what if you could avoid all those problems?...To find out, Ho...recruited two dozen men in the earliest stages of infection [sic] and placed them on combination therapy. All the men appeared healthy before treatment. For them, ironically, the first signs of illness have been the side effects of the drugs they are taking, not the virus. Three have dropped out because they couldn't take the nausea and the cramping." With what view of humanity is this cause for celebration? Something pretty hellish vis-a-vis gays, it seems. This represents consistency too. For a long article in 1992, Time conjured the perverse defeatist headline, "The wildfire of the AIDS epidemic has made gays a community even as it has consumed their lives."



It does not seem to have occurred to any of the leading press experts like Laurence Altmann of the New York Times, Nigel Hawkes of The Times, Steve Connor of The Sunday Times and Phyllida Brown of New Scientist that "more of the same" can only cause more grief: a cruel joke – Ho ho ho! – played on hapless victims, cajoled by well-meaning but drug-crazy doctors into saturating their bodies with nasty chemicals, which even if initially they might seem to provide some benefit, experience should have taught them, have a knock-on effect which was worse than the original disease.

All that Ho apparently knows or cares about is his 1995 theory that there is a "titanic struggle" going on between billions of HIV particles a day which the body's immune system "clears"

> *Time magazine, "that jocose and malicious publishing enterprise"*
>
> – Gore Vidal, *Ms Sontag's New Novel* 1967

(just like that – "don't bother me with trivia" such as how) which goes on for an average of 10 years – some struggle! – without speeding up or slowing down. This must have been the shortest-lived of the various fantasies regarding "HIV": in Science barely a year later researchers investigating the average age of T-cells in diagnosed people concluded, "Thus, our data do not support the idea of high rates of production and destruction of CD4+ T cells as depicted in the "sink" model as proposed by Ho et al." (Science, 29/11/96, Vol 274, No. 5292, pp1543-1547)

It might be that by an incredible stroke of luck Ho's wonder potions have a beneficial effect by providing suitable precursors (or nutrients) from which the patient's liver can manufacture something temporarily that the ailing body badly needs. Ho claimed by adding some Protease Inhibitors, he found that "HIV" can be reduced to "undetectable" levels and some patients seem to get better. Leaving aside that a colleague admitted the initial counting technique overestimated by 60,000 times, a snag is, as Edward King in his estimable organ, the National AIDS Manual, February 1997, helpfully informs us, undetectable means less than 200 particles per millilitre. One might have thought it meant as near to zero as dammit. Remember, Ho is supposedly using a technique (PCR) that is so sensitive, it will detect a "needle in a haystack." And now we hear it means there are still even by Ho's dubious reckoning rather a lot of HIV particles knocking around – in 8 pints @ 200/ml = 1.8 million particles.

By comparison, conventional infectious disease theory teaches that an invading pathogen begins to replicate exponentially and, simultaneously, the body's immune system is mobilised to eliminate the invading pathogen. A couple of minor points are worth mentioning: (i) time is needed by both sides to reach full battle readiness, (ii) the patient, without exception, develops a temperature, (iii) the patient feels ill, and (iv) the battle is resolved within a matter of days.

The contrast between this and Ho's simpleton's account of how HIV infection works could hardly be more striking. Has anyone of the well-known commentators asked why? Ah, but why bother: is it not axiomatic that AIDS "science" is fiendishly tricky, and HIV works in mysterious ways, surpassed in this respect only by the Lord Almighty? Small wonder that AIDS science totters from one dead end to another, despite the most intense research effort in medical science, ever.

As Time Warner Inc knows, illness is pruriently popular. One of the corporation's highly profitable facets, Home Box Office (HBO), launched in 1972, is now advertising its new AIDS movie In The Gloaming, starring Robert Sean Leonard and Glenn Close, "about a gay man dying of AIDS complications who returns home to reconcile with his parents." Someone please tell Ms Close that Fatal Attraction was a ripping yarn, not a way of life. HBO started satellite distribution in 1975, inaugurating the age of cable television. In 1991, HBO Olé was launched in Latin America, and in 1992 HBO Asia. The Gloaming looks set to descend on hapless millions.

Wrote Vance Packard in 1957 in The Hidden Persuaders, "The depth approach to influencing our behaviour is being used in many fields and is employing a variety of ingenious techniques. It is being used most extensively to affect our daily acts of consumption...this approach is barely out of its infancy". By 1997 it is somewhat more developed. Time will tell.

Protease Inhibitors in Provincetown

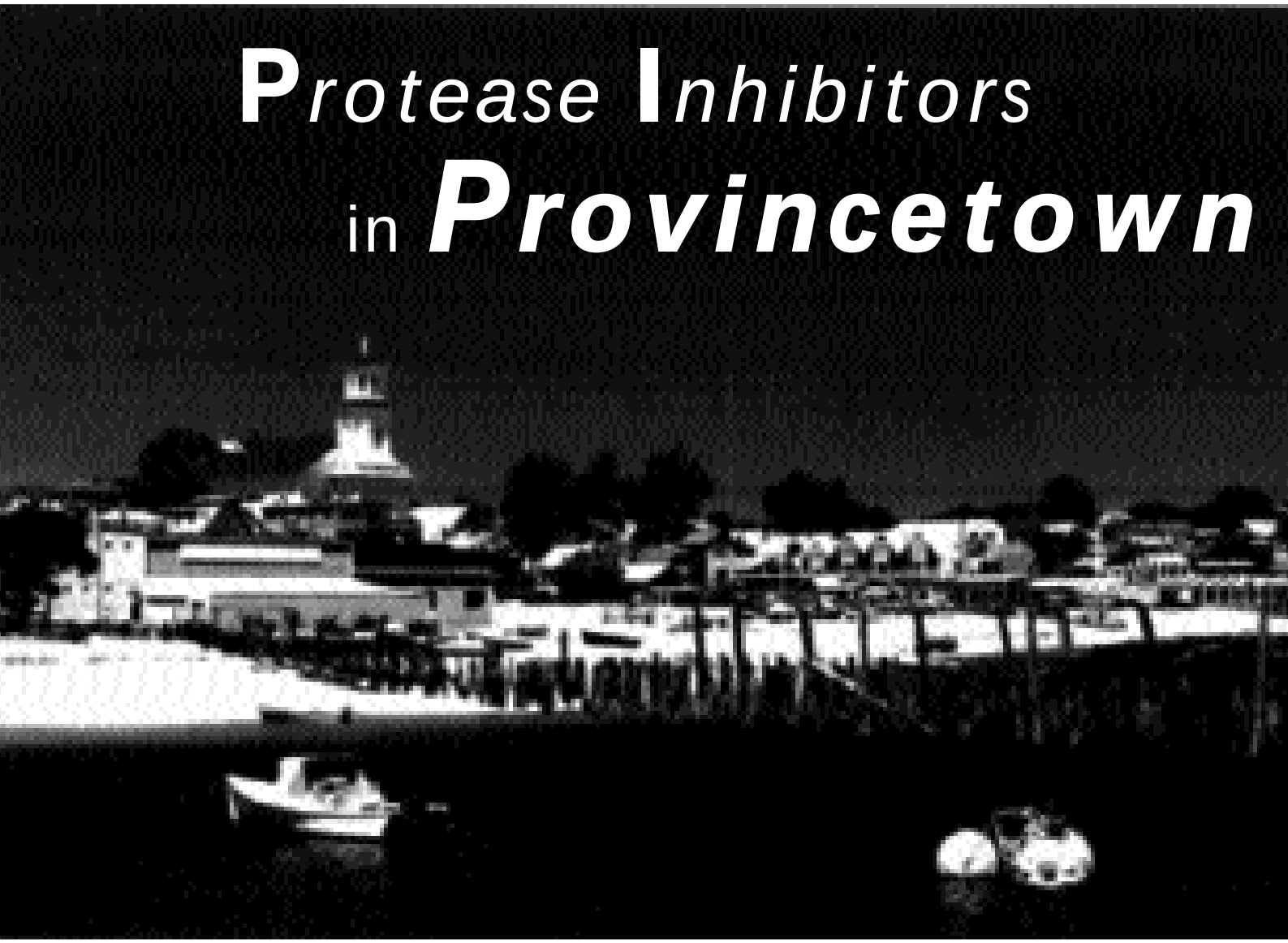


PHOTO: Robert Dennis

John Lauritsen

The "magic of Provincetown" has become a magnet for gay men with diagnoses of "AIDS" or "HIV-positive". For a decade now they have been arriving in Provincetown – their medical records in hand, their various welfare benefits established, and their life insurance policy (if any) cashed in – to spend their final days here.

All over the world are gay men whose happiest memories are of vacations in Provincetown, which for most of the 20th century has been the premier gay resort. During the summer all of Commercial Street, from Town Hall west, is a promenade: drag queans mingling with grizzled old men in leather (even in August), bodybuilders strutting their stuff, local residents walking their mutts, and hundreds of all kinds of very nice guys who can relax and be themselves in the fellowship of their own kind. There are middle-aged and elderly couples who have been coming to Provincetown ever since they were young.

But Provincetown is more than a gay resort. Located at the very tip of Cape Cod and surrounded by water on three sides, it is one of the oldest towns in the United States, founded in 1727. It is here that the Pilgrims first landed in 1620, and wrote and signed the Mayflower Compact. The population is diverse, and includes fishermen, craftsmen, and writers. For over a century Provincetown has been a colony for artists, who consider the light to be unique. Most of the land of the Outer Cape is taken up by the National Seashore, which is off limits to development of any kind. Within the space of a few miles are Provincetown's primevally beautiful sand dunes, salt water marshes, swamps, cranberry bogs, forests, sand beaches, the ocean and bay, and a large and beautiful natural harbor. The atmosphere seems to encourage healthful physical activities, and gay men go in for fishing, sailing, swimming, jogging, cycling, and walking. (There are eleven self-guiding nature walks in the National Seashore, and innumerable unofficial trails.)

And now Provincetown has its AIDS enclave, a full-fledged outpost of the AIDS industry. In addition to two AIDS support groups, the Unitarian Universalist Church has established an AIDS Ministry with its own minister. One private clinic alone has 250 AIDS patients, and for those who need or prefer big city doctors, a van makes regular trips between Provincetown and Boston. Drug manufacturers come to town, offering free dinners along with "treatment information" to those who are "HIV-positive". On the average there is an AIDS obituary every week or two in the local papers.

A recent article in the Wall Street Journal by Barbara Carton, "Life After Death: New AIDS Drug Brings Hope to PROVINCETOWN", describes the impact the new class of AIDS drugs, the

"protease inhibitors", are having on the diagnosed, their counsellors, and their "service providers". The operant word is "hope", which is also the theme of well-orchestrated advertising campaigns being waged by several pharmaceutical companies. Although Glaxo-Wellcome is still the biggest player in the AIDS market, it is no longer the only one. Its competitors have demanded, and are getting, a piece of the pie.

Hope is portrayed visually in the recent "Be Smart About HIV" ads, sponsored jointly by the National Minority AIDS Council, the National Lesbian and Gay Health Association, and Glaxo-Wellcome. The models in the ad seem radiantly happy, hugging each other. Gone are the hangdog expressions found on the models in Burroughs Wellcome's "Living With HIV" ads of five years ago. The caption on the ad says simply, "See your doctor about new treatment options."; it is clear from the display of teeth in wide-open smiles, that the "treatment options" are good news.

Hope is also the theme of a spate of news stories about AIDS patients near death, who started protease inhibitor therapy, after which they gained weight and energy and began looking forward to a full life expectancy.

Carton's Wall Street Journal article indicates that this new hope is not without its drawbacks. In one support group there is a joke, "Well, if we're not going to die, do we have to go back to work?" The problem is not trivial:

> "People are missing the boat in not designing programs for the long-term survivor with HIV," says Alice Foley, the town's former nurse, who is now retired. "You've got to mainstream them back into a working environment.... A lot of these guys haven't worked in eight or ten years." (Carton 1996)

However, many do not want to return to their previous jobs, which they found "unfulfilling". They refer to themselves as "retired".

How realistic is the present euphoria over protease inhibitor therapy? Not at all. Even if one believes the anecdotal reports, it does not follow that a temporary return to health is a consequence of the treatment. One of the most fundamental mistakes in reasoning is known as the "post hoc ergo propter hoc" (after this therefore because of this) fallacy. The mere observation that event A is followed by event B does not by any means prove that A causes B.

The consensus that the protease inhibitor cocktails are "working" beneficially falls apart as soon as one scrutinizes it. First of all, the anecdotal reports are highly selective. The successes are trumpeted from coast to coast. The failures are blacked out. The situation is piquantly illustrated in Carton's article:

> Karin Anderson, who leads a weekly support group in PROVINCETOWN for people taking care of friends or partners with AIDS, says her seven-member group is becoming increasingly polarized. That is because the protease inhibitors are working for half the patients, but the rest are getting much sicker. [emphasis added] The social worker says she may eventually have to split the support group in two. [!] (Carton 1996)

And those who "are getting much sicker" are going down the collective memory hole.

It goes without saying that we should be skeptical of anecdotal reports – and should be aware that not all reports on the protease inhibitors are favorable, for example:

> If you think AZT was bad – you wouldn't BELIEVE how bad these protease inhibitors are! I have witnessed two deaths in the last month. One, an ethnic Chinese, turned black – yes black – before succumbing. Jaundice and hepatitis after 4 days of use (Crixivan)! MAC outbreak in 3 days (which means pure immune suppression). Hospitalized in 1 week. Dead in 10 days. Nice stuff! (Internet posting of 5 July 1996, Warren F. Shaw)

Even in those cases where the AIDS patient has gotten better following protease inhibitor therapy, it does not follow that the improvement was due to beneficial effects of the drugs. Among alternative explanations, the most obvious is the placebo effect, which can be powerful.

Patients taking protease inhibitors did so as part of a herd decision, in the context of hope generated by pharmaceutical propaganda. They expected to get better. They encouraged each other to get better, and some of them did. The others were ignored, a form of ostracism.

In other words, benefits from the protease "cocktails" – if any – must be psychological. There is no way that these chemicals could have real health benefits.

PHOTO: Bob Giard

John Lauritsen is a retired survey research analyst, now living in Provincetown after 32 years in New York City. He has been in gay liberation since the 60s and is the proprietor of Pagan Press, founded in 1982. His books include *Poison by Prescription: The AZT Story* (1990) and *The AIDS War* (1993).

The Case Against Protease Inhibitors

Most fundamentally, protease inhibitor therapy is based on a false premise, that the retrovirus HIV is the cause of the dubiously defined illness known as "AIDS". At this point in time, debating the merits of the HIV-AIDS hypothesis is like flogging a dead horse. That foolish hypothesis was demolished by, among others, Peter Duesberg a decade ago, and anyone who still believes in it is uninformed, lazy, and/or stupid. (Duesberg 1996a, 1996b, 1996c; Eleopulos 1988)

The alleged benefits of protease inhibitors are unproven by scientifically credible research. Developments on the AIDS-drugs front happen so quickly that it is impossible to keep up with everything, but to the best of my knowledge no protease inhibitor has been tested against a placebo (that is, against no drug at all). Claims of benefits are based, not on improvement to the health of human beings, but on results from experimental and highly questionable laboratory measurements, primarily the so-called "viral load" tests, which are an offshoot of the polymerase chain reaction (PCR) test. Although being used to evaluate the success of protease inhibitor therapy, the viral load tests have not even been approved for use by the FDA. (Rasnick 1996, Philpott and Johnson, 1996)

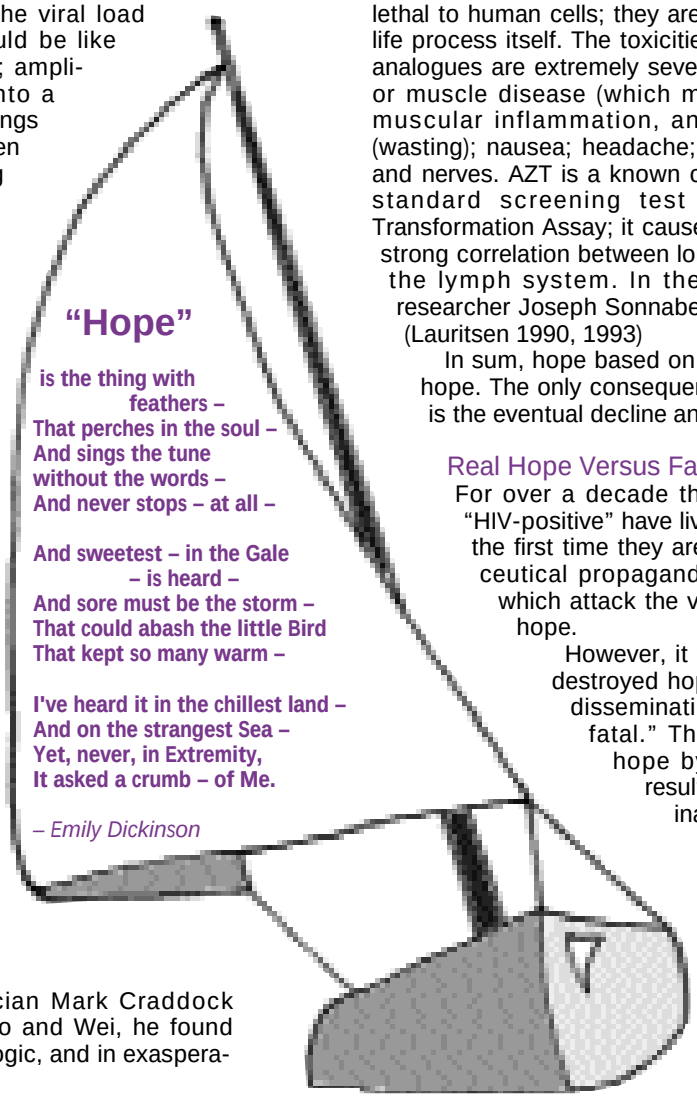
Kary Mullis, who won the Nobel Prize in Science for inventing the PCR, is thoroughly convinced that "HIV" is not the cause of "AIDS". With regard to the viral load tests, which attempt to use PCR for counting viruses, Mullis has stated: "Quantitative PCR is an oxymoron." PCR is intended to identify substances qualitatively, but by its very nature is unsuited for estimating numbers. Although there is a common misimpression that the viral load tests actually count the number of viruses in the blood, these tests cannot detect free, infectious viruses at all. The tests can detect genetic sequences that are from viruses, or theorised to be so, but not viruses themselves.

What PCR does is to select a genetic sequence and then amplify it enormously. It can accomplish the equivalent of finding

a needle in a haystack; it can amplify that needle into a haystack. Like an amplified antenna, PCR greatly amplifies the signal, but it also greatly amplifies the noise. Since the amplification is exponential, the slightest error in measurement, the slightest contamination, can result in errors of many orders of magnitude.

To make an analogy: using the viral load tests to gauge viral activity would be like finding a few fingernail clippings; amplifying the fingernail clippings into a small mountain of fingernail clippings mixed in with other junk; and then having an "expert" come along and interpret the pile as representing a platoon of soldiers, fully armed and ready for battle.

In short, the viral load tests are a scam. When molecular biologists Peter Duesberg and Harvey Bialy analyzed the 1995 papers by Ho and Wei (Nature 373) that launched the whole viral load bandwagon, they found that estimates of free virus had been overestimated by several orders of magnitude. In the Wei study, 100,000 so-called "plasma viral RNA" units really amounted to less than two infectious viruses per milliliter of plasma. And in the Ho study, 10,000 "plasma virions" corresponded to less than one infectious virus. Duesberg and Bialy concluded, "there is no evidence for infectious virus in Wei et al.'s and Ho et al.'s patients." (Duesberg 1996a)



"Hope"

is the thing with
feathers –
That perches in the soul –
And sings the tune
without the words –
And never stops – at all –

And sweetest – in the Gale
– is heard –
And sore must be the storm –
That could abash the little Bird
That kept so many warm –

I've heard it in the chillest land –
And on the strangest Sea –
Yet, never, in Extremity,
It asked a crumb – of Me.

– Emily Dickinson

When Australian mathematician Mark Craddock analyzed the same reports by Ho and Wei, he found gross errors in mathematics and logic, and in exasperation posed the question:

> Just what exactly will it take to get the people doing HIV research to turn away from high tech, unproven methods, arcane speculations about molecular interactions etcetera etcetera and ask themselves "Do any of us have the faintest idea what we are doing?" (Duesberg 1996a)

Claims have been made that the protease inhibitors act only against HIV's protease, but not against healthy human protease compounds. The point is important, because the body makes and needs its own protease compounds, which play a crucial role in the assimilation of nutrients. This claim of selectivity is highly suspect, and reminiscent of claims made for AZT a decade ago: that AZT acted selectively against viral DNA synthesis rather than human cellular DNA synthesis. The AZT claim, based on research conducted by Burroughs Wellcome, has since been proven false by at least a half dozen independent studies, which found that AZT is 1000 times more toxic to human cells than was claimed when the drug was approved for marketing in 1987. (Duesberg 1996a)

The protease inhibitors were approved for marketing so quickly that their toxicological profiles are far from complete. To my knowledge no reports have been published on animal studies or on such tests as the Cell Transformation Assay, so the carcinogenic potential of the drugs is unknown. There can be no doubt, however, that they have a broad range of serious toxicities, adversely affecting every organ in the body. (Ostrom 1996)

As bad as the protease inhibitor toxicities might be by themselves, the situation is far graver when they are administered as part of drug "cocktails", which include AZT or similar nucleoside analogues. By their very nature the latter class of drugs are lethal to human cells; they are terminators of DNA synthesis, the life process itself. The toxicities of AZT and the other nucleoside analogues are extremely severe, and include anemia; myopathy, or muscle disease (which manifests itself as muscular pain, muscular inflammation, and muscular atrophy); cachexia (wasting); nausea; headache; and damage to the kidneys, liver and nerves. AZT is a known carcinogen: it is highly positive in a standard screening test for carcinogenicity, the Cell Transformation Assay; it causes cancer in rodents; and there is a strong correlation between long-term AZT therapy and cancer of the lymph system. In the words of physician and AIDS researcher Joseph Sonnabend, "AZT is incompatible with life." (Lauritsen 1990, 1993)

In sum, hope based on protease inhibitor cocktails is false hope. The only consequence that can rationally be expected is the eventual decline and death of the patient.

Real Hope Versus False Hope

For over a decade those with diagnoses of "AIDS" or "HIV-positive" have lived under a spell of doom. Now, for the first time they are being offered hope – by pharmaceutical propaganda linking that hope to chemicals which attack the very basis of life. That hope is false hope.

However, it was the AIDS establishment which destroyed hope in the first place: by incessantly disseminating the lie that "AIDS is invariably fatal." The AIDS establishment destroyed hope by claiming falsely that a positive result on the unvalidated, unreliable and inaccurate HIV-antibody tests meant an active viral infection, which would invariably lead to "AIDS", which was invariably fatal. The AIDS establishment destroyed hope with its false equation: HIV = AIDS = DEATH.

In actuality, there is no reason why those with positive results on the HIV-antibody tests should not live to a ripe old age, provided they take care of themselves and keep poisons out of their body. This is real hope.

Those who have been diagnosed as having full-blown "AIDS" (that is, who have been sick with one or more of the 29 "AIDS-indicator diseases") may need medical help, including drugs, to help them recover from those specific diseases, but they most certainly do not need any drugs designed to attack HIV. HIV is not the cause of "AIDS"! Steps should be taken to strengthen the body so that it will have a chance to heal itself. With the wisdom of millions of years of evolution, it probably can. This is real hope.

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From Hype to Hesitation

Huw Christie

Proteins and proteases

Rather amazingly, genetic substance in all living things and even in viruses – which most virologists do not consider strictly "alive" – is responsible for instructing the creation of proteins, using amino acids as building blocks. The system sparkles with complexity and at the same time seems ruthlessly purposeful. The first theory of genetic structure and function was established (at least to most people's satisfaction) 40 years ago.[1]

'Proteins' is what we call the basic structural components of all living things. Once proteins are made they are manipulated by enzymes – biological molecules that act on others. One of the largest groups of enzymes is known as the proteases. Their ability is to divide, or cleave, larger proteins into smaller proteins. The protease that has recently most interested "HIV"-scientists is an aspartyl protease. There are several other aspartyl proteases in humans, including pepsin (a digestive enzyme in the stomach) and renin (one of the many proteases that regulates blood pressure).

"HIV"-scientists have worked with various fragments from cells, and theories, to construct a plan of how "HIV" could exploit protease. The current model of "HIV" proposes some large proteins are cleaved before the virus particle could mature. A retrovirus would need protease to arrange envelope proteins at its exterior. And a protease to cleave what are called the structural proteins of its inner core. There would be the virus' own enzymes too – usually proteins themselves. Computer models of how to block protease activity have been developed, and drugs synthesised to try to do this: enter the Protease Inhibitors.

Yet certainly scientists aren't sure at all where the proteases they associate with "HIV" come from or what they do. For example, a large envelope protein of molecular weight around 120,000 – gp120 – is widely accepted by "HIV"-scientists to be cleaved from an even larger 'precursor' protein, gp 160: all AIDS experts agree gp 120 would be essential on mature "HIV" for it to be infectious – though in practice no-one can say they have seen it.[2] While some "HIV" experts think this 'precursor' cleavage of gp160 is performed by a non-"HIV" protease – "The intracellular cleavage of gp160 by a host cell protease...is essential for viral activities such as infectivity...[representing] a powerful strategy for identifying, characterising and inhibiting the host T-cell protease essential for HIV infectivity and AIDS"[3] others think "the aspartyl protease of HIV-1 cleaves the large gag [gene] (p55) and gag-pol [gene] (p160) polyproteins.."[4] (The agent of cleavage seems to be not the only area of dispute.)

Since it has never been possible to qualify or quantify these activities in an actual HIV, it's little wonder that there are about as many theories of what could go on as there are winds that blow.

From theory to practice

Dr David Ho, director of the Aaron Diamond AIDS Research Centre in New York, in a paper in Nature in 1995[5] first proposed the theory that "HIV infection" during "latency" involves a "titanic struggle" between a multitudinous daily replication of virus and an equivalent turnover of T-cells. Although this theory has been all but discredited, even in mainstream journals[6], it has led to the current practice of using Protease Inhibitor drugs to stem "viral replication", as interpreted from fragments of RNA from a person's blood – "viral load". The unlicensed "viral load tests", using PCR (Polymerase Chain Reaction) technology, are used to try to work out whether the drugs stop the activity interpreted as "viral replication".

In February this year, New Scientist bounced back onto the "AIDS" trampoline following the Fourth Conference on Retroviruses and Opportunistic Infections with an article about the application of some of the current ideas on proteases in "AIDS" medicine.[7] "The tide of optimism over improved treatments is premature, an AIDS conference in Washington DC heard last week," reported Michael Day. "Viral load is creeping back up even in patients on triple therapy," said Clive Loveday, a virologist at the Royal Free Hospital, London. In some patients, he added, the cocktails do not have a strong effect even in the short term. Prof. Ian ("Concorde trial") Weller was rueful: "My gut feeling is that we've gone over the top again." Ho himself seems to know the current therapies have been prematurely hyped: "We're testing proof of principle," he said, "not designing practical medicine for AIDS patients."

Fast-tracking the drugs

In haste however, some of the drugs designed to inhibit protease activity – from US Abbot Laboratories and Merck, and Swiss Roche – have been licensed for prescription in several countries already, with more in waiting. According to The Economist, pharmaceutical companies are hoping to "hoover up billions."[8]

"The new AIDS drugs won Food and Drug Administration approval so rapidly that researchers still don't have a clear understanding ...protease patients are, in effect, guinea pigs in one of the largest and most expensive medical experiments of our time," opined the Wall Street Journal.[9] Said Dr Andrew Carr of the Centre for Immunology at St Vincent's Hospital, Sydney, "It is therapeutic chaos. Doctors are prescribing what patients ask for, or they're guessing, adding different drugs when they feel like it. I've never seen anything in medicine quite like it."[10] Around 100,000 people are trying Protease Inhibitors in the US alone. Dr Scott Hammer, a research physician at New England Hospital in Boston last October, said "In a perfect world we'd have the answers before we treated so many people, but that's not how things are."[11]

⇒

Latest trial hype

Indeed until recently, trials with these drugs have been done by the manufacturers themselves. Results were usually based on laboratory "viral load" findings – the estimated number of theorised virus particles in a patient. Not only has it been widely accepted by researchers that it has never been possible to know whether such "viral load counts" indicated "viable" or "defective virus" since they only count genetic fragments: it was also not known how "viral load" related to well-being. "AIDS researchers constantly point out these days, reducing the viral load...in a patient's blood does not necessarily mean he or she will suffer fewer AIDS-related diseases."[12] For example it has been shown that people with "high viral load" may be well.[13]

And of course, scientists who do not buy the retrovirus model of AIDS have presented evidence that the "viral load tests" themselves may be misleading in several ways, including appearing to confirm there's a retrovirus there at all.[14] Among them is Nobel laureate Kary Mullis who invented the PCR before "viral load" became fashionable, who has said "Quantitative PCR (using it to count, rather than multiply) is an oxymoron."

PHOTO: Arthur Tress

This 25th February however, the results were released of a non-industry study of short-term clinical outcome using PIs – i.e. actual health effects in people – sponsored by the US National Institute of Allergy and Infectious Disease (NIAID).[15] The study involved 1,156 people with AIDS diagnoses who took either a two-drug combination of nucleoside analogues AZT, and 3TC or D4T – 579 trial participants – or a three drug combination of the nucleoside analogues plus a protease inhibitor – (indinavir, brand name Crixivian, from Merck) – 577 people. After nine months to a year of treatment, in the two drug group, 63 people either had died or had new "AIDS" illnesses. In the three drug group, the number was 33. In the former there were eighteen deaths, in the latter, eight.

The study officially concluded that it was not possible to say the difference in death rates was statistically significant,[16] meaning what seems to be a difference, when everything is taken into account, isn't.

Trial leader Dr ("Perfect world") Hammer said he had breathed a sigh of relief that the trial had not been stopped back on 16th January. Why? At that time the Data and Safety Monitoring Committee decided the results of the two groups were so similar there was no compulsion to stop the trial and put everyone onto PIs. For Hammer, apparently a month in mid-winter has now made all the difference: "Definitive".

The Director of NIAID, Dr Anthony Fauci may have been evasive when his turn came to comment on what was offered – "evidence that combination approaches using protease inhibitors can reduce the risk of death." When results are officially not statistically significant, this is about as far as speculation can stray. And it is rather different from claiming they do reduce the number of deaths. It is unclear what other medical interventions may have occurred that could have influenced the outcome. It is known for example when the licensing of AZT was rushed through, life-saving blood transfusions were needed by 30 trial participants due to drug-induced anaemia, though this was at best unclear from the final report.[17]

In 1996, in New York City with 16% of US AIDS diagnoses, "AIDS" deaths dropped by 30%. But health officials did not attribute the drop to increased use of protease inhibitors. According to assistant commissioner of the city's Department of Health, Mary Ann Chiasson, the "AIDS" death rate began to fall before the main drugs were introduced. She suggested the decline may be linked more closely to better general health practices and more effective treatment of opportunistic infections.[18]

Drug reactions

Data on the effects of PIs grows. Certain lifestyle issues have been increasingly discussed, including non-prescription drug use. A man collapsed and died after taking the illegal recreational drug ecstacy at a London gay club – though he had used ecstacy before, he had recently started treatment with a protease inhibitor.[19] Abbot Labs, makers of Ritonavir, have sent letters to doctors about what they describe as these "theoretical dangers"[20]. PIs are also dangerous mixed with common antihistamines – hayfever medications, motion sickness medications et al. Two deaths from cardiac arrhythmia have been attributed to this combination. At least 14 other drugs are contra-indicated.[21]

Routine effects of PI "therapy" range from nausea, diarrheoa and fatigue to spasms, kidney stones and liver damage.[22] The complicated daily regime of pill-popping, up to 12 a day, at different times from other drugs, co-ordinated around meals, seems unsustainable for many people, despite the threat that deviation from it "results in resistance to the drugs".

Because absorption of PI compounds is generally low – more than 98% of Roche's Saquinavir binds with "non-HIV" plasma proteins (ref) – they are taken at high doses[23]. However, K. McKnight-Smith in the HIV Herald reported PIs "may not just inhibit the HIV [sic] protease enzyme; they may affect some of the human protease enzymes. Researchers believe safe doses may have to be low [sic] as a consequence of this interference".[24]

Invoking a scorched earth policy, Ho says, "Even 10,000 [viral copies] is really unacceptable." He advocates an HIV treatment of "hit it early and hit it hard". What's the politically correct analysis these days of an eye for an eye and a tooth for a tooth?

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New Wave in France

A recent conference in Paris began to create room for non-conventional immune medicine, reports AIDS analyst and author **RENAUD RUSSEIL** of the Forum Multi Communication.

France bears the burdensome honour of having given birth to the so-called world-wide AIDS virus, while the USA was the country where the naming ceremony took place, with the famous Dr Robert Gallo as godfather and Dr Margaret Heckler, Secretary of State for Health in the brilliant Reagan Administration of the glorious eighties as godmother!

Being aware of the global weight of the AIDS paradigm, including the politics, pharmaceutical lobbies, and the personal glory of frustrated scientists, we can consider the organisers of the Colloquium Medecine of the 3rd Millenium to have been extraordinarily successful not least because this conference was not censured by any political, pharmaceutical lobbies, or medical institutions supposed to protect "right medical practices". During my three years research in Europe on AIDS and alternative therapies for immune deficiency, I have met or heard about many doctors using more or less conventional, and non-conventional medicines who have a lot of unofficial success with so-called HIV+ people, but who refuse to give interviews or to meet journalists – if their personal views regarding AIDS were known by the mighty French Medical Council (Ordre National des Medecins), they would stand a high chance of being summarily ejected from the profession and forbidden to practice, they might have to pay heavy fines and could eventually be jailed for "challenging the health of the citizens". This brave and uncensured Colloquium took place in Paris from 17th to l9th January 1997, under the initiative of the European Network for a Politic of Life and the Vital Energy International Association; Agnes Charlet from Strategique was the program coordinator.

The second day of the conference began the focus on immunity and AIDS. A highlight of the day was Dr Jeffrey Liephart from San Diego California who presented his LIFE program* built on 19 cofactors, to deal with and to sustain the immune system from a psychological and physical point of view. Another famous speaker was Ms Niro Assistent, who changed her serology from antibody+ to antibody- after a year of symptoms diagnosed as immune related. For her, "The healing process is a communion between the soul and the personality. A diagnosis is a process of awareness which carries a tremendous power of transformation." Among participants from France were several HIV+ gays who have since chosen a simple lifestyle close to nature. They commented that when they were diagnosed with AIDS or HIV, they had to look at themselves and their own life, to identify that which was truly challenging their health.

Among the speakers' topics, one could find nearly all the regular alternative therapies such as homeopathy, nutrition, massage, meditation, plus floral elixirs from Doctor Bach, etc., as well as psychological exercises using NLP, meditation for relaxation, etc., all claiming their link with the relatively new approach of Psycho-Neuro-Immunology. There were also many testimonies of success with alternative therapies from antibody diagnosed people – gays, transfused, etc. Still, there is no official action or therapy in France challenging the HIV hypothesis.

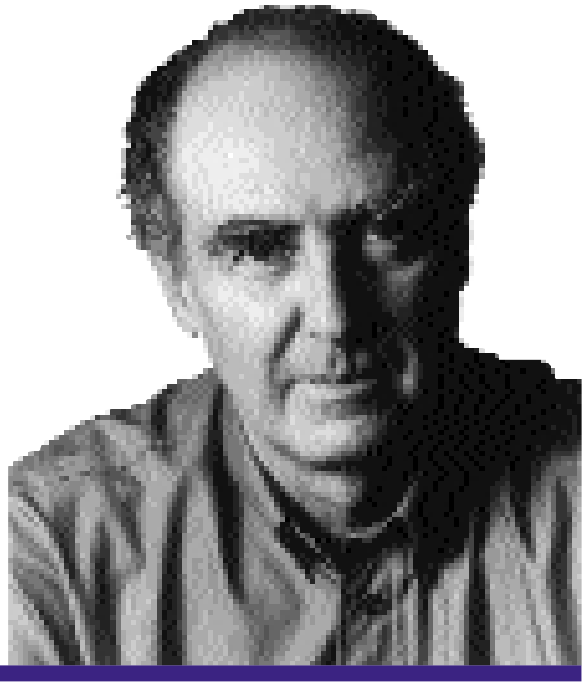
Renegade professor from the Pasteur Institute, Mirko Beljanski, invented a therapy which gave a lot of good results in the beginning of the nineties in HIV+ asymptomatic people. He was taken to court for illegal practices and officially lost the fight. But due to thousands of letters of support, he was only sentenced to a symbolic fine of one French Franc ! This decision of the French Court in itself bore witness to the social conflict in the whole AIDS medical paradigm in France.

The third day of the Colloquium gathered on the stage a politician who is also PhD in physics – European Deputy Paul Lannoye from Belgium; a lawyer mostly defending non-conventional health practitioners who are taken to court for their illegal (though often successful) health practices – Ms Isabelle Robart; the director of a complementary Insurance Company willing to promote non-conventional therapies – M. Jacques Millereau; and the French President for the European Association for Osteopathy – M. Michel Fischer. We learnt that: a) the Parliament of the European Union (in Brussels) is preparing a European policy under the initiative of Paul Lannoye to acknowledge the main non-conventional medical practices; b) that most cases where therapists are taken to court in Europe for illegal (albeit successful) medical practices are taken to the International Court of Human Rights where they are successful; and how the French Medical Council can put pressure on people and institutions to slow down and block the many efficient non-conventional medical practices which are nowadays being used by 20-50% of the European population.

Between 300 and 400 people attended the whole conference, but unfortunately and not surprisingly, the general French press did not cover the event!

LIFE: Learning Immune Function Enhancement.

Leon Chaitow



*Holistic doctor **LEON CHAITOW** combines practical experience, intellectual wisdom and some controversy in a wide-ranging interview focused on immunity and health with Rafael Ramos and Huw Christie*

How would you distinguish the practices of conventional or allopathic medicine from complementary/alternative (C/A) medicine in removing diseases?

Allopathic medicine which can be described as conventional or orthodox medicine, tends to deal with illness piecemeal without a lot of regard for, or attention to, the context in which the illness exists – the person with the illness, their current biochemical status, biomechanical structure and function, or psychosocial situation.

In mainstream medicine, named conditions have protocols of care and these are followed in a pragmatic manner, with little concern for what has led to the problem or what follows. In this way a patient in a modern medical setting is dealt with episodically – 'this is what is going on now and this is how it will be handled' – by rote, by the book.

Complementary/alternative (C/A) medicine – at least as I understand and practise it – has a wider perspective which triggers questions such as:

Why is this person displaying these symptoms now, taking account of their nutritional status, level of toxicity, current or previous illness or treatments, lifestyle habits, stresses and anxieties and how is their body handling all of this? What aspects of the person's defensive (immune, repair and eliminative) functions require enhancement and how can the complex stress load they are carrying, whether infectious, biomechanical, psychosocial, biochemical – or other, be reduced? What therapeutic interventions are most likely to be helpful – without making further or excessive demands on the body's capacity to function and defend itself? In other words C/A medicine tries, at its best, to deal with the person and not the illness and has an objective of enhancing the body's self-regulating (homeostatic) mechanisms and systems, offering a potential for improvement and recovery, rather than imposing solutions. Another way of seeing the difference is to suggest that C/A medicine is health oriented rather than disease focused.

In this way C/A medicine might supply nutritional support, introduce detoxification methods, deal with symptoms in a gentle manner, perhaps utilising herbal or hydrotherapy, or bodywork methods – all of which have few if any side effects; employ stress reducing methods and systems which encourage immune function and reduce adaptive demands, and in a variety of ways attempt to empower the person who is ill by helping them to understand why they are ill, what can be done to encourage a return to health, or better functioning, or symptom control. At times this undoubtedly also calls for orthodox, allopathic methods of care, and it is the combination of the best of complementary and alternative medicine with the best of mainstream interventions which offers the greatest hope, I believe.

What encouraged you to practice at the London's Hale Clinic?

I suppose on reflection I chose to work at the Hale Clinic for a number of pragmatic reasons. It is geographically close to my home which is just off Baker Street, so I can walk to work – often through Regent's Park. It is extremely convenient in the services it offers – reception, room maintenance and so on, are all taken care of as part of the package. There are also dozens – in fact well over a hundred – highly skilled practitioners and therapists covering most aspects of C/A medicine, to whom easy referral can be made, as well as one of London's greatest resources – the Nutri Centre – with its vast stock of nutrients, herbs, homeopathic remedies etc., as well as its library of books for reference or purchase – and most important of all – the knowledge of its senior staff, which can be tapped into when complex queries arises.

Do you think that current medical practices, in particular Western orthodox, are interested in promoting self-health and healthful living – how to live and adjust lifestyle so the conditions and circumstances of diseases can be avoided?

I have seen a vast change in the attitudes of orthodox practitioners towards the importance of lifestyle and nutrition over the

past ten to fifteen years. I work a day a week in an NHS practice, also within walking distance of my home. I often spend time sitting in with GPs during their sessions with patients, as they do with me from time to time, when I am seeing the patients they refer for naturopathic or osteopathic attention. As a result I have developed a greater understanding of the orthodox GPs' struggle to cope with the flood of human problems which they face daily. With less than ten minutes per patient they cannot possibly delve in any depth into these factors, but they are interested, and they do their best, in the main. The practise of many orthodox doctors is moving towards a greater appreciation of the importance in health terms of lifestyle, social conditions, nutrition etc and of the value of self-help measures, particularly in regard to stress management.

Initiatives with which I am involved will I hope increase GP awareness of these factors, and will teach them many of the skills needed to increasingly practice aspects of complementary health care in regular GP settings.

Naturopath & Osteopath

Born and educated in South Africa Leon Chaitow came to study in the UK graduating (N.D. and D.O.) from British College of Naturopathy and Osteopathy in 1960. Postgraduate training includes acupuncture 1963-65, cranial osteopathy 1969-78 and orthomolecular nutrition 1970-72. He is author of 56 popular health titles and seven textbooks.

He is co-founder and former editor of the *Journal of Alternative and Complementary Medicine* 1990-95, and currently editor of the *Journal of Bodywork and Movement Therapies*, a peer review journal published by Churchill Livingstone.

Senior lecturer, University of Westminster since 1993, in the MA in Therapeutic Bodywork (MAThB) and MSc in Complementary Health Studies (MScCHS) courses. He has given annual lecturing/teaching programmes at naturopathic, chiropractic and massage schools in Israel and USA since 1984 combined with research for writing projects.

He is married since 1971 to Alkmini, a Greek national who has assisted in all phases of his career since then, as practice manager, secretary and at times co-author.

The Chinese do not draw any distinction between food and medicine. In the West however consumers often fall prey to food manufacturers and industrial farming. Are there practical opportunities in our society to obtain truly healthy food?

There is certainly a greater opportunity now to purchase organically produced food than some years ago, although cost is sometimes a barrier to its wide availability. I guess the purchase on a regular basis of some produce, or the self-production of organic and free range foods in Britain is largely confined to a minority of middle-class consumers. The hope must be that with demand growing, costs will fall so that such food become more widely available, as it is in some European countries.

What's your understanding of the nature of what AIDS may be?

AIDS seems to comprise an extreme example of adaptation overload. Let me explain one of the models which help me to understand health and disease. We all recognise the fight/flight reaction in response to stress. Something, anything, causes an alarm response. There are neurological and hormonal responses to this challenge which prepares the body to respond to that threat. The heart rate increases, blood pressure goes up, muscles tense, adrenalin release produces a sugar rise in the blood to fuel the action, changes occur in the gut, in the hormonal centres and so on. If the threat is satisfactorily dealt with (by fighting or running away – or in modern times by appropriate action) the body symptoms return to normal.

However, if more than one threat occurs, not in isolation but constantly and recurrently in different ways, the protective and defensive responses of the body become chronically overloaded, and I'll talk more about this in a minute. We first need to see what has developed into the AIDS epidemic in the context of a universally compromised immune system. Everyone on the planet is now contaminated with dioxin, DDT, petrocarbons, pesticides, fungicides and heavy metals – among other things. We carry a huge toxic load from day 1 of our lives, and this severely compromises immune function and may be a factor in the exponential rise in allergic conditions in kids today – asthma and so on. Within that context of global immune suppression we should also see a picture of specific groups who have even more compromised immune functions.

Controversially, a particular concern I have is over the assault on under-developed immune systems which we call immunisation – in which cocktails of killed and partially killed, and sometimes live microorganisms, are pushed into the bodies of infants. This process may be playing a part in the further decline in immune defence capabilities and may have been partially causal in the decline in the immune system's ability to maintain vigilance against other, newer hazards, in which because of gene modification, the mutation of microorganisms – monsters we had not dreamed of have entered the picture. I have dealt with the possible link between immunisation and AIDS in my book Vaccination and Immunisation – dangers, delusions and alternatives which C.W. Daniels had the courage to publish a few years back when other publishers were afraid to do so. In this I also show how contaminated polio vaccine in the late 1950s and early 1960s could have factored into the puzzle of the onset of AIDS.

Let's get back to your question about how AIDS might have evolved – imagine someone in whom there is also a degree of constant or recurrent emotional stress and distress involving perhaps relationships, employment, social factors and health worries, as well as nutritional imbalance – perhaps with associated toxic accumulation over and above the burden we all carry, brought about through an imbalanced dietary pattern, excessive use of stimulants such as alcohol, caffeine, rich foods, tobacco and perhaps other social and/or medical drugs.

This individual's problems might also involve nutritional deficits which are incidentally widespread in western society – with even organically grown vegetables now containing only half the zinc they did a century ago. There may also be current and perhaps recurrent minor infections – herpes, candida, various viral, yeast, parasitic and bacterial infections – possibly sexually acquired, or related to unhygienic factors and practices, plus the effects of the drugs used to treat these diseases ... all of these elements demand adaptation on the part of the body, with defence, immune, repair, eliminative and other functions and system working overtime to maintain a semblance of reasonable function.

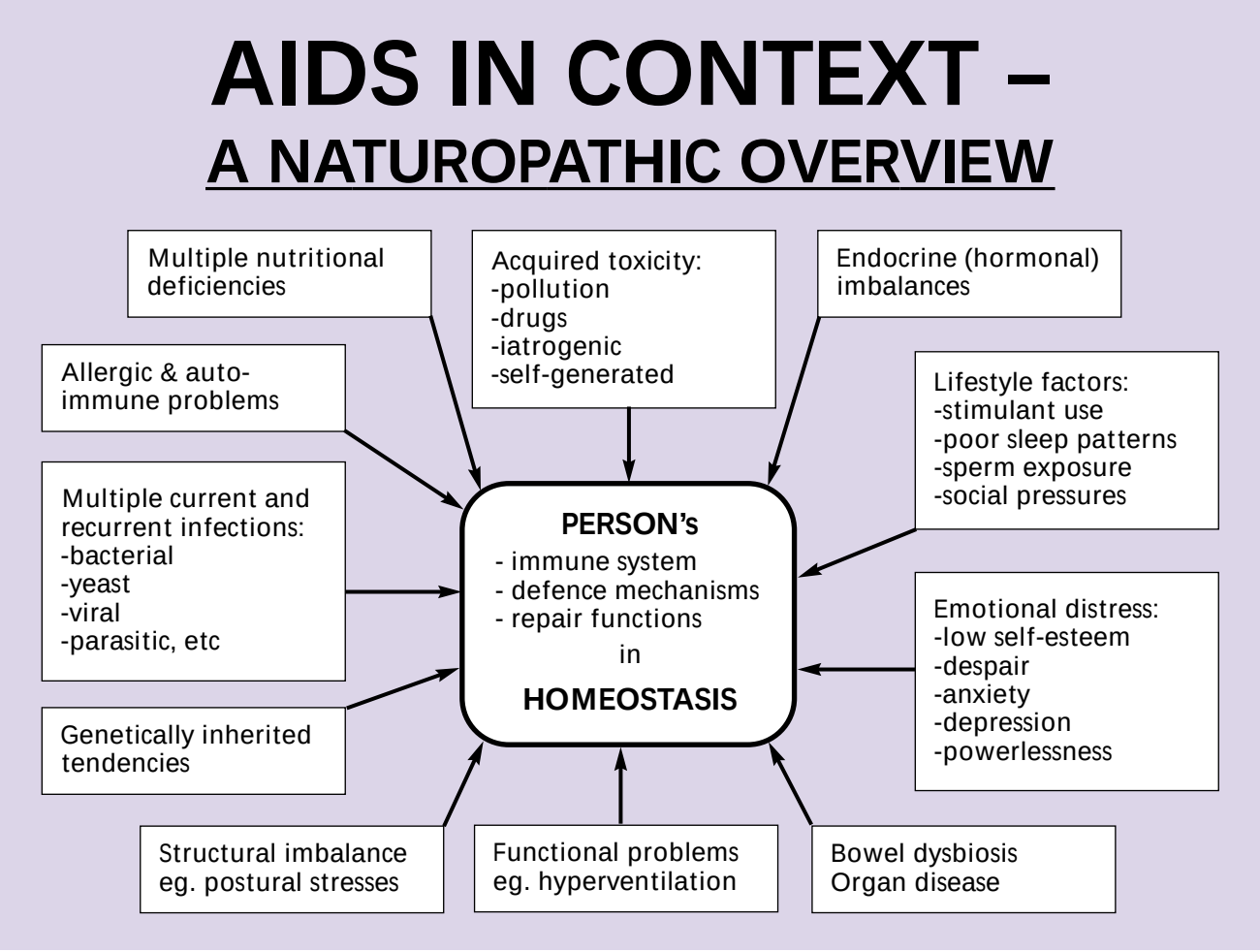
Add to this picture some unusual elements – some particularly damaging social drugs – amyl nitrite and amphetamines for example – on top of the extreme degrees of social and emotional stress and distress already mentioned. Consider also the effects which multiple course of antibiotics would have had on the person's immune function – creating a bowel status which further exacerbates the picture because of the damage caused to the vital intestinal flora – which in good health people act to detoxify the gut, manufacture vitamins, recycle important hormones, maintain control over opportunistic invaders such as yeasts...and much more. With digestive function weakened, absorption compromised, gut permeability increased and therefore allergies occurring – the spiral of ill-health would rapidly increase. Sleep patterns would be harmed, energy would decline and general vulnerability or susceptibility would be heightened.

When toxic and stress loads exceed the defence capacity of the body, severe ill-health occurs, perhaps involving the lungs, liver, nervous system, skin and so on, and as this occurs general function declines even further. The ability to withstand infection could become so compromised as to be negligible at which time life threatening infections occur.

Epitomised by Gay Bowel Syndrome in the late seventies it would seem that such a scenario was underway in a number of groups. In severely nutrionally and hygienically compromised communities such as Haitian refugees and intravenous drug addicts, for example. Amongst those haemophiliac patients receiving regular transfusions, other immune challenges were a feature, involving the drugs and relative purity of the blood they were receiving.

In the gay community other factors seem to have been key players – including sex enhancing drugs, widespread promiscuous behaviour with recurrent STD ailments – and the treatment these attracted – plus enormous degrees of emotional stress. You can argue about the particular cocktail of factors, in homosexual or heterosexual settings, from which any particular individual's disease emerged, but it's within the spectrum of the overall stress load (in its widest sense including toxicity, psychosocial and emotional distress, deficiencies, infections, and the efficiency or lack of it, of defence, repair and immune functions – that the causes lie, I believe.

Out of this sort of scenario, I argue, AIDS grew...with or without a specific organism called HIV.



Have you read the scientific works that show what's detected as HIV is not a virus at all: what do you think of this?

Is HIV an entity, does it exist? That is one hell of a question. I have read some of the mixed scientific opinions on this topic – but certainly not all, and have come, from such reading and from my own predisposition to see infectious agents as secondary rather than primary factors in ill health, to a position which I will try to explain.

Clearly we can see from recent evidence that HIV – and virus load – test results are unreliable. I can't yet necessarily go as far as Dr Eleopulos, and say that there is no such thing as an HIvirus, but I believe that within the frenzied complex occurring in someone in the early stages of immune deficiency, a number of cofactors and coincidental processes need to be present and active in order for the sequence of events we know as AIDS to unfold. Within this, complex autoimmune responses may be one factor, along with a long list of viral, fungal and other infections – as well as probably gross nutritional deficiencies and all too commonly general toxic build-up and allergic features – in other words a combination of toxicity, infection, deficiency, vulnerability and susceptibility would seem to have be present before AIDS can occur, and what's called HIV may or may not be a requirement within all of that. All infectious agents arguably are opportunistic – as with all living organisms they will thrive in an environment which suits them and which is not hostile to them. If we provide, by virtue of a toxic and deficient body, a suitable soil for bacteria, viruses, fungi or whatever, and if our defence capabilities are weak, they will flourish and we will suffer.

The combination of factors which allow this to happen would not seem to need to be the same in each person – just enough to allow self-regulating defence and immune functions to be overwhelmed.

What seems certain now is that, leaving aside the meaning and accuracy of testing which is another question altogether, it is possible to be tested as HIV+ and not become ill; that it is possible to be tested HIV positive and then to be negative again, and that apparently HIV free individuals have developed all the symptoms of what we know as full-blown AIDS. I have documented some of these situations in the book I co-wrote with Jim Stroheker – You Don't Have To Die which received such a critical review in Continuum a few years ago because it did not come out with an absolute 'there is no such thing as HIV' statement.

So HIV, if it exists, would seem at most, to be a part of the process, and not an absolute requirement for the evolution of AIDS. It is also possible that a specific entity called HIV does not exist, but that the genetic fragments, traces and shadows which

are found as part of the evidence for its existence only relate to the debris of the disturbances going on.

At times C/A therapists have been criticised for their tendency to interpret health problems in such a way as to justify the "need" for the particular therapy they offer. For instance, allergists may attribute headaches and skin rashes to allergies, and nutritionists explore the possibility of nutritional deficiencies. Herbalists, chiropractors, acupuncturists, ayurvedic, psychotherapy practitioners, etc. would also like to offer an explanation and establish the need for their services. But further underlying causes of diseases, in particular lifestyle practices or influences may be overlooked. How would you choose and apply a particular therapy in the face of a multifactorial life-threatening condition like AIDS?

You have very neatly touched on one of the greatest weaknesses of alternative/complementary medicine as practised in the UK. Holistic in attitude perhaps but narrow in focus. Unless complementary health care is offered in team settings where collaborative efforts can be offered to recipients, or unless the therapist/practitioner offering assistance has a wide range of skills, based on a philosophical bedrock which allows for an understanding of what's going on, there will only be piecemeal treatment involving individual symptoms and unconnected therapeutic interventions, which is no better than the allopathic symptom-oriented approach.

Of course there may be benefit from one C/A approach or another, but unless the biochemistry – nutrition, toxicity etc; mentoemotional, spiritual and structural features are all being considered, with focus on restoring as best possible digestive, neurological, hormonal and other functions, only a part of the picture will be addressed and results will be less than ideal.

All the methods you list, and many more, have something to offer the sick individual, whether they have AIDS or not, but only an integrated and coordinated approach which takes the individual's specific needs into account can offer the best for them. A group approach, or a naturopathic approach, are the best, since naturopathy incorporates nutrition, detoxification, stress management, manipulative methods, herbal medicine and in many instances acupuncture as well. The problem is that there are very few 'general practitioners of natural medicine' – which is what a naturopath is – and so for the time being individual aspects of ill-health or dysfunction need to be addressed by specialised groups within the alternative/complementary professions.

I hope that in time, with initiatives now being developed, at least some GPs will acquire sufficient knowledge of basic naturopathic methods to be able to offer a wider access to these approaches. They can then refer patients to 'specialist' complementary therapists and practitioners as needed.

In a syndrome as complex as AIDS, is there a problem with therapies interfering with each other? Do conventional and A/C therapies cancel each other out? A recent letter of Lambeth Southwark & Lewisham Health Authority to one of our subscribers stated that: "research into the efficacy of A/C therapies in HIV/AIDS has been limited, and therefore it is beyond the remit of a District Health Authority to fund work of this nature". In your opinion, what are the underlying assumptions of this rationale and what will be the consequences for diagnosed people who need and demand A/C therapies?

Worldwide, A/C therapies have offered people with HIV/AIDS comfort, support and often enormous benefit, in turning their health status around. What the decision by the Health Authority suggests is that their focus financially will be elsewhere – probably on combination drugs – the use of which is far more 'experimental' and less proven than A/C health care methods. Combination therapy will, I believe, like AZT before it, 'end in tears', literally and tragically.

In answer to the first part of your question, yes of course, inappropriate treatments can 'interfere' with each other. It is important to keep in mind that treatment, however gentle, calls for an adaptive response from the body, and this uses energy and is to a degree stressful. When a body is already ravaged by multiple ailments, the adaptive defence capabilities are stretched and are often to an extent non-functional. So treatment has ideally to be tailored to the needs of the individual, to their ability to respond, and should not add unnecessarily to adaptive demands. Less is often more in treatment terms when complex syndromes exist.

What are your views of the costs of NHS orthodox therapies? For instance, Positive Nation estimated in November 1996 that in the UK the cost of prescribing triple combination anti-HIV drugs, together with regular hospital visits and tests such as CD4 and viral load, will be about £10,000 per person per year. These clinical practices are offered to diagnosed individuals faithfully as the "best known benefits" of contemporary medical science.

My views on unproven medical methods are probably unprintable. We are in an economically constrained period which will probably not improve for many years and this wasteful use of limited resources, on unproven, questionable, medical interventions, as well as tests which are of dubious value, is at best sad and at worst offensive. On the other hand the people employing and recommending these approaches almost certainly act with the best of intentions – however we know where that leads! The problems lie in the difficulty in changing people's perspectives and perceptions and this is where the work of organs such as Continuum are so valuable.

To a large extent effective health care depends on self-care. If future iatrogenic diseases are to be avoided – illnesses that are

HETEROSTASIS

i.e. when homeostatic adaptive capacity is exhausted

There are just two options available:

1. To focus on restoring immune competence, enhance defence capabilities and supporting repair functions.
2. To reduce the multiple interacting stressors impacting on the individual without creating new problems.

ALL SUCCESSFUL COMPLEMENTARY OR ALTERNATIVE HEALTH CARE MEASURES WHICH ENCOURAGE THE ABOVE ARE POTENTIALLY USEFUL AND THESE INCLUDE:

NUTRITIONAL SUPPORT
STRESS REDUCTION METHODS
NON-TOXIC ANTI-FUNGAL, ANTI-VIRAL, ANTI-BACTERIAL, ANTI-PARASITIC METHODS
PROBIOTIC METHODS
ACUPUNCTURE AND TCM
HERBAL IMMUNE SUPPORT
HOMOEOPATHIC CONSTITUTIONAL METHODS
HYDROTHERAPEUTIC-HYPERTHERMIC METHODS
OZONE/OXYGEN TREATMENTS
NON-SPECIFIC 'CONSTITUTIONAL' METHODS SUCH AS BODYWORK (MASSAGE), HEALING, DEEP RELAXATION, MEDITIATION, AUTOGENICS, ETC.
STRUCTURAL NORMALISATION (OSTEOPATHY/ CHIROPRACTIC)
DETOXIFICATION METHODS
COUNSELLING AND PSYCHOTHERAPY, ETC., ETC., ETC., ETC.

PLUS STANDARD MEDICAL ATTENTION WHICH DOES NOT IMPOSE ANY ADDITIONAL STRESS LOAD ON THE ALREADY DISTRESSED SYSTEM

caused by prescription drugs and medical intervention, AZT being one example – how could people learn to depend less on the physician and/or avoid turning into life-long patients?

Again information is the only way to change people's beliefs and attitudes, and ultimately practices. I have seen an amazing change in the 36 years I have been in practice, with the popular press now carrying positive health enhancing articles and features on a regular basis. Change occurs organically, in an evolutionary rather than revolutionary manner, which is why I see the future of complementary health care within the NHS, not outside it. I could not have predicted that the movement from being called a 'quack' in the early 1960s, to 'fringe' in the late 1960s, to 'alternative' and eventually 'complementary' in the 70s and 80s, to being inside the establishment, practising in an NHS setting and teaching complementary medicine and naturopathic methods in a major University in the 90s, would have occurred. But it has. So change comes via concerted and dedicated effort, but it takes time, and education and information are the keys to the changes you so correctly highlight as being necessary.

The European Commission is planning to control vitamin and mineral supplements from Brussels. Nothing will in principle be banned this way, but most EU countries seem to want to regulate higher-dosage vitamin and mineral supplements as pharmaceutical drugs. What do you think the implications of these measures will be for the Nutri Centre at the Hale Clinic and other health food shops and their consumers?

If the changes you indicate are made, and they are probably inevitable if we remain members of the EU, we will survive. As long as food sources such as blue-green algae exist, and probiotics such as bifidobacteria and acidophilus, are available, and nutrients in some form – even if only in Recommended Daily Average (RDA) dosages, we will still – hopefully – have herbal approaches and food to satisfy our needs. My work in the NHS has taught me that when, because of financial constraints, we cannot use the expensive and the complicated, we can still achieve a lot by going back to diet, lifestyle habits, detoxification – using controlled fasting for example, hydrotherapy and bodywork, and we can still get good results. So while life may become difficult with change, it should concentrate our minds on our basic objectives, removing some of the shortcuts which high dosage supplementation offers, but not depriving us of the opportunity to work with the body and its self healing mechanisms.

An International Alternative HIV/AIDS Conference is being organised this year in Washington D.C. The purpose of such a conference will be to clarify and place in the public arena via organised media the untenable scientific position of the orthodoxy on HIV/AIDS, to integrate the AIDS-analyst movement and bring about the changes and solutions to the AIDS phenomena. How would you see A/C medicine contributing to the importance of this Washington Conference?

A/C medicine must be part of such conferences – it is all part of the information and education process of which I have spoken. The gradual influencing of key minds and attitudes pays dividends over time even if immediate response is small.

Hippocrates said "Healing is a matter of time, but it is also a matter of opportunity". What do you recommend Continuum readers do who require an A/C therapy but cannot afford the Hale Clinic?

I regret I cannot give a good answer here, as I have not kept abreast of what is available to people with HIV/AIDS in the UK over the past few years, during which time I have focused more on other areas of my teaching and writing work. Because of my limited availability – one day weekly when I am in the UK which is only about 8 months a year – I personally decline the care of anyone in need of supervision. I am happy to advise and on an overall strategy but cannot be around to deal with crisis.
This limitation probably does not apply to other naturopaths who have an interest in this area of work, and it is only by asking that appropriate help is found. It also pays to state clearly what your economic situation is, what can be afforded. I along with many practitioners waive or reduce fees when I deem it appropriate, and no-one should be shy to ask. The Nutri Centre and many excellent manufacturers, such as BioCare offer reductions to people with HIV/AIDS or readers of Continuum.
Continuum might consider a deeper investigation into this question – What's available? What are costs? What charities offer C/A care? And so on, and keep this resource information updated. Keep up the good work.

Books by Leon Chaitow include:

- ***World Without AIDS*** (co-authored with Simon Martin, published in the UK by Thorsons), Lambert's Book of the Year, 1990
- ***You Don't Have to Die – Unravelling the AIDS Myth*** (co-authored with Jim Stroheker, published in USA by Burton Goldberg Group)
- ***Candida Albicans – could yeast be your problem?*** (Thorsons)
- ***Holistic Pain Relief*** (Thorson's)
- ***Fibromyalgia and muscle pain*** (Thorson's)
- ***Thorson's guide to amino acids*** (Thorson's)
- ***Principles of Fasting*** (Thorson's)

For health care professionals:
- ***Acupuncture treatment of pain*** (Healing Arts Press)
- ***Palpation Skills*** (Churchill Livingstone)
- ***Muscle Energy Techniques*** (Churchill Livingstone)

Micro-Algae

Nutrient-dense foods from the dawn of life

Chris Baker

Micro-Algae are primitive, single-celled aquatic plants that evolved out of the primal soup that was planet Earth some 3 - 3 1/2 billion years ago, believed to be amongst the first life that nature created. Measured in microns, they exist at the beginning of the food chain and the evolution of life, and in recent years are being rediscovered as an important source of food.

The three algae species now commonly available are **Klamath Lake Blue-Green Algae, Spirulina** and **Chlorella.** All contain high levels of amino acids, vitamins and minerals. They provide the highest concentrations of protein and beta-carotene (pro-vitamin A, an antioxidant), of any foods and supply other micronutrients not found elsewhere, contributing to their reputation as healing foods. Their use extends from antiquity by the Mayans and the Aztecs to the present by the Kanembus people near Lake Chad in sub-Saharan Africa.

Klamath Lake Wild Blue-Green Algae (KBG)

This is considered by some to be the most nutritionally important of the three, particularly because it is the only one gathered from the wild. All KBG algae is harvested from the dense natural blooms that flourish annually in the Upper Klamath Lake in Oregon. This 140-square mile body of fresh water is notable for its exceptionally high mineral content from its seventeen tributary rivers and streams that flow through a volcanic basin high in the Cascade Mountains, a remote region of natural beauty. The unpolluted lake is one of the few remaining alkaline lakes on the planet. Harvesting is not considered ecologically detrimental as KBG algae is vigorously prolific, the amounts taken growing back within a few days.

Klamath Blue-Green algae contains the eight essential amino acids in proportions that correspond very closely to human dietary need, making its protein content (which is high at 60%) between 75% and 95% assimilable. KBG algae thrives in a very high light intensity and contains a correspondingly high level of chlorophyll, the plant pigment responsible for photosynthesis, valued for its detoxifying, wound healing and anti-inflammatory properties. Paul Pitchford, in *Healing with Whole Foods*, says people "with an extensive background of antibiotic use normally benefit by improving the intestinal flora with chlorophyll rich foods such as micro-algae...".[1]

KBG algae is unique in metabolising molecular nitrogen directly from the air – it breathes nitrogen – synthesising peptide molecules that are the precursors to neurotransmitters which are used by the brain in communication between neurons. It stimulates the opening of neural pathways and people using KBG algae have reported improved mental clarity, concentration and alertness. It may therefore be helpful in dealing with lethargy and depression.

One gram of KBG algae gives 133% RDA of Vitamin B12, deficiency of which a recent study has found to be associated with immune suppression and increased likelihood of illness.[2] B12 is also known to be deactivated by large doses of vitamin C[3] and is sometimes lacking in a vegan diet. KBG algae also provides significant amounts of all other vitamins and minerals in naturally chelated forms with high bio-availability.

Spirulina

With some similarities to KBG algae, Spirulina is also blue-green in colour but is not normally available harvested from the wild, all quality commercial varieties being cultivated in plastic tanks, subject to an artificial environment. It contains higher levels of Beta-carotene than even KBG algae and slightly more amino acid content; the chlorophyll level is significantly lower. Most is spray-dried, which is known to reduce enzyme activity and cause loss of heat-sensitive vitamins and results in lower bio-availability of proteins.

Chlorella

Chlorella is an emerald green coloured algae more evolved than KBG and Spirulina, and contains a more advanced nucleic acid structure. It is also cultivated artificially and, having a tough cell wall is usually processed to render the nutrients available. Chlorella Growth Factor (CGF), isolated in the 1950s and related to the more complex nucleic acid structure is a substance unknown in other foods and has been shown to promote growth and repair of normal tissue without stimulating disease or tumour processes. Substances in Chlorella have also been shown to stimulate interferon production and enhance anti-tumour and immune function.

Diet Supplementation

Many vitamin and amino acid supplements are highly processed and purified substances far removed from the natural balance and form of good organic food sources. With so many supplements now being advocated for nurturing health in the context of immune suppression there comes the risk of overdoing it and thus countering the benefits that are sought – more is not necessarily better. Micro-algae, by comparison, offer the densest possible supply of nutrients in a natural balance and, being directly assimilable, make few demands on the digestive system. Of the three discussed, only KBG algae is a wild food, growing naturally in an unpolluted habitat. Each micro-alga has its own unique properties and benefits, and some formulae include all three algae along with other nutrients.

All are available in powder, capsule and tablet form, and sometimes as liquid extract. Supplementation of Spirulina is often taken at 10-20g/day; because of their detoxifying properties KBG and Chlorella are generally recommended at a lower dose of 1/2g/day initially, increasing to 1 or 2 g/day or more in illness and stress conditions. Micro-algae are foods and, as such, intuition might guide the amount consumed and over what period.

References

1. *Healing With Whole Foods*, Paul Pitchford. North Atlantic Books, 1993.
2. *Positive Times*, March 1997.
3. *Diet and Nutrition: A Holistic Approach*, Rudolph Ballentine. Himalayan Int. Institute 1978.

Algae from Upper Klamath Lake,* a booklet of further information on Wild Blue-Green Algae, is available on request from *Continuum.

Supplement: The Drug-AIDS Hypothesis

by Peter Duesberg and David Rasnick

MICHAEL VERNEY-ELLIOTT introduces the major new paper that forms this issue's Supplement

Peter Duesberg, the world's foremost retrovirologist, has declared since 1987 that HIV is a conventional retrovirus, without a disease-causing supernumerary gene, is not sexually transmitted, and is principally transmitted by female to offspring. He states that what is called HIV, for these and many other reasons, is not and cannot be the cause of AIDS. He is currently engaged in a debate, principally in this magazine, with other leading scientists as to whether HIV has really ever been proved to exist as an isolated virus, which he believes it has. Even if this is not so, both sides of that debate agree that what is called HIV cannot be the cause of AIDS.

Having since 1987 refuted the idea that a human retrovirus can be the cause of AIDS, Duesberg has searched the epidemiological evidence for an alternative cause for the acquired immune deficiency syndrome ("AIDS"). He has propounded the drug-AIDS hypothesis for some time, and in this latest paper he and co-author David Rasnick have presented his arguments in exhaustive detail, with 338 references. The paper is very persuasive.

The authors begin by expounding the scientific credo of Richard Feynman, who states that good science will present all the relevant facts concerning an hypothesis, not merely those which support it, and leave the readers to make up their own mind. This means that the true scientist must be his own Devil's Advocate, and state the con's as well as the pro's in presenting a scientific theory. My personal experience of Duesberg is that he has always obeyed this precept, whilst the vast majority of so-called 'AIDS experts' have consistently and wilfully presented only the specious arguments which seem to support their frequently illogical theories, sometimes deliberately obfuscating or suppressing contradictory evidence.

Duesberg gives a perfect example of this scientific chicanery, citing a paper published by Nature purporting to show AIDS in non-drug-using patients which, in fact, showed nothing of the kind, and all the patients in the study had in fact used recreational drugs. A line on an illustrative graph claimed to represent non-drug users, but the text mentioned no such patients. The line was an artefact, used to support a shaky, flaky piece of research. Even worse, a subsequent independent study of the database used in the paper revealed in the same cohort of patients, 45 HIV negative drug users with AIDS defining diseases. These were not mentioned in the paper, obviously because they would have shown that the drugs caused the diseases and HIV was irrelevant. Unfortunately, this rotten science has prevailed since the beginning of 'AIDS', and shows no sign of abating.

Space allows for only a few of the many points which particularly struck me in Duesberg's hypothesis. Duesberg gives a list of diseases known to afflict long-term drug addicts and their babies since an earlier drugs epidemic at the beginning of this century in the USA. "These diseases include immunodeficiency, pneumonia, tuberculosis, dementia, candidiasis, weight loss, diarrhea, fever, night sweats, congenital abnormalities, mouth infections, impotence, epileptic seizures, paranoia, lymphadenopathy, hemorrhages, hypertension and many others." (12 refs. cited) This looks almost identical to a list of 'AIDS' defining diseases. Moreover, "Patients and deaths from drug diseases... show essentially the same sex and age distribution..." (as AIDS).

When AIDS first appeared, drug causation was widely suspected and supported by scientists like Blattner, Curran, Friedman-Kien, Goedart and Jaffe, all of whom did a volte face and joined the HIV junta in 1984. Despite the fact that, epidemiologically, drugs are a much more convincing explanation for AIDS than a retroviral infection, these men still show solidarity with an increasingly threadbare scientific theory, "without even offering a refutation of the drug hypothesis."

In the best Feynman tradition, Duesberg does not shirk the objection that not all drug users develop AIDS. He illustrates his thesis that "The dose is the poison" by pointing out the following: "In adults it takes about ten years of injecting or oral use of heroin, cocaine and amphetamines to develop tuberculosis, bronchitis, pneumonia, irreversible or hardly irreversible weight loss and other drug-induced diseases. [8 refs. cited.] The time lag from initiating a habit of inhaling nitrites to acquire Kaposi's sarcoma has also been determined to be 7-10 years [4 refs. cited]." The ten year use of drugs is remarkably reminiscent of the embarrassingly elastic 'HIV incubation' period.

In a particularly telling section, the paper lists 11 examples from the literature of the devastation caused by AZT/nucleoside analogues cynically minimised, wilfully misinterpreted or disregarded by conductors of drug studies. For instance, Samuel Broder, who first pushed AZT as an antiviral drug, when confronted by the 46.4% increase in lymphoma in patients taking AZT claimed it as a victory for AZT, in that it kept the patients alive long enough for half of them to develop cancer.

The dishonesty in failing to admit the link between drug use/addiction and AIDS reaches right up to Government level, as this paper shows. Despite paying lip service to the War Against Drugs, the US govemment restricts their efforts largely to token drug seizures and pursuing dealers. They have consistently failed to stress the illnesses caused by drugs, as has been done in successful campaigns against smoking. As far as AIDS and drug users are concerned, the message has been rather 'Say no to shared needles' than 'Say no to drugs', (which tragically should include AZT/DNA synthesis inhibitors). The American government for reasons of its own fails to realise that to link the wars against drugs and AIDS would stand a better chance of winning, rather than losing, both. Obviously, to undermine the prevailing view that HIV is the sole cause of AIDS would damage the already tarnished scientific reputations of the "HIV" junta, and to focus on drugs would rouse the ire of powerful drug cartels – both recreational and pharmaceutical.

This paper is exhaustively researched, fully referenced and convincingly argued. Anyone interested in the true cause and nature of 'AIDS' – Acquired Immunosuppressive Drug Sickness – should read it several times. Duesberg's hypothesis is testable – studies of heavy drug users, using HIV positive and negative controls, should reveal identical immune deficiencies, disease incidence and early mortality. To date no-one has carried out such a study. It is long overdue.

CONTINUUM

supplement

vol 4, no 5 february/march 1997

The Drug-AIDS Hypothesis

by **Peter Duesberg** and **David Rasnick**

The war on the new AIDS epidemic has been a complete failure in terms of public health benefits: 50,000 to 75,000 Americans develop AIDS per year and over $8 billion are spent annually on AIDS research and treatment by the US taxpayer alone, but there is no vaccine, and no effective drug, and not one AIDS patient has been cured. It is proposed here that this failure is the responsibility of the hypothesis that AIDS is caused by a virus named HIV. This hypothesis has monopolized AIDS research and treatment since 1984, but it neither explains nor predicts numerous AIDS facts, nor has it produced any public health benefits. In order to solve AIDS we propose here the drug-AIDS hypothesis.

The drug hypothesis holds that all American AIDS diseases that exceed their normal low background are caused by the long-term consumption of recreational drugs, anti-HIV/AIDS drugs or both. This hypothesis is based on the only new health risk to emerge during the past 25 years in America and Europe: the drug epidemic. In America the consumers of recreational drugs such as cocaine, amphetamines, nitrite inhalants, and heroin soared from negligible numbers in the 1970s to currently 20 millions, or 8% of the population. In addition, over 200,000 HIV-positives take since 1987 daily prescriptions of inevitably toxic DNA chain-terminators such as AZT and simultaneously consume many other orthodox and unorthodox toxic anti-HIV/AIDS medications. All AIDS facts confirm the drug hypothesis: 1) AIDS is new because the drug epidemic is; 2) over 95% of American AIDS patients are long-term users of recreational and anti-viral drugs, because drugs cause AIDS; 3) 9 out of 10 AIDS cases are males because they consume 90% of the drugs; 4) the age distributions of diseases and deaths from drugs and AIDS are both 25 to 54 years because drugs cause AIDS; 5) babies develop AIDS from sharing intravenous drugs with their mothers during pregnancy; 6) Kaposi's sarcoma is a homosexual male-specific AIDS disease because male homosexuals use carcinogenic nitrite inhalants as sexual stimulants almost (98%) exclusively; 7) termination of drug use has prevented and has even cured pediatric, male homosexual and intravenous drug-AIDS cases.

According to the drug-AIDS hypothesis AIDS is preventable by banning anti-HIV/AIDS drugs and by advertising the medical consequences of recreational drugs. Such a program could be as successful as the campaign that has reduced smoking 40% by advertising the medical consequences of tobacco use. The drug-AIDS hypothesis could save 50,000 to 75,000 lives per year, $8 billion that are annually spent unproductively on AIDS research and therapy based on the virus hypothesis, and much of the $15 billion that is annually spent on "supply control" in the failed War on Drugs by lowering demand with advertisements that drugs cause AIDS.

The solution to AIDS and the drug epidemic are as close as a very affordable and testable, independent AIDS hypothesis.

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Be bold in formulating hypotheses
and humble in the presence of facts.
—Oswald Avery[1]

1. RICHARD FEYNMAN ON SCIENCE

As an introduction to AIDS science we advance the untestable hypothesis that almost all current AIDS researchers would have written the rest of our article if they practiced the standards of science advocated by the late physicist Richard Feynman. According to Feynman's standards, current AIDS research is "cult science":

> ...I call these things cult science, because they follow all the apparent precepts and forms of scientific investigation. ... But there is one feature I notice that is generally missing in cult science. ... It's a kind of scientific integrity, a principle of scientific thought that corresponds to a kind of utter honesty – a kind of leaning over backwards. For example, if you're doing an experiment, you should report everything that you think might make it invalid – not only what you think is right about it. ... If you make a theory, for example, and advertise it, or put it out, then you must also put down all the facts that disagree with it, as well as those that agree with it. ...the idea is to try to give all of the information to help others to judge the value of your contribution; not just the information that leads to judgment in one particular direction or another.
>
> The easiest way to explain this idea is to contrast it, for example, with advertising. Last night I heard that Wesson oil doesn't soak through food. Well, that's true. It's not dishonest; but the thing I'm talking about is not just a matter of not being dishonest, it's a matter of scientific integrity, which is another level. The fact that should be added to that advertising statement is that no oil soaks through food, if operated at a certain temperature. If operated at another temperature, they all will – including Wesson oil...
>
> We've learned from experience that the truth will come out. Other experimenters will repeat your experiment and find out whether you were wrong or right. Nature's phenomena will agree or they'll disagree with your theory. And, although you may gain some temporary fame and excitement, you will not gain a good reputation as a scientist if you haven't tried to be very careful in this kind of work. And it's this type of integrity, this kind of care not to fool yourself, that is missing to a large extent in much of the research in cult science...
>
> But this long history of learning how not to fool ourselves – of having utter scientific integrity – is, I'm sorry to say, something that we haven't specifically included in any particular course that I know of. We just hope you've caught on by osmosis. ... And this is our responsibility as scientists, certainly to other scientists, and I think to laymen.[2]

2. WHY HIV-AIDS SCIENCE CANNOT SUCCEED

2.1. The American/European AIDS epidemic.

The AIDS epidemic in America and Europe is defined as a significant increase, since 1981, of 30 previously known diseases (Table 1) affecting mostly 25 to 44 year old men and some (10%) women[3-7] . In America these cases have shot up from negligible numbers in this age group in the 1970s to annually about 50,000 to 75,000 patients now[3] (Fig. 1). Because Kaposi's sarcoma rose from an almost non-existent background of about 50 cases per year in 1981[8, 9] to thousands of almost exclusively male homosexual cases annually now, it has become the signal disease of AIDS[3]. It is for this reason that the new epidemic has been accepted as a new disease, "HIV disease", in numerous publications[5]. In fact, AIDS in America and Europe is a new epidemic of old diseases that primarily affects 25 to 44 year old males.

2.2. The war on AIDS.

By any measure the war on AIDS has been a complete failure. Since 1981, over 500,000 Americans and over 150,000 Europeans have developed AIDS, and the US taxpayer alone has paid over $45 billion for AIDS research and treatment, but no vaccine, no cure, and no effective prevention has been developed, and not a single AIDS patient has been saved[7, 10, 11]. This war has been fought in the name of the hypothesis that the Acquired Immunodeficiency Syndrome (AIDS) is infectious, caused by the Human Immunodeficiency Virus (HIV), and that this virus (i.e. AIDS) is sexually transmitted[5, 12, 13].

The HIV-AIDS hypothesis was announced in April 1984 at an international press conference in Washington by the Secretary of Health and Human Services (HHS) and the National Institues of Health (NIH) researcher Robert Gallo – even before it had appeared in any American scientific publication[10, 14]. For the last twelve years the HIV hypothesis has been international dogma and the basis of all AIDS research and therapy[4, 5, 8, 9, 11, 13, 15].

According to the HIV-AIDS hypothesis 30 previously known diseases, including microbial or immunodeficiency diseases such as pneumonia, tuberculosis, candidiasis (yeast infection), diarrhea, and classical non-immunodeficiency diseases such as Kaposi's sarcoma, dementia, weight loss and lymphoma, are all consequences of viral immunodeficiency and called AIDS when antibody against HIV is present[5, 16] (Table 1). For example, tuberculosis is now diagnosed as AIDS in the presence of antibody against HIV; in the absence of the antibody, it is still diagnosed as tuberculosis.

TABLE 1
AIDS-DEFINING DISEASES IN THE U.S. IN 1995[1]

Immunodeficiencies	(in %)	Non-immuno-deficiencies	(in %)
pneumonia	33	wasting	15
candidiasis	14	Kaposi's sarcoma	6
tuberculosis[2]	10	dementia	4
cytomegalovirus	7	lymphoma	3
toxoplasmosis	4		
herpesvirus	4		
total	**72**		**28**

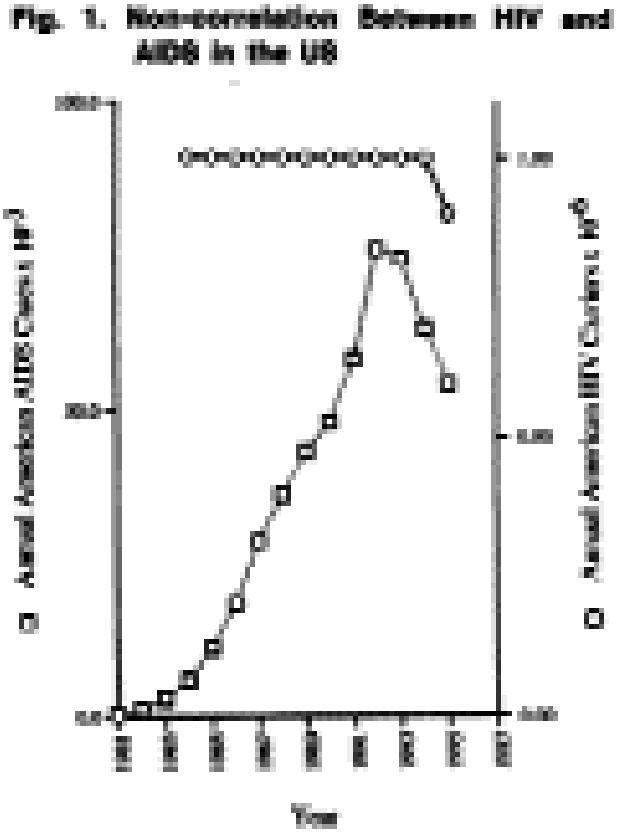
1 The data are from the Centers for Disease Control (HIV/AIDS Surveillance Report, 1995)
2 including other mycobacterial infections

2.3. AIDS facts incompatible with the HIV-AIDS hypothesis.

Even a brief survey of the facts of AIDS shows that the proponents of the HIV hypothesis have not followed Feynman's advice to " put down all the facts that disagree with it":

1) Although AIDS is postulated to be a new infectious epidemic, it fails all epidemiological standards of infectious disease[17]:

(a) Infectious diseases spread equally between the sexes – but AIDS does not. Nine out of 10 American AIDS patients are males[3].
(b) The recipient has the same disease as the donor – but not in AIDS. After a contact with a Kaposi's sarcoma patient a person may develop dementia or diarrhea or pneumonia or no disease at all[18].
(c) According to Farr's law of epidemiology, a new infectious disease spreads exponentially in an uninfected population[19], like a



seasonal flu – but American and European AIDS lingers in fringe groups, spreading slowly, but non-exponentially, over years[20] (see Fig 1).

Numerous facts confirm that AIDS is not infectious. Although there is no anti-HIV vaccine nor any effective anti-viral drug, the professional literature has yet to describe the first doctor (except for a few undocumented, anecdotal claims[15]) who has contracted AIDS from the over 500,000 American[3] and over 150,000 European AIDS patients[350]. The wives of 15,000 American HIV-positive hemophiliacs have also not developed AIDS, although HIV is said to be sexually transmitted[21-23]. And since 1984 not even one of tens of thousands of HIV scientists has developed AIDS from exposure to HIV[10, 22, 24].

Chimpanzees are as susceptible to HIV as humans, but none of over 200 animals inoculated with HIV since 1983 has developed AIDS[25, 354]. Even the CDC now admits that it "may be difficult to identify [AIDS from contact infection] because most persons with AIDS have had contact with many different people. In particular, drug users and homosexual and bisexual men may have had contact with hundreds of partners that they did not know very well."[26].

2) Although viruses are not selective, AIDS in America and Europe is restricted, over 95%, to fringe groups with life-threatening health risks other than the hypothetical risk, HIV[3, 25]. These risks include the intravenous drugs taken by a third of American AIDS patients, and the many illicit sexual and mental stimulants, and the highly toxic anti-HIV drugs taken by male homosexuals who make up over 60% of the American AIDS patients (see 3. and 4.). The remainder are typical diseases of hemophiliacs and transfusion recipients, that fall into the AIDS definition but represent the normal incidence of these diseases in these groups under the new name, AIDS[3, 7, 11, 13, 25-27].

3) Although HIV is a long-established virus in the US – because the number of carriers has remained completely stable since its discovery[24, 25, 28] (Farr's law) – AIDS is a new epidemic in America (see Fig 1).

4) Although only 1 in 1,000 T-cells is ever infected by HIV, and HIV like all other retroviruses[25] does not kill infected cells, most AIDS patients lose T-cells[10, 25, 29-31]. If HIV were responsible for immunodeficiency it would act like a single bullet that kills 1000 soldiers.

5) Although dementia, weight loss and Kaposi's sarcoma are not consequences of, and frequently not even associated with immunodeficiency, they are blaimed on the immunodeficiency virus, HIV[13, 24, 25] (Table 1).

6) AIDS appears, if at all, typically only 10 years after HIV infection[13, 32, 33]. But HIV, multiplying over 100-fold every 1-2 days, has the capacity to produce 10^{14} viruses in 2 weeks – enough to infect every cell in the human body. If HIV could cause AIDS, AIDS should appear within 2 weeks after infection[10, 17, 24, 30, 31, 34].

7) Although pathogenic viruses cause the same disease in all people, Kaposi's sarcoma occurs almost exclusively in male homosexuals[10, 24, 35]. If HIV could cause Kaposi's sarcoma, transfusion recipients, like the 15,000 HIV-positive American hemophiliacs or the 3 million Americans who annually receive blood transfusions[25], should have this cancer. But paradoxically, no Kaposi's sarcoma has ever been transmitted by transfusion[7, 22, 23, 36].

8) Although HIV is widespread in American/European hemophiliacs the mortality of hemophiliacs has decreased (until 1987, when most started receiving AZT)[22, 23, 37], that of male homosexuals has increased[3], and that of intravenous drug users[38-40] and sub-Saharan Africans[41] has stayed about the same since HIV has been diagnosed in these groups. If HIV were the cause of AIDS the mortality of all infected groups should have increased.

9) HIV is claimed to be sexually transmitted in spite of the fact it takes, on average, 1000 unprotected sexual contacts to contract the virus[42, 43]. Therefore, HIV depends for its survival on perinatal transmission, which is 25 to 50% efficient[25, 44] – just like all other animal and human retroviruses of its kind[25, 45]. It follows that HIV is biologically not a sexually transmitted virus.

10) Although HIV is claimed to be fatal, it is not possible that either a perinatally or even a sexually transmitted microbe could be fatally pathogenic. Such a microbe would exterminate itself together with its host within a few generations.

11) Although HIV is postulated to cause 30 AIDS diseases, it meets all four classical standards of a harmless passenger virus[17]:

(a) The time of infection by the passenger is irrelevant to the onset of a disease, if one occurs. This applies exactly to HIV and AIDS; hence the arbitrary assertion that HIV takes on average 10 years to cause AIDS (see 6.).

(b) The passenger virus can be either active or passive, either rare or abundant during any disease. This also applies exactly to HIV and AIDS, although abundant HIV in AIDS is extremely rare[30, 46].

(c) The passenger virus can be entirely absent during any disease. This also applies exactly to HIV and AIDS; hence HIV-free AIDS[47] (see 6.8.).

(d) If the passenger virus is activated by a failing immune system, but does not cause opportunistic disease symptoms of its own, it is a harmless passenger. Indeed, there is no report in the literature that AIDS patients are clinically distinguishable from each other based on the presence of HIV or on its activity[30, 46]. Likewise, all other conventional retroviruses (without non-essential genes) do not contribute a disease symptom when they are activated in immunosuppressed or congenitally infected animals[45]. By contrast, herpes virus HHV-6[48] or cytomegalovirus are passengers that may impart specific pathogenic properties to an immunodeficient patient[49].

Since HIV meets all these criteria with regard to AIDS to the letter, it is a harmless passenger virus.

2.4. Conclusions.

Instead of explaining the "facts" about AIDS, the HIV hypothesis generates numerous paradoxes and contradictions. Since there are no paradoxes in science, only bad hypotheses, the HIV hypothesis must be flawed. A flawed hypothesis also explains the failure of the war on AIDS. Even the best and most expensive science cannot produce results in the name of a flawed hypothesis. Therefore, independent hypotheses must be found to solve AIDS[34]. The search for a plausible cause of AIDS quickly leads to the only new health risk that has affected America and Europe since World War II, the drug epidemic.

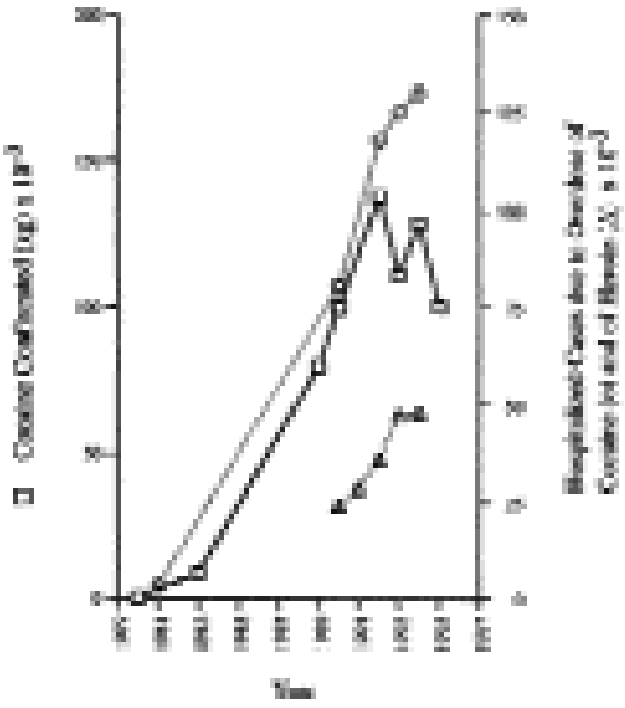
3. THE AMERICAN/EUROPEAN DRUG EPIDEMIC

3.1. Chronology of the drug epidemic in America.

During and after the Vietnam war, in the 1970s, the number of illicit recreational drug users in America soared from a negligible background to currently about 20 million who use drugs chronically, or about 8% of the total US population of 250 million. In addition, 75 million Americans (30%) use such drugs occasionally[50-52]. This sudden epidemic of drug addiction followed a 40 year period (from World War II until the upsurge in the 1970s) during which there was very little illicit recreational drug use.

Prior to World War I, heroin, cocaine, and nitrite inhalants were legal, and widely prescribed as medicines and sold as recreational drugs[53-55].

Fig. 2. The American Drug Epidemic



Those who became addicted generated an early drug epidemic that lasted about 35 years, "from around the mid-1880s until the 1920s"[51]. The concurrent diseases and social consequences soon led to anti-drug legislation, which together with the political situation of the wars ended "the first cocaine epidemic"[51, 54, 56]. According to the Bureau of Justice Statistics: "Cocaine abuse decreased substantially by the 1920's, and then virtually disappeared from the American scene until the 1970's. During the 1930's drug interest dwindled due to concern with the events in Europe. During WW II international trafficking was eliminated. As the 1950s ended, efforts to treat, rehabilitate and care for drug addicts were made for the first time since the turn of the century."[51].

As of 1964 the Bureau chronicles the appearance of the new American drug epidemic: "rapid rise in marijuana use; amphetamines and barbiturates move from homes to the streets; rise in heroin addicts leads to methadone maintenance pilot programs (1964). By the late 1960s increases in cocaine, heroin and marijuana use prompted concern about drugs..." In the 1970s the "Vietnam war produces drug testing and dependence among returning veterans." And by 1980 "crack appears in American cities" and "AIDS first described in medical literature. Athletes die from overdoses, showing the lethal implications of crack/cocaine (1986)"[51].

The director of NIDA wrote in 1985, "Over the past 10 years, cocaine ... has evolved from a relatively minor problem into a major public health threat."[57]. In 1986 scientists from the National Institute on Drug Abuse (NIDA) published an epidemiological overview of drug use in the US in Science. According to the NIDA scientists cocaine addiction spiraled in the US from "negligible" numbers in 1973 to 9,946 non-fatal and 580 fatal medical cases in 1985[58]. The new cocaine epidemic has since increased more than 10-fold, raising the numbers of cocaine patients to 80,355 cases in 1990, and 123,423 in 1993 and 142,878 in 1994[25, 50, 58-61] (see Fig. 2 and Table 2). Cocaine emergencies hit a new record of 13,496 cases in California in 1994, up from 3,688 in 1985[62]. Even popular writers have accurately chronicled the rise of the new American drug epidemic, as for example Jill Jonnes in Hep-cats, narcs, and pipe dreams[54].

In step with its medical consequences cocaine consumption escalated to unprecedented records. By 1996 the number of regular cocaine users had reached 3.6 million, with 28 million who had at least tried the drug once in their lifetime[51, 61]. To keep up with their demand cocaine imports had to be increased 200-fold, from 2 tons in 1980 to 400 tons in 1990, and have since been kept at this level[25, 52, 61] (Fig. 2). These data are based on cocaine seizures that increased from 500 kg in 1980 to 100 tons in 1990 and have since remained at this level[61, 63, 64] (see Fig 2). The Bureau of Justice Statistics estimates that only 10-20% of the imported cocaine is confiscated, and that American consumption is currently at least 400 tons per year[52, 65]. This corresponds to about 110 g for each of the 3.6 million regular users per year, which is rather close to the estimated daily consumption of 1g per day per addict[66].

Heroin-related hospital emergencies doubled, from over 30,000 in 1990 to 63,232 in 1993[50] (Table 2 and Fig. 2). Heroin deaths climbed from 2,260 in 1991 to 3,522 in 1994 according to the Drug Abuse Warning Network (DAWN)[60] (Table 2). About 1,500 kg of heroin were confiscated annually between 1992 and 1995[61]. In view of these alarming statistics the popular press[50, 59, 67, 68] including the San Francisco Chronicle warned that "a growing segment of the population [is] attracted by its [heroin] deadly mystique and encouraged by its low prices ..."[69].

According to a 1994-survey of the NIDA "more than 5 percent (221,000) of the 4 million women who give birth each year use illicit drugs during their pregnancy"[50]. Many of these mothers are among the AIDS patients listed as intravenous drug users, and many of their babies are listed as pediatric AIDS cases by the Centers for Disease Control (CDC)[3] (see 6.8. and 6.9).

Based on the amounts confiscated, 2 million doses in 1981 and 97 million doses in 1989, amphetamine consumption has spiraled 50-fold in the 1980s[64]. Non-scientific reports describe new upsurges of amphetamine consumption in the US and Europe among male homosexuals[70, 71] and others[72]. According to the US Department of HHS, "amphetamine-related emergency room episodes... [presenting with] violent paranoid behavior as well as stroke, seizure and death..."[73] increased from 8,800 in 1990 to 17,665 in 1993[50, 60] (see Table 2). In California amphetamine or 'speed' hospitalizations rose even faster from 1,466 in 1984 to 10,167 in 1994[72, 74]. And the Drug Abuse Warning Network reports a three-fold increase in amphetamine deaths from 252 in 1991 to 751 in 1994[60] (Table 2).

There are no American statistics from the Bureau of Justice on the consumption of nitrite inhalants, even though nitrites have been banned for recreational use in the US since 1988. Despite this ban they are sold legally as room deodorizers[76-78]. Before the ban about five million doses of amylnitrites were consumed in the US in 1980, mainly by male homosexuals[55, 79, 80]. After the ban, in 1993, 4.2 million Americans, including 2.8 million men and 1.4 million women, had used nitrites based on a survey from the National Institute on Drug Abuse[339].

3.2. Chronology of the drug epidemic in Europe.

Europe was hit by a drug explosion ("Drogen-Explosion") at the same time as America. Based on the amounts confiscated by the Bundeskriminalamt (BKA), the German consumption of cocaine, heroin, amphetamines, LSD and cannabis increased 1000 to 10,000 fold from the 1960s to the 1990s (Table 2a)

TABLE 2

CHRONOLOGY OF DISEASES AND DEATH FROM ILLICIT RECREATIONAL DRUG USE IN THE U.S.[1,2,3]

Drug	Event	1990	1991	1992	1993	1994
cocaine	death	—	2,938	3,285	3,633	3,687
	hospital	80,355	101,189	119,843	123,423	142,878
amphetamines	death	—	252	334	566	751
	hospital	8,800	7,363	10,615	15,630	17,665
heroin	death	—	2,260	2,782	3,558	3,522
	hospital	33,884	35,898	48,003	63,252	64,013
all drugs	death	—	6,246	6,870	7,602	8,541
	hospital	371,208	393,968	433,493	460,910	518,521

1. Office of National Drug Control Policy. Drugs & Crime Data. *Drugs & Crime Clearinghouse* 1996; July 1996.
2. U.S. Department of Health & Human Services. Annual emergency department data 1993. *Data from the Drug Abuse Warning Network (DAWN)* 1993; 81-110,
3. U.S. Department of Health & Human Services. Annual Medical Examiner data. *Data from the Drug Abuse Warning Network (DAWN)* 1994; 1-82, 1994.

TABLE 2a

DRUG CONSUMPTION BEFORE AND AFTER THE "DROGEN-EXPLOSION" (DRUG EXPLOSION) IN GERMANY AND THE EUROPEAN UNION[350, 353]

	amounts confiscated in Germany		in the European Union
Drug	before	after	
		kilograms	
cocaine	0.09 (1963)	1,846 (1995)	29,000 (1994)
heroin	1.8 (1968)	933 (1995)	5,900 (1994)
amphetamines	6.6 (1972)	138 (1995)	1,900 (1994)
cannabis	5.5 (1962)	14,245 (1995)	733,400 (1994)
		doses	
ecstasy	730 (1987)	380,858 (1995)	1,250,000 (1994)
LSD	10 (1967)	71,069 (1995)	61,000 (1994)

TABLE 3

DRUG DEATHS AND DISEASES IN THE USA BY AGE AND SEX 1985-1994[1,2,3]

Drug		% male	% 18-54 years
cocaine	users	70, 82[4]	
	hospital	67	99
	death	80	
heroin	users	69, 83[4]	
	hospital	71	99
	death	83	
amphetamines	users	80	
	hospital	61	97
	death	79	
nitrites	users	98[5]	>98
	hospital		
	death		
all combined	users	75, 78[6], 86[7]	>75
	hospital	71	
	death	77	

1. Bureau of Justice Statistics. Drugs, crime, and the justice system. 1992;
2. U.S. Department of Health & Human Services. Annual emergency department data 1993. *Data from the Drug Abuse Warning Network (DAWN)* 1993; 81-110.
3. U.S. Department of Health & Human Services. Annual Medical Examiner Data. *Data from the Drug Abuse Warning Network (DAWN)* 1994; 1-82, 1994.
4. Wesson D, Smith D. Cocaine: treatment perspectives, in *Cocaine Use in America: epidemiologic and clinical perspec tives,* N. Kozel and E. Adams (eds.) NIDA US Dept. HHS, Washington, DC, 1985;
5. San Francisco Department of Public Health, Lesbian & Gay Substance Abuse Planning Group. Lesbian, Gay and Bisexual Substance Abuse Needs Assessment. 1991, August; Ascher MS, Sheppard HW, Winkelstein Jr W, Vittinghoff E. Does drug use cause AIDS? *Nature* 1993; 362: 103-104.
6. Clinton W, The White House. The National Drug Control Strategy: 1996. The White House, Washington DC, 1996.
7. Bureau of Justice Statistics. Special Report—Drug Law Violators, 1980-1986. 1988.

3.3. Epidemiology and age distribution of recreational drugs.

In contrast to infectious diseases, the epidemiological distribution of recreational drug use is far from random. Instead it is highly differentiated in the American and European populations (Table 3). About 70-80% of the American consumers of hard recreational drugs such as cocaine, heroin and amphetamines are males over 18 years of age based on information from the Bureau of Justice Statistics, the NIDA, The White House and Public Health Services other than the CDC (Table 3). The National Drug Control Strategy: 1996 from the White House reports that 78% of the drug users are males, and that 74% are 21-44 years old[52]. Patients and deaths from drug diseases (see 3.3.) show essentially the same sex and age distribution (Table 3). Almost all drug decedents are over 18 years of age, and most are over 25[60, 61, 84] (see Table 3). According to a German study the median age of death of European intravenous users of cocaine and heroin is 30 years[38]. Their American counterparts die between 25 and 44 years[40, 85].

The drug epidemiology is further differentiated based on sexual persuasion. While cocaine and heroin are used independent of sexual preferences in all major American and European cities, including New York[86-89], Baltimore[90, 91] and Milan[92], nitrite inhalants are almost entirely, and amphetamines are partially, monopolized by male homosexuals (see 3.3.). However, in contrast to the hard illegal drugs used for psychoactive effects only (Table 3), those used specifically as sexual stimulants by male homosexuals like nitrite inhalants are not recorded nationally, neither by the Department of Justice nor by any of the many divisions of the Department of HHS. Therefore, we have put together the pattern of drug use by homosexuals from non-scientific reports and from sporadic reports in the scientific literature.

Numerous non-scientific reports confirm the popularity of the "gay drug"[91] (nitrite inhalants) among male homosexuals in America and Europe[7, 76-78, 91-95] (see Table 4). The Swiss gay interest journal, aK, just surveyed the availability of poppers which "seit Jahren von vielen Leuten – vor allem Schwulen – beim Sex zwecks Verstärkung der Lust verwendet wird" [used as a gay drug for years][340]. The journal points out the fierce competition among sex shops for the gay market, particularly in view of the enormous profit margins of over 1000%. Bottles containing poppers that cost less than 1Sfr to produce sell for up to 58 Sfr in Zurich, Lucerne, Bern, and Basel.

[350].

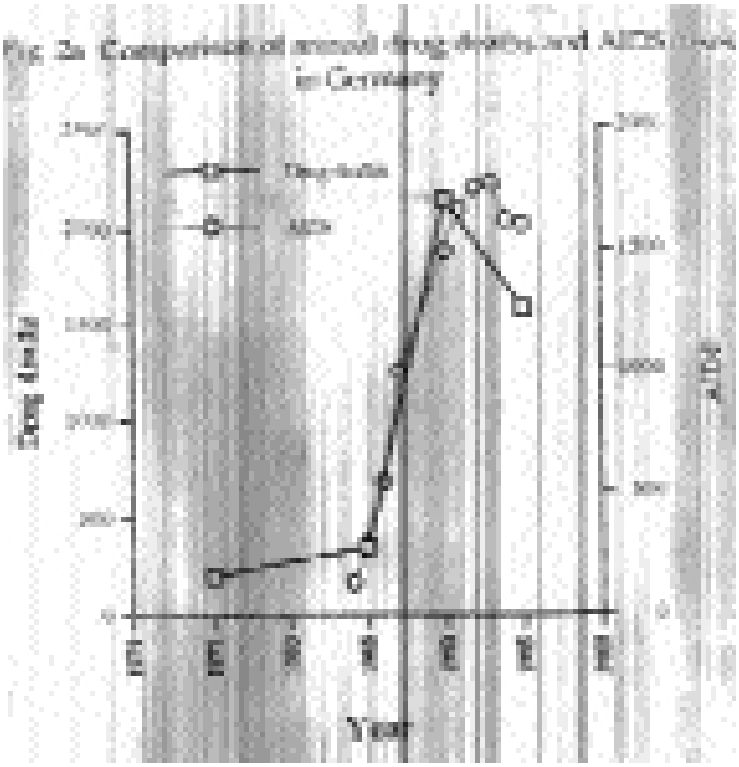
According to the Deutsche Hauptstelle gegen die Suchtgefahren (Center for drug addictions) in 1997, 19.3% or 3.9 million of the 18 to 59 year old former West German males, and 9.9% or 1.9 million of the females have used illicit drugs at some time[351]. The majority of these had used haschisch (cannabis) but 7.5%, or 1.5 million, males and 4%, or 0.75 million, females had used hard drugs such as cocaine, heroin and amphetamines. Altogether 19.3%, or 7.5 million, of the former West Germans have used illicit drugs in their lifetime, and 5%, or almost 2 million, are monthly users[353]. About 200,000 are lifetime users, and 80,000 are regular users of inhalants ("Schnüffelstoffe"), probably including nitrite inhalants[353]. Among the 80 million current Germans, four million are addicted to alcohol and 120,000 to heroin[350].

The German Rauschgiftbilanz reported an 11.2% increase in the consumption of illicit recreational drugs in 1994 compared to 1993[75]. And the number of first time users reached 15,000 in 1995, up 5% from 1994[350]. Most of these, 83%, were over 21 years old.

In 1993, 122,240 Germans were reported for drug offenses and 29,086 were convicted. There were 2,125 deaths officially blamed on drug use in Germany in 1991, 1,565 in 1995 and 1,712 in 1996[350, 353]. This represents a 10-fold increase since the decade that started in 1975 with 195 drug deaths (Fig. 2a). As can be seen in Fig. 2a the rise in German drug deaths paralleled the rise in AIDS cases. Like in America, German males outnumbered females about 3 to 1 in the consumption of hard recreational drugs (cocaine, heroin and amphetamines, use of nitrite inhalants is not recorded in Germany)[351], and 9 to 1 in AIDS cases[352].

Drug consumption by the combined European Union almost matches, and in the case of heroin, even exceeds the American epidemic based on the amounts confiscated (Table 3a). For example, 5.9 tons of heroin were confiscated in Europe in 1994 compared to 1.5 tons in the US (see above). At the same time, 29 tons of cocaine, 1.9 tons of amphetamines, 733 tons of cannabis and 61,000 doses of LSD and 1.25 million doses of ecstasy were seized in the European Union in 1994[350].

A review of the European recreational drug explosion by the popular Springer Verlag (press) mentions just two health consequences: "heart arrest" from cocaine, "itching" and "collapse of the immune system" from ecstasy[350].



Source of drug deaths: Springer Verlag. *50 Jahre Springer – 50 Jahre Zeitzeuge.* Axel Springer Verlag, Hamburg, 1996; *Jahrbuch Sucht – 97.* Neuland Verlag, Geesthacht, Germany. 1997.

Source of AIDS cases: 120. Bericht des AIDS-Zentrums im Robert-Koch-Institut über aktuelle epidemiologische Daten. *AIDS-Forschung* 1996; 11: 47-56.

The *AIDS-Forschung* report further states that the cumulative incidence of AIDS in Germany were 14,078 cases by December 1995, of which 9055 had died, and 90% were males.

TABLE 4

DRUG USE BY HOMOSEXUALS WITH AIDS AND AT RISK FOR AIDS

Drug	Atlanta[1] 1983: 50 AIDS, 120 at risk	San Francisco[2] 1987: 492 at risk	San Francisco[3] 1990: 182 AIDS	Chicago[4] 1993: 5000 at risk	San Francisco[5] 1993: 215 AIDS*	Vancouver[6] 1993: 136 AIDS	USA, Europe, Australia[7] 1994: AIDS	London/ Manchester[8] 1996: 685 at risk
nitrite inhalants	96%	82%	79%	71-100%	100%	98%	50%**	80%
ethylchloride	35-50			18				
cocaine	50-60	84	69	40-66	yes	yes	12-34	40
amphetamines	50-70	64	55	26-46	yes	yes	6-27	48 ecstasy/ 57 speed
phenylcyclidine	40	22	23					
LSD	40-60		49	yes				48
metaqualone	40-60		51	44				
barbiturates	25	41	30	yes				
marijuana	90		85	88			41-68	76
heroin	10	20	3					25
alcohol			46	95			90	95
cigarettes			33				50	58
AZT					most	most	15-64	
drug free	0	0	0	0	0	0	0	0

For references see end of supplement * See section 7 ** 6-month reported use

According to the journal the popper market has recently been upset because sales have been banned in some Swiss states because amyl nitrites, but not other nitrites, are listed as poisons by the Federal Public Health Office, BGA.

In agreement with the non-scientific literature, the AIDS epidemiologist David Ostrow reported that nitrite inhalant use in a study of over 5000 male homosexuals from Chicago, Baltimore, Los Angeles and Pittsburgh, the MAC cohort, showed a "consistent and strong cross-sectional association with ... anal sex"[95]. The San Francisco Department of Health and the NIAID sponsored San Francisco Men's Health Study also report that 98% of nitrite inhalant users are homosexuals[79, 80] (Table 3). Like male homosexuals from San Francisco[80, 99, 100] and Chicago/Baltimore/Los Angeles/Pittsburgh[101, 102], those from Vancouver[100, 103], Sydney[100], Amsterdam[100] and London[104, 105] also show a specific affinity for nitrite inhalants, because of "their ability to briefly relax the smooth muscles of the anal sphincter and thereby facilitate penetration"[102] (see Table 4).

The current American use can be estimated from British sales statistics because nitrites were legal in the UK until 1996, and because the drug use habits of the homosexual communities in the US and UK are comparable. For example, in 1984, 86% of British male homosexual AIDS patients from St Mary's Hospital in London had inhaled nitrites compared to 86.4% from clinics in New York, San Francisco and Atlanta[341]. Since in 1995 at least 1.5 million bottles (15 ml each) were sold for a profit of £8.5 million in the United Kingdom[76], it is likely that the current American use is proportional to its British counterpart. This assumption is confirmed by numerous epidemiological studies of cohorts of American male homosexuals (see 3.2, Table 4). Even the NIDA and the CDC announced informally at a nitrite-AIDS conference in 1994[342], that "nitrite use by gay men in Chicago and San Francisco" has increased in the 1990s after a decline in the late 1980s[343].

Recently amphetamines have gained popularity, compared to nitrites, as sexual stimulants among America male homosexuals[70]. Says the director of an outpatient treatment center in Los Angeles, "Look at the demographics. It's such a nasty drug, the way it destroys the body and the mind. Crystal (amphetamine) is a gay person's drug and a gay community problem."[70].

According to the CDC from before 1984[106-108], and according to independent observers to this date[25, 76, 77, 80, 93, 103, 105, 108-111], American and European male homosexuals at risk for AIDS or with AIDS stand out not only for the amounts, but also for the bewildering combinations of recreational drugs used (see Table 4). For example, the biggest American survey of about 5000 male homosexual men, the MAC study, reports various combinations of 13 recreational drugs[101, 102] (see Table 4). The median age of these 5000 American homosexual men at risk for AIDS and with AIDS is 32 years[112].

In an interview with the gay magazine The Advocate about a "Morning party" to benefit the Gay Men's Health Crisis (GMHC) on Fire Island in New York in August 1992 Larry Kramer, founder of GMHC and author of the novel Faggots, commented:

> I loathed the Morning Party. The Morning Party sent me into a depression I cannot begin to descibe. After twelve years of the plague, I should come back and see the organisation that was started in my living room having a party like that! ... There were 4,000 or 5,000 gorgeous young kids on the beach who were drugged out of their minds at high noon, rushing in and out of the Protosans to fuck, all in the name of GMHC.

Among the 685 respondents to "the biggest ever survey of gay men's drug use" conducted in England in the summer of 1996 by Gay Times, 80% had used poppers (nitrite inhalants), 48% ecstasy (amphetamines), 57% speed (amphetamines), 40% coke (cocaine), 48% acid (LSD), 25% heroin, 76% cannabis, 58% cigarettes, 95% alcohol[105] (Table 4). A tricontinental epidemiological study confirms and extends the bewildering pattern of recreational drugs consumed by male homosexuals with AIDS or at risk for AIDS in the US and Europe and finds the same pattern repeated in Australia[100].

Remarkably not one of the many studies recording drug use by homosexual men with AIDS or at risk for AIDS has ever identified even one AIDS patient who was drug-free (see Table 4)!

3.4. Drug diseases.

The ultimate costs of the American/European drug epidemic are the staggering numbers of drug diseases and drug deaths: in 1994, 8,541 Americans died from illicit recreational drugs, and 518,521 were delivered to emergency rooms for drug diseases[51] (see Table 2). In Germany there were 2,125 deaths officially blamed on drug use in 1991, 1,565 in 1995 and 1,712 in 1996.[350, 353]. Because of the high morbidity and mortality associated with long-term intravenous and oral drug use, addicts typically die at an average age of only 30 years[25, 38, 40, 85, 113].

The first scientific paper on drug diseases describes immunodeficiency caused by morphine addiction in Paris, France, in 1909[114]. An early American study by the pathologist Willis Butler first drew attention in 1921 "to the fact that most addicts suffered from a serious illness, such as syphilis or tuberculosis"[53]. Since then numerous scientific studies, listed in Table 5, have documented the drug diseases of long-term drug addicts and their babies. These diseases include immunodeficiency, pneumonia, tuberculosis, dementia, candidiasis, weight loss, diarrhea, fever, night sweats, congenital abnormalities, mouth infections, impo-

tence, epileptic seizures, paranoia, lymphadenopathy, hemorrhages, hypertension and many others[25, 39, 70, 115-122].

Table 5 also records the many overlaps between the well established drug diseases and the diseases embraced by the CDC's AIDS definition of 1993 (see 2.). These overlaps were unintentionally confirmed in August 1996 by a drug treatment specialist of the Federal Bureau of Prisons from Greenville, IL, at a seminar in Kona, Hawaii. The specialist reported that every one of the over 300 AIDS patients he treated over the past 10 years had been a drug user outside and often even inside the prison[123].

The pathogenicity of recreational drugs is the product of 1) direct drug biochemistry, and 2) indirect factors affecting the lifestyle of those addicted to illicit drugs.

1) Biochemistry of drug diseases. Cocaine, heroin and amphetamines each function as a catalyst of neurotropic reactions. Cocaine and heroin are natural compounds and amphetamines are synthetic adrenalins, used in Germany during World War II to suppress fatigue and anxiety in pilots and tank commanders[124]. A typical daily dose of 1-2 g of cocaine[66, 350], or heroin[121] or amphetamine[113] consists of about 10^{21} molecules, or 10^{7} molecules for every one of the 10^{14} cells of the human body. At that concentration these catalysts are so active that recipients forget to eat, to drink, to sleep and lose many of the inhibitions that control undrugged life – the reason for their popularity and eventual pathogenicity.

The pathogenicity of cocaine and heroin is exhaustively documented in numerous pre-AIDS publications and in rare AIDS publications that acknowledge HIV-free AIDS (see Table 5). However, little is in the professional literature about the pathogenicity of amphetamines[113]. The toxicity of amphetamines, like that of many other new drugs, has been credited to HIV because amphetamines became popular only during the AIDS epidemic. Nevertheless, drug treatment specialists have informally descibed amphetamine diseases. Says one specialist from St. Vincent's Hospital in New York: "We are just starting to see heavy usage types in our emergency rooms in New York City. What's troubling about this drug isn't just the way it destroys the body – life expectancy for those intravenously injecting crystal is two years – but the bizarre psychotic symptoms that develop."[70]. Even an orthodox AIDS specialist from AIDS project Los Angeles, now director of an AIDS foundation in France, acknowledges the pathogenicity of amphetamines, although coded in HIV-jargon, "there is ample evidence to suggest that crystal accelarates premature progession to full-blown AIDS in people dealing with HIV infection. Studies have shown that crystal eats T-cells for breakfast, lunch and dinner."[70].

The pathogenicity of nitrite inhalants is the result of non-physiological chemical reactions. Nitrite inhalants react with all biological macromolecules, mutating and inactivating DNA and RNA, diazotizing proteins, killing vitamins and oxydizing hemoglobin to inactive methemoglobin[25]. At the recreational dose of 1 ml per day[25, 125, 126] the user introduces about 10^{21} molecules into the lungs, or 10^{7} molecules for every cell in the human body – enough for abundant toxicity. Under these conditions nitrites are cytotoxic and immunotoxic in animals and humans[125, 127]. The cytotoxicity of nitrites on the epithelial tissues of the lung are enhanced by the toxins of cigarette smoke, which also suppresses the immune system[128]. In addition to their cytotoxic potential, nitrites are among the best established mutagens and carcinogens[129-132].

The pathogenicity of nitrites has been recognized long before the AIDS epidemic, and continues to be acknowledged even by orthodox HIV/AIDS researchers if only as a co-factor of HIV, the hypothetical source of all evil. For example, in view of the toxicity of nitrite inhalants, a prescription requirement was instated by the US Food and Drug Administration (FDA) in 1969[133]. The FDA also limits nitrites as food preservatives to less than 200 ppm (parts per million), because of direct toxicity and because "they have been implicated in an increased incidence of cancer"[129] and because they are listed as carcinogens by the National Research Council since 1982[132]. In 1988 the NIDA published a monograph entitled "Health Hazards of Nitrite Inhalants" that warns about the AIDS risks, particularly Kaposi's sarcoma risks of nitrite inhalants[55, 125]. As a result of the NIDA monograph, the US Congress banned the sale of nitrites in 1988 citing an "AIDS link"[134], a decision which was followed by the "Crime Control Act" in 1990 with a Public Law (100-690) [7, 25, 135].

Based on the results of the NIAID-sponsored MAC study, AIDS epidemiologists David Ostrow et al. in 1993 expressed concern about the nitrite-AIDS connection: "From the earliest case control studies conducted by the Centers for Disease Control's (CDC) Task Force on Kaposi's Sarcoma and Opportunistic Infections (Jaffe et al., 1983) to recent studies of predictors of human immunodeficiency virus-type 1 (HIV) infection (Penkower et al., 1991), recreational psychoactive drug use has been associated with HIV-related illness or infection among homosexual men."[102]. In 1995, the National Institutes of Environmental Health Sciences reconfirmed the nitrite-AIDS hypothesis. Based on exposure of mice to isobutylnitrites (IBN) (poppers) for 15 weeks the Institute published in 1995, "The results suggest that, in the absence of impaired pulmonary host defenses, IBN produces significant and partially reversible suppression of systemic humoral immunity"[136]. And in the summer of 1996 the Royal Pharmaceutical Society first banned the sale of nitrites in the UK citing: "Our primary concerns were the health risks associated with the drug, including the suggestive links between poppers and Kaposi's sarcoma"[137].

Also in 1996 a Swiss court convicted a sex offender for popper use because poppers cause "headache, arrhythmia, vertigo, fainting, paralysis, and unconsciousness". During the same year an official of the Swiss Public Health Office, BGA, stated to the gay interest journal aK that it was not possible yet to predict the health effects of popper use ("noch keine Risikoabschätzung des Poppers-Gebrauchs möglich"), although he acknowledged that a man had just died after inhaling two grams of amyl nitrite[340].

2) Lifestyle factors contributing to drug pathogenicity. Many drug diseases are consequences not only of direct drug toxicity, but also of frequent drug-induced suppression of appetite causing malnutrition and sleep depravation,[121] both of which are the world's leading causes of immune suppression[138]. These health risks are compounded by poverty due to the enormous costs of illicit drugs. For example, an average cocaine habit of 1g per day costs $800 per week[66].

One of the first to ring the alarm about drug diseases among male homosexual drug users was the American writer John Lauritsen, author of Death rush, poppers and AIDS[139] and The AIDS War[96]. In The AIDS War Lauritsen descibed in 1993 the explosion of drug use in the gay scene in London:

> Every Saturday night an estimated 2,000 gay men attend a dance club where drug consumption is the main activity. According to London sources, virtually 100 per cent of the men are on drugs, from 3.0 in the morning, when the club opens, until it closes many hours later. Especially popular is a variety of Ecstasy (amphetamines), whose ingredients are claimed to include heroin. Poppers are sold legally in London. No one seems to think they even count as drugs, as gay physicians, writing in the gay press, have said that poppers are harmless.
>
> None of the major AIDS organisations have properly warned

TABLE 5

DRUG DISEASES DIAGNOSED BEFORE THE AIDS ERA, AND IN HIV-FREE ADDICTS

Disease	Drugs used*	AIDS-defining	Refs**
immunodeficiency	C H N A	YES	1
Kaposi's sarcoma	N	YES	2
candidiasis	C H	YES	3
pneumonia	C H N	YES	4
lymphadenopathy	C H	YES	5
tuberculosis	C H	YES	6
weight loss	C H	YES	7
dementia/encephalopathy	C H	YES	8
diarrhea	C H	YES	9
fever	C H	YES	10
spontaneous abortion, premature birth, congenital abnormalities	C	YES	11
night sweats	C H		12
impotence	C H		13
severe atherosclerosis	A		14
tooth loss/caries	C H		15
dematitis	C H		16
hepatitis	C H		17
epileptic seizures	C H		18
endocarditis	C H		19
bronchitis	C H		20

*A = amphetamines; C = cocaine; H = heroin; N = nitrities
**See end of supplement for refences

about the dangers of drugs. At most, their risk-reduction literature has urged people to use alcohol and drugs in moderation, so as not to affect the 'judgement'. Drugs are portrayed as risky only to the extent that they might facilitate a lapse into 'unsafe sex'. Poppers – which cause genes to mutate, which cause severe anemia, which can kill through heart attacks, which suppress the immune system – are depicted as bad only if they cause someone to forget condoms.[96].

But recently even the established gay press appears to show some concern that recreational drugs may do more than facilitate HIV infection. For example, the British magazine Gay Times cited in its survey of the bewildering drug use of male homosexuals in 1996 (Table 4) the concerns of a first aid officer from a London gay club:

I see some faces in the same dire state every week for years and I personally think there's gonna be an awful lot of very ill people in a few years time. Taking all these substances on such a regular basis cannot be good for you. Medically it can't. Sooner or later, something's got to give[105].

And an article in 1996 in the American gay magazine The Advocate with the title "A deal with the devil" asked philosophically:

So why is it that in the gay world, where almost half the urban male population is dead or sick from an epidemic closely associated with substance use, there is such ambivalence about drugs that AIDS organizations profess to see nothing wrong with raising money from events that glamorize drug use? Why, despite the bitter legacy of AIDS, do we continue assuring ourselves that being gay means we have to be totally non-judgmental about the very things that have wiped us out?[71]

3.5. Conclusion.

The chronology and epidemiology of the American and European drug epidemics, which affects primarily 25-54 year old males, coincide exactly with the AIDS epidemic. Moreover, a comparison of the long-established list of drug diseases with the CDC's long catalog of AIDS-defining diseases proves that drugs alone could be responsible for the AIDS epidemic (see Table 5). It is for this reason that throughout the epidemic drug-aware AIDS researchers found it difficult to distinguish between the drug and AIDS epidemics as the following titles of their articles indicate:

1) 1987: AIDS and intravenous drug use: the real heterosexual epidemic[140].
2) 1989: Cocaine abuse and acquired immunodeficiency syndrome: tale of two epidemics[116].
3) 1991: The Twin Epidemics of Substance Use and HIV[20].
4) 1991: AIDS, drugs of abuse and the immune system: a complex immunotoxicological network[119].
5) 1993: Entangled epidemics: cocaine use and HIV disease[118].
6) 1995: New picture of who will get AIDS is dominated by addicts[141].
7) 1996: Clinical features of drug use and drug use related to HIV[39].

4. THE EPIDEMIC OF AZT AND OTHER ANTI-HIV/AIDS MEDICATIONS

4.1. DNA terminators licensed as a cure.

In 1987 the American and European illicit drug epidemic had been joined by a new epidemic of toxic legal drugs, the DNA chain-terminators, such as AZT, that are prescribed to hundreds of thousands of HIV-positives together with a litany of other orthodox and unorthodox anti-HIV/AIDS drugs (see 4.2. and Table 6). In America, AZT was licensed in record time as an antiviral drug in 1987 by the Food and Drug Administration (FDA) based on studies conducted by its sister institutions from the Department of HHS, the National Cancer Institute[142] and the NIAID[143] together with the drug's manufacturer Burroughs Wellcome.

The fast approval of AZT– despite its inherent toxicity – was a major coup of AIDS researchers[144]. By going public more aggressively than any other scientists before, American AIDS researchers from the NIAID, NCI and CDC had mobilized patients, homosexual AIDS risk groups and journalists to demand protection from the predicted AIDS explosion at any cost. As a result of this pressure the FDA and AIDS researchers fast-tracked first the approval of AZT and then that of ever-more untested anti-HIV/AIDS drugs[145]. Surprisingly, all of these drugs were eagerly welcomed by the medical and public press and above all by unsuspecting AIDS patients. The politics behind the approval of AZT first by the FDA and the American medical orthodoxy, and then by the rest of the world has been described in two recent books, Good intentions[146] and Inventing the AIDS Virus[10].

AZT and other DNA chain-terminators are now used both as AIDS prophylaxis and therapy in the hope that they will terminate HIV DNA synthesis without terminating cell DNA synthesis[147]. However, there are several problems with this optimistic plan:

1) The licensing study conducted in 1986 by the National Cancer Institute (NCI) and Burroughs Wellcome has erroneously underestimated the toxicity of AZT for human cells a 1000-fold[142]! Although at least 7 independent studies have since pointed out this 1000-fold error[148-154], the recommended prescription dose has only been reduced 3-fold, from 1.5 g of AZT per day in 1987 to 0.5 g now[155, 156].

2) The initial success of the American clinical licensing study conducted by the NIAID and Burroughs Wellcome, that claimed a 19-fold reduced AIDS-mortality[143], could not be reproduced by numerous independent studies from other countries, including the UK[157], France[158], The Netherlands[159], Australia[160], and also not by an independent American study that was not supported by the NIAID and Burroughs Wellcome[161].

3) Contrary to the manufacturer's information, DNA chain-terminators, such as AZT, ddI, ddC, 3TC and d4T were not designed to kill viruses but to kill human cells. Most of them were originally synthesized over 30 years ago, long before AIDS was known, to kill human cells as cancer chemotherapy by terminating cellular DNA synthesis[162]. Thus DNA chain-terminators are inevitably cytotoxic[144].

4) Even in the light of the HIV-AIDS hypothesis, AZT treatment as anti-HIV therapy is irrational. Since only about 1 in 1000 T-cells of AIDS patients is infected[24, 25, 29-31], AZT will kill 999 uninfected T cells for every one that is infected[144, 146, 163, 164]. Such a therapeutic index predicts that AZT cannot be beneficial as an anti-HIV drug. Moreover, since HIV is postulated to cause AIDS by killing T-cells, it is irrational to kill the same HIV-infected cells twice – once with HIV and again with AZT[25].

5) Although AZT and other DNA chain terminators are prescribed since 1987 to healthy and ill HIV-positives for the rest of their lives, there are as yet no animal experiments that have ever tested to what degree

TABLE 6

ANTI-HIV/AIDS DRUGS TAKEN BY HIV-POSITIVES[1]

Drug	HIV-positives (n=2,801)
Anti-infectives (see below)	1,584 (57%)
Analgesics/antipyretics	1,539 (55%)
Vitamins	1,307 (47%)
Antihistamines	810 (29%)
Antacids/antidiarrhetics/laxatives	571 (20%)
Anxiolytics/sedatives	517 (18%)
Corticosteroids (topical/systemic)	423 (15%)
Sympathomimetics (adrenergics)	381 (14%)
Antidepressants/tranquilizers	323 (12%)
Antitussives/expectorants	316 (11%)
Electrolytic/caloric diuretics	280 (10%)
Cardiovascular	195 (7%)
Vaccines	133 (5%)
None of the above (confirmed)	0 (0%)
Anti-Infectives by name	
Penicillins	550 (20%)
Acyclovir	476 (17%)
Topical antifungals	442 (16%)
Erythromycin	376 (13%)
Aerosolized pentamidine	260 (9%)
Cephalosporins	254 (9%)
Co-trimoxazole	246 (9%)
Systemic antifungals	244 (9%)
Tetracyclines	210 (7%)
Miscellaneous ß-lactam	83 (3%)
Dapsone	84 (3%)

1 Fogelman I, Lim L, Bassett R, Volberding P, Fischl MA, Stanley K, Cotton DJ, for the AIDS Clinical Trials Group. Prevalence and patterns of use of concomitant medications among participants in three multicenter human immunodeficiency virus type 1 clinical trials. *Journal of Acquired Immune Deficiency Syndromes* 1994; 7: 1057-1063.

these inevitably toxic substances accelerate death. Moreover, animal experiments would be necessary to determine how AZT and other antiviral prescription drugs interact with the many recreational drugs that are, or have been, consumed by most AZT recipients – a question that none of the licensing studies has even addressed. It is therefore not possible to know how HIV-positives could possibly benefit from AZT's hypothetical anti-HIV effects in view of its certain cell toxicity.

As of 1996 the DNA chain-terminators are prescribed in combination with another group of experimental anti-HIVdrugs, the protease inhibitors, under new labels, that give the impression that these "cocktails" are entirely new treatments[28, 165-168]. But the morbidity and mortality of the long-term consumption of protease inhibitors alone or in combination with DNA chain terminators has neither been determined in animals nor in humans. Surprisingly, the fate of the first two groups of AIDS patients that are claimed to have benefited by protease inhibitors published in two articles and two editorials in Nature in January 1995 has not been mentioned since[32, 33, 344, 345]. The absence of any follow-up of these promising claims is particularly odd since Nature has published numerous articles on AIDS and protease inhibitors.

4.2. Epidemiology of AZT and supplemental anti-HIV/AIDS medications

1) AZT and other DNA chain-terminators. Every year since 1987 about 200,000 HIV-positive people are prescribed AZT and other DNA chain-terminators as anti-HIV drugs for the rest of their lives[25, 165]. Because of the high cost (about $10,000 per year) most AZT recipients are Americans or Europeans[25, 28].

As of 1996 about 1.8 million (200,000 HIV-positives per year over 9 years) Americans and Europeans have been on AZT for an average of 1 year. This is because within one to two years the average AZT recipient succumbs to the toxicities of AZT and of recreational drugs, and because many drop out after only a few months due to unbearable drug intoxication[25, 155, 169]. In the words of the HIV/AIDS establishment, "AZT loses its effect after a year or two because the virus becomes resistant"[170]. The above estimate is compatible with the total of $2.5 billion in AZT sales by Glaxo/Burroughs Wellcome[171]. Since the wholesale price for a daily dose of 500 mg AZT per person for one year is $2,000[25], $2.5 billion corresponds to 1.25 million years of AZT prescriptions since 1987.

Since recreational drugs are acknowledged AIDS risks[13, 27], and since AZT is prescribed as AIDS prophylaxis and therapy, the epidemiology of AZT use is in fact similar to that of recreational drug use[102, 125, 172]. Although national statistics are not available, numerous studies indicate that the vast majority of AZT recipients are adult male homosexuals, and that a minority includes HIV-positive hemophiliacs, intravenous drug users[86, 90], transfusion recipients and babies[22, 23, 37, 173] (see 7.9.). Only a few cases are from the general population[10].

Even unborn American and French children and their HIV-positive mothers are now treated with AZT to prevent perinatal transmission of HIV[44]. Although the risk to such children of picking up HIV from their mothers is only about 25%, all HIV-positive mothers are injected with AZT during the second and third trimesters, as well as their babies for six weeks after birth to prevent HIV transmission. In other words 75% of developing fetuses of HIV-positive mothers are treated for 6 months with DNA chain-terminators, although they will never even pick up HIV; and their mothers are treated although they will not transmit HIV. The procedure has been promoted as a milestone in the prevention of AIDS[174, 175]. But the teratogenic risks of AZT do not justify this optimistic pronouncement (see 4.3, 7.9.).

The point that AZT functions like all other chemotherapies by killing all growing cells unselectively has not been lost to its manufacturer Glaxo Wellcome. Using the license earned for AIDS therapy, Glaxo Wellcome has recently also cornered the lucrative chemotherapy market for AZT. The British magazine Continuum describes the situation with some sarcasm in December 1995:

> CLEVER DRUG OR IS IT THE MARKETING?
>
> AZT, commonly described in the annals of the AIDS literature as an "antiretroviral" that "targets HIV-infected cells" looks set to carve out a new role for itself – attacking leukemia and psoriasis. Both conditions involve abnormal proliferation of cells.
>
> A study published in the New England Journal of Medicine by researchers from the University of Southern California reports the use of AZT with interferon-alpha in 19 patients with adult T-cell leukemia-lymphoma[176]. The condition is said to be caused by HTLV-I, one of Robert Gallo's discoveries/inventions, a claim to be treated with caution therefore. They reported five remissions and 11 'major responses'. There was no control group. The logic goes that since AZT kills cells, particularly rapidly growing ones such as cancerous cells, then it will be effective. AZT was also used in a study of psoriasis sufferers by Madeleine Duric of the University of Texas, Houston. In four out of 12 sufferers most of the psoriasis was cleared up. The theory to support the finding is that since AZT stops cell replication it slows skin proliferation, which is normally rapid. Other researchers have said there are better treatments already available for psoriasis (so don't rush out and buy shares in Glaxo Wellcome just yet).
>
> Glaxo Wellcome must be commended for creative marketing (we don't think) producing a drug that can kill any rapidly replicating cells in one lot of patients, and selectively, so we are told, kill HIV-infected cells in another lot of patients. Is it a clever drug or clever marketing? These results will have the additional benefit of rapidly replicating AZT sales[177].

In other words AZT is now prescribed to cancer and psoriasis patients to kill growing cells by inhibiting cellular DNA synthesis. But according to Glaxo Wellcome, it is prescribed to HIV-positives and AIDS patients as a specific inhibitor of HIV DNA synthesis because it "interferes with the HIV viral RNA dependant DNA polymerase (reverse transcriptase) and thus inhibits viral replication. ... Chain termination has not been demonstrated with cellular alpha-DNA polymerase to this date"[147]. Thus Wellcome and the HIV/AIDS orthodoxy offer the same drug as inhibitor of cell DNA synthesis to cancer and psoriasis patients, and as a specific inhibitor of HIV DNA synthesis to AIDS patients. Clever marketing that is!

In view of this, one wonders how soon AZT will also be offered as an abortion pill, like methotrexate another chemotherapeutic drug[178]. According to an FDA official the prescription of AZT as an abortion pill would not require a new license, because once approved by the FDA "it can be prescibed for dandruff."[179].

2) Other anti-HIV/AIDS drugs. The consumption of AZT and other DNA chain terminators by healthy HIV-positives at risk for AIDS and AIDS patients is typically supplemented by a bewildering list of further prescription and over-the-counter drugs. A list of 23 anti-HIV/AIDS drugs taken by 2801 American HIV-positives, including 524 AIDS patients, is recorded in Table 6[40]. Nearly all of these HIV-positives were male homosexuals (83%) or intravenous drug users (12%) who took those drugs because they wanted to prevent or cure AIDS.

A study entitled "Polypharmacy Among Patients Attending an AIDS Clinic: Utilization of Prescribed, Unorthodox, and Investigational Treatments" describes even higher drug use by 189 HIV-positives from San Francisco of which 94% were male homosexuals and 2% were intravenous drug users[180]. In telephone interviews 96% of these people reported prescription drugs, 67% over-the-counter drugs, 31% investigational drugs, 29% recreational drugs, and 29% "alternative" drugs. An average of 2.3 medications were taken simultaneously by healthy HIV-positives and 5.6 medications were taken simultaneously by those with AIDS symptoms. The authors of the study "conclude that use of polypharmacy among some AIDS clinic patients is common, could create an increased risk for adverse drug reactions, and may affect clinical drug trials."

Larry Kramer, the HIV-positive playwright and founder of the gay activist organization Act-Up, has described his own anti-HIV/AIDS polypharmacy under the title "Checking in, my chart"[181]. Following the advice of several AIDS luminaries such as Anthony Fauci, David Ho, Joseph Sonnabend, Alvin Friedman-Kien and others, Kramer composed his own polypharmacy of 19 drugs for an annual price tag of $19,000[145]. This chart includes: "AZT [against AIDS], acyclovir [against genital herpes], Zantac, colchicine [mitosis blocker], propranolol, spironolactone, myphyston [liver cirrhosis and hepatitis], Eucerin, Moisturel, Retin-A, mycolog, flucinonide, sulfacet-r, Nizoral [fungal dermatitis], Hisminal and Humbid [bronchitis], and Shaklee vitamins, zinc, NAC" and a "turquoise stone which a fortune teller, many years ago, advised"[181]. Before developing AIDS and medical drug addiction, Kramer offered a client's eye-view of homosexual life-style, including a long list of the 56 most popular recreational drugs in his novel Faggots[6, 10].

The polypharmacy of the AIDS patient and activist Peter Di Giulio from San Francisco, who suffers from weight loss, chronic diarrhea, skin ailments, and neuropathy, even exceeds that of Larry Kramer. At an annual cost of just over $41,000 "Di Giulio has no choice but to organize his life around his medications": the DNA chain terminators d4T, 3TC (for HIV), Cytovene (for cytomegalovirus) and Zovirax (for herpes), the protease inhibitor Crixivan, the antifungals Diflucan and Septra (for PCP), anti-mycobacterials Biaxin and Myambutol, the anti-diarrheal Lomotil, Valium for anxiety, and an assortment of ten vitamins and supplements[346].

The polypharmacy of adult HIV-positives even extends to children. The treatments prescribed to an American group of 20 boys and 22 girls serve as an example. These children were originally diagnosed as HIV-positive only at 7 years of age, but were HIV-positive from birth due to perinatally acquired HIV[182]. At the time of HIV diagnosis, 5 of 42 (12%) were also diagnosed with some AIDS-defining diseases. Yet all but 2 of the children were treated with anti-HIV/AIDS drugs. At an average of 11

years of age the following medications were administered to the children:

> Most of the children are receiving multiple chronic medications, with 90.5% (38 of 42) receiving antiretroviral therapy, 78.6% (33 of 42) receiving PCP prophylaxis, 33.3% (14 of 42) receiving fungal prophylaxis, and 23.8% (10 of 42) receiving herpesvirus prophylaxis. Among the children receiving antiretroviral therapy, 78.9% (30 of 38) are receiving zidovudine [AZT]. Other medications frequently prescribed include meter dose inhalers for reactive airway disease in 33.3% (14 of 42) of patients and nutritional supplements for failure to thrive and wasting syndrome in 52.4% (22 of 42) of patients. Only 2 of the 42 children in the cohort are not receiving any medications, with 4 receiving one medication, 14 receiving two, 10 receiving between 3 and 5, and 12 receiving between 6 and 12 different medications daily. Sixty-two percent (26 of 42) of the children receive monthly intravenous infusions of immunoglobulin[182].

4.3. Diseases caused by AZT and other anti-HIV medicines.

AZT functions as an analog of natural thymidine (T). If AZT is incorporated instead of T into a growing DNA chain, DNA synthesis terminates for lack of a 3'OH end, and the cell dies (see Fig. 3). A standard daily prescription of 0.5 g AZT corresponds to about 10^{21} molecules per body, or 10^{7} per human cell, enough to kill most growing cells, especially the fastest growing ones – the immune cells, red cells and epithelial cells – by terminating DNA synthesis[154, 183]. Stopping the regeneration of these cells over several days causes anemia, nausea, lymphocytopenia, hepatitis, and wasting disease[25, 147, 184, 185]. AZT also prevents mitochondrial DNA synthesis in non-proliferating cells. Specifically, non-renewal of mitochondrial DNA causes muscle atrophy, hepatitis, and dementia[25, 112, 154, 186]. In addition, AZT is carcinogenic[25, 187]. The long catalog of AZT diseases overlaps extensively with the CDC's even longer catalog of AIDS-defining diseases[16].

Considering the toxicity and mode of action of the DNA chain terminators, it is not surprising that to date the professional literature has yet to offer the first AIDS cure with AZT or the other anti-HIV drugs[10, 24]. In 1993, the British-French Concorde trial, the largest controlled study of its kind, even buried the hope that AZT might prevent AIDS[188]. Instead, the final report of the trial confirmed in 1994 that AZT is not only unable to prevent AIDS, but even increases the mortality of recipients by 25% compared to the untreated controls[155].

Once the ice of absolute control on AZT by the NIAID, NCI, and Glaxo Wellcome was broken by the non-American Concorde trial, a series of American and European studies confirmed and extended the predictable toxicity of AZT. Although in coded language and with disclaimers that a specific detrimental outcome does not discredit the presumed merits of AZT these results show that AZT not only fails to prevent AIDS, but actually causes AIDS diseases and accelerates death (see 7.9):

1) An American study of intravenous drug users observed in 1993 that, "The rate of CD4 lymphocyte depletion did not appear to slow after the initiation of zidovudine therapy…"[86].

2) An Indian-English collaboration reported in 1994 that among 104 babies of AZT-treated pregnant women 8 aborted spontaneously, 8 were aborted "therapeutically" and another 8 were born with serious birth defects, including holes in the chest, abnormal indentations at the base of the spine, misplaced ears, triangular faces, heart defects, extra digits and albinism[189]. Zidovudine users in this study may have experienced more rapid CD4+ cell depletion. And according to the magazine Science an unpublished study from the National Cancer Institute in Bethesda MD "showed an increase in cancer in the offspring of pregnant mice treated with high doses of AZT."[355] The article betrays the journal's bias for AZT therapy by implying a normal incidence of cancer in the offspring of mice which was reportedly increased by AZT. Obviously there is no detectable spontaneous incidence of cancer in newborn mice.

3) The American MAC study of 5000 male homosexual men observed that, "HIV dementia among those reporting any antiretroviral use (AZT, ddI, ddC, or d4T) was 97% higher than among those not using this antiretroviral therapy"[112].

4) Another analysis of the of homosexual men from the MAC study revealed that AZT treatment increased the risk of pneumonia 2 to 4-fold[190].

5) And four years after introducing AZT prophylaxis against AIDS[156], Paul Volberding et al. published in 1994 "the average time with neither a progression of disease nor adverse event was 15.7, 15.6, and 14.8 months for patients receiving placebo, 500 mg zidovudine, and 1500 mg zidovudine, respectively."[191]. Thus even Volberding now confirms the Concorde study's conclusion that AZT does not prolong life or prevent AIDS, but instead accelerates AIDS.

6) An independent British study even found that AZT prophylaxis reduced survival from 3 to 2 years and also observed AZT-specific AIDS diseases, "wasting syndrome, cryptosporidiosis, and cytomegalovirus infection ... almost exclusively" in AZT-treated AIDS patients[192]. This result confirmed Concorde's observation, in particular the 25% higher mortality of those on AZT.

7) The results of AIDS prophylaxis by AZT proved even more devastating for American hemophiliacs: The AIDS risk of hemophiliacs on AZT was 4.5 times higher and their mortality was 2.7 times higher than that of untreated controls[193].

8) The mortality of British HIV-positive hemophiliacs has increased even 10-fold since 1987, since most are subjected to AZT and other anti-HIV/AIDS treatments[21-23, 37, 173].

9) In 1996 an American study from the National Institute of Child Health and Human Development concluded that AIDS prophylaxis with AZT also harms children: "In contrast with anecdotal clinical observations and other studies indicating that zidovudine favorably influences weight-growth rates, our analysis suggests the opposite."[194].

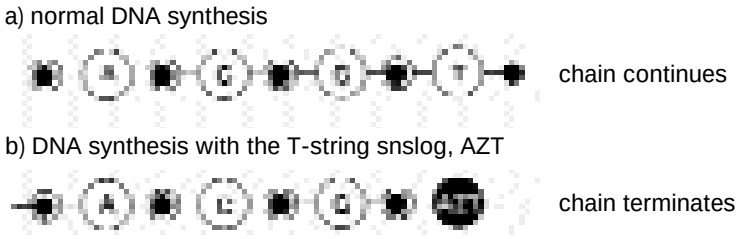
10) Even before the Concorde study a rare publication critical of AZT by the NCI reported in 1990 that AZT increased the annual lymphoma risk 50-fold compared to untreated controls[187].

But despite the devastating evidence that AZT enhances morbidity and accelerates death by causing AIDS defining diseases on its own, the faith of the medical orthodoxy in FDA approved AZT seems unshakable. No news is bad enough to discourage AZT prescriptions[28, 165] (see 7.9.).

Nevertheless, recently a few mainstream AIDS doctors have openly registered dissent, although not in the form of dedicated articles. Says Jay Levy, professor of medicine at the University of California at San Francisco, "With all the hoopla about antiviral drugs, and you get any virologist aside and they'll say this is not how we are going to win, it's high time we look at the immune system"[195]. Lecturing his medical students, another professor of medicine at the University of California at San Francisco, Donald Abrams, is even more direct according to a university magazine:

> In contrast with many of my colleagues at SFGH [San Francisco General Hospital] in the AIDS program, I am not necessarily a cheerleader for anti-retroviral therapy. I have been one of the people who's questioned, from the beginning, whether or not we're really making an impact with HIV drugs and, if we are making an impact, if it's going in the right direction.
>
> Despite the promising evidence, definitive proof of protease inhibitors' efficacy can be provided only by randomized clinical trials with placebo. Because new antiviral drugs are continuously being developed, conducting such trials is virtually impossible due to the reluctance of patients to continue treatment with and "old" drug. Abrams spent the first half of his lecture describing analogous problems during the testing and approval of AZT, the first drug used in AIDS therapy.
>
> AZT, a nucleoside analog, belongs to a class of drugs that inhibit DNA polymerization by terminating growing DNA chains. The study which demonstrated that AZT might be of benefit was a placebo control trial begun in 1986 involving 288 patients. Although the study was originally intended to last 24 weeks, it was cut short and unblinded half way through because of statistically significant differences in deaths between the two groups.
>
> Abrams lamented that although "18 more people made it to this arbitrary milestone of four to eight months after pneumocystis... I didn't feel that this was showing that we were prolonging survival." Abrams blamed the "very powerful rhetoric" of the emerging community of AIDS activists, who demanded an end to clinical trials. "Somebody should write a book about the impact of that decision on HIV clinical trials history," added Abrams "because everything

Fig 3
Human DNA is a string of 10^{9} A, T, C and Gs linked in a specific sequence



changed because of that demand."

Abrams recounted his early misgivings about AZT, which loses its effect after a year or two because the virus becomes resistant. He was also disturbed by findings demonstrating that a high dose of AZT resulted in a smaller rise of CD4 cells than a lower dose. "Maybe if we just stop it altogether people will be better off," he said.

Members of the audience were surprised to learn of the paucity of solid, clinical research behind AZT and other nucleic acid chain terminators, which prevent infected T-cells from transcribing the RNA viral genome into DNA, thereby inhibiting viral pathogenesis. Abrams exposed the tragic farce of past AIDS research and therapy--people who thought they were doing something useful were actually wasting time and valuable resources.

How should the clinician apply the new therapies? Abrams described his approach with patients. "I have a large population of people who have chosen not to take any antiretrovirals since I've been following them since the very beginning... They've watched all of their friends go on the antiviral bandwagon and die, so they've chose to remain naive [to therapy]. More and more, however, are now succumbing to pressure that protease inhibitors are 'it'... We are in the middle of the honeymoon period, and whether or not this is going to be an enduring marriage is unclear to me at this time, so, I'm advising my patients if they still have time, to wait."[170].

Some of the most damning admissions to the existence of AZT-specific AIDS diseases come from the suppliers of the drug themselves. The warnings on the product label of an AZT bottle supplied by Sigma, a non-medical provider of the drug, points out, with skull and cross bones, AZTs toxicity to the bone marrow, the very source of T-cells (Fig. 4). Even the primary provider of AZT, the Glaxo Wellcome company states in the Physicians Desk Reference that, "It was often difficult to distinguish adverse events possibly associated with zidovudine [AZT] administration from underlying signs of HIV disease..."[147]. Finally, the National Institutes of Child Health and Development recently confirmed that, "Zidovudine use is confounded by progression of HIV disease"[194].

The inevitable damage caused by AZT prescriptions is compounded by many of the concomitant medicines taken by most, if not all HIV-positive Americans with AIDS and at risk for AIDS (Table 6). For example, some of the antiviral drugs like ganciclovir and acyclovir are also DNA chain terminators that are nearly as toxic as AZT[196]. As expected they were observed to produce "pancytopenia"[197] by killing hemopoietic cells, and to have "direct [toxic] effects on myeloid and erythroid progenitor cells"[147, 198]. Moreover, even American AIDS researchers are concerned that many of the anti-infectives used as anti-HIV/AIDS drugs have "nephrotoxic, cytotoxic, and myelosuppresive [effects], such as amphotericin B, co-trimoxazole, dapsone, interferon, pentamidine, vincristine, flucytosine, adriamycin, vinblastine, and others [which] could potentially increase the risk of hematologic toxicities in patients being treated with ZDV [AZT]"[198] (see also Table 6). In other words these drugs are immunosuppressive because they intoxicate and kill immune cells.

As yet there are no placebo-controlled human or even animal studies in the literature on the toxic effects of protease inhibitors, although over 60,000 Americans are daily users of the most popular brand[347]. However, the popular press acknowledges effects such as "suicidal thoughts, twitching, central nervous disorders…extreme nausea, hallucinations, intense trembling" after several months on the drug[346]. And the HIV/AIDS researcher Jerome Groopman of the Beth Israel Medical Center in Boston informed Newsweek in December 1996 that, "some patients have been 'showing signs of the benefits wearing off'" – an effect that is termed "crashing" by the magazine. Even the surrogate markers of presumed benefits of protease inhibitors, like decreased "viral load"[32, 33, 344] , are lost over several months as "viral load has shot back up again and no one knows why"[347]. In an article "The media's love affair with AIDS research: Hope vs. hype" even Science now makes a careful retreat from the hype of protease inhibitors: "From the moment researchers first reported these data...they raised red flags. Not only are these studies small and ongoing...Also drug-resistant strains of HIV [the HIV orthodoxy's euphemism for drug toxicity] already have taken over in some patients and may eventually spoil the gains seen in most – especially given the trouble many patients have in keeping to the regimen of taking dozens of pills every day."[355]

4.4. Conclusions.

Although AZT cannot prevent or cure AIDS, and although AZT and the other DNA chain terminators are among the most toxic drugs legally available, and although AZT is already known to cause AIDS diseases and accelerates death on its own, about 200,000 HIV-positive Americans are daily recipients of AZT. Most of these are healthy because there are no more than 50,000 to 75,000 American AIDS patients per year[3]. In addition most, perhaps all American HIV-positives at risk for AIDS also take other "concomitant medications"[198] that have known immunosuppressive and other detrimental effects, such as cortisones, dapsone, pentamidine and others[147, 183]. Furthermore, most HIV-positive and HIV-negative people at risk for AIDS also consume bewildering combinations and doses of recreational drugs (see 3.). In other words, most Americans at risk for AIDS and with AIDS are walking pharmacies, consuming excessive doses of toxic recreational and toxic medical drugs.

Fig 4
The label on a bottle of AZT from the *Sigma* Co.

The advisory on the label reads: "TOXIC. Toxic by inhalation, in contact with skin and if swallowed. Target organ(s): Blood bone marrow. If you feel unwell, seek medical advice (show the label where possible). Wear suitable protective clothing.

5. DRUG-AIDS HYPOTHESIS

Since drugs are the only new health risk of Americans and Europeans since the 1970s, and AIDS is the only new epidemic, it is proposed here that the drug epidemic is the cause of the American and European AIDS epidemic. The hypothesis is:

All AIDS diseases in America and Europe that exceed their long-established, normal backgrounds (i.e. >95%) are caused by the long-term consumption of recreational drugs, such as cocaine, heroin, nitrite inhalants, and amphetamines, and by prescription of anti-HIV drugs, such as AZT.

Hemophilia-AIDS, transfusion-AIDS, and the extremely rare AIDS cases of the general population reflect the normal incidence plus the AZT-induced incidence of these diseases under a new name. The rarity of AIDS in the general population is the product of (a) the low-frequency of AIDS defining diseases in Americans who do not use drugs or have congenital diseases, and (b) the low incidence of HIV-antibody in only 1 in 300 individuals tested (see 2, Fig. 1).

African AIDS is a new name for old diseases caused by malnutrition, parasitic infections and poor sanitation[10, 25].

The key to the drug hypothesis is that with drugs, the dose makes the poison[199]. Only long-term consumption accumulates sufficient dosage to cause AIDS-defining diseases. Occasional or short-term recreational drug use causes first the desired euphoria which is followed either by reversible diseases or by no diseases at all. That is why it takes 20 years of smoking to acquire the tabacco dose for lung cancer or emphysema, 20 years of drinking to acquire the alcohol dose for liver cirrhosis, and 10 years of drug use to acquire the toxic dose leading to AIDS. In other words, drugs used at recreational doses are slow pathogens.

In contrast to drugs, infectious agents are self-replicating, and hence

(if at all) fast pathogens. By multiplying exponentially in the body pathogenic infectious agents generate sufficient doses of toxic substances to cause diseases within days or weeks[49, 200]. Thus, microbes are either fast pathogens or no pathogens at all.

Hardly anybody remembers that from 1981 to 1984, before the HIV hypothesis became national dogma, recreational drugs such as nitrite and ethylchloride inhalants, cocaine, heroin, amphetamines, phenylcyclidine, and LSD, were proposed by epidemiologists and toxicologists as the causes of AIDS. The reason for the early suspicion of drugs was simple. Nearly all AIDS patients were either male homosexuals who had used these drugs as aphrodisiacs and psychoactive agents, or were heterosexual intravenous drug users[106, 125, 127, 133, 139, 201-206]. Before April 1984 many independent investigators and even scientists from the CDC in Atlanta considered AIDS a collection of drug diseases.

For example, between 1981 and 1982 the former CDC head James Curran stated, "At this point our best clue to the cause of the disease was 'poppers'"[207]. Curran's clue was gleaned from anecdotal evidence including the first two Kaposi's sarcoma patients seen by Dr. Alvin Friedman-Kien, professor of dermatology at New York University. Both of these patients were male homosexuals who "had a multiplicity of sexual partners over an extended period of time as well as using a variety of recreational drugs – cocaine, marijuana, LSD, THC, MDA, and amyl nitrite." Friedman-Kien regularly called CDC officials to report his experience with AIDS: "…as patients started coming in, it turned out that all of them, 100 percent, had been using amyl nitrite"[207]. The CDC's AIDS researcher Harold Jaffe, now director of the HIV/AIDS division, also reported, through information gathered anecdotally, that over 90% of the surviving AIDS patients he talked to admitted regular nitrite use[106, 207].

Evidence continued to mount strongly supporting a correlation between nitrite use and AIDS. This included two Lancet articles, one by NIH researchers James Goedert, William Blattner et al.[127], another by an English team[81], the data collected by Harry Haverkos of the CDC's Kaposi's sarcoma opportunistic infection (KSOI) task force, and an abundance of prior studies on the immunotoxic effects of nitrates and nitrites[125].

Drugs seemed to be the most plausible explanation for the restriction of AIDS to risk groups, because drug consumption was the only dangerous common denominator of male and female intravenous drug users and male homosexuals. This original drug-AIDS hypothesis was euphemistically called the "lifestyle hypothesis"[208].

The drug-AIDS hypothesis was just as plausible then as it is now. Drug toxicity provides chemically plausible causes of disease. Based on their intrinsic chemical properties drugs used by AIDS patients are either indirectly toxic, cytotoxic, mutagenic (genotoxic), carcinogenic, or a combination of these. And, since its appearance in 1981 AIDS coincides exactly, both chronologically and epidemiologically, with the American and European drug use epidemics (see 3. and 4.).

However, since the enthusiastic acceptance of the HIV hypothesis by the Secretary of HHS and the press in April 1984, the drug hypothesis has been suppressed and discredited by the medical and scientific establishment, by the public press and by AIDS activists, and all federal funding for the drug hypothesis has been terminated[6, 10, 11, 95, 209] (see 7.). Asked in 1996 about the CDC's negligence in considering the drug-AIDS connection, Curran, now dean of the School of public Health at Emory University in Atlanta, told the Wall Street Journal, "treating drug addiction wasn't directly part of the CDC's mandate, stopping the spread of AIDS among needle-sharing addicts 'fell between the cracks'"[27]. In the preceeding paragraph the article reports that, "the CDC's biggest single prevention program, AIDS prevention ... accounted for $589 million ". But that was all spent on HIV, not a nickel was left for drugs.

In view of the popularity of the national HIV-AIDS dogma, five of the six early American proponents of the drug hypothesis, Blattner, Curran, Friedman-Kien, Goedert and Jaffe converted to the HIV hypothesis, without even offering a scientific refutation of the drug hypothesis. Haverkos survived as a semi-proponent of the drug hypothesis by adopting HIV as a cofactor[78].

But despite its poor press the drug hypothesis stands scientifically unrefuted. Indeed, the efforts to refute the drug hypothesis have instead provided new data to support it[109, 110, 210, 211] (see 7.).

6. PREDICTIONS ARE PROVING THE DRUG-HYPOTHESIS

A good hypothesis must predict and explain the outcome of man's or nature's experiments. According to Feynman, "nature's phenomena will agree or disagree with your theory". The following examples document that the drug hypothesis predicts and explains the American and European AIDS epidemic exactly.

6.1. American and European AIDS restricted to recreational drugs and AZT.

The drug hypothesis predicts that all AIDS-defining diseases that exceed their long-established normal background (i.e. >95%) are restricted to recreational and anti-HIV drug users. The rare AIDS cases from the general population, including hemophiliacs and transfusion recipients[212], represent the spontaneous and AZT-induced incidence of AIDS defining diseases in these groups under the new name AIDS[22, 23, 25] (see 5.).

Indeed, the following positive and negative evidence confirms this prediction. Even the CDC acknowledges that a third of the over 500,000 American AIDS patients are intravenous drug users[3]. Prior to 1983 the CDC had also confirmed that the remaining two thirds of American AIDS patients were male homosexuals who had all used a multiplicity of recreational drugs, above all nitrite inhalants, amphetamines and cocaine[106] (Table 4). After 1984, by which time the CDC had adopted the HIV hypothesis, independent publications continued to document illicit recreational drug use by American and European homosexual AIDS patients (see 3. and Table 4). Since 1987 a large percentage of HIV-positive male homosexuals also took anti-HIV drugs, above all AZT, as AIDS prophylaxis or therapy (see 4. and 7. and Table 6).

Negative evidence further supports this assessment. Despite the over 100,000 papers published on HIV and AIDS, the AIDS establishment has never been able to demonstrate that even a small group of healthy HIV-positive Americans or Europeans, who had neither used recreational drugs nor antiviral drugs such as AZT, either developed AIDS or developed more AIDS defining diseases than an HIV-free control group[213]. All studies linking HIV to AIDS investigate people with life-threatening health risks such as drug addiction, hemophilia or exotic lifestyles.

No controlled study in the medical literature has found any HIV-positives any sicker or dying sooner than matched HIV-negative controls[10, 25]. Yet, such groups could be easily recruited from the US Army that annually rejects 1 out of 1000 healthy applicants just for having antibodies against HIV[213].

Although the CDC offers rare AIDS cases outside the drug risk groups as examples for drug-free AIDS, that institution has never been able to provide the control statistics to prove that these cases exceed the normal low background in the drug-free population[3]. If matched groups – that only differ in HIV – are ever compared, the mortality of the HIV-positives is exactly the same as that of the HIV-negatives, as for example American transfusion recipients[214], sub-Saharan Africans[41], and intravenous drug users[38, 40, 85].

Thus drugs explain the restriction of AIDS to risk groups, precisely.

6.2. Nine out of ten American/European AIDS patients are males.

The drug hypothesis predicts that American and European AIDS is predominantly male, because males consume over 78% of the hard injected drugs (Table 3)[52, 60], over 98% of nitrite inhalants[79, 80] and most of the AZT (see 3., 4. and 7.).

Indeed, the CDC reports that 87% of all American AIDS patients are males[215]. And the sex ratio of the European AIDS epidemic is a mirror image of the American drug epidemic[25]. This sex distribution is the sum of the following constituents:

1) The CDC reports that a third of all American AIDS patients are intravenous drug users[3]. According to the NIDA, the US Department of HHS and the Bureau of Justice Statistics, and the White House 75-78% of intravenous drug users are males[25, 51, 52, 60, 84] (see 3. and Table 3).

2) The CDC also reports that nearly two thirds, over 60%, of all American AIDS patients are male homosexuals[216]. Based on self-answered questionnaires[217] (of the CDC and independent investigators) all of these were frequent users of nitrite inhalants, ethylchloride inhalants, amphetamines, cocaine, and other drugs that facilitate sexual contacts, particularly anal intercourse. Indeed, not a single drug-free AIDS case has ever been identified (see 3. and Table 4).

Since intravenous drug users, who are 75% male, make up one-third of all AIDS patients, and male homosexuals make up almost two-thirds of all American AIDS patients, the drug hypothesis explains why 87% of all American AIDS patients are males. The same applies to the European AIDS epidemic.

6.3. AIDS and deaths from recreational drugs have the same age distribution.

The drug hypothesis predicts that the age distributions at death from AIDS and from recreational drugs coincide.

Indeed, this prediction is already proved. In 1994, 89% of all American AIDS cases[3], and 82% of all American drug deaths fell into the age group between 25 and 54 years[60]. In 1990, 82% of the cocaine-related and 75% of the morphine-related hospital emergencies were 20-39 years old, again overlapping very closely with the age distribution of AIDS patients[218]. Moreover, according to the same sources, 77% of the drug deaths and 82% of the AIDS cases in 1994 were males – a remarkable coincidence (Table 3).

6.4. Pediatric AIDS caused by maternal drug addiction.

The drug hypothesis predicts AIDS in babies who shared intravenous drugs and AZT with their mothers – regardless of HIV.

In fact, over 80% of pediatric AIDS cases in America and Europe are babies born to mothers who were intravenous drug users[25, 194, 219-221]. Since 1989, many were also prescribed AZT and other anti-HIV drugs after birth (see 4. and 6.9.). The remainder reflects the normal low incidence of AIDS-defining diseases among newborns, particularly among newborns of poor and homeless mothers.

6.5. Why AIDS now?

The drug hypothesis predicts that American and European AIDS is new because it is a direct consequence of the drug use epidemics that spiraled after the Vietnam war, from negligible numbers in the 1970s to currently about 20 million illict drug users in America (see 3.). Allow a grace period of several years for recreational drugs to achieve the dosage needed to cause irreversible disease[25] and you can date the origin of AIDS in 1981 (see 3. and 6.7). In addition, the drug hypothesis predicts that additional AIDS cases were generated since 1987 by the epidemic of AZT prescriptions for 220,000 HIV-positives[25] (see 4.).

According to the CDC's HIV/AIDS Surveillance Reports, AIDS in America increased from a few dozen cases annually in 1981 to about 50,000-75,000 since 1990[212] (Fig. 1). The peak in 1992 and 1993 also reflects several increases in the list of AIDS-defining diseases; the last of which increased this list to 30 in 1993[16] (Fig. 1). After 1993 the annual incidence of AIDS cases has leveled off and even appears to decline (Fig 1). A comparison of Figures 1 and 2 graphically underscores the parallels between the AIDS and drug epidemics since 1981. Thus American and European AIDS is new because the drug epidemic is new. In fact, both the newness and slope of the AIDS epidemic are predicted by the newness and slope of the drug epidemic, as postulated by the drug-AIDS hypothesis.

6.6. Risk group-specific AIDS diseases.

The drug hypothesis predicts drug-specific AIDS diseases and explains the following risk-group-specific AIDS diseases as drug-specific AIDS diseases:

1) Kaposi's sarcoma specific for male homosexual nitrite users. Kaposi's sarcoma as an AIDS diagnosis is 20 times more common among homosexuals who use nitrite inhalants than among AIDS patients who are intravenous drug users, or hemophiliacs[35, 125].

According to the drug hypothesis Kaposi's sarcoma is a nitrite-specific AIDS disease. Indeed, male homosexuals are 58-times more likely to use nitrite inhalants as sexual and mental stimulants than heterosexuals[79] (see 3.). Due to their carcinogenic potential, nitrites were originally proposed as the cause of Kaposi's sarcoma[203, 205]. The fact that up to 32% of Kaposi's sarcomas of homosexual men can be diagnosed as pulmonary Kaposi's sarcoma[222, 223], lends additional support to the nitrite-Kaposi's sarcoma hypothesis, because the lungs are the primary site of exposure to nitrite inhalants. Meduri et al. point out that the "pulmonary involvement by the neoplasma has been an unusual clinical finding" in the Kaposi's sarcomas of male homosexuals compared to all "classic" Kaposi's sarcomas[224]. Indeed, "aggressive and life-threatening" Kaposi's sarcoma, particularly pulmonary Kaposi's sarcoma, is exclusively observed in male homosexuals[223-226]. Pulmonary Kaposi's sarcoma had never been observed by Moritz Kaposi, nor by anyone else prior to the AIDS epidemic[227].

Moreover, it appears that the nitrite-induced AIDS-Kaposi's sarcoma and the classic, spontaneous Kaposi's sarcomas are entirely different cancers under the same name. The "HIV-associated" Kaposi's sarcomas observed in male homosexuals are "aggressive and life-threatening"[225], often located in the lung and fatal within 8-10 months after diagnosis[222-224, 226]. The classic "indolent and chronic" Kaposi's sarcomas are only diagnosed on the skin of the lower extremities and hardly progress over many years[15, 224, 228]. Nevertheless, the distinction between classic and AIDS-Kaposi's sarcoma is rarely ever emphasized and may have escaped many observers due to the "difficulty in premortem diagnosis", and because "pulmonary Kaposi's sarcoma was indistinguishable from opportunistic pneumonia..."[226].

The immunotoxicity and cytotoxicity of nitrites also explains the proclivity of male homosexual nitrite users for pneumonia, which is the most common AIDS disease in the US and Europe[25, 125] (Table 1). The cytotoxic effects of nitrites are compounded by the immunotoxins and cytotoxins of cigarette smoke. For example, in two groups of otherwise matched HIV-positive male homosexuals, cigarette smokers developed pneumonia twice as often as non-smokers over a period of 9 months[128].

2) High mortality and specific diseases of intravenous drug users. High mortality and tuberculosis, pneumonia, mouth infections, immunodeficiency, lymphadenopathy, candidiasis, fever, weight loss and dementia are each characteristic of intravenous drug users[25, 85, 115, 117, 119, 120] (see 3.) and AIDS patients (see Table 5).

A recent review article has tried to resolve the "confusion [that] may arise as to the aetiology of specific symptoms" from intravenous drug use and from HIV, "since they may mimic each other"[39]. But, after confirming that drug use causes lymphadenopathy, diarrhea, dementia, epileptic seizures, impotence, tuberculosis and other clinical features by itself, the article fails to resolve the confusion (see 3.). Since it lacks drug-free HIV-infected patients with the specific diseases of intravenous drug users, the confusion remained. In other words, the article confirmed, despite its intent, once more that AIDS diseases of intravenous drug users are drug diseases.

Because of drug-induced diseases intravenous drug users only reach a very low average age. A German study found the average age at death of intravenous drug users was 29.6 years for HIV-free and 31.5 years for HIV-positive addicts in 1995[38]. American studies show that both HIV-positive and negative intravenous drug users die between the ages of 25 and 48 years[40], and from the same AIDS-defining and other diseases in 1988[85]. The average age at death of amphetamine addicts was also determined to be about 30 years[113]. Thus drugs, not HIV, determine the specific diseases and high mortality of intravenous drug users.

3) Low birth weight and mental retardation of AIDS babies. Low birth weight, mental retardation and immunodeficiency for lack of B-cells are specific AIDS diseases of AIDS babies[212].

According to the drug hypothesis these are drug diseases because 80% of American/European babies with AIDS are born to mothers who were intravenous drug users during pregnancy[25, 50, 194, 221]. Moreover, HIV-free "crack babies" of drug-addicted mothers have exactly the same diseases as HIV-positive infants[229] (see 6.8.). The remaining 20% are due to congenital diseases such as hemophilia, and infant morbidity and mortality due to poverty[25].

4) Anemia, wasting, lymphoma and high mortality of AZT recipients. Anemia, leukopenia, lymphoma, pancytopenia, diarrhea, weight loss, hair loss, impotence[25], muscle atrophy, dementia, hepatitis[184], and pneumocystis pneumonia[190] are specific AIDS diseases typical of those prescribed AZT and other DNA chain terminators. They are all predictable consequences of the termination of DNA synthesis (see 4.).

Indeed, compared to untreated controls AZT recipients have 50-times more often lymphoma[187], die either 2.4-times more often[193] or 25% more often[155], or live only 2 years instead of 3 with AIDS with the above diseases[192] (see 7.8). And babies treated with AZT before birth develop birth defects or are aborted, and those treated after birth experience "a negative effect on growth"[194] (see 7.8).

6.7. Not all drug users develop AIDS.

The drug hypothesis predicts that drug diseases only occur after a pathogenic threshold of drug toxicity has been accumulated over a lifetime. Short term users of drugs at recreational doses will experience either no diseases or reversible diseases.

In adults it takes about 10 years of injecting or oral use of heroin, cocaine and amphetamines to develop tuberculosis, bronchitis, pneumonia, irreversible or hardly reversible weight loss, and other drug-induced diseases[113, 115, 117, 230-234]. The time lag from initiating a habit of inhaling nitrites to acquire Kaposi's sarcoma has also been determined to be 7 to 10 years[25, 35, 108, 133]. Clearly, irreversible damage is achieved much faster in a developing fetus than in a fully developed adult.

Since most recreational drug users give up drugs for personal, economic, and health reasons before they experience serious medical consequences, only a fraction will develop drug diseases[121]. Thus the 500,000 individuals annually delivered to hospitals for reversible drug diseases, and the 50,000 to 75,000 for irreversible AIDS diseases[50] are only a small fraction of the over 20 million American illict drug users. Likewise, the 600-800 annual American AIDS babies[3] are only a small fraction of the 221,000 that are born to American mothers who use drugs during pregnancy[50] (see 3.).

In addition, only a fraction of the 220,000 HIV-positive persons on daily prescriptions of AZT and other anti-HIV drugs, that, like AZT, are designed to kill human cells, are annually converted to AIDS patients[155]. The annual percentage of healthy AZT-recipients developing AIDS is not published, but can be estimated at 25 to 35% considering that out of 220,000 on AZT between 50,000 and 75,000 Americans each year develop AIDS (Fig. 1).

Thus the American AIDS patients are those 50,000 to 75,000 of the 20 million recreational drug users and the 220,000 AZT recipients who have achieved the highest lifetime doses of toxicity – just like the lung cancer and emphysema patients reflect the highest lifetime tobacco dose among the 50 million smokers in the US[235].

6.8. Non-correlations between HIV and AIDS.

The drug hypothesis predicts (a) HIV without AIDS, (b) AIDS before HIV, and (c) AIDS without HIV. Each of these predictions is confirmed.

1) Long-term survivors or "non-progressors". In view of the appearance of growing numbers of HIV carriers who are healthy even 15 years after infection, the HIV orthodoxy has created a new category of HIV carriers, termed long-term survivors or "long-term non-progressors"[236]. Many publications confirm this prediction.

The first mainstream paper on long-term survivors described a healthy male homosexual blood donor and five blood recipients who by 1992 had survived HIV for 10 to 12 years[237]. The HIV orthodoxy has therefore proposed that the existence of the non-progressors is due to non-virulent, mutant strains of HIV and that such viruses would be ideal vaccine strains. However, these optimistic proposals were not backed up by functional evidence for non-virulence[236, 238].

According to the drug hypothesis the non-progressors should be HIV-positive people who are not using recreational drugs or AZT. For example, the HIV-researchers David Ho et al. inadvertantly provided the key to long-term survival: "none had received antiretroviral therapy"[239]. Likewise, Alvaro Munoz reported that not one of the long-term survivors of the largest federally funded study of male homosexuals at risk for AIDS, the MAC study, had used AZT[240]. Another orthodox HIV study acknowledged "only 38% of the HLP [healthy long-term HIV-positives] had ever used zidovudine or other nucleoside analogues compared with 94% progressors". Clearly the wording "had ever used" implies that AZT had been discontinued after a short traumatic, but reversible experience.

Independent scientists document that in addition to abstaining from antiviral drugs long-term survivors are those who have given up or never taken recreational drugs[241-243]. Timothy Hand, from the Ogelthorpe University in Atlanta GA, adds much weight to this view:

> While healthy, 'non-progressing' HIV carriers are considered rare (and doomed), they may in fact vastly outnumber the sick and dying. This is certainly implied by the ubiquitous estimate of HIV prevalence in America of one million. Long-term AIDS survival is now a hot topic in the literature, and anecdotal reports[244, 245] as well as numerous scientific studies[99, 239, 246-252] suggest that most long-term survivors have shunned antiviral drugs. This point is often understated in these studies, and is not made in the titles or abstracts. In David Baltimore's editorial on 2 of these studies, avoidance of antivirals was not mentioned at all[253]. Needless to say, none of these studies was funded by a pharmaceutical firm.
>
> Interestingly, nearly all of these studies suggest a protective role of cytotoxic CD8+ T-cells and/or natural killer cells in healthy survivors. Many focus on the importance of maintaining cell-mediated immunity, rather than on "killing HIV". Thus HIV infection per se seems to entail little danger, unless it is followed by antiviral therapy[254].

Similar observations have been made by the late homosexual AIDS activist Michael Callen:

> In researching his 1990 book Surviving AIDS, Callen interviewed nearly fifty people who had lived for many years not just after being pronounced HIV-positive, but after an AIDS diagnosis. He found that only four had ever used AZT; three of those had since died, and one was dying of AZT-induced lymphoma. But the overwhelming majority of long-term survivors had somehow managed to resist the enormous pressure to take AZT.
>
> The pressure did not just come from doctors, Callen told the Amsterdam meeting[7, 255], but from a certain segment of AIDS activism that seemed driven by a 'drugs-into-bodies' mentality. 'I feel many AIDS activist friends who are in the forefront of this frenzy are very misleading to people with AIDS, who are frightened and desperate. They only seem to talk about two possible outcomes of taking experimental drugs: one is that it works and one that it does not work. There is a third, apparently much more common possibility, which is that you will be worse off than if you did nothing at all. And nobody likes to talk about that because it is so unpleasant'. He had seen the devastation wreaked by AZT, watching with horror as friends with AIDS 'turn the colour of boiled ham from AZT poisoning, endure the melting away of their muscles, become transfusion dependent, and experience drug-induced psychosis'. Yet his perception of a person diagnosed with AIDS in 1992 was that 'they would sell their grandmother into slavery to get a slot in the latest drug-of-the-month clinical trial'.
>
> Another feature of the long-term survivors was that they rejected the predominant scientific view that HIV-positivity meant inevitable decline of the immune system towards an early death[7].

In December 1995 The Advocate, the largest national gay magazine, published the story of Dennis Leoutsakas, a man who is HIV-positive "for at least 17 years [but] doesn't have AIDS – and no one knows why"[256]. According to the article, "most HIV researchers have insisted that HIV infection will, in almost every case, eventually lead to AIDS" – a belief underscored by their preferred term for nonprogressors: slow progressors.

Wearing his HIV blinkers the author of the article fails to see the formula for Leoutsakas' "slow progression": "Leoutsakas, 47: A former IV-drug user who last shared a needle in 1978 ... first tested positive in 1987. He has a T-cell count ... between 650 and 950. In addition, Leoutsakas has had none of the opportunistic infections that define AIDS – no pneumonia, no Kaposi's sarcoma, no fungal infections, nada. Leoutsakas says doctors have attempted to explain his case by theorizing that, like the Australians[237], he is infected with a weakened form of HIV – but it's really just speculation." ... "Leoutsakas has no theory of his own – and no special formula for his well-being. He's never taken AZT or any other antiretroviral drugs." No more IV-drugs, no antiretroviral drugs – but "no formula for his well-being"!

And in October 1996 even an orthodox professor of medicine at the University of California at San Francisco taught his medical students the secret of long-term survival with HIV (see 4.): "I have a large population of people who have chosen not to take any antivirals since I've been following them since the very beginning... They've watched all of their friends go on the antiretroviral bandwagon and die, so they've chose to remain naive to therapy. More and more, however, are now succumbing to pressure that protease inhibitors are it ... We are in the middle of the honeymoon period, and whether or not this is going to be an enduring marriage is unclear to me at this time, so I'm advising my patients if they still have time, to wait."[170]

Unknowingly the vast majority of HIV-positives are long-term survivors! Worldwide, they number 17 million, including 1 million HIV-positive, healthy Americans and 0.5 million HIV-positive, healthy Europeans[257, 258]. Most of these must have been HIV-positive for at least 10 years now because the numbers of the Americans and Europeans have not changed during the period 1984 to 1988 when the epidemic of HIV-testing began in the respective countries[25, 28].

Since no more than 6% of the 17 million people worldwide with antibodies to HIV have developed AIDS over the last 7 to 10 years, the risk of AIDS to an HIV-carrier is less than 1% per year[258]. However, even this low figure is not corrected for the normal occurence of the 30 AIDS-defining diseases in HIV-free controls. There is not a single controlled study in the vast AIDS literature proving that HIV-positive people who are not drug users have a higher morbidity or mortality than HIV-free controls[10, 213] (see 7., Tables 4 and 5).

Another totally drug-free group of long-term survivors is the 200 American chimpanzees who have been inoculated with HIV since 1983. As of 1997 not even one of these had developed AIDS although they are just as susceptible to HIV as their human cousins[354].

To save the reputation of the "deadly virus" in the face of long-term survivors, orthodox HIV researchers have already posted warnings that "regrettably ... the proportion of individuals who might demonstrate such a benign course is very small"[259]. Others have postulated rare HIV attenuating mutations without providing functional evidence[236, 238]. Gallo et al. went even further by postulating human mutants, who fall victim of HIV because they lack "major HIV-suppressive factors"[260]. According to Gallo's hypothesis most American homosexuals, hemophiliacs and intravenous drug users are mutants!

2) Drug users developing AIDS prior to HIV infection. Prospective studies have demonstrated that the T-cells of male homosexuals using psychoactive drugs and sexual stimulants may decline prior to infection with HIV. For example, the T-cells of 37 homosexual men from San Francisco declined steadily prior to HIV infection for 1.5 years from over 1200 to below 800 per µl[261]. Some even had fewer than 500 T-cells 1.5 years before seroconversion[262]. Although recreational drug use was not mentioned in these articles, other studies of the same cohort of homosexual men from San Francisco described extensive use of recreational drugs including nitrites[80, 107, 109, 140, 263]. Likewise, 33 HIV-free male homosexuals from Vancouver, Canada, had "acquired" immunodeficiency prior to HIV infection[264]. Again this study did not mention drug use, but in other articles the authors reported that all men of this cohort had used nitrites, cocaine and amphetamines[47, 103, 265].

The MAC study reported that about 450 (16% of 2795) HIV-free, homosexual American men from Chicago, Baltimore, Pittsburgh and Los Angeles had acquired immunodeficiency, having less than 600 T-cells per µl, prior to HIV infection[101]. Many HIV-positive and -negative men of this cohort had essentially the same degree of lymphadenopathy: "Although seropositive men had a significantly higher mean number of involved lymphnode groups than seronegative men (5.7 compared to 4.5 nodes, $p<0.005$), the numerical difference in the means is not striking"[266]. According to previous studies on this cohort, 71% of these men had used –based on self reporting– nitrite inhalants, in addition to other

drugs[266]; 83% had used one drug, and 60% had used two or more drugs during sex in the previous six months[267].

Indeed, not a single prospective study of male homosexual cohorts at risk for AIDS ever measured drug use directly. Instead, each relied only on self reporting, using questionnaires that focused on recent use of a few selective drugs[31, 47, 217, 263] (see 7.). By contrast, all HIV tests were based on experimental methods that maximize positivity such as antibodies against the virus instead of the virus itself, or amplification of fragments of viral nucleic acid instead of standard infectivity tests (see 7.).

Another study of the same cohort observed that the risk of developing AIDS correlated with the frequency of receptive anal intercourse prior to and after HIV infection[268], which correlates directly with the use of nitrite vasodilaters (see 3.)[25, 98, 102, 125, 269].

Thus, in male homosexuals at risk for AIDS, AIDS often precedes infection by HIV, not vice versa. Since the cause must precede the consequence, drug use remains the only plausible, group-specific choice to explain "acquired" immunodeficiencies prior to HIV. If male homosexuality were to cause immunodeficiency, about 10% of the adult American male population should have AIDS[25, 270], and the disease should have been well established long before 1981.

Prospective studies of intravenous drug users also document T-cell losses prior to infection by HIV. For example, among intravenous drug users in New York "the relative risk for seroconversion among subjects with one or more CD4 [T-cell] count <500 cells/µl compared with HIV-negative subjects with all counts >500 cells/µl was 4.53"[271]. A similar study from Italy showed that a low number of T-cells was the highest risk factor for HIV infection[272]. Again, a decrease in T-cells is a risk factor for HIV infection, and not vice versa.

This confirms the hypothesis that HIV is a marker of drug consumption, rather than the cause of AIDS: the more drugs are consumed intravenously or as an aid to sex, the higher is the risk of HIV infection[25].

3) HIV-free AIDS. Intravenous drug users, their babies, male homosexuals consuming aphrodisiac and psychoactive drugs, hemophiliacs, and poor Africans develop the same AIDS-defining diseases with or without HIV. One summary of the AIDS literature describes over 4,621 clinically diagnosed AIDS cases who were not infected by HIV[47]. Additional cases are described that are not in this summary[220, 262, 263, 266, 273, 274]. They include intravenous drug users, male homosexuals using aphrodisiac drugs like nitrite inhalants, hemophiliacs developing immune suppression from long-term transfusion of foreign proteins contaminating factor VIII, and Africans subject to malnutrition, parasitic infection and poor sanitation[23, 47].

The following examples of clinical AIDS in HIV-free male homosexuals (1-9), and in intravenous drug users and their babies (10-26) illustrate this point:

1) The first five AIDS cases, diagnosed in 1981 before HIV was known (i.e. presence of HIV is speculative), were male homosexuals who had all consumed nitrite inhalants and presented with Pneumocystis pneumonia and cytomegalovirus infection[275].

2) In 1985, and again in 1988, Haverkos analyzed the AIDS risks of 87 male homosexual AIDS patients with Kaposi's sarcoma (47), Kaposi's sarcoma plus pneumonia (20) and pneumonia only (20)[205, 276]. All men had used several sexual stimulants, 98% had used nitrites. Those with Kaposi's sarcomas reported 2 times more sexual partners and 4.4 times more receptive anal intercourse than those with only pneumonia. The median number of sexual partners in the year prior to the illness was 120 for those with Kaposi's and 22 for those with pneumonia only. The Kaposi's cases reported 6-times more amylnitrite and ethylchloride use, 4-times more barbiturate use, and 2-times more methaqualone, lysergic acid and cocaine use than those with pneumonia only. Since no statistically significant differences were found for sexually transmitted diseases among the patients, the authors concluded that the drugs had caused Kaposi's sarcoma.

Although the data for Haverkos' analysis had been collected before HIV was known, Haverkos' conclusion is valid. This is because the development of AIDS was drug dose dependent, and thus was either sufficient or at least necessary for AIDS. Indeed, HIV was found in only 31%[277], 43%[278, 279], 48%[280], 49%[281], 56%[264], and 67%[107] of cohorts of homosexuals at risk for AIDS in Amsterdam, Chicago-Washington DC-Los Angeles-Pittsburgh, Boston, San Francisco and Canada respectively, that developed the same AIDS diseases as described by Haverkos.

3) A 4.5 year tracking study of 42 homosexual men with lymphadenopathy but not AIDS reported that 8 had developed AIDS within 2.5 years[202] and 12 within 4.5 years of observation[282]. All of these men had used nitrite inhalants and other recreational drugs including amphetamines and cocaine, but they were not tested for HIV. The authors concluded that "a history of heavy or moderate use of nitrite inhalant before study entry was predictive of ultimate progression to AIDS"[202]. Thus drug doses of 2.5 to 4.5 years were necessary for AIDS.

4) Before HIV was known, three controlled studies compared 20 homosexual AIDS patients to 40 AIDS-free controls[203], 50 patients to 120 controls[106] and 31 patients to 29 controls[204] to determine AIDS risk factors. Each study reported that multiple "street drugs" were used as sexual stimulants. And each study concluded that the "lifetime use of nitrites"[106] were 94% to 100% (!) consistent risk factors for AIDS[204].

5) A 27-58-fold higher consumption of nitrites by male homosexuals compared to heterosexuals and lesbians[79, 283] correlates with a 20-fold higher incidence of Kaposi's sarcoma[35, 284] and a higher incidence of all other AIDS diseases in male homosexuals compared to most other risk groups (Tables 3 and 4). Again, drug use proved to be necessary for AIDS.

6) After the discovery of HIV, 5 out of 6 HIV-free male homosexuals from New York with Kaposi's sarcoma reported the use of nitrite inhalants[285]. Soon after, another 6 cases of HIV-free Kaposi's sarcoma were reported in an HIV-free "high risk population" from New York[286]. This indicates directly that HIV is not necessary and suggests that drugs are sufficient for AIDS.

7) In 1992, two HIV-free, male homosexuals, erroneously treated with AZT because of a false positive HIV-antibody test, developed fatal AIDS including pneumonia and muscle atrophy. Their case was described in the Oakland Tribune and in the New York Native because of a malpractice suit against Kaiser Hospital and the manufacturer of AZT, but was not followed up by the media, suggestive of a settlement[287]. One of us has testified in three legal cases against AZT therapy, and in each case settlements were reached that barred further publicity.

8) A rare, recent publication describes 4 HIV-free, male homosexual AIDS patients with Kaposi's sarcoma in the New England Journal of Medicine[273]. This publication was published in the orthodox literature at the same time as a "new Kaposi's sarcoma virus" was considered by the AIDS establishment. This shows that the HIV orthodoxy can accept HIV-free AIDS cases, but only at the expense of substituting another AIDS virus in the place of HIV[288].

9) An independent re-analysis of the database of male homosexual AIDS patients from San Francisco who had used nirtrite inhalants, amphetamines, cocaine, and other recreational drugs in addition to AZT originally described in 1993[80, 289], identified 45 HIV-free patients with AIDS defining diseases that had been omitted from the original study[110].

10) Among intravenous drug users in New York representing a "spectrum of HIV-related diseases," HIV was only observed in 22 out of 50 pneumonia deaths, 7 out of 22 endocarditis deaths, and 11 out of 16 tuberculosis deaths[85].

11) Pneumonia was diagnosed in 6 out of 289 HIV-free and in 14 out of 144 HIV-positive intravenous drug users in New York[290].

12) Among 54 prisoners with tuberculosis in New York state, 47 were street-drug users, but only 24 were infected with HIV[291].

13) In a group of 21 long-term heroin addicts, the ratio of helper to suppresser T-cells declined during 13 years from a normal of 2 to less than 1, which is typical of AIDS[5, 292], but only 2 of the 21 were infected by HIV[232].

14) Thrombocytopenia and immunodeficiency were diagnosed in 15 intravenous drug users on average 10 years after they became addicted, but 2 were not infected with HIV[231].

15) The annual mortality of 108 HIV-free Swedish heroin addicts was similar to that of 39 HIV-positive addicts, i.e. 3–5%, over several years[293].

16) A survey of over a thousand intravenous drug addicts from Germany reported that the percentage of HIV-positives among drug deaths (10%) was exactly the same as that of HIV-positives among living intravenous drug users[294]. Another study from Berlin also reported that the percentage of HIV-positives among intravenous drug deaths was essentially the same as that among living intravenous drug users, i.e. 20–30%[295]. This indicates that drugs are sufficient for and that HIV does not contribute to AIDS-defining diseases and deaths of drug addicts.

17) Lymphocyte reactivity and abundance was depressed by the absolute number of injections of drugs not only in 111 HIV-positive, but also in 210 HIV-free drug users from Holland[296].

18) The same lymphadenopathy, weight loss, fever, night sweats, diarrhea and mouth infections were observed in 49 out of 82 HIV-free, and in 89 out of 136 HIV-positive, long-term intravenous drug users in New York[297].

19) Among intravenous drug users in France, lymphadenopathy was observed in 41 and an over 10% weight loss in 15 out of 69 HIV-positives. The numbers were 12 and 8, respectively, out of 44 HIV-negatives[233]. The French group had used drugs for an average of 5 years, but the HIV-positives had injected drugs about 50% longer than the negatives.

20) Among 97 intravenous drug users in New York with active tuberculosis, 88 were HIV-positive and 9 were HIV-negative; and among 6 "crack" (cocaine) smokers with tuberculosis, 3 were HIV-negative[298].

21) Among heroin addicts from New York, having injected an average of 5.7 years, natural killer cell activity was reduced 2-fold and T4/T8-cell ratios from 2 to 1.5[89].

22) A survey of the causes of death of 412 intravenous drug users from New Jersey, revealed many HIV-free cases, including at least 48 pneumonias, 35 tuberculoses, and 6 encephalopathies[40].

23) Similar neurological deficiencies were observed among 12 HIV-infected and 16 uninfected infants of drug-addicted mothers (Thomas Koch, UC San Francisco, personal communication)[299]. Moreover, babies with and without HIV, but from HIV-positive mothers, had lower psychomotor indices than babies from HIV-free mothers. The probable reason is that HIV is again a marker for the cumulative dose of intravenous drugs consumed by the mother[25].

24) The psychomotor indices of infants "exposed to substance abuse in utero" were "significantly" lower than those of controls, "independent of HIV status." Their mothers were all drug users but differed with regard to drug use during pregnancy. The mean indices of 70 children exposed to drugs during pregnancy were 99 and those of 25 controls were 109. Thus maternal drug use during pregnancy impairs children independent of HIV[300].

The same study also reports a "significant difference" based on the HIV status of these children. The mean score of 12 HIV-positives was 88 and that of 75 negatives was 102. As is typical for the AIDS establishment, HIV-positive babies of non-drug using mothers were grouped with those from drug-using mothers (see 7.). But although the study did not break down the scores of the HIV-positive infants based on "exposure to substance abuse in utero", it documented that 4 of the 12 HIV-infected infants were "above average," i.e. 100-114 – and that 4 of the 12 mothers did not inject drugs during pregnancy!

25) Ten HIV-free infants born to intravenous drug-addicted mothers had the following AIDS-defining diseases "failure to thrive, persistent generalized lymphadenopathy, persistent oral candidiasis, and developmental delay..."[301].

26) One HIV-positive and 18 HIV-free infants born to intravenous drug-addicted mothers had only half as many leukocytes at birth than normal controls. At 12 months after birth, the capacity of their lymphocytes to proliferate was 50- 70% lower than that of lymphocytes from normal controls[302].

Each of these non-correlations between HIV and AIDS is predicted by the hypothesis that recreational drugs and other non-contagious risk factors cause AIDS.

6.9. Discontinuation of drug use either stabilizes or cures AIDS.

The drug hypothesis predicts that termination of drug use stabilizes or cures AIDS diseases, except for those that have reached a critical threshold of no return. Indeed, this has been documented in several examples:

1) AZT-recipients. Ten out of 11 HIV-positive, AZT-treated AIDS patients recovered cellular immunity after discontinuing AZT in favour of an experimental vaccine[303]. Two weeks after discontinuing AZT, 4 out of 5 AIDS patients recovered from myopathy[304]. Three of four AIDS patients recovered from severe pancytopenia and bone marrow aplasia 4-5 weeks after AZT was discontinued[305].

2) Heroin/cocaine-addicts. The incidence of AIDS diseases among HIV-positive intravenous drug users over 16 months was 19% (23/124) and only 5% (5/93) among those who stopped injecting drugs[234]. The T-cell counts of HIV-positive intravenous drug users from New York dropped 35% over 9 months, compared to HIV-positive controls who had stopped injecting[88].

3) Recreational and anti-HIV/AIDS drugs. The health of male homosexuals is stabilized or even improved by avoiding recreational drugs. For example, in August 1993 there was no mortality during 1.25 years in a group of 918 British HIV-positive homosexuals who had "avoided the experimental medications on offer" and chose to "abstain from or significantly reduce their use of recreational drugs, including alcohol"[242]. Assuming an average 10-year latent period from HIV to AIDS, and a random distribution of infection times prior to AIDS, the virus-AIDS hypothesis would have predicted about 116 (918/10 x 1.25) AIDS cases among 918 HIV-positives over 1.25 years. Indeed, the absence of mortality in this group over 1.25 years corresponds to a minimal latent period from HIV to AIDS of over 1,148 (918 x 1.25) years. On July 1, 1994, there was still not a single AIDS case in this group of 918 HIV-positive homosexuals (J. Wells, London, personal communication).

Another "good example that medicines hurt more than they help is the story of Roger Cobb, co-chairman of the consumer caucus for the Commission on AIDS Care, Service and Treatment for Philadelphia and nine surrounding counties. 'Sixty days after I started substance abuse treatment, I learned that I was HIV-positive,' recalls Cobb, who had used crack and cocaine, among a smorgasbord of other drugs, for more than 21 years. 'A little while later I started treatment with AZT for about 14 months.' It was during this time that he developed what he calls 'the look.' 'I had the sunken face, the ashy skin; I lost weight – everything. Against my doctor's advice, I decided AZT was not for me, so I decided to try something else.' And 'the look'? 'The look is fabulous now,' says the 40-year-old, who is working on his master's degree in social work. 'I'm back to me'"[348].

4) Recreational drug users. The T-cells of 29% of 1,020 HIV-positive male homosexuals and intravenous drug users in a clinical trial even increased over 2 years[306]. These HIV-positives belonged to the placebo arm of an AZT trial for AIDS prevention and thus were not treated by AZT. It is probable that under clinical surveillance the 29% whose T-cells increased, despite HIV, have given up or reduced immunosuppressive recreational drug use in the hope that AZT would prevent AIDS (see 4.2).

5) AIDS babies, born to drug-addicted mothers, recover. HIV-positive babies, born to mothers who were intravenous drug users during pregnancy, provide the best controlled examples for the prediction that termination of drug use prevents, or cures AIDS – despite the presence of HIV. For example, Blanche et al. have observed for three years 71 HIV-positive newborns who had shared intravenous drugs with their mothers prior to birth. After three years, 61 of these HIV-positive children were healthy, although some had developed "intermittent" diseases from which they had recovered during their first 18 months. Contrary to the HIV hypothesis, the T-cells of these children increased after birth from low to normal levels – despite the presence of HIV.

Only 10 of these children developed encephalopathy and other AIDS-defining diseases of which 9 died during their first 18 months of life. The study points out that the baby's risk of developing AIDS was related "directly with the severity of the disease in the mother at the time of delivery".

The recovery of babies born with AIDS symptoms from maternal drug use was apparently impaired by iatrogenic intoxication with AZT and other anti-AIDS drugs, "prophylactic treatment [with] ... sulfamethoxazale and zidovudine [AZT] was started earlier and was more frequent among the children born to mothers with class IV disease (AIDS)"[307]. Based on the severity of their symptoms about 60% of the children were treated prophylactically with AZT "for at least one month", and 50% were treated with sulfa-drugs[307].

A very similar picture emerges from a collaborative European study of HIV-positive newborns[308]. The study reports that over 60% of congenitally-infected children were healthy at 6 years after birth – although many had experienced transient AIDS diseases, such as pneumonia, bacterial infections, candidiasis and cryptosporidial infection during the first year after birth. About 20% of the HIV-positive children had died or developed long-term AIDS during the first year after birth, and another 20% during the second and third years – and that is exactly the percentage that was "treated with zidovudine [AZT]", 10% before 6 months of age and 40% by 4 years[308].

Although this study does not even mention the health and health risks of the mothers, previous reports from the European Collaborative Study group have documented that "nearly all children were born to mothers who are intravenous drug users"[25, 219]. In 1991, the European Collaborative Study group reported that 80% of the children with pediatric AIDS were born to mothers who were intravenous drug users[220]. The 1991-study further points out that "children with drug withdrawal symptoms" were most likely to develop diseases, and that children with no withdrawal symptoms but "whose mothers had used recreational drugs in the final 6 months of pregnancy were intermediate" in their risk to develop diseases[220].

An American study reports that during the first 18 months after birth a group of HIV-positive babies lagged on average behind a control group of HIV-free infants in all developmental parameters[194]. But the study also reports intravenous and other drug use by the mothers, and that "up to 60% at 18 months" of HIV-posities were on AZT. By 18 months 40% of the HIV-positive babies had apparently completely recovered from maternal drugs, despite HIV, because they were neither treated with AZT nor were any deaths reported. However, up to 60% apparently had suffered intermittent diseases from AZT and residual damage of maternal drug use. Thus the normal performance of 40% of the HIV-positive group, 18 months after withdrawal from maternal drugs, was hidden by the subnormal performance of the HIV-group that was an average of AZT recipients and untreated babies (see 7.7).

It follows that discontinuation of recreational and antiretroviral drugs before a critical threshold is reached prevents or even cures AIDS in HIV-positives.

In sum, this chapter documents that the drug-AIDS hypothesis correctly predicts all facts of American/European AIDS, while the HIV-

hypothesis predicts none.

7. HOW THE HIV/AIDS ORTHODOXY DIVORCES DRUGS FROM AIDS

Despite abundant evidence for drug pathogenicity, the orthodox medical literature almost unanimously disregards diseases from recreational drugs. Wearing their HIV/AIDS blinkers, AIDS researchers even fail to make the drug connection when matched groups of drug users, differing only in HIV, have the same diseases and high motrtality. Whereas, the diseases and high mortality of HIV-positive drug users are credited to HIV, those of HIV-negatives are credited to other microbes and even to contaminants of street drugs rather than to the psychoactive drugs themselves[38, 39, 85, 288, 309] (see 3, and below).

But even when drug use is recognized as a direct AIDS risk, the role of drugs is divorced from AIDS by unscientific manipulations including misrepresentations, double-standards, omissions of facts and controls and outright censorship. The following examples substantiate these assertions:

7.1. Disregarding drugs.

Although 3.6 million Americans are regular users of cocaine and at least 0.6 million are addicted to heroin (see 3) and a third of the 500,000 American AIDS patients are confirmed long-term intravenous drug users[3, 10, 25], the pathogenic effects of long-term cocaine and heroin use are not studied anywhere in the US and Europe[10, 15, 25, 116]. But at least 100,000 American PhDs and MDs are studying the hypothetical pathogen HIV[116].

A tendentious article in Science described the mood perfectly in 1994 with the quote from a distinguished HIV/AIDS toxicologist, "heroin is a blessedly untoxic drug"[15]. But unbeknown to Science and its readers, growing numbers of American entertainment stars and junkies are dying from heroin. In the same year in which Science described the "blessedly untoxic" heroin, the US Dept. of HHS recorded 2910 male and 601 female heroin "decedents" (see 3.1 and Table 2) [60]. The stories of some were just described in the San Francisco Chronicle under the title "Heroin is in fashion – and death statistics prove it"[310].

Uninformed or even misinformed (see below) by the trusted medical orthodoxy, the general public and even those who have a direct interest or mandate to warn against drug use are unaware of drug diseases. For example, the Bureau of Justice Stastistics, the Drug Strategies foundation and drug control officials from the White House who published The National Drug Control Strategy: 1996 never warn about the medical consequences of drug use, except that they might lower vigilance against infection by HIV and other microbes[27, 51, 52, 54, 73] (see 3.3).

Although the National Drug Control Study: 1996 is concerned about the safety of "America's [non-drug using] citizens" because "Hardcore drug users frequently are 'vectors' for the spread of infectious diseases such as hepatitis, tuberculosis, and HIV." [52], the Study misses the point that drugs cause the immunodeficiency necessary for these microbes to be pathogenic. It is for this reason that hardcore drug users are virtually the only "American citizens" who are victims of these microbes.

Although inhaling nitrites has been illegal in the US since 1988, because of an "AIDS link"(see 3), inhaling has been practised by at least 4.2 million Americans in 1992, according to a survey of the National Institute on Drug Abuse[81]. In spite of this, nitrites are not listed as an illegal drug category of their own by the Bureau of Justice Statistics[51], Drug Strategies[50], the Drug Abuse Warning Network (DAWN) of the US Department of HHS[60, 82], or the President's National Drug Control Study: 1996 [52].

Although the majority of American AIDS patients – male homosexuals, and probably all Kaposi's sarcoma patients – have been using cytotoxic and carcinogenic nitrite inhalants and many other toxic recreational drugs, non-injected drugs are not reported as an AIDS risk category by the CDC's HIV/AIDS Surveillance Reports. But no HIV infection "category" is too small to be left out of the Surveillance Reports, as for example the less than 10 annual male AIDS cases that reportedly result from "sex with a person with hemophilia"[311].

The San Francisco Chronicle just demonstrated the consequences of the orthodox blindness to the drug-AIDS connection under the title "HIV hits former USSR – a small city's story,"[349]. The journal is shocked that "half of the town's drug-injecting subculture is believed to be infected [by HIV]" and that "AIDS will be more common here than America". But neither the journal nor the journalist even gave a thought to the possibility that "to shoot raw opium" may be the cause of the predicted AIDS epidemic.

7.2. Misrepresentation of facts, example 1.

The CDC provides the first example of misrepresenting facts to dissociate drugs from AIDS. After the publication in April 1983 of two different AIDS viruses in Science, one by Gallo (HTLV-I)[312] the other by Montagnier[313] (now termed HIV), the CDC was ready to abandon the drug hypothesis. But in view of the overwhelming correlations between drugs (particularly nitrites) and AIDS, functional evidence was necessary to discard the drug hypothesis in favor of viral AIDS.

To accomplish this transition the CDC commissioned a study of the immune effects of nitrite inhalants on mice and published the results in an anonymous one-page-paper in the CDC's house journal, the Morbidity Mortality Weekly Reports[314]. The study concluded that, "None of the animals exposed to IBN (isobutyl nitrite) showed any evidence of immunotoxic reactions. Methemaglobinemia [oxidation of hemoglobin] was noted in animals exposed to 300 ppm (parts per million) of IBN, and some evidence of thymic atrophy, possibly stress-related..." The study was apparently published in a hurry because "... detailed histologic examinations have not been completed." Yet the CDC concluded with the authority of its office that, "…these drugs are not responsible for the basic immune defects characteristic of AIDS."

The CDC's action was exceptional on several grounds:

1) Rather than following its usual practice of reporting AIDS information supplied by other researchers and institutes this time the CDC conducted its own experimental study on AIDS.
2) The CDC study referenced two Lancet papers as the initial evidence of a correlation between nitrites and AIDS. But until then the CDC had not refuted or attempted to refute publications from others.
3) The CDC's anonymous investigators exposed mice to a concentration of nitrites that is orders of magnitude below that inhaled recreationally[126]. According to a reporter who interviewd one of the investigators of the CDC study in 1994, "Lewis explained that, in determining the dose, they had to adjust it below the level where they were 'losing' the mice..."[95] – a fact that might have been useful to include in the text of a paper that concluded that, "drugs are not responsible for ... AIDS"[314].
4) Considering that T-cell deficiency is the hallmark of AIDS, it is hard to understand how the CDC could dismiss "thymic atrophy" in nitrite exposed mice as "stress related".

7.3. Misrepresentation of facts, example 2.

In an effort to dissociate the new American drug epidemic from the new AIDS epidemic the office of the director of AIDS research of the NIAID, Anthony Fauci, also published an anonymous paper, "The relationship between the Human immunodeficiency Virus and the Acquired Immunodeficiency Syndrome,"[13]. The paper claims that drugs cannot cause AIDS, because AIDS is new but drug use is old. The NIAID asserts that, "a temporal association between the onset of the extensive use of recreational drugs and the AIDS epidemic is also lacking. The wide-spread use of opiates in the United States has existed since the middle of the 19th century. ... the number of individuals aged 25 to 44 years reporting current use of marijuana, cocaine, inhalants, hallucinogens and cigarettes declined between 1974 and 1992, while the AIDS epidemic worsened."

However, the NIAID's information is hard to reconcile with information from the Bureau of Justice Statistics, the White House, the Department of HHS Drug Abuse Warning System, the NIDA and even private investigators (see Tables 2 and 3, Fig. 2). These and other sources document that:

1) The American drug epidemic of the "middle of the 19th century" had declined after World War I and completely ended during World War II[51].
2) The percentage of drug users at the peak of the early American drug epidemic was significantly smaller than the current one, namely 250,000 addicts out of 75 million Americans in 1900[51, 54] compared to 20 million addicts out of 250 million now[50, 51].
3) The amounts consumed in the early epidemic were much lower, about 11 tons of cocaine for 90 million Americans in 1906, compared to about 400 tons for 250 million now (see 3. and Fig. 2).
4) Before World War I, nearly a third of all Americans died from pneumonia, tuberculosis and other AIDS defining diseases, and the average age at death of Americans was about the same as that of AIDS patients now[1, 315]. Thus, drug-AIDS mortality would have been hidden in the normal background mortality from the dominant infectious diseases of that time.

It follows that either the NIAID, or many others including the Bureau of Jusice Statistics, the Department of HHS, the NIDA, the White House as well as non-governmental sources misrepresent the facts. Even the major source of drug use in the NIAID's anonymous report, David Courtwright's Dark Paradise: Opiate Addiction in America Before 1940, documents that the number of American opium addicts had dwindled to a few thousand, mostly doctors, by 1940, and that drug arrests had fallen below 3000 per year by that time[53].

7.4. Different standards of verification for HIV and drugs.

Since infectious HIV is virtually never detectable in AIDS patients, AIDS epidemiologists accept antibodies against the virus as evidence for the virus[25, 30, 46]. However, antibodies signal virus neutralization – the reason why infectious HIV is undetectable in most AIDS patients. Thus evidence for a prior defeat of the virus with antiviral immunity, is taken as evidence for a current or future viral disease. However, the principal of vaccination teaches just the opposite: antiviral immunity is the only current and future protection against viruses. The search for HIV is further biased in favor of being positive, because antibodies against many other microbes will register as anti-HIV antibodies due to the inherent false positive rate of all antibody tests[47, 316, 317]. Thus antibodies are grossly exaggerated standards for the presence of a virus.

To determine recreational drug use AIDS epidemiologists rely only on "self-reporting", instead of using standard drug tests[217, 263]. This epidemiological honor system is certain to minimize drug-AIDS connections because people tend to forget and to deny socially unacceptable behavior like drug use. Indeed, denial is one of the first indications of all addictions. According to drug treatment experts: "deception is the rule in the illicit drug market place..."[121]. Thus, unverified questionnaires are underestimates of drug use.

Moreover, comparisons between HIV and other possible causes of AIDS are 100% biased in favor of HIV because of the HIV-based AIDS definition (see 2). According to this definition HIV/AIDS researchers are entitled to exclude HIV-free AIDS cases from their AIDS statistics. Thus, citing 100% HIV-AIDS correlations as proof for the HIV hypothesis is not only misleading but is in fact deceptive[34]. It is, therefore, not surprising that even the most popular recreational drugs of a given risk group, like nitrite inhalants among male homosexuals[80, 103] (Table 4), lose out against HIV when studied by HIV/AIDS epidemiologists. An unbiased search for the cause or causes of AIDS would first define AIDS diseases clinically, and then report the coincidences with all the suspected causes.

Based on the presumptuous HIV-AIDS definition and the double standards of verification for drug use and HIV, two articles have recently refuted "Duesberg's drug-use hypothesis"[80] (see 7.5) One of these was even commissioned as a commentary by Nature[80], and was sponsored by the NIAID, the other was published in The Lancet[103]. For further emphasis the articles were accompanied by international press releases to enhace their impact on unsuspecting non-AIDS professionals and the general public[209, 318-320].

7.5. Omission of facts and controls.

The conclusion of the Nature commentary that all claims that drugs cause AIDS "have no basis in fact" was not only based on questionable standards of verification, but also on the omission of crucial facts and controls[80]. For example:

1) The authors proudly display, on a blue colored background, a graph of "drug-free", HIV-positive AIDS patients losing their T cells over time. The graph demonstrates that the authors are clearly aware that a drug-free control group of HIV-positive AIDS patients is necessary to refute the drug hypothesis of AIDS, while at the same time supporting the orthodox view that HIV causes AIDS. However, the drug-free group reported by the authors proved to be an empty set, as no drug-free AIDS patients were recorded in the Nature commentary[109, 321]. Our independent analysis of the data base also failed to identify the missing group of drug-free AIDS patients[110, 209]. Despite our challenge in The Lancet[211], Genetica[110], and Science[322], to this date the authors have failed to come up with an explanation as to the origin of their drug-free group[323].
2) The re-investigation of the database of the Nature commentary further revealed that 45 drug-using, HIV-free patients had been omitted from the paper, although they had AIDS defining diseases[110]. This brazen manipulation of the facts was legitimised with the CDC's HIV antibody-based AIDS definition[323] (see 2).
3) The Nature commentary also omitted the fact that 73% of the HIV-positive AIDS patients were on AZT. However, in response to our challenge the authors acknowledged the AZT prescriptions 2 years later[289].

Thus the drug hypothesis was refuted by claiming non-existing, drug-free AIDS patients, by hiding HIV-free AIDS patients, and by omitting widespread AZT use by AIDS patients.

Numerous other epidemiologists have also investigated "HIV disease progression"[100] to AIDS in drug users[86, 87, 90-92, 99, 102, 104, 267] without offering drug-free controls. Indeed, there is not a single epidemiological study in the bulging AIDS literature that ever described a group of HIV-positive people, without confounding health risks like drug use or hemophilia, progressing from HIV to AIDS[10, 213]. This absence of drug-free controls is the single most damaging flaw of AIDS epidemiology.

For example, Alcabes et al. conclude from a study of HIV-positive intravenous drug users from New York that, "The results of this analysis provide evidence for a mechanism by which the clinical factors that predict more rapid progression to AIDS, such as bacterial infection, might work, and why other factors, such as drug injection, are unrelated to AIDS risk"[86]. But no control is offered for drug-free AIDS.

Based on analyses of HIV-positive intravenous drug users, "with 45% injecting at least once per day," Margolick et al. conclude "that progression of HIV-1 infection in IV drug users, as reflected in the decline of CD4 cell counts, is no more rapid than that reported for other risk groups"[90]. In an effort to exclude the role of drugs in AIDS, the authors pointed out that in a particular six-month survey interval there was no "effect of active vs inactive drug use" on T-cell loss. However, there was no verification for "inactive" drug use, and no informatiom as to whether "inactive" street drug use was substituted by methadone, which is itself immune suppressive[324]. Moreover there was no effort to determine the cumulative lifetime drug dose of active or "inactive" drug users that is essential to evaluate drug pathogenicity. There was also no information as to whether "other risk groups" included drug-free controls.

Moreover, a "Tricontinental" study from San Francisco, Vancouver, Amsterdam and Sydney that was sponsored by the American NIAID claimed that cohorts of HIV-positive male homosexuals using batteries of recreational drugs including, "alcohol, tobacco, cannabis, nitrites, cocaine and amphetamines" in addition to AZT developed AIDS from HIV infection alone without offering a population of drug-free HIV-patients as a control. The study concluded that, "None of the presented hazards is significant." Although the study reported that, "there were no appreciable differences in the use of alcohol, tobacco or nitrites," it insisted that, "Notably, nitrite use was not associated with disease progression, and the use of tobacco appears not to be related to progression to AIDS or P. carinii pneumonia (data for the latter not shown)"[100]. A remarkable "Tricontinental" conclusion!

Likewise, the NIAID-sponsored MAC study of male homosexuals published that there is "No evidence for a role of alcohol or other psychoactive drugs in accelerating immunodeficiency in HIV-1 positive individuals"[101] although it had never identified even one drug-free, HIV-positive homosexual with AIDS in 10 years[82]. Indeed, a recent report from the MAC study, published in the Journal of Substance Abuse seems to contradict their earlier message: "Men who combined volatile nitrite (popper) use with other recreational drugs were at highest risk both behaviorally and in terms of human immunodeficiency virus-1 (HIV) seroconversion throughout the study." All of the 500-800 homosexual men at "highest risk" studied had used nitrites, in addition to various combinations of 12 other recreational drugs[102].

Because of their complete disregard for the medical consequences of drug use, most AIDS epidemiologists do not even look for a drug-free AIDS case although many acknowledge bewildering drug use (see Tables 4 and 6). An event at a conference on the role of nitrites in Kaposi's sarcoma in 1994 illustrates this bias perfectly. Asked whether there was even one AIDS patient who never used drugs, an investigator of the largest group of male homosexuals ever studied for "HIV disease progression," the MACS cohort, responded, "I never looked at the data in this way"[82, 95]. But the MAC study, which is supported by the NIAID with several million dollars annually, has repeatedly recorded heavy drug use for over 10 years (Table 4)[101, 102, 267].

However, until drug-free controls are available, conclusions that HIV rather than drugs cause AIDS are un-informed speculations. In fact the sheer multiplicity of epidemiological studies describing "HIV-disease progression" only in drug users from San Francisco[80, 100], Vancouver[100, 325], Chicago – Los Angeles – Baltimore – Pittsburgh[101, 102], Sydney[100], Milan[92], Amsterdam[100], London[104] can hardly be an accident. It suggests that drugs are causing AIDS.

To avoid the pitfalls of confounding variables of HIV, matched groups must be compared that differ only in one variable[326]. Thus an appropriate statistical analysis of the role of drugs in AIDS would compare two groups of HIV-positives (or two groups of HIV-negatives) matched for all variables but drug use. Based on Feynman's standards of science, there are three contending explanations why so many AIDS-epidemiologists have omitted drug-free controls: (a) either they are ignorant of drug toxicity, or (b) they are ignorant of confounding variables in epidemiological studies, or (c) there are no drug-free AIDS cases, because drugs cause AIDS.

7.6. Confounding "confounding viariables".

The Nature commentary also demonstrates the "proper methods" used by HIV researchers to eliminate "confounding variables" such as drug use from the non-confounding variable HIV[80].

In view of the "fact" that homosexual men who were "heavy" nitrite users had twice as much Kaposi's sarcoma as those who were "light" users, the authors argued as follows: "This crude association is apparently the basis for Duesberg's hypothesis. Further analysis of the data reveals a similar association between drug use and HIV positivity, and when controlled for HIV serostatus, there is no overall effect of drug use on AIDS. A similar effect, a marginal association that drops after control-

ling for HIV serostatus, is seen in cases which end in Kaposi's sarcoma. Thus when proper methods are used to assess the role of confounding variables, there is no evidence of a drug effect"[80]. With this reasoning the article proudly rejected the drug hypothesis with, "such claims have no basis in fact." The anti-drug bias of Nature is so pervasive that the editor openly censored[327] all critics pointing out confounding by drug use[109, 110, 210, 328]. However, The Lancet allowed two critical letters[46, 211].

Called to task on the possibility of confounding two years later in Science, the authors simply restated their conclusion without lifting the secret of their "proper methods": "The standard statistical methods that we used to differentiate cause from confounding factors showed, in this case, that HIV was the cause and that drug-use association was spurious"[323].

In short, Nature has refuted the drug hypothesis by first commissioning a commentary that relied on AIDS patients who had all (!) used a multiplicity of recreational drugs in addition to AZT, and then by openly censoring all objections to its methodological flaws and unscientific manipulations – a bewildering achievement coming from the world's oldest science journal.

7.7. Grouping drug-using with non-drug using HIV-positives.

This manipulation credits the diseases of drug users to non-drug users within the same study group of HIV-positive people. For example, HIV-positive babies who either shared recreational drugs with their mothers or received AZT from their doctors are grouped with babies who neither received drugs from their mothers nor AZT, and the diseases of the HIV-positive "group" as a whole are then compared to those of HIV-free babies[194, 300, 307] (see 6.9). But mothers of HIV-free babies typically have not used cocaine, nor are HIV-free babies ever treated with AZT[25].

Likewise, the mortality of groups of HIV-positive hemophiliacs who on average have received many more immunosuppressive transfusions than HIV-negatives and of which most are now treated with AZT and other toxic antiviral drugs, is compared to that of untreated, HIV-free hemophiliacs (see 7.8)[21-23, 37, 173]. Naturally, all excess mortality from immunosuppressive transfusions, AZT and other anti-HIV/AIDS drugs is credited to HIV. This practice obscures the role of drugs and other non-contagious risk factors in AIDS in favor of HIV.

7.8. Hiding evidence that AZT accelerates death, eleven examples.

In an effort to hide the emerging tragedy, the medical establishment either trivializes or disclaims the evidence that AZT causes diseases and accelerates death. An analysis of several of the above cited examples of AZT-accelerated morbidity and mortality (see 4) documents this assertion:

1) The observation that among male homosexuals, "HIV dementia among those reporting any antiretroviral use (AZT, ddI, ddC, or d4T) was 97% higher than among those not using this antiretroviral therapy" is interpreted by its authors with little concern for percentages: "This effect was not statistically significant"[112].

2) The stunning results that HIV-positive hemophiliacs on AZT have 4.5-times more AIDS and have a 2.4-times higher mortality than untreated HIV-positive hemophiliacs, is excused by the NIH researcher James Goedert, the former proponent of the nitrite-AIDS hypothesis (see 3), with the casual explanation, "probably because zidovudine was administered first to those whom clinicians considered to be at highest risk"[193]. But, although AZT apparently increased the morbidity and mortality of hemophiliacs significantly, Goedert et al. did not question the appropriateness of AZT therapy.

3) Darby et al. report in Nature in 1995 that the mortality of HIV-positive British hemophiliacs increased 10-fold since the introduction of AZT in 1987[173]. The authors acknowledge that "treatment, by prophylaxis against Pneumocystis carinii pneumonia or with zidovudine [AZT] has been widespread" in HIV-positive hemophiliacs. But instead of even considering that these drugs could have play a role in accelerating the deaths of hemophiliacs, they argued that "HIV-associated mortality has not been halted by these treatments"[173]. They failed to explain why HIV-associated mortality would have risen 10-fold only after the introduction of AZT and other anti-AIDS therapies in 1987, rather than in the two decades before 1985 during which HIV was unknowingly transfused into hemophiliacs together with clotting factor[23].

4) Saah et al. explain their observation that male homosexuals on AZT have a two- to four-fold higher risk of Pneumocystis pneumonia than untreated controls as follows: "Zidovudine was no longer significant after T-helper lymphocyte count was considered, primarily because nonusers had higher cell counts..."[190]. The fact that an inhibitor of DNA synthesis designed to kill human cells would reduce lymphocyte counts was not mentioned.

5) An evaluation of AIDS prophylaxis with AZT produced in 1994 the following results: "the average time with neither a progression of disease nor adverse event was 15.7, 15.6, and 14.8 months for patients receiving placebo, 500 mg zidovudine, and 1500 mg zidovudine, respectively. …After 18 months, the 500-mg group gained an average of 0.5 month without disease progression, as compared with the placebo group, but had severe adverse events 0.6 month sooner." On this basis the authors concluded that, "…a reduction in the quality of life due to severe side effects of therapy approximately equals the increase in the quality of life associated with a delay in the progression of HIV disease"[191]. It remains unclear, however, how one gains 0.5 months "without disease progression" while one has "severe adverse effects" 0.6 months sooner.

In view of this one wonders why since 1994 at least 220,000 mostly healthy, HIV-positive people continue to receive AZT, either by itself or combined with other drugs like protease inhibitors, all of which have no therapeutic value and cost the patient or tax payer over $12,000 per year[25].

6) The blunt result that AZT prophylaxis reduced survival from 3 to 2 years, and caused "wasting syndrome, cryptosporidiosis, and cytomegalovirus infection ... almost exclusively" in AZT-treated AIDS patients, was interpreted like this: "The study of patients who progress from primary HIV infection to AIDS without receiving medical intervention gives insights into the effects of medical intervention on presentation and survival after developing an AIDS defining illness". But the nature of these "insights" was not revealed by the authors[192].

7) The largest test of AIDS prophylaxis with AZT of its kind, the Concorde trial, found no prophylactic value, but instead revealed a 25% higher mortality in AZT recipients than in untreated controls[329]. In view of these awkward results Seligmann et al. reached the patronizing conclusion: "The results of Concorde do not encourage the early use of zidovudine [AZT] in symptom-free HIV-infected adults"[155].

8) A study that treated HIV-positive, intravenous drug users from New York with AZT observed: "The rate of CD4 lymphocyte depletion did not appear to slow after the initiation of zidovudine therapy…". This led to the conclusion: "Our data failed to provide evidence for an effect of zidovudine on the depletion of CD4+ lymphocytes, but the direction of the modeling results suggested that zidovudine users in this sample may have experienced more rapid CD4+ cell depletion"[86].

9) As of 1994 the American NIAID and the CDC promoted the prevention of maternal HIV transmission with AZT[44, 174, 175, 330]. But the costs of the hypothetical triumph of reduced HIV transmission in terms of birth defects and abortions were omitted from the reports of the original trial[174, 175, 330-333]. However a study from outside the US reported 8 spontaneous abortions, 8 therapeutic abortions and 8 serious birth defects, including holes in the chest, abnormal indentations at the base of the spine, misplaced ears, triangular faces, heart defects, extra digits and albinism among the babies born to 104 AZT-treated women. But these bewildering results were interpreted as just "not proving safety, thus lending tenuous support to the use of this drug"[189].

Indeed, "spontaneous" or therapeutic abortion as a result of AZT was not an unforseeable accident. A review in The Lancet on "non-surgical abortion" documents that chemotherapeutic drugs, like methotrexate, have been used to abort normal and ectopic pregnancies since 1952[178]. The article concedes early "concerns over teratogenicity", but concludes: "used correctly, the method could bring great benefits"[178].

10) In 1996, the American National Institute of Child Health and Human Development reported the consequences of AIDS prophylaxis with AZT for HIV-positive babies: "In contrast with anecdotal clinical observations and other studies indicating that zidovudine favorably influences weight-growth rates, our analysis suggests the opposite. Because our analysis of zidovudine effect on standardized growth outcomes was based on limited numbers of patients (no more than 10 at any one visit with prior zidovudine use) and because we could not control for stage of HIV disease in the study design, the result indicating no effect or a negative effect of zidovudine on growth should be interpreted with caution. Presumably, zidovudine use is confounded by progression of HIV disease. The observation that standardized LAZs [length for age scores] were lower after the start of zidovudine therapy than before may suggest merely that sicker infants received zidovudine. However, our findings suggest that the widely held view that antiretroviral treatment improves growth in children with HIV disease needs further study"[194]. Thus AZT toxicity was shifted to HIV.

But if the lower health standards of AZT-treated babies were due to prior "HIV disease", it would have been necessary to conclude that AZT failed to reverse or even maintain the "HIV disease" of these babies. But that possibility was not mentioned nor apparently even considered by the AZT-doctors. Moreover, the likelihood that AZT was the cause of the babies' diseases was obscured by averaging the diseases of AZT-treated with those of untreated HIV-positive babies (see 7.7).

11) The disquieting observation that AZT increases the annual lymphoma risk of HIV-positives 50-fold, from 0.3 to 14.5%, per year was resolved by the NCI director, Samuel Broder and his collaborators, by claiming a victory for AZT: "Therefore, patients with profound immunodeficiency are living longer [on AZT], theoretically allowing more time for the development of non-Hodgkin lymphoma or other malignancies"[187].

7.9. Conclusions.

HIV/AIDS scientists fall far short of Feynman's standard, "to try to give all the information to help others to judge the value of your contribution...It's not dishonest; but the thing I'm talking about is not just a matter of not being dishonest, it's a matter of scientific integrity, which is another level." HIV/AIDS scientists ought to inform others that the overwhelming correlation between drugs and AIDS can not be just a coincidence, and that the literature already documents that the drugs used by AIDS patients can cause each of the 30 AIDS-defining diseases and deaths.

8. A POSSIBLE SOLUTION AT LAST

It is concluded that the HIV hypothesis has been unproductive and non-predictive because AIDS is neither an infectious epidemic nor caused by HIV. Thus, far from solving AIDS, the HIV hypothesis has actually escalated the epidemic by monopolizing AIDS reasearch and therapy, and by delivering harmful medications. As the theoretical basis of all anti-AIDS treatments the HIV hypothesis is solely responsible for over 1 million year-long prescriptions of AZT and all other toxic antiviral drugs that have never cured an AIDS patient. On the contrary, AZT and other anti-HIV/AIDS drugs have been shown to accelerate death.

The HIV hypothesis is also responsible for the promotion of recreational drug use. By ignoring, obscuring and even directly refuting in the professional literature, the possibility that nitrites, cocaine and heroin could cause diseases, the medical orthodoxy misinforms a vulnerable and trusting public about the medical consequences of recreational drug use[15, 80, 325]. The long arm of the international AIDS establishment even reaches out specifically to the public with targeted press releases to convince everybody that drugs are harmless as long as they are taken with clean needles and condoms to protect against HIV infection[319, 320, 334]. This misinformation campaign and the campaign that clean needles for unsterile street drugs (!) and condoms protect against all medical consequences of drug use encourage rather than discourage recreational drug use by the unsuspecting public[7, 10, 96].

By contrast, our independent analysis of the AIDS epidemic reveals that AIDS is simply the clinical consequence of the American/European drug epidemic. The drug hypothesis resolves all long-standing paradoxes and contradictions of the HIV-hypothesis and predicts AIDS exactly, the hallmark of a good hypothesis. Therefore, it should have a very high priority in AIDS research. Drug toxicity could be tested experimentally in animals, and in human cells in tissue culture. In addition, drug toxicity could be tested epidemiologically in humans who are addicted to recreational drugs or are prescribed AZT. Such tests could be conducted at a microscopic fraction of the cost that is now invested in the HIV hypothesis.

According to the drug hypothesis AIDS would be entirely preventable and at least partially curable, if:

1) AZT and all other anti-HIV drugs were banned,

2) illicit recreational drug use was terminated,

3) AIDS patients were treated for their specific diseases with proved medications, e.g. tuberculosis with antibiotics, Kaposi's sarcoma with conventional cancer therapy, and weight loss with good nutrition.

In addition to saving about 50,000 to 75,000 lives per year from AIDS, the drug hypothesis could save the American tax payer up to $23 billion annually. Eight of the $23 billion are spent on AIDS treatment, research and education based on the unproductive HIV hypotheasis[335, 336], and $15 billion are spent on the War on Drugs[50, 52, 61, 335, 336]. The War on Drugs is "primarily focused on supply control efforts"[50,52], but has failed completely to stop the American drug epidemic.

But if the wars on AIDS and drugs were based on the health consequences of long-term drug use, they could be just as successful as the federal anti-smoking program. Based on education that smoking causes lung cancer, emphysema and heart disease, smoking has dropped in the US from 42% of the adult population in 1965 to 25% in 1995[235]. And only 15.5% of Californians smoked regularly in 1995, down from 26% in 1984. In view of this the CDC's director of the Office of Smoking and Health proudly announced, "Not only are these states [California and others] doing something right, but other states are looking at them and seeing that this works"[337]. Thus by adopting the drug-AIDS hypothesis the CDC could also win the war on AIDS.

However, there are an number of monumental obstacles, 15 years in the making, that block the possible solution of AIDS based on the drug hypothesis:

1) The HIV/AIDS orthodoxy's annual budget of $8 billion from the US taxpayer alone,

2) The thousands of AIDS organizations, including countless public health and activist careers and the tens of thousands of scientific reputations that are exclusively built on HIV[7, 10],

3) The numerous medical and social benefits available to HIV-positive activists and patients[338],

4) The staggering commercial interests in HIV-tests, over 20 million tests per year at $ 50 or more in the US alone, HIV-vaccines and anti-HIV drugs,

5) The prospects of numerous complaints and malpratice suits against the HIV/AIDS orthodoxy from those who were told they are destined to die based on HIV tests or were helped to die with AZT,

6) The prospect of a profound loss of confidence of the American public in its medical and scientific elite[7, 10].

Thus the current HIV/AIDS orthodoxy cannot afford the drug hypothesis, and must do everything in its power to keep it from being presented to the American people.

Likewise, the $15 billion federal establishment that conducts the War on Drugs would risk its large budget and thousands of career positions if the War on Drugs were won in the name of the hypothesis that drugs cause AIDS.

In sum, the drug hypothesis is testable and predicts that AIDS is entirely preventable and treatable by controling drug use. The solution of AIDS and significant progress in the War on Drugs are as close as a very testable and affordable non-HIV/AIDS hypothesis.

Acknowledgements.

We thank Fred Cline, Harry Haverkos, Phil Johnson, Serge Lang, Russell Schoch and Richard Strohman for information and advice, and Siggi Duesberg for review and preparation of the manuscript. This investigation was supported in part by the Council for Tobacco Research, USA, and private donations from Robert Leppo, San Francisco, Tom Boulger, Los Angeles, Carol J. Wilhelmy, San Mateo, the participants of the Anthony Robbins Life Mastery University 1995 and 1996, Robbins Research International, San Diego, and a foundation that prefers to remain anonymous.

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Publication of this paper was made possible by the generous financial support of Eleni Papadopulos-Eleopulos, Valendar Turner and John Papadimitriou.

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The AIDS Cult

Essays on the Gay Health Crisis

John Lauritsen & Ian Young, Editors

Published by Asklepios (Pagan Press)
ISBN O-943742-10-2 paperback. US$15

Alex Russell

The AIDS Cult offers essays that examine the psycho-social origins of the 'HIV/AIDS' belief system. The opening essay, 'The fantasy group origins of AIDS' by the late Caspar Schmidt, a psychoanalyst with a practice in New York, written in 1984, was astonishingly prophetic of our current rethinking of the 'AIDS' construct.

Ian Young, in the preface, states that 'HIV believers' and 'AIDS critics' have ignored the psycho-social factors that have arguably contributed to the unnecessary deaths of thousands. Schmidt nominates 'AIDS' as a "bio-psycho-social disorder" and contends that 'AIDS' is psychologically contagious, being 'spread' through mass-hypnosis rather than microbes. He proposes that chronic and inescapable fear can elicit a biochemical reaction in the body, which in time causes "psychogenically-reduced cell-mediated immunity." For Schmidt, 'AIDS' can be explained through the concept of group fantasy – people are collectively in a trance: "I would like to present the evidence available to me in support of the hypothesis: a) that AIDS is a typical example of epidemic hysteria, b) that the epidemic has at its core an unconscious group delusion, which can be called the group-fantasy of scapegoating, c) that the combination of these unconscious group tensions brought about a subtle and sophisticated, but nevertheless sacrificial witch hunt, in which the participants were the Moral Majority, d) that these attacks resulted in an epidemic of depression based mostly on shame; e) that the core sign of AIDS, the reduction of cell-mediated response, is one of the typical vegetative signs of severe depression; f) that the epidemic represents, in the group's unconscious fantasies, an equivalent war, during which the group keeps careful count of the sacrifices; g) and finally that, since the epidemic is psychogenic, the prediction can be made that the group will decide when it should be over (when they have 'had enough'), a decision which will be broadcast to the group members through the media, so that after a suitable lag period the epidemic will resolve and the incidence will descend from epidemic to endemic levels."

The epidemic of group hysteria is specific to certain groups, therefore 'AIDS' cannot be an epidemic of pathogenic origin. Schmidt lists numerous examples of workplace group hysteria where the 'sufferers' imagine that they have been poisoned: "This shared fantasy of a poison threat is found in all cases of epidemic hysteria...these fantasies are culture-specific in contents, based on the theory of disease for each culture... From mediaeval Spain through to Nazi Germany, Jews were believed to poison wells, or were blood poisoners of the group. In southern Italy people were bitten by tarantulas, thus poisoning their blood for life..." The 'poison threat' is registered psychically as an external assault analogous to outside 'invasion' of the imaginary 'HIV'. An 'HIV positive' test result or an 'AIDS' diagnosis may trigger psychosomatic symptoms which are then misinterpreted as 'HIV'-driven dementia.

Co-editor Lauritsen expands the argument that psychosis and psychosomatic conditions are induced by the psychological terrorism of 'HIV/AIDS' propagandists: "Highly sophisticated psychological techniques are being used to make gay men perceive themselves as sick, and become sick, in order to qualify as consumers of AZT. The 'Living With HIV' campaign is, quite literally, a form of voodoo" – or government approved euthanasia. Schmidt observed that his 'AIDS' patients suffered syndromes of long-standing stress connected with guilt feelings about their sexuality and suffered from intense, socially induced shame resulting in histories of psychosomatic complaints and a 'suicide syndrome'. Psychosomatic symptoms are solutions for anxieties of psychotic intensity which is why so many gay men needed the demon icon 'HIV'. Thus the group fantasy of 'HIV/AIDS' unified a fragmented gay community with the solidarity of pseudo-disease-identity: 'I'm HIV'.

'HIV/AIDS' diagnosis initiates psychosomatic conditions as well as psychotic fantasies; belief in an early death will result in an early death. Michael Ellner and Andrew Cort's chapter, 'Programmed To Die: Cultural Hypnosis & AIDS' focuses on the psychic powers of bone-pointing (voodoo death) as a contributory factor in causing the premature deaths of the 'true HIV/AIDS believers'. It is intrinsic that one 'believes' in 'HIV/AIDS' for the hex to work; as the authors state: "The hex is harmless to a non-believer, but to a believer it is deadly. After having a bone pointed at them, healthy people go home and obediently die". Voodoo death, or bone-pointing are cultural practices originating in Haiti, Africa and Australia and are now practised at the Terrence Higgins Trust and Project Inform; instead of the bone, they point a Living Will form at you.

George N. Hazlehurst's chapter, 'AIDS as Information Disease', examines how the 'AIDS' establishment – through ignorant doctors, counsellors and journalists – has programmed thousands to die a premature death via its dis-information and propaganda. Hazlehurst states: "These people need to be deprogrammed if they are to recover...the probability that such a plan could succeed is far from certain, especially in the presence of continuing negative propaganda by the establishment and the continuing attraction of the cult-like mass of HIV+ true believers in a certain death". The acronym 'HIV' has penetrated the unconscious of millions to such a profound extent that the announcement that 'HIV' never existed will inevitably cause massive trauma in the 'loss' of such an identity-totem.

Freud's thesis on the Death Instinct as auto-destructiveness fits the psychological profile of many 'HIV' believers. We need to reprogramme 'AIDS' counsellors away from their Kubler-Ross style bone pointing strategies. Cass Mann, in 'Deadly Counsels', chillingly asks: "How many of the deaths, especially suicides, of people with 'AIDS' have been caused by the deadly psycho-pathology underlying most 'AIDS' counselling?"

THE AIDS CULT

and its seroconverts

part 2

Ian Young

This is part 2 of an essay of which the first part was featured in the last issue of Continuum. *An expanded version of the whole article appears in* The AIDS Cult: Essays on the Gay Health Crisis, *edited by* ***John Lauritsen*** *and* ***Ian Young*** *(Asklepios, Box 1902, Provincetown, MA 02657-0245, USA.)* ***See Review*** *in this issue.*

"Purposely, the twenty-something boys, who have never known a sex life without AIDS, fatalistically expose themselves to HIV as a test of ritual manhood"
—Jack Fritscher, Mapplethorpe: Assault with a Deadly Camera, 1994

"Deliver me from blood gatherers, O God, Thou art the God of my health."
—Book of Common Prayer

Eric Rofes of the National Gay and Lesbian Task Force, who provides an introduction to HIV Negative, describes himself and other antibody-negative gay men, the "population of supposed survivors," as people "left to walk the earth like robots or zombies, telling ourselves and others that everything's fine while we are actually numb, cut off from our emotions." This contrasts vividly with the dark, vampiric glamour of AIDS. Walt Odets refers to "the appeal of illness." All these attitudes fuel the desire to seroconvert.

Another common observation made of HIV testing is that testees often doubt or question their Negative results, but seldom their Positive ones. The psychologist Rachel Schochet found that the more bereavements men had experienced, the more they tended to doubt their own Negative status – and the more they engaged in unprotected sex.

This doubting of Negative results is built into the administration of the testing system itself. Positive results, we are told (falsely), are never wrong, but Negative results may be "premature" or "false Negatives", or unreflective of the alleged virus' supposed "window of opportunity". And so when we test Negative, we are encouraged to restrain any relief we might feel, and to return regularly to the Test Site. If we did not keep coming back like a yoyo, presumably we would snap our strings and go careening off, cavalierly spreading HIV around, to ourselves or to others, typhoid Mary off on a bender. In fact, the AIDS System, by failing to support thoughtful self-knowledge, and by subliminally suggesting that a Positive outcome is inevitable and desirable, encourages the behaviour it claims to prevent. The constant state of anxiety it instills damages both the mental faculties and the immune system.

The HIV antibody test (usually called "the HIV test" or "the AIDS test") is surrounded by an enormous amount of stress, with unfortunate immunological consequences. "Paul Fielding", a pseudonymous gay man quoted by Johnston, makes the point that "you weren't supposed to have stress, because stress could destroy your T-cells...So you had to try to smile living in a pressure cooker."

Warnings about "risk groups" and "risk behaviours" strike a profoundly ambiguous note in a society where risk is associated with entrepreneurial behaviour, glamorous chance-taking and competition, and is highly valued. Risking danger has always provided a test of manhood for rebellious youth: practising "unsafe sex" is a challenge, a way of accepting a dare, a contemporary version of the "chicken run" depicted in Rebel Without a Cause.

The French writer Hervé Guibert, wrote of his lover Muzil, who routinely visited the baths for sex, in spite of his poor health. Muzil remarked that "the baths have never been more popular, and now they're fantastic. The danger lurking everywhere has created new complicities, new tenderness, new solidarities. Before, no one ever said a word; now we talk to one another. We all know exactly why we're there."

The much vaunted safe sex and AIDS education programs have been a spectacular failure

The "danger lurking" is of course the demonized "AIDS virus" whose alleged propensity for "lurking", "hiding", and other "clever" behavior is said to explain the many cases of HIV Negative AIDS. And the men are there to live dangerously.

Pervasive pressure to seroconvert has produced the phenomenon of the compulsive repeat tester, the uninfected individual who is caught on a "testing treadmill", making frequent visits to a Test Site, or to several Test Sites ("Is it a good lab?") and always doubting Negative results. Johnston discusses an attempt in

Boston to start a discussion group for such compulsive retesters. "The group didn't work, because they all wanted individual attention...They didn't want their story to compete with anybody else's, because their story was the most important." A compulsive need for attention is easily met by the ministrations of the AIDS industry, which is set up to provide all the attention needed, once seroconversion is achieved. The compulsive retester is a seroconvert in the making.

The much vaunted Safe Sex and AIDS Education programs of the Eighties and Nineties have been a spectacular failure. They are as counterproductive as the campaign against unmarried teenage pregnancies in the Black community – and for the same reason: the underlying causes of the phenomena remain unaddressed.

In my own city, Toronto, promiscuous unsafe sex is a popular feature of the bathhouses which have been springing up again over the past few years. Some of them are now licenced to sell beer, which they supplement, unofficially, with poppers and crack cocaine (smoke it in your room) as additional perques. Here too, the rate of seroconversion among young men – and subsequent entry into the ramshackle labyrinth of the AIDS System – is climbing. And Xtra's obituary column isn't getting any smaller.

It is becoming apparent that the actual consequences of the AIDS System are at variance with its stated aims. There are unconscious factors at play here – unidentified, even unacknowledged. "Something is happening to us which no-one wants to face."

Odets describes the AIDS System's current approach to prevention as based on a "public health/social marketing model" composed of relentless propaganda ("Information and Education") and the utilization of what he delicately describes as "selected community leaders" to mould group behavior. Complex psychosocial issues are avoided; feelings about sex and death, personal worth, goals, intimacy and human needs remain for the most part unexplored outside a relatively few independent therapy groups. Its simplistic strategy is based on the assumptions that sex for gay men is merely a mechanical procedure without human meaning, and that immune suppression can be contracted only through intimate contact with the blood or semen of an "infected" partner. (Public concerns about saliva, tears and sweat are occasionally expressed, but so far have been fairly successfully dismissed.)

The nature of the relationship of "HIV" to AIDS has been a subject of fierce dispute, though the debate has been rather one-sided: the skeptics (who include a scattering of scientists and three Nobel prizewinners) present detailed critiques, which the HIV fundamentalists either ignore or respond to with abuse. If, as seems increasingly likely, "HIV" turns out not to be the sole cause of AIDS, every AIDS Education program on the continent will have to be rethought from the ground up and some people might even be cleaning out their desks. Naturally, critiques of HIV dogma are vehemently resisted by the growing army of HIV support staff.

The question of how Positive results are achieved seems equally problematic. HIV Positive test results have frequently registered in individuals who have been exposed to certain pathogens such as malaria, or who have suffered a recent bout of influenza. The current tests, it seems, are not as specific as they might be. A ground-breaking paper from Australia, published in Bio/technology in June of 1993 demonstrated that the favored "AIDS tests" fail three basic criteria: they are not specific, there is no standard interpretation, and their results are not reproducible.

In addition, several series of research experiments have shown that under certain conditions, lab animals may develop antibodies to "parts of HIV" without ever having been in contact with the virus. When some animals in a group were exposed to proteins and developed antibodies, other, unexposed, animals in the same "cohort" also began to test Positive. Could gay men, too, be developing antibody Positive status in resonance with already "infected" members of their Cohort? If so, it might help to explain the increasing number of "anomalous seroconversions" now being reported.

The issue of drugs (both legal and illegal) provides another example of poorly examined assumptions generating a dangerously simplistic approach. Official AIDS education literature almost always warns that recreational drugs may "impair judgment" and so "lead to unsafe sex", but the health risks and immunosuppressive qualities of many drugs are seldom mentioned. In the absence of community-based programs to counter heroin use, we are simply urged to bleach, and never share, the hygienically wrapped needles generously distributed by AIDS organizations. Many physicians regard drugs and alcohol as "coping mechanisms" and sanction their abuse by troubled gay patients. Kicking a drinking or drug habit, like giving up promiscuous sex, is regarded as a near impossibility for gay men, and substance abuse programs (particularly if peer-run) are often regarded as threatening to the doctor-patient relationship.

The version of public health marketing that dominates AIDS Education is patterned on the treatment of addictive/compulsive disorders. This is hardly surprising as the medical establishment has traditionally assumed that gay men necessarily regard sex as a mechanical process without deeper meaning. Educational proposals that attempt to address spiritual matters are dismissed as unrealistic. Inquiry into the reasons for addictive/compulsive behavior would entail an examination of socioeconomic pressures, motivations and group beliefs – and is usually ruled out as too difficult, too dangerous or too expensive.

We encourage what we assume. The current AIDS System fosters the addictive/compulsive psychology that social beliefs ascribe to gay men, and group behavior is then played out according to social expectations, alternating between two phases representing control and release.

The compulsive, Control phase involves strict abstinence or avoidance – in this case, rigid adherence to the proclaimed principles of Safe Sex, which are presented as unclear, yet essential – even when there is no apparent reason for them, as with sex between Negative partners. This attitude generates tension, confusion, demoralization and suspicion.

In the second, addictive, Release phase, the restrictive psychic controls become too stressful and collapse into a "slip" or "binge", involving deliberate self-exposure to "HIV" and other pathogens, often under the influence of immunosuppressive substances and mental states. Attempts are made to prevent, minimize, postpone or substitute for the Release phase. But such simplistic attempts at enforcing control (whether by propaganda or legal injunctions) rarely work, and when they fail, guilt feelings are reinforced. The notorious failure of most "diet" plans provides a typical example.

One of Odets' most astute insights is that social organizations often act as containers for forbidden feelings. Shared, organizationally approved feelings are

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substituted for genuine ones; emotional impoverishment is masked, and anger repressed. Rather than encouraging thoughtfulness and understanding on the part of gay men, current AIDS Education programs have insisted on politically correct scripts, placing us in the familiar role of dependent children.

Odets sees HIV-diagnosed gay men as allowing themselves to be cast in the role of the "needy" child in a family, with antibody Negative men assuming the role of the resentful, "needless" child, desperate for his share of attention from parental figures. If the sick sibling is perceived as getting all the attention, one solution is to become sick oneself. The metaphor of gay men as children or perpetual juveniles is not new; of late, even gay protesters have adopted it: "acting up" is, after all, what children do to get attention.

And there is something else going on here. The growing ranks of seroconverts are approaching the seroconversion process as an opportunity for something that young men, and especially young gay men, in our society, desperately need – an initiatory rite of passage.

Our society's ideology is a consumerist one, and its rituals tend to be the vapid pseudo-activities of consumerism – shopping, smoking, television watching, package holidays. But rites of passage (coming of age, for example) demand a special kind of ritual to mark the transition from one psychological and social state to another. Apart from the melancholy duties of draft and voter registration, the only such rituals now generally available to young men involve the acquisition of a driver's licence and a first car (either purchased or stolen).

Rites of passage signal the ritual death of the old self and a symbolic rebirth into a new identity, accepted and honored by the community. For young gay men, "coming out" once served this function, but as secrecy about being gay has lessened and sexual categories are blurring, coming out has become less meaningful to young gays, and unsettlingly inconclusive. For the most part, significant gay rites of passage have simply been unavailable. Instead, we are offered rituals of addiction and compulsion, which we adopt as our own. Seroconversion fills the need for a gay rite of passage.

Journalist and AIDS dissident Celia Farber has aptly called HIV "a demon, which we worship with our terror" and attempt to placate with buildings, organizations, conferences, and global programs. No such cult can continue for over a decade without developing its own forms of ritual obeisance, and the AIDS system has proved to be no exception.

The HIV testing ceremony is highly ritualized, demanding a visit to a special, rather fearsome place – a sacred place, the Test Site – with priests and acolytes in attendance: the various physicians, psychiatrists, social workers, peer counsellors and AIDS workers hovering or bustling about, many wearing their white robes of office.

The ceremony involves a literal blood sacrifice, drawn with a hypodermic needle by a nurse or paramedic. Some initiates faint. It is accompanied by highly structured readings from sacred texts – AIDS Education and Safe Sex scripts. It incorporates a Time of Trial – the stressful period of several days or weeks involved in waiting for one's results. During this time, one's thoughts are concentrated almost continuously on "HIV" as the shared object of fear and devotion. And – if the test is passed, if the results are Positive – one is embraced into the community with new status, HIV Positive status, and increased attention. One enters the AIDS System, "the HIV/AIDS Community".

The very way we look at the phenomenon of AIDS has its psychological consequences. Belief in HIV as the cause of AIDS has led not only to a vast, self-perpetuating AIDS industry, but to the establishment of a medico-religious cult.

A recent issue of a Canadian gay magazine contained a news item about a Toronto gay man, Sean Martin, who had been diagnosed as HIV Positive. A year later, a second test reversed the verdict, and Martin is quoted as saying that though the HIV Positive friends he had made were "very nice to me about it", telling them he was Negative was one of the toughest things he'd ever done. He couldn't help feeling that he was "abandoning" them, he said, and his new status made him feel he was "breaking the faith."

In his classic study of modern initiatory behaviors, the psychologist Luigi Zoja writes that "the archetypal need to transcend one's present state at any cost...is especially strong in those who find themselves in a state of meaninglessness, lacking both a sense of identity and a precise social role." This description appears to fit many of the men interviewed in Odets' and Johnson's books; it is particularly applicable to seroconverts.

The gay health crisis has reached a stage in which seroconversion has become institutionalized as the most important rite of passage in the life of a gay man. Significantly, its place in consumer society is a paradoxical one. The seroconvert who adopts the Positive Lifestyle is, like the drug addict, someone who participates in social ritual, but denies the dominant social imperative – to be a "responsible" economic being. His Positive status gives him the permission and the means to solve one of the perennial problems of youth – how to conform and rebel at the same time.

In his consideration of drugs and ritual, Zoja points out that in our society, the addict "is not absent from the economic picture, but rather present in a destructive way." The seroconvert is also motivated to be "present in a destructive way." He drops out of the workaday world to live on disability or viatical benefits – income predicated on the assumption, the tacit agreement, that he will soon die. And after he "progresses" to "full-blown AIDS" he is even more "present in a destructive way."

This suicide by degrees, abetted by so many forces, is the latest manifestation of the Homosexual as Sacrificial Victim, an idea embodying remnants of ancient themes of ritual sacrifice. The Sacrificial Victim has finally become aware of his role, but as yet unable to slough it off, has begun to accede to it with some degree of deliberation. The seroconvert sets out to prove himself worthy of the sacrificial ritual, the testing, that he undergoes. This quest exemplifies what Zoja calls the "negative sacrifice, where only the destructive part of the act survives, and which is carried out by that person we call a negative hero." Of course, there is a positive side as well. The afflicted homosexual also becomes a "cross carrier", taking onto himself a complex of rejected and projected group feelings, fears and impulses. With his death, all these are, temporarily, exorcised.

In the classic pattern of initiation, desire for the death of the old self is followed by symbolic rebirth and the welcoming of the new self into the community of initiated peers. In the self-sacrifice of the seroconvert, this process is inverted: the old, negative self, rather than being overcome and sloughed off, is incorporated, with all its negativity, into the new self, who, instead of being enriched with new life, assumes new burdens of guilt and early death – burdens which novels, movies and folklore have long projected onto the figure of the Homosexual.

Seroconversion induces both the expectation of a short life and the feeling that one's desirability as a lover is diminished. It is a combination that frequently leads to the feeling: I'm dying and no-one will want me, so I may as well party with whatever short time I have left. And so the party becomes a Dance of Death. In his book The Savage Garden, the novelist and diarist Paul Reed muses that many of his friends "have resumed a life that is in many ways similar to the life we pursued a decade ago – the gym, an afternoon rest...the clubs...The difference is that we now no longer work to pay the bills, we simply collect our disability checks. And we no longer feel that this is the beginning of a hot, fast life. It may be the last

party, the final fling."

In the Nineties, that final, AIDS-related "fling" has become both a phobia and a macabre obsession. One gay club in Manhattan recently hosted a creepy and popular new event called "Res-Erection", which consisted of a go-go boy feigning death in a pseudo-Victorian setting while "horny revelers circled him and felt him up." Tres fin de siecle!

It is becoming painfully evident that the AIDS Establishment's admonition to gay men to stay healthy is proving less effective than its subliminal inducements to seroconvert, to enter a system predicated on early death. Old assumptions about the homosexual's social status as scapegoat and victim are easily assimilated by the "victim culture" of the Nineties which encourages troubled individuals to seek relief from their problems by adopting the role of irresponsible victim – which illness, addiction or past abuse is felt to confer.

It is curious that the authors of both these studies apparently believe that, in Odets' words, "a quirk of nature and timing has brought this epidemic to gay communities." One can only wonder which epidemic is being referred to. AIDS? Or the "psychological epidemic" that has grown up alongside it? Or are these concurrent epidemics merely aspects of the same overall pattern of psychoimmune disturbance – with the same underlying psychic, socioeconomic and environmental causes?

The health crisis in the gay community did not begin with the onset of AIDS in 1981; it was preceded by many years of psychological disturbance and chronic depression, reactions to a homophobia that was endemic and corrosive. In the Seventies, the already high instance of alcoholism and venereal disease among gay men was compounded by epidemics of drug abuse, hepatitis and intestinal parasites. By the first notices of what would come to be called AIDS, the immune systems of most gay men living the lifestyle that was promoted to them had already been severely compromised.

In the early Nineties, the psychohistorian, medical researcher and AIDS activist Casper Schmidt noted a pattern of psychoimmunological events in many of the gay men who develop AIDS. Their immune disturbances, he found, began with chronic depression, rooted in childhood unhappiness and related to socially induced guilt, internalized homophobia and a protracted "fight or flight" syndrome. As these feelings somatized into the body, the result was a chronically increased level of cortisol production, a steady depletion of T-cells, frantic overproduction of antibodies, and eventual immune collapse.

The evidence presented by Johnston and Odets suggests a continuation of this pattern into a second generation, with the ominous difference that now, with the phenomenon of the seroconvert, gay men's identification of illness and early death as their destiny has moved more fully into group consciousness. Accepting the subliminal logic of HIV fundamentalism, gay men are beginning to see seroconversion and entry into the AIDS System as a gesture of solidarity with their fellows, a rite of passage, and a political act.

It is unlikely that anyone with a strong sense of self-worth would deliberately seek to seroconvert. But for a gay man who has internalized the negative judgements placed on him by family and society, it may well be "a lot simpler to think about (having) AIDS than about being gay." The film Interview with the Vampire, a work replete with coded references to a variety of contemporary fears (euthanasia, AIDS, immigration, gay families) contains the telling line: "If you think you deserve to die and you don't kill yourself, that makes you evil." To many, the evils of AIDS seem preferable to the perceived evil of living as a homosexual. AIDS itself may be horrible, but contracting AIDS is a relatively easy – and pleasurable – form of suicide.

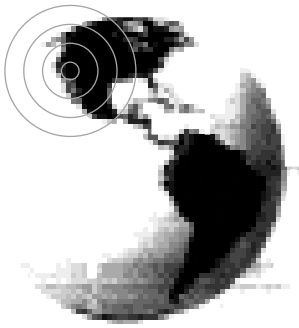
AIDS today is not what it was in the early Eighties when the term was coined to avoid the embarrassing acronym GRID – Gay Related Immune Disorder. The definition has changed: illnesses which were once considered key AIDS symptoms are now excluded if HIV is judged not to be present; even the official record now lists well over 4,000 such cases. Pelvic inflammatory disorder in women may now result in an AIDS diagnosis if HIV is shown or assumed to be present. T-cell counts, ignored in the early years of AIDS, are now combined with the ever-changing list of disorders to produce diagnoses on a "one from column A, two from column B" basis. Pneumocystis carinii, long considered a protozoa, is now acknowledged to be a fungus. Consensus is growing that Kaposi's sarcoma, long regarded as almost a hallmark of AIDS in gay men, is not caused by HIV, and investigations into a suspected "KS virus" are underway. The most popular AIDS drug, AZT, has been discredited, and physicians are reduced to offering their antibody Positive patients the experimental drug (or "cocktail") of the moment on a "try it, you might like it" basis. Many of these drugs are highly toxic, especially when combined, and their "side-effects" read like a list of AIDS symptoms. In short, things are a mess. Meanwhile, the AIDS conveyor belt rolls on, providing employment for an ever-increasing army of support personnel. And every week, the roll of sick and dying young men grows longer.

Gay men have long served as repositories for a complex of group fears and fantasies about sex, sickness and death. Psychohistorian Lloyd deMause has drawn attention to society's periodic killing off of "its own id-representatives, its youth, who represent itself in the life-phase when it was most sexual and most aggressive." In the past, this filicidal syndrome has usually been acted out through war. The frequent employment of war metaphors in AIDS literature of all kinds suggests that in the Eighties and Nineties, AIDS is taking the place of war, or has become a new kind of war. Under the veneer of a compassionate liberalism, psychobiochemical assault is being inflicted on gay men: not as a conscious intention, but as the result of policies predicated on certain unconsciously held ideas.

Gay men have long served as repositors for a complex of group fears and fantasies about sex

It is time to rethink this crisis, to begin to understand how we might extricate ourselves from the nightmare that has overtaken us, and enveloped us now for almost two decades. We will not understand the phenomenon of the seroconvert until we begin to investigate the destructive hold of unconscious belief systems in which we all participate. Until then, all the AIDS Education and Safe Sex Information in the world will not prevent new cohorts of young men from summoning up their courage and heading from the Test Site to the tattoo parlor to take up their cross.

Near Enough *is* Good Enough?



Leading AIDS-dissident retrovirologist ***PETER DUESBERG*** *defends the existence of HIV*

Continuum's Virus Isolation Challenge launched on 1st December 1995

I am honoured by the profound and passionate reactions of Hodgkinson, Lanka and Papadopulos-Eleopulos *et al.* to my letter on the existence or the non-existence of HIV[1-3]. However, I cannot surrender to the HIV-non-existentialists for the following two scientific reasons:

1) The weakest point of the HIV-non-existentialists is their failure to explain the origin of "19 sequences encompassing the full-length, 10kb-HIV-1 genome"[3] and "19 full-length HIV genomes"[1]. Hence Papadopulos *et al*'s unanswered question: "Can one exclude the possibility that the 19 'full length HIV genomes' described so far, even if they all had the same length of 9150 bp [base pairs] and identical sequences are nothing more than a chance finding among the many molecular species present in the cultures, or even the uncultured lymphocytes....?"[3], that were "taken from AIDS patients and AIDS risk groups", as Hodgkinson points out.[1]

—Yes, one can exclude that. Remember the odds of coming up with even one nucleotide sequence of 9150 bp by chance are astronomically low, namely 1 in 4^{9150} which is very very close to zero (see my letter in the July/August *Continuum*[4]). The chance of coming up 19-times with the same HIV-DNAs, even "from cultures treated with chemical or physical oxidants"[3] are another 19 orders of magnitude lower than finding it once by chance. Indeed the odds are much much lower than finding 19 guys on this planet with the same phone numbers.

Science offers but one rational origin for such sequences appearing "very occasionally"[1] in species, namely viruses or other infectious agents. Thus the virus hypothesis is not a "specious"[1] explanation for the origin of 9150 bp DNA that is "very occasionally" found in AIDS patients.

2) The HIV-non-existentialists also fail to realize that available isolation efforts have already adequately identified the 9150 bases as the genome of a virus. In order to "isolate" a given infectious agent, one needs no more than to isolate it from all other, possibly contaminating, infectious agents – this is in fact Koch's second postulate.

Since viruses have an extracellular and intracellular existence, viruses can be isolated from two entirely different sources:

(i) Viruses have been traditionally isolated from extracellular fluids. Such viruses may be contaminated by extracellular proteins, nucleic acids and possibly other microbes. Montagnier's original isolate of HIV from extracellular fluids is an example. Indeed, Montagnier's isolate appears to meet functional standards of isolation adequately, because two of the world's leading retrovirologists, Robert Gallo of the NIH and Robin Weiss of the Chester Beatty have re-isolated *only* HIV from Montagnier's virus stock[5,6]. If Montagnier's virus had been grossly contaminated by other viruses or microbes, those would have been found by Gallo and Weiss.

(ii) Since the 1980s viruses can also be isolated as infectious nucleic acids from infected cells. Such infectious nucleic acids initiate replication of virus in uninfected cells from which new virus particles are subsequently released. In this case viral nucleic acid is contaminated by cellular nucleic acid, and possible other intracellular viruses.

As I pointed out in my Missing Virus Reward claim in the July/August *Continuum,* infectious HIV DNA has been isolated from infected cells several times by molecular cloning[4]. This cloned, infectious HIV DNA of 9150 bases represents an almost theoretical isolation, as it is a 100,0000-fold purification from all nucleic acids of the cell and its possible viruses. This is because the human cell contains 1 million kilobases of DNA and HIV only 10. Contrary to Papadopulos *et al*'s slogan – "No isolation no cloning" – cloning is isolation, and is in fact the most rigorous isolation science has to offer for retroviruses.

Thus the high standards of virus isolation from extracellular materials postulated by Papadopulos *et al.* and Hodgkinson may be relevant for crystallographers or chemists who want to analyze the structure of a virus, but are not relevant for functional isolation.

In view of this I hope to liberate the minds of HIV dissidents from HIV for the cause that unites us all – the solution of AIDS. It seems tragic that over 99% of AIDS researchers study a virus that does not cause AIDS and that the few who don't are now engaged in a debate over the existence of a virus that doesn't cause AIDS.

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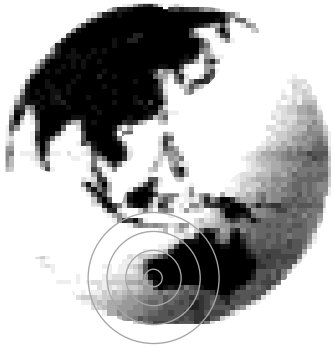
Why *no* whole virus?

Eminent AIDS-analysts, biophysicist ***ELENI ELEOPULOS*** *and colleagues, answer Peter Duesberg's criticism of their case that HIV has never been isolated*



We gratefully acknowledge Peter Duesberg's criticisms of our paper "HIV Isolation: Has it really been achieved?".[1] Before responding it will be useful to define some terms and objectives.

Virus

A virus has two distinct properties, one physical and the other behavioural. A virus is a microscopic particle able to generate exact copies of itself when placed inside a living cell, that is, the particle is infectious.

Those who espouse the viral theory of AIDS accept that a viral particle, and not a naked protein or DNA or RNA fragment, is transmitted from person to person and is both necessary and sufficient to induce the several dozen laboratory abnormalities and diseases that constitute the clinical AID syndrome.

Isolation

The essence of isolation is the separation of desired matter from all other matter not the object of concern.

Isolation of a putative viral particle is necessary to:

(a) document and analyse its constituents;
(b) conduct experiments in order to prove it is infectious and thus a virus;
(c) obtain reagents (proteins and nucleic acids) for diagnostic and other uses
(d) prove that the pathological effects, if any, are due to the virus and nothing else.

1 19 'HIV' genomes

"...the weakest point of the HIV-non-existentialists is their failure to explain the origin of "19 sequences encompassing the full-length, 10-kb-HIV-1 genome" and "19 full-length HIV genomes"".

(a) Let us repeat that the claim of the existence of "19 sequences encompassing the full length, 10-kb-HIV-I genome", "19 full-length HIV genomes" is not one of our making but that of the HIV experts we quote. The same experts accept that of the "19 full-length HIV genomes", no two are the same either in sequence or even in length;

(b) The question we set out to answer in our critique was not what is the origin of the 19 full-length HIV-1 sequences but does the presently available data prove that these sequences represent the genome of a unique, exogenous retrovirus, HIV? The answer, we repeat, is NO.

Nonetheless, although it was not our task to determine the origin of these sequences, we did present a number of alternative mechanisms that science offers as a "rational origin for such sequences" in addition to "viruses or other infectious agents".

2 Odds of assembly

"Remember the odds of coming up with even one nucleotide sequence of 9150 bp by chance are astronomically low, namely, 1 in 4^{9150} which is very close to 0."

It is apparent that we and Peter Duesberg are referring to two entirely different systems, one completely random and the other heavily biased by cell and culture conditions. True, the probability of assembling a particular sequence of RNA (DNA) of 9150 bases randomly selecting each of the four nucleotides is one in 4^{9150}. However, this statistical reasoning bears no resemblance to how nucleic acid polymers are assembled either *in vivo* or *in vitro* and thus on the probability of finding a particular unique sequence. That this is the case is best illustrated by Spiegelman's minivariant, a 220-nucleotide stretch of RNA of unique length and sequence which was discussed in our *Continuum* paper. The

probability of assembling such a unique RNA stretch by chance is 1 in 4220, also "very close to 0", yet, under certain conditions in the laboratory, the Spiegelman minivariant is frequently produced indicating that the assembly of nucleotides is anything but a random process. Furthermore, the 19 unique sequences do not have to be assembled from the four, individual nucleotides. They may result, for example, by recombination of:

(a) stretches of pre-existing cellular DNA sequences;

(b) stretches of DNA sequences of endogenous retroviruses which form 1% of the cellular DNA, a phenomenon accepted to take place quite frequently and to result in the assembly of novel genomes. It is also accepted that the conditions affect the recombination both qualitatively and qantitatively.

It is significant that as far back as 1985 both Gallo and Montagnier accepted that it is not possible to generate "HIV" and the effects attributed to it unless the cells are activated (stimulated) and that this year Chermann and his colleagues showed that the infected cultures contain fragments of the "HIV genome" but after PHA stimulation there is an increase in the "full-length genome" and a concomitant decrease in the fragments.[2] Whatever the odds may be of obtaining by chance the conditions necessary to generate "even one nucleotide sequence of 9150 bp", it is certain not 1 in 4^{9150}.

3 Viral genome

"The non-HIV-existentialists also fail to realize that available isolation efforts have already adequately identified the 9150 bases as the genome of a virus".

In our extensive search of the HIV literature we could not find even one reference, (although it is possible we may have missed some), in which the HIV genome was reported to of 9150 nucleotides. The closest length was reported Montagnier's group who, in 1984, reported it to be 9.1 to 9.2 kbases and, in 1985, as 9193 bases.[3,4] If the 9150 base DNA is the genome of a virus then an absolutely necessary but not sufficient condition is that the virus in all infected individuals will have a length of 9150 bases. Yet, two HIV genomes of the same length have yet to be reported. More importantly, the length of an RNA (DNA) fragment, no matter how often such a fragment is detected, provides no information regarding its origin. The only way to prove it belongs to a unique virus is to isolate a viral particle and demonstrate it has a genome of 9150 bases. This has not been done and the "available isolation efforts" do not contain even suggestive evidence let alone proof that a 9150 base long RNA is a constituent of a particle, any particle much less a viral particle.

4 Koch's postulate

"In order to isolate a given infectious agent, one needs no more than to isolate it from all other, possible contaminating, infectious agents, this is in fact Koch's second postulate".

At the Xth International Medical Congress held in Berlin in 1890, in response to the question as to how to obtain irrefutable proof that a bacterium caused a specific disease, Robert Koch included in his answer the requirement that "The pathogen must be isolated and bred in adequate numbers in pure culture."[5] Apart from omitting the second part, "bred in adequate numbers in pure culture", Peter Duesberg's definition of isolation is somewhat obscure. Can a physician for example, claim to have isolated his patient with hepatitis by placing him in a room with patients who may have coronary artery disease, fractures or appendicitis, but none of whom have infectious diseases? In fact, in 1987,[6] Peter Duesberg himself defined the second Koch postulate as, "it [the pathogen] must be isolated from the host and grown in pure culture", that is, in the absence of "all other, possible contaminating" agents including non-infectious agents.

5 Re-isolating 'HIV'

"Montagnier's original isolate of HIV from extracellular fluids is an example. Indeed, Montagnier's isolate appears to meet functional standards of isolation adequately, because two of the world's leading retrovirologists, Robert Gallo of the NIH and Robin Weiss of the Chester Beatty have re-isolated only HIV from Montagnier's virus stock. If Montagnier's virus had been grossly contaminated by other viruses or microbes those would have been found by Gallo and Weiss".

There is no evidence in Montagnier's "original isolate" which proves isolation of a virus no matter how liberal a definition one applies to the word "isolation". As far as "functional isolation" is concerned, suffice it to say:

(a) In 1983, like Gallo in 1984, Montagnier reported HIV as a "typical type-C RNA tumor virus"[7] having a characteristic "cylindrical core".[8] By 1985 it was reported that the nucleotide sequences between Montagnier's first HIV isolate, LAV-1 BRU and Gallo's first isolate, HTLV-IIIB, "differ by less than 1% overall".[9] Even though Montagnier had sent supernatant(s) from LAV-1 "infected" culture(s) to the Gallo laboratory, "with the express understanding that it could be used for biomedical, biological and molecular biological studies", neither Montagnier nor Wain-Hobson considered such differences as proving Gallo's HTLV-IIIB was LAV-1 BRU and in February 1986 wrote, "Thus there is only a single AIDS retrovirus, and LAV, HTLV-III and ARV represent different isolates of the same virus" (italics ours).[9]

Indeed, if there "is only a single AIDS retrovirus", a unique retrovirus, then genomic differences of "less than 1%" should be the rule, not the exception. However, unexpectedly, not long afterwards it was discovered that "If you were to test two HIV-positive people at random and analyse the genetic material of their strains, they would differ, on average, by about 13 per cent".[10] As

a result, the French accused Gallo of misappropriating their strain which they had sent to him in 1983. In other words, Gallo's isolate of HTLV-IIIB was not a "different isolate" of HIV but LAV-1 BRU which Gallo transmitted to the permanent cell line HT (HUT78). At the same time they suggested that HIV-1 including their LAV-1 BRU is not a "typical type-C RNA tumor virus" but "possibly a lentivirus", that is, a taxonomically distinct retrovirus containing a conical core. Although there was no proof, this suggestion was soon accepted as fact by almost everybody apart from Gallo's group which for many years insisted that HIV belonged to the same family as HTLV-I and that it is a type-C particle. Furthermore, as already mentioned, the length of LAV-1 BRU was reported to be 9.1 to 9.2 kb (9193) while that of HTLV-IIIB as 9749.[11] By 1991, Gallo et al including Chermann presented evidence including sequence analysis, which showed "that Gallo's IIIB did not come from the Pasteur Institute".[10, 12]

(b) In January 1991 Weiss stated that he "cannot exclude the possibility" that his isolate, CBL1, is either Montagnier's LAV-1 BRU or Gallo's HTLV-IIIB. The reasons given were:

(i) nucleotide sequences representing 2,443 nucleotides (one quarter of the "HIV genome") in env, tat, and nef, showed that CBL1 "has 98.0% amino acids in common with LAV-1 BRU and 97.8% with HTLV- IIIB (BH10 clone), whereas the similarity in the same regions between BH10 and BRU is 98.3%. The tat sequence was most variable, with 94.2% of the CBL1 sequences identical to both BRU and BH10";[13]

(ii) "...monoclonal antibodies raised against CBL1 gag proteins do not distinguish between CBL1, BRU and IIIB".[13]

However:

(i) the genomic differences reported by Weiss are greater than "the less than 1%" differences reported between LAV- 1 BRU and HTLV-IIIB;

(ii) should not the antibodies raised against one strain of HIV react with all the other strains? If different strains of HIV can be distinguished by an antibody test then how can one perform HIV antibody tests without having an antibody test for each strain?

(iii) a few months later other British researchers reported that "CBL-1 and HTLV-IIIB show striking differences in their biological properties".[14]

Given the above data it is not possible to claim that Gallo and Weiss re-isolated Montagnier's virus. In fact, the groups do not agree between themselves as to the crucial questions of which samples were given and received, and even less as to which samples were sequenced.[10,12]

In addition, there are two basic scientific reasons which make it impossible for Gallo and Weiss to "have re-isolated only IIV from Montagnier's virus stock":

(i) To isolate HTLV-IIIB Gallo used the H9 (HUT78) cell line. However, evidence exists that the H9 cell line releases retrovirus-like particles even when not "infected with HIV''.[15] Furthermore, the HUT78 cell line was established from a patient with "malignancies of mature T4 cells" , a disease which, according to Gallo, is caused by the exogenous retrovirus, HTLV-I. Indeed, as far back as 1983, he claimed to have shown that the HUT78 cell line contained HTLV-I proviral sequences.[16] Weiss obtained his "CBL-I material" from the leukaemic cell line CEM, a cell line shown to harbor retrovirus even when not infected with "HIV".[17]

(ii) One aspect on which all HIV experts concur is that gpl20 is indispensable for HIV infectivity. Suffice it to quote from Jay Levy's and Wain-Hobson's most recent papers. "The likely steps in HIV infection are as follows. The CD4-binding site on HIV-1 gpl20 interacts with the CD4 molecule on the cell surface. Conformational changes in both the viral envelope and the CD4 receptor permit the binding of gpl20 to another cell-surface receptor, such as CCR5. This second attachment brings the viral envelope closer to the cell surface, allowing interaction between gp41 on the viral envelope and a fusion domain on the cell surface. HIV fuses with the cell. Subsequently, the viral nucleoid enters into the cell, most likely by means of other cellular events. Once this stage is achieved, the cycle of viral replication begins"[18] (italics ours). "HIV-encoded gpl20 recognizes the host-encoded CD4 receptor. This interaction leads to a conformational chage in gpl20, allowing it to bind to a second receptor, CCR-5...At some point to be defined, the amino acid terminus of gp41 is uncovered allowing penetration of the host cell membrane and fusion of the viral and host cell membranes. Stripped of its lipid protection, the capsid complex moves into the cytoplasm, and reverse transcription is initiated''.[19]

We could find no data regarding the type of "material" Weiss received from Montagnier. The samples received by Gallo "were cell-free supernatants of LAV cultures". However, as Hans Gelderblom and others have attested, cell-free viral particles do not contain knobs, (spikes), that is, gpl20.[20, 21] This makes it impossible not only for Gallo to "have re-isolated only" HIV-I BRU but even to have transmitted it to his cultures.
Given the facts that:

(i) AIDS patients and those at risk are diagnosed as infected with many agents. These include cytomegalic inclusion virus, Epstein- Barr virus, herpes simplex virus and Hepatitis B virus. The latter is present not only in hepato-cytes but like, "HIV", also in T-lymphocytes.[22, 23] It is also accepted that most cultures contain Mycoplasma;[29]

(ii) To "infect" their cultures, Montagnier, Gallo and Weiss did not use "pure HIV" or even the material which from the cultures banded in sucrose density gradients at 1.16 gm/ml, but "cell-free" culture fluids;

it would have been a miracle, if they had looked, for "Montagnier's virus" to have not "been grossly contaminated by other viruses or microbes" and for Gallo and Weiss not to have found such agents irrespective of which strain of "HIV", Montagnier's or theirs, they had "re-isolated".

6 All cells have RNA

"...viruses can also be isolated as infectious nucleic acids from infected cells".

Viruses are not mere nucleic acids. Neither can the introduction of nucleic acids into cells and their reproduction be considered as proof for viral infection. If:

(a) one starts with a presumption, but no proof, that a cell is infected with a unique retrovirus;

(b) chooses from its RNA a fragment of arbitrary length, and calls it retroviral RNA

(c) inserts the RNA (cDNA)into a cell and reproduces the same RNA (cDNA) and interprets this as infection;

(d) construes (a)-(c) as proof of isolation of a unique retrovirus;

then, given the fact that the same steps can be achieved with any cellular RNA (DNA), one would have no choice but to consider every single fragment of cellular RNA (DNA) as retroviral, and that all cells are nothing more than an assembly of retroviruses.

7 Others

"...such infectious nucleic acids initiate replication of virus in uninfected cells from which new virus particles are subsequently released".

This may be the case with the genome of other infectious agents but this has never been shown for the genome of HIV.

8 Cloning

"...infectious HIV DNA has been isolated from infected cells several times by molecular cloning".

This matter has been discussed at length in our Continuum paper. Suffice here to stress two points:

Retroviruses are not "cloned, infectious HIV DNA of 9150 bases" but "enveloped viruses with a diameter of 100-120 nm budding at cellular membranes. Cell released virions contain condensed inner bodies (cores) and are studded with projections (spikes, knobs)".[25] Furthermore, such particles share the physical property of banding at a density of 1.16 gm/ml in sucrose density gradients, a fact long used in their isolation . Cloning of a virus is defined as obtaining EXACTLY the same virus by introducing its genome into a cell. However, to date, nobody has reported such particles by "cloning, infectious HIV DNA of 9150 bases", or DNA of any other length. In fact, nowhere in the HIV literature can one find particles which have "a diameter of 100-120 nm" AND which are "studded with projections (spikes, knobs)", let alone such particles banding at 1.16 gm/ml in sucrose density gradients. Since cloning is a process leading to the production of an exact copy of whatever object one starts with, how can one claim cloning of something before there is proof that it ever existed?

SUMMARY

What does one have to do and how hard does one have to plead in order to obtain answers to fundamental questions regarding a retrovirus which has menaced the world and in whose name hundreds of thousands of people have died or been poisoned?

For example:
1. How is it possible to transmit a cell-free retrovirus, "HIV", when it is accepted that:

(i) gp 120 is absolutely necessary for the virus to enter the cell and for the "cycle of viral replication to begin";

(ii) to date nobody has reported the existence of cell-free particles with the dimensions of retroviral particles possessing knobs, that is, gp 120?

2. How can one claim that AIDS patients and those at risk are infected with a unique retrovirus, HIV, when to date nobody has even reported in fresh, cultured tissue, or tissue co-cultures, particles fulfilling the principal morphological and physical characteristics of retroviral particles?

We agree with Peter Duesberg that "the cause that unites us all" is finding a solution to AIDS. With this our aim we were among the first to put forward non-infectious factors as agents to explain AIDS in gay men and furthermore we were the first to propose a non-infectious theory with a unifying mechanism to explain the development of AIDS in all risk groups.[26] Indeed, our theory also predicts a non-infectious explanation for the phenomena which others have inferred as "isolation" of a novel retrovirus from AIDS patients. However, once HIV was accepted as the causative agent, we realised that the single most important obstacle in finding the explanation for AIDS is the belief in HIV. For this reason, from the beginning and unlike anybody else, we have critically analysed the data which claim proof for the existence of a unique, exogenous retrovirus, HIV, in AIDS patients and have always maintained that no such proof exists.

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No viral identification ∴ no cloning as proof of isolation!

*Virologist **STEFAN LANKA** was a principal collaborator in the isolation of marine virus* ectocarpus siliculosis*, published in* Virology *in 1995. He maintains claims of HIV isolation meet none of the scientific standards required for proof of its existence*

The latest reaction of Peter Duesberg[1] to the ascertainment that "HIV" does not exist[2], and to the thorough line of argument that all claims about and characteristics ascribed to "HIV" do not withstand specific scientific examination[3], raises questions:

—Why does he so vehemently defend something for which there are not only no proofs but also no necessity, and which has pushed millions of people into fear of a retroviral plague transmitted through sex and blood?
—Why do "HIV"-virologists never subject their "viruses" to the same generally accepted standard techniques of molecular biology as all other virologists and biologists do?

In his latest monograph of 5.11.96 Peter Duesberg introduces a more untenable claim than ever, which neither he nor anybody else can substantiate, to suggest again that there is a genetic entity "HIV": he equates cloning, a standard technique of multiplying a given genetic sequence, with virus isolation and the existence of "HIV"!

After the question of the existence of "HIV" was first posed and people began to rethink "HIV" and to understand that with the available, exact identification techniques of Genetics, Biochemistry and Virology not a single aspect of the existence of "HIV" has been proved, apparently there was a desire quickly to postulate new criteria for its existence. That this new line of argument is put by Peter Duesberg, known for his critique of the idea of an infectious AIDS yet otherwise one of the godfathers of retrovirology is revealing.

But the quicksand beneath Duesberg's construct is visible:

—when instead of referring to the established criteria of structural identification, he now postulates functional criteria: "cloning (multiplying) is isolation", though the thing to be cloned has never been identified as part of "HIV". No structural criteria with which one can exactly identify genuine biological entities are to be used in the case of "HIV" – no analysis of the form and size of an isolated virus, the kind and composition of its proteins (e.g. if one wants to use the proteins in an approved antibody-test), its genetic substance (e.g. if one wants to carry out the test-tube-experiments which Duesberg cites or do viral-load measurements). We are encouraged arbitrarily to believe in only the repetition of processes, which ad hoc were ascribed to be viral attributes.

—when he claims there are at least 19 full-length HIV genomes – that 19 molecules of the complete genetic substance of "HIV" exist in this world though this has not been shown or claimed in a single scientific publication.

For the purpose of secure identification of a virus, the right means – the means of structural isolation – have to be applied before one carries out functional examinations with parts of the virus. For a clear understanding of this important argument, the main terms are again briefly explained here:

A virus is an acellular form of organism, being no more and no less than a piece of genetic substance (according to a given species of virus, always of the same length) and a covering surrounding the genetic substance, composed mainly of proteins (according to a given species of virus, always of the same form and size). Viruses are stable because they have to leave cells or even the organism in order to infect other cells or organisms anew. Using centrifugation techniques it is no problem to separate viruses from all contaminating components and in doing so to isolate them – then photograph them, then represent their proteins and genetic substance in a direct way.

In the case of "HIV" this has not been done up to today, for "HIV" as a whole or therefore for any of its components – its proteins or genetic substance[2,3].

The scientific conclusion is that the existence of "HIV" has so far not been proved; the logical explanation, given that all character-

istics ascribed to "HIV" are well-known cellular entities and characteristics, is that "HIV" never was, and the claim of the existence of "HIV" is not sustainable.

The idea which led to the claim that HIV exists is based on a decisive false assumption. From 1970 on some scientists and much of the public were led to believe that since a certain biochemical function, reverse transcription with its then unfamiliar mode of action, did not fit the dominant world picture of genetics, it would be explained only through the claim of the existence of a new class of viruses, the retroviruses. The shock of reverse transcription was that it is possible to make genetic substance out of messenger substance, which until then was believed to be impossible. However, that the detection of reverse transcription is not, as some research directions still assume, a sign of certain death, e.g. HIV=AIDS=Death (Gallo, Ho and colleagues), or a reference to the "most harmless viruses in the world" (Duesberg) was proved when it was shown that reverse transcription reflects a repair mechanism of damage in cellular genetic material – in one revealing experiment, the chromosomes of yeast[5]. So,tragically, in 1970 the detection of a healing process gave birth to the idea of a new class of viruses and eventually "HIV", because astonishingly researchers were not willing to rethink their models or listen to what nature has to tell them. The stubbornly held notion that reverse transcription was inevitably "retroviral" was first employed in the war against cancer as "cell-multiplying viruses", then as the opposite, in the war against (medically induced) AIDS as "cell-killing viruses".

It is of the greatest importance in this context that "HIV"-researchers – when trying to detect the activity of reverse transcription which is always the first step in the attempt to identify "retroviral" structures and characteristics, instead of using the natural genetic messenger material, the RNA-genome of the virus which should be there if the viruses existed – always use, without any explanation why, synthetic messenger-material templates[6]. Above all it is known that those templates are not specific for the process of reverse transcription – that they are efficiently recognised and transcribed by the normal, common, cellular genetic-material-producing enzymes as well[3].

It has been long known that what "AIDS" researchers have presented as photos of "HIV" show normal cellular particles in use for export/import and other tasks[7]. As those particles are designed, in contrast to viruses, for cellular use only, they are very unstable when removed from their context, and not able to be isolated and photographed in an isolated state. Genuine viruses are so stable that it is easy, in order to prove successful isolation, to photograph them directly as three dimensional particles in the electron microscope without prior chemical fixation. In contrast, the cellular-transport and other particles are so unstable (excluding cell organelles like Mitochondria, the energy producing sites which are able to be isolated in a stable form) they can only be photographed in a chemically fixed state, in cells, tissues or in supernatants. As these particles are not isolated and therefore are together with other materials – the chemically fixed and resin-embedded cells, tissues or liquids – the mixed material has to be cut in very thin sections (Ultrathin sections) to be able to see anything – it's not possible in the electron microscope to look through thicker sections. Of course existing viruses can be photographed in ultrathin sections too but, and this is the point, in their isolated form.

All that have been shown to us "HIV" are ultrathin sections of cellular particles[2, 3].

The whole idea of "HIV" would collapse if it was possible to bring this fact to public attention.

It should be clarified: it is very normal that genetic material – DNA, natural or artificially multiplied – when put onto cells is able to enter those cells, may integrate itself into the cells' chromosomes and eventually may be activated to produce its proteins. The idea of vaccination with "naked DNA" (to which I strongly object for various reasons) is based on these known mechanisms. To add a DNA clone to cells and later to prove its presence and probable activity is nowadays a standard experiment in lectures on biology but in no way a proof for the existence of "HIV".

So one can only guess why molecular biologist Peter Duesberg refers to such a standard experiment as proof of the existence of "HIV". As the group around Eleni Eleopulos et al. has shown[3] neither he nor anybody else has shown that the genetic pieces of "HIV" used in the transfection experiments he cites[9] were isolated out of a virus. Only if researchers were able to multiply from cells exactly that genetic material which previously had been isolated from a virus, only then the claim of virus detection would be valid: virus-isolation logically always goes first. Or may anybody postulate new viruses, sprinkling his or her genetic material onto cells, detecting this material in the cells and claiming a new virus? A repeated artefact remains an artefact. To call such re-detected DNA "infectious DNA" is conspicuously misleading.

When Peter Duesberg refers explicitly[1] to a publication in which we read, "...tested blood cells of 409 antibody-positives including 144 AIDS patients and 265 healthy people. In addition 131 antibody-negatives were tested. HIV-specific DNA subsets ... were found in 403 of the 409 antibody-positives, but none of the antibody-negative people"[10] while these claims and statements are not at all substantiated in the further reading[3], it becomes obvious that he simply cannot have correctly read this publication which clearly touches clinical aspects, and that he thereby risks grossly violating his scientific ethics.

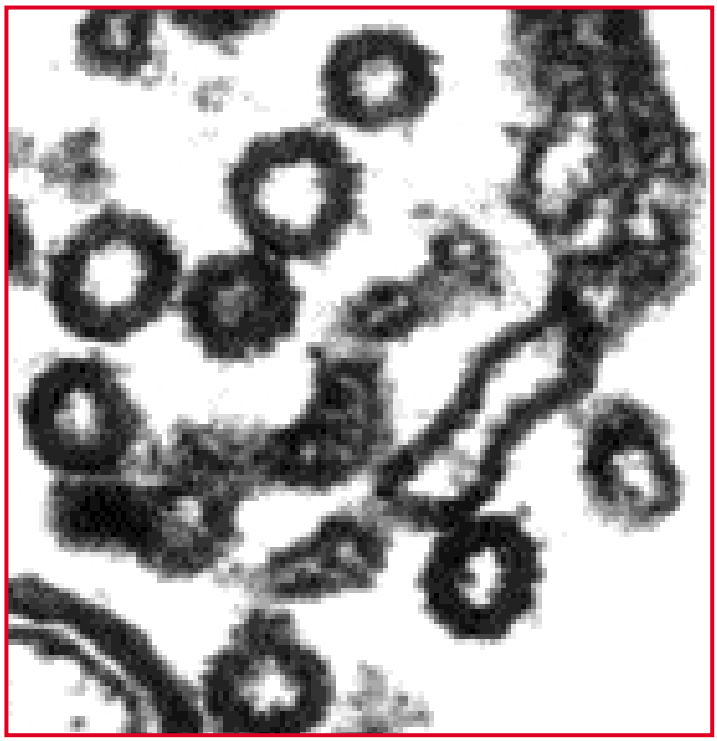
And when those ethical gentlemen, Duesberg's colleagues, "two of the world's leading retrovirologists Robert Gallo and Robin Weiss"[1] are invoked – without doubt about their claims either – for having "re-isolated only HIV from Montagnier's virus stock" without recognising any further contamination, Peter Duesberg's pseudo-rationale needs an explicit comment:

—If one looked for other "retroviruses" in Montagnier's stock, they would be found in great numbers these days. The human genome carries thousands of such genes that can be traced back to the action of reverse transcription[3] and were named "retroviral elements" by "retrovirologists" in an ad hoc decision[2].
—In Robert Gallo's humiliated hunt for a credible new retrovirus, he was not taking care over or notice of "grossly contaminating viruses" but instead mixed up together – it actually happened – the materials of 10 patients, in order to be able to create "HIV"[2].
—Gallo himself wrote in the very important statement of the 27th September 1983 (after the decisive conference in Cold Spring Harbour!): " ... the virus described by Montagnier I have never seen [sic], and I guess that he has a mixture out of two. On the other side some of his data are interesting but not at all conclusive ..."[11].

When Duesberg urges: "As I pointed out in my Missing Virus reward claim in the July/August Continuum, infectious HIV DNA has been isolated from infected cells several times by molecular cloning"[1], he himself is honest enough to claim that this "infectious HIV DNA" has been isolated not out of "AIDS"-patients but from special "infected cells". He conceals that those cells underwent a very particular treatment, and had DNA added before[2, 3]. He cites only literature in which ex-cathedra the same claim as his is made without a single reference that the importuned "infectious HIV DNA" was detected in or isolated from a virus[3]. Predictably, three references – Fisher et al., Barnett et al. and Levy et al. – which Duesberg cites[1] to support his claims reveal that phenomenon typical of AIDS research: in the headline and the abstract of the publication things are exactly named and specific claims are made that are wholly unsubstantiated in the further text. One has only to read the smallprint of the technical comments (examples are commented on in ref. 3, n.b. pages 16-18) to see and understand the misconceptions behind them. When Duesberg lends his reputation and charismatic authority to such duplicitous science with its fatal consequences, without any reflection of the detailed critique[3] and especially without any analysis in his field of expertise it is very

precarious and alarming. The explanation for his contrived insistence with highly technical and quasi-exact vocabulary that contrary to the complete case of Papadopulos et al.[3], there is somewhere out there a "HIV", detectable only through cloning because "cloning ... is in fact the most rigorous isolation science has to offer for retroviruses", may be that though a genuine retrovirus "HIV" has never identified, "retrovirologist" Duesberg can't or doesn't want to admit it – for reasons that may not be obscure.

But it is increasingly beyond indulgence that Duesberg piles up claims of 19 complete genomes (complete genetic sequences) of "HIV" which it has been possible to artificially multiply in the form



Electron micrograph of HIV showing infectious gp120 knobs? Actually, normal sub-cellular vesicles – transport "balloons" – grown in a test tube. (Molecular Biology of the Cell, 1994)

of clones, then, to build up theories of probability bereft of significance gives the impression that they all have the same length when no scientist before him has ever claimed this, ever seen such things or of course ever published such claims. In the only reference he could have meant[4] it's enough to read the title "Recovery of virtually full-length HIV-1 provirus of diverse subtypes from primary virus cultures using the polymerase chain reaction", to understand that Duesberg wildly appropriates references that seem suitable for his purpose without actually knowing them. The cited method, the polymerase chain reaction (PCR), is not able to construct something like a viral genome[12]. It certainly has to be clarified that concocted and size-selected genetic molecules like "HIV"-clones can never "represent an almost theoretical isolation" somehow on account of their lengths being in a proportion of 1 to 100,000 against the length of the full human genetic material. Such clones result from the process of concocting smaller molecules, produced in a test tube using the cellular genetics and cellular enzymes, and then, to present a "whole" sequence, uniting the smaller sequences in theory, on paper, or in a computer, following a blueprint from the arbitrary rules of retrovirology.

It beggars amazement how one may state ex cathedra that ".. the high standards of virus isolation ... may be relevant for crystallographers or chemists ... but are not relevant for functional isolation", when it is those unspecified "HIV" proteins created in cultured cells when "HIV"-researchers tried to induce reverse transcriptase activity that are used in the "AIDS"-test, which is an instrument of sentence over death and life. What by God is then relevant in this kind of "science"? "Not relevant for functional isolation"! What for heavens sake is meant by "functional"? That the "AIDS"-test works when one believes in its function?

And it is incomprehensible how "AIDS" expert Prof. Duesberg continues to discuss "AIDS" as if there were an autonomous clinical picture which one may call "AIDS". Every concerned person knows by now that "AIDS" has a different meaning on every continent, with its different causes. "AIDS" is an inadmissible artificial diagnosis: it has been legitimised through the introduction of "HIV" as a constructed cause. The AIDS-myth with its exploitation of the fear of an alleged deadly sex-plague has been blindly launched into the realm of seemingly scientifically-based biological fact through the pseudo-rational "HIV" detection technique. But the two terms according to the rules of construction depend on each other. The clarification of the question whether "HIV" exists, with the most secure method of identification available (and this would be only the isolation of complete "HI-viruses") is a sine qua non for dismantling the mass-delusional trance called "AIDS". Only then may the task of research with the needed temperance and precision, into the causality of the concrete disease complexes behind "AIDS", be addressed[14].

The danger that the "AIDS"-critical movement splits or temporarily weakens over the question whether "HIV" exists is therefore secondary, and in any case subordinate to, the right to life of every person. The common matter is to secure the human rights of every stigmatised person, not a personal cult. The human rights do include free, and in this case essential, access to information. Censorship – and worse, misleading, for political or personal reasons, be it ignorance or the "will not to know" – is endangering human lives. It is urgent. "The one who comes too late is punished by life" (general political knowledge). Those who too late or never receive essential knowledge may die in the throes of an "AIDS" diagnosis or commit suicide (sad, bad wisdom amongst HIV+s and PWAs). That "HIV" has never been identified as secure biological matter is of the greatest importance and must immediately be told to every stigmatised person. No HIV – no false diagnosis AIDS – no death sentence – no false treatment – no unnecessary suffering – no needless dying, but new chances for people who for complex reasons got seriously ill, amongst them being labelled as "AIDS"-cases and "HIV"-positives at all, and then falling victim to medical shortsightedness based on laboratory-technical constructs.

There is no (HI-)Virus. Stupid?

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Vitamins – essential

Boo Armstrong

Vitamins have had so much good press in recent years that you could be forgiven for thinking that here was yet another miracle in a bottle. Vitamins are important, crucially so; they cannot be made in our bodies, and combined with all the other nutrients that you should be getting from your food they enable you not only to maintain your level of health if you are healthy, but to heal yourself when you are sick.

Given the modern attitudes towards health and disease where "drugs cure diseases", it is sometimes easy to step onto a slightly alternative path by substituting your medical drug habit for a vitamin one. However, there is a much more fruitful road to tread.

There are huge amounts of books and articles written about the benefits of vitamin supplements for all kinds of ailments, including those of the immuno-compromised state called AIDS. The benefits of using vitamin supplements when your body is unwell cannot be overestimated, but buying into the habit of popping pills of any kind can take away the very essence of what will help you to heal yourself – the belief and the trust in your body's own abilities to heal itself and to maintain good health when all your needs, and primarily your nutritional needs, are met.

Vitamins are found in abundance in plant foods – apart from vitamin D, and vitamin B12 which is made by tiny micro-organisms which live in soil and in our own internal soil of the gut when conditions are favourable. With an appreciation of this abundant source, and of our evolutionary history of eating foods in their natural state, it is easy to make the mental leaps which are necessary before eating our way back to good health. There are practicalities involved in learning how to cook without destroying goodness, how to shop without increasing our toxic load and how to be without draining ourselves of goodness and these are all part of a fantastic learning process.

Vitamins are bound up in proteins and other vitamins and minerals, in a balance which plants need to survive. Unsurprisingly, these are the same structures in which we need them too. It is easy to benefit from nature's wisdom if we make the effort to learn how. Buying fresh produce is important because as plants begin to wither they lose not only their vitality but their vitamin levels as well. Organic food is well worth the extra money, a sound investment in your health and now becoming easier to get hold of with the abundance of delivery-to-your-door schemes set up around the country. Plants which are grown intensively lack many nutrients – they are fed on fertilisers which will make a plant grow but not thrive. Add to their already limited diet a mass of pesticides, herbicides, waxing agents and who knows what genetic manipulation and you can see that their immune systems will be pushed to the limit too – and their vitamin reserves will be sapped – which doesn't bode too well for the human eating them.

The part of plants which protects them from external damage – which keeps the inside in and helps to maintain their integrity – is the skin. In inorganic produce this is where you find the most chemical toxins which makes peeling inorganic carrots a necessity before eating them. The skin is the part of the plant which stores nutrients. In grains it is the husk, with high levels of B vitamins, which so often gets ground away in industrial processes. It is ironic that we buy wheatgerm in order to increase our levels of B vitamins and wheatgerm oil for vitamin E when a lifetime of eating wholegrains ensures that we get these important nutrients in their correct balance – not only are our nutrient levels more realistic for a functioning human creature, but we also take on that energy of the plant, the sense of integrity of being whole, which is part of the journey of living – finding yourself and being true to your own needs.

Cooking grains is a simple process – add water and put heat underneath. With the range of beautiful grains available in their whole form from health food shops, and many supermarkets, the excuses for not giving yourself the best become quite weak, so when strength is your goal why use excuses?

What could a nutritional therapist do for you?

- Help you save money. Your food supplement should be based on your needs, not on random guesswork.
- Help you save effort. Some people select very difficult diets for themselves, (such as all-raw diets) believing that they have to suffer to encourage better health. But nutritional therapists don't just use one diet, they use a variety, including diagnostic diets, diets to help improve the digestion, hypoallergenic diets, cleansing diets and specific carbohydrate diets. You will be given different diets according to need as your treatment develops.
- Give you encouragement. If Aids is not caused by a deadly virus, (and who has seen any evidence that it is?) then your body will be grateful for all natural health-promoting measures you can take: detoxification, investigating allergies and nutritional deficiencies, antifungals, helping your liver and digestion work better, and so on. Nutritional therapists are experienced in all these areas.

For further information and a list of qualified, registered nutritional therapists nearest to you, send £1 plus sae to: Society for the Promotion of Nutritional Therapy (SPNT), PO Box 47, Heathfield, East Sussex TN21 8ZX. Add £5.99 for a copy of *Principles of Nutritional Therapy*, the authoritative guide to the subject by the SPNT's Director Linda Lazarides (recommended in the *Daily Mail*, *Health Guardian* and *Hello* magazine).

Nutritional Therapists are complementary medical practitioners who counsel clients with the use of special diets and a wide variety of nutritional products to assist specific metabolic functions.

PHOTO: Melissa du Fretay

The husk with high levels of B vitamins so often gets ground away

To get the best of your food, on all levels, it is important to assist your digestive processes by chewing your food slowly, letting your saliva start to break down the complex web of nutrients, savouring the flavour to stimulate the flow of digestive juices and hormones and allowing the essence of the healthy plant to merge with your own.

Thanking the plants for growing and helping us to grow is not something we give time to when we grab a sandwich or heat up an instant meal to eat during a meeting or while marking the students' homework or whatever it is you do.

Do not underestimate the benefits of cooking wholefoods properly and loving every second of eating them – even though it can sound like hippy waffle and give you the appearance of a healthy happy flower child.

To a stressed-out body and mind trying to cope with frail emotions, B vitamins are essential. So too are the antioxidants, vitamins whose role when inside us is to get hold of toxins and facilitate their removal from our bodies. You can tell which foods contain the important antioxidant flavonoids and carotenes by looking at them – they are the bright vibrant, colourful plants. The bright colours would be dull and lifeless if they had no antioxidants. Do not be confused by chemical additives – a green fruit pastille is not the same as a green spinach leaf and doesn't have a fraction of the goodness.

The antioxidant vitamins are A, C and E. Vitamin A is particularly good for your lungs and skin. Instead of challenging your chances of long-term survival and increasing the burden on your detoxification system by taking Septrin as a prophylactic for lung complaints – try organic carrot juice instead. If your lungs are still battle worn from a life of pollution they might fire up and cough when you give them A in abundance. Instead of freaking out and rushing to the doctors for a PCP test, rejoice in your lungs coming alive, learning how to function and trying to eliminate toxins.

Vegetable juicing in general is a great way to increase your vitamin levels, especially when your appetite has been ruined by stress and drugs. If the thought of eating a few pounds of vegetables is out of your comprehension, try juicing them for a power-packed nutrient hit which will make you feel fantastic to boot. None of this, "Oh I must take my medication now and then I'll be sick and feel so tired and drained, oh woe is me" – you can actually give your body what it wants to create health and feel the benefit. A word of warning is that you really should respect your juicer and clean it out every time you use it, otherwise you will develop some stomach-churning smells in your kitchen.

Juicing should not undermine the use of vitamin supplements when appropriate. Just as doctors come in handy when you've been run over or shot, vitamin supplements come in handy when you are unwell or when you make the choice to harm your body by consuming vitamin-depleting food, drink or drugs.

Vitamins do work together in our bodies so supplementing could be in a safe multivitamin pill which will offer you levels of goodness which we all need, without doing you any harm – though with no regard for your individuality.

In order to give your body what it really needs, in terms of vitamins, it is best to see a nutritionist and work with them in developing a range of foods and/or supplements suitable for you, your body and where you are at. The alternative is to inform yourself and make choices which feel right to you – attend a nutrition class and learn the basics, read up in books and magazines and talk to your friends about what works for you and for them. We do after all have all the knowledge that we need to be well.

As well as supplementing with a goal of improving your health and staying well vitamins can also be useful after a night on the town, a stress-filled family Xmas or whatever.

Antioxidant vitamins are essential if you are a smoker. A daily pill will help to lessen the damage caused by the smoke. Drinking alcohol depletes your body's levels of B vitamins, as does stress and overworking so it is worth keeping a jar of the whole B complex handy.

The answers are out there, whether you want scientific proof that vitamin B3 increases T-cell functioning or verbal affirmation from a friend that vitamin C helps when you have an infection.

Most importantly the answers are inside you – only you know how you really feel. No doctor can really tell you how healthy you are, it is what you feel which is important. Learn to live the life which makes you healthy, empower yourself with knowledge (make sure you learn about vitamins) and most importantly kia kaha – stay strong.

Vitamins

A (retinol; Beta-carotene) contributes to the pigments of the eye. Deficiency causes night-blindness and other symptoms. It can be obtained from various animal products, especially liver, and from vegetables such as carrots.

B is a general term for any of a group of vitamins, formerly thought to be one substance, that are essential for the working of various different enzymes. They are found in a wide variety of animal and plant foods.

C (ascorbic acid) serves to aid cells to adhere to one another and to maintain connective tissue. Deficiency results in scurvy. It is found mainly in fresh fruits and vegetables.

D (calciferol) is involved in the absorption and deposition in the bone of calcium and phosphorus. It is obtained especially from fish oils and liver, but can be synthesised in the skin in the presence of sunlight. Deficiency results in rickets.

E protects some types of molecule in the body from oxidation. It is found in a wide variety of foods.

K also widely distributed in foods, is needed to synthesise a substance essential for blood clotting.

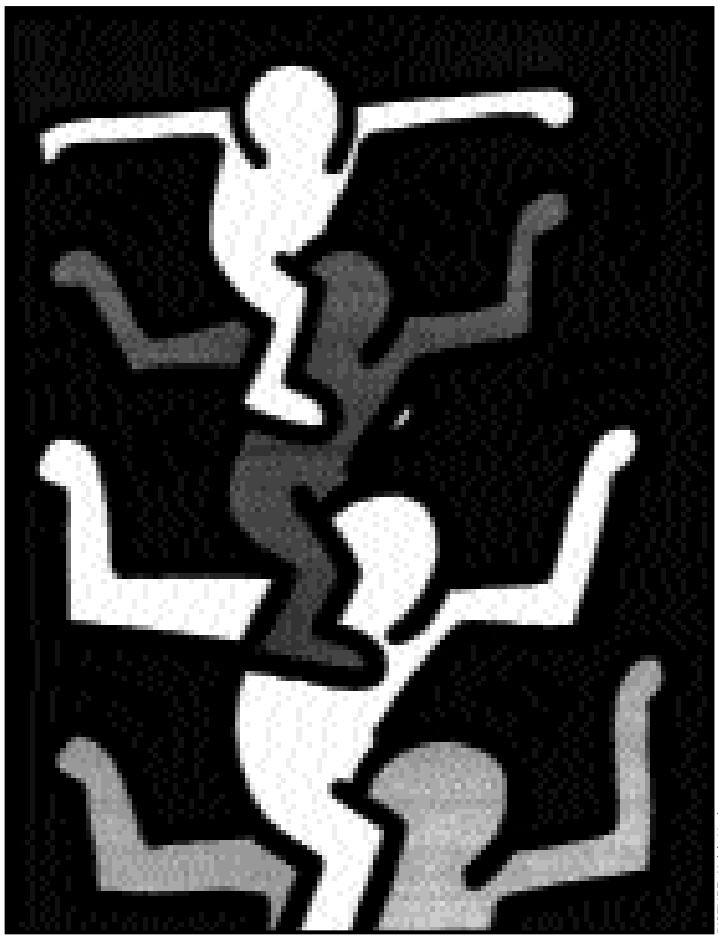
Worksh

It was in April last year that I accepted Continuum's invitation to create workshops for Continuum readers. One reason I reflected before accepting this invitation was simply that at 31 I thought myself too young to be already presenting my own workshops – after all, my own teachers and trainers were middle-aged women and men. But then I read yet another article thrown at us by the endless "HIV/AIDS" propaganda machine, and it was simply one too many. I decided, "To hell with conformity! I'm ready when life calls me!".

I remember my late boyfriend Barry, who was OK with the "dissident information" while I was around representing trust and confidence, yet unable to build up confidence within himself and thereby keep up healthy boundaries when by himself. He finally gave in and died of medical poisoning. This was when I first learnt how crucial emotional support is. Later in San Francisco I trained in precisely how essential emotional support is and how it can help in building up self-trust, self-confidence and self-empowerment – however, only years later I learnt how it can also be abused or simply be used on wrong assumptions. It is not support for dying that is needed in "AIDS" but encouragement and emotional support to live despite the infectious spread of convenient lies. Over many hours I have put together what I consider a safe and inspiring workshop for vulnerable people, including many counselling tools, externalised emotional work, gestalt exercises, art-therapy, guided imagery and other techniques I have learnt in my therapy training

The aim of the workshop is to put each individual back in touch with his/her soul. It is the emotional level that gets blocked first when encountering a crisis in one's life. If we do not regain our feelings we will exhaust ourselves from within – laying out the psychological grounds for exhausting one's immune system. So let me take the time here to carry you gently though not in too much detail through this workshop, entitled: "HIV Insight" – a nine day (six plus three) intensive workshop for Continuum readers personally affected by the "HIV" myth, to understand individual responses and increase personal coping.

Michael U. Baumgartner



PICTURE: Keith Haring

The workshop starts with a one-to-one meeting between each participant and myself, following the initial interview which every interested person is offered. The content of the one-to-one is the quite extensive application form. This form helps to bring to our attention the participant's past in terms of fragments of biography, lifestyle and assessment of the participant's psychological and physical health, and so helps to identify some personal areas of focus for the following six days. The participants then come together as a group to tune in on some facts on "HIV" and "AIDS", confronting the fiction we have grown so accustomed to. The effect on our lives of this fiction will be what we actually deal with in the next six days.

1 The first day is dedicated to one's past. Both individually and (as it happens in the case of the first workshop) as practising homosexual men, participants will be looking into their lives before their "HIV-antibody-positive" diagnosis. Where were you coming from personally (inner world) and professionally/socially (outer world)? How was life as a practising homosexual man fulfilling, both physically and on the emotional-cognitive level? Or was it not? What was your perception of your life and your future? What stage in your life were you at, when this diagnosis hit? How did this spell shake it up? How did this intrusion fit into your unconsciously chosen path or mess up your life?

2 Leading to the next step of the workshop, we will focus on life changes since the diagnosis, and what the important implications are which are the basis for how you presently live your life. First we look at the internal then the external consequences of that trauma – I call them the dramas we create while enslaved by our individual biography. This will give the centre of the second day of the workshop. You will be looking into emotional and cognitive responses and learning to see how your life today is a direct response to these. The deals you broker with yourself become the dramas ruling your life in the present, permitting survival but hindering living. Some of you might understand that no personal trauma (drama) just happens to you. As uncomfortable as it might seem, we create a drama when we do not yet have the resources for emotional responsibility and unconsciously view traumas as punishment. What would have happened to you or what could happen, if you do not stop this possibly blind ride on the roller coaster of your life and take a close look at your path, will summarise this day.

3 On the third day of the workshop, anger, rage and its spiritualised form, wrath – all of which are part of the life-force and its powers, both negative and positive, called aggression – will take over the arena. Aggression is one of the most important energies of our lives, allowing survival, and it can help us access the power to live our dreams. However, if it is not purified it can be the most destructive force in our lives. Often our dramas allow us to give in to our self-destructive anger as a way to remain victims of our past: we do not have to live, for suffering grants us attention. Getting in touch with your anger, purifying it and finding ways of releasing it – not just once but as a joyfully incorporated continuing process until we can make use of it instead of being slaves to it – will be the aim of this day.

4 A lively person is a gentle person so a saying goes. While surviving creates tension that can in the long run exhaust even our physical resources, life asks for the ability to adapt and stay flexible. To be in touch with our grief and able to

ops for Change

The "HIV" Challenge

express it, to be able to cry, helps us stay gentle in our lives and open for necessary adaptations. On this fourth day, getting in touch with your hurt will get all your attention. With carefully designed exercises each participant will be put in touch with his/her bereavement issues, and creatively find ways to transform them. The context and conduct of the workshop provides a safe space for all feelings and provides healthy ways to express emotions without at any stage forcing outbursts. To feel invited is the basis for us to gather, share and thereby heal.

5 On the fifth day participants will look into some constructive options for their lives. What you might have dreamed of, desired, yet never thought of as a meaningful possibility of great importance – the things people let themselves be diverted from by created dramas, the thing called our destiny or our karma, which we constantly or unconsciously create every day. You will explore the blocking mechanisms that can prevent you being the wonderful person you are meant to be.

Even more, you will look into ways by which you can turn handicaps into supportive and attentive mechanisms to help you from blindly running forward. What is it you want in your life for yourself and for the world? What are you willing to give? Each of us and our free contributions are essential to the future of this planet. What is it that you need in order to gleam and shine to fulfil your possibilities?

How to create a conscious future with healthy coping strategies when life does not behave quite the way you planned it, is the aim of this day, and summarises the whole workshop. Yet there are two important tasks still ahead.

6 On the last day of the workshop you will start walking along a challenging path for the near future. You will choose a task – new to your intellectual life, yet now approachable – and you will be guarded by the gentle "tough love" of a "new" friend. A final exercise will open you to qualities of new levels of friendship quite likely different from those familiar to you.

Centred, with some new peace of mind, participants will be stronger for having learned ways of coping when life hits out, for example in the form of fascistic "HIV" propaganda. Knowing you are not alone, and experiencing new forms of relating, most likely will be a crucial form of support until we meet again for a long weekend about twelve weeks later.

On this weekend, which concludes this workshop, we will reflect on the past weeks since parting. Participants will talk about their individual tasks, and give feedback on their tough loving experiences. Further support systems will be introduced. Yet most of all, people will check on whether they really want to go on their path, if they feel ready for the storms ahead, unknown to them as yet but most likely to happen – now that you have become more captain of your boat rather than the boat-person you may have been accustomed to being.

The intention of these workshops is to give some general insight into "HIV/AIDS", leading to a deeper understanding of individual behaviour. They are addressed to Continuum readers directly affected by the "HIV" myth. As every group is different so will the workshop be. The structure of this particular workshop will remain and adapt along the way. There will I hope be different workshops according to the needs of the people affected by this scientific disaster and offered by Continuum. These workshops are conducted by myself with trained assistance. All my therapeutic work is carried out under the supervision of a trained therapist, including the design and conduct of this and other workshops.

This workshop is designed to be residential starting on a late Friday afternoon and ending on a Thursday afternoon. Each participant is offered the opportunity to put individual understanding and healing in the centre of his or her own life for a week. He or she will be asked to make a financial contribution according to his/her budget and with careful personal consideration of the value and importance of this – his or her own – work

For information about the next workshop as well as registration call Continuum on UK 0171-713 7071.

With special thanks to the volunteers of Continuum for encouraging me to do this work and Judith Brand for helping me put my experiences and thoughts together in a fruitful way.

Michael U Baumgartner is a licensed social-worker currently working in a clinical position in a psychiatric hospital in Bern, Switzerland. His training includes: as an AIDS Chaplain and art-therapy-intern at San Francisco General Hospital, art-therapy and biography-work with Judith Brand and externalised emotional work with Beth Winer, based on the work of Elisabeth Kubler-Ross, in Switzerland. He has worked with well over 500 individuals affected by the "HIV" myth in Switzerland, the US and England. He is Programme Director of the next AIDS-Analyst Conference and is representing *Continuum* at the Human Rights Committee in Geneva, Switzerland. He is a member of the Executive Committee of Continuum. This workshop is offered as a new aspect of Continuum's resources and will be conducted on a regular basis.

Continuum welcomes your letters – write to the editor by post or email. Published letters may be edited for clarity and length.

Getting in touch

I was looking just now at recent issues, hoping to find a lead for a person who was telling me yesterday about his considerable stress/distress over blotches (KS?), and the seemingly quite unprofessional and nasty pressure he's getting from the Royal Free (or some hospital) to get going on AZT etc. He bears it all in miserable loneliness. Please tell me about how he might meet others? Surely he's not the only person resisting/questioning his own "KS"-diagnosis?
Peter, London
We will gladly forward letters from readers who may be able to help.

Where to next?

Science must not be used for economic, military and social manipulation by using fear to create the illusion of new illnesses for which detection and remedy are both created by the same monopoly. Make it clear that the doctors and the medical profession are not to blame for the AIDS fiasco. Their training is financed and conditioned by the same pharmaceutical giants who hold the monopoly.

Look at the ethics of patenting biological tests based on human cells. Was it ethical to patent a "test for HIV" when no isolation of either virus or antibody had been achieved? And then the crux of the matter is the antagonism to the notion that our individual (and collective) way of life has a direct influence on our health, and that change and learning health is possible but doesn't make Megabuck$!

Where to next: A new model of AIDS with Oxidative Stress as "a better fit". A new global therapeutic model based on creating health rather than endlessly fighting illness – this model is applicable to all diseases of civilisation today.
Mark Griffiths
Domaine Le Casse Haut
11300 Villelongue d'Aude
France

Existence of HIV

The Perth group seems to put too rigorous standards for isolation of HIV. The existence of HIV (as a transmissible agent) has never been shown even in a BLIND and RANDOMISED experiment on infection-transmission-detection (in cell cultures, of course), without any isolation itself. Such an experiment is much easier to control, and it leaves much less room for falsification and ambiguous interpretation as compared to the multi-stage procedure suggested by the Perth group. Please pay attention that the greatest achievements of virology were based just on such methods – nobody could isolate viruses at the time of Pasteur, and even many years later.
Dr. Vladimir Koliadin
Ukraine

South African dissent

Thank you for the copy of Continuum. I'll try to send as many copies of the contents page as possible to AIDS organisations, etc. so that they are aware of Continuum's existence.

I have written a philosophical piece on the HIV/AIDS debate for my newsletter NOUMENON which can be accessed on the WEB. If you want to use it in any way, please do. Also, I presented a paper on Educational Drama and Theatre with a special focus on AIDS education based on my experience with a huge drama AIDS project here in South Africa. This was published in book form as Drama and Theatre in Education– Contemporary Research (Captus Press, 1996). My article is entitled 'Fuzzy Logic – A Theoretical Perspective for Educational Drama and Theatre.'

It is interesting that another chapter is by Professor Lynn Dalrymple on the Drama in AIDS Education (Dramaide) project here in KwaZulu-Natal, a division of which I managed until my inquiry into the debate which ruffled quite a few feathers and lead to the contract with my university not being renewed. This action was taken not too long after I brought down Dr Harvey Bialy to present a seminar on the controversy.
Kriben Pillay
Reappraising AIDS South Africa
http://pixie.udw.ac.za/~kriben/noumenon.htm

Antibiotic news

I have read the book by Jeffrey A. Fisher The Plague Makers [published in 1994 by Simon and Schuster, New York]. Fisher, immunologist, pathologist and leading expert on the development of medicine at WHO explains how the use and misuse of antibiotics led (after 1945) to resistance against various antibiotics and mutation of fungi and bacteria into aggressive pathogens, that transfer their resistance genes to other bacteria in the organism. Later on he shows how irresponsible use of antibiotics in the USA (240 million prescriptions in 1991 by MDs) and in Africa, where they are sold in small quantities at the local market against any kind of illness, led to a pandemic of resistance and immune deficiency.

In two chapters he describes how misuse of modern antibiotics in the gay community led to immune deficiency, (which he traces back mainly to the mutation of mycoplasma, according to Montagnier's findings in 1992 and the mutation of bacteria), questioning the role of HIV (with Root-Bernstein), which he cannot recognise as it is a construction, a reductionist genetic model.

The fact that the syndrome of AIDS (like various other illnesses without a positive result to HIV-test kits) is effected by the ongoing misuse of modern antibiotics since 1970, which is continuously played down and hidden by the pharmaceutical industry and by doctors not even instructed in their professional use, has to be put up for public discussion. It could show what really happened and why the reductionist genetic HIV-AIDS hypothesis was created and continuously repeated to allow testing of DNA blockers and other genetic treatment in genetic medicine and the gen-

LIVE, LIVE, LIVE!

Here I sit with my two Yorkshire terriers – yes, I went out and purchased another and only God knows how I am going to pay for her, but miracles never cease to happen. I got another because Sadie needed someone to play with and I'm busy writing my memoirs.

I hope the New Year has brought you the things that you want or it will do. I may seem to be doting this month as I write about the puppies and the real reason I got them – these dogs will live for twelve to thirteen years. So I have to be here that much longer cause if I'm not who will feed and take care of them? This is part of the positive thinking I always talk about. Dare to do something that your doctors tell you not to. If the medical profession had their way we would be on a great amount of medication and not well at all. This message isn't for those of you who are almost ready to let go because you have been with your doctor for donkey's years and anything he says must be truth. It's for the rest of us who are not ready to throw in the towel.

I know some of the things I say are kind of hard to take but when ages ago they told me I only had a few years to live even if I did what they told me and took the pills, well... as I have said in the past say no to fashionable drugs and yes to vitamins and you truly will live longer and for goodness sake get yourself a pet so you have a reason to get out and about.

You can save one of the dogs at the RSPCA for about £25.00 including shots and have a companion for those times when your partner must stay out or whatever, your pet has a home and you have your health.

If you have the October '95 issue read my Lifestory and take the vitamins I do and stay away from AZT and Septrin and all the rest of the crap and you'll feel 100% better for it. Now get out there and LIVE! LIVE! LIVE! Next month I'll start a recipe a month along with my column.

Happy Easter!

With love,

Goldie Glitters

WHO WANTS TO BE A HERETIC HACK?

Joan Shenton
Meditel Productions

Only last month it was announced that AIDS wards had been shut in two leading London teaching hospital because there were no AIDS patients. At last, I thought, the dissident hacks will be vindicated.

It is ten years since we AIDS dissidents began to raise our voices. We've said it all a hundred times. HIV does not cause AIDS. AIDS is not infectious. There will be no heterosexual epidemic.

But what do our orthodox colleagues in the media do? Parrot the AIDS gurus whilst they queue up to claim credit. It's the success of the latest drug cocktail cries Chris Mihill in *The Guardian.* On the nightly news more pundits are paraded across the screen telling us the safe sex campaigns did it (when we know that the figures for sexually transmitted diseases and unwanted pregnancies has been steadily rising).

No, it's no fun being a heretic hack. However right we get it, we are reviled or, worse still, ignored. How quickly does Thesaurus, in its definition of heretic, descend from the moral high ground of "non-conformist", "unorthodox", "objector" and "unbeliever" to the depths of derision with "deviationist", "laughing-stock", "crank", "oddity" and "queer fish". And this is precisely how our journalist colleagues see us.

Some of us have fared better than others. Peter Duesberg, the original AIDS heretic has had the honour of being described as a latter-day Darwin or Copernicus (*The Independent*), and compared with Galileo (*The Times*). By the way it took 350 years for Galileo to be finally pardoned a few years ago by the relevant committees in the Vatican!

But the best we can hope for is for Steve Connor in *The Independent* to call us flat earthers, repeating the Chief Medical Officer's contention that we are "irresponsible bordering on the criminal" and for Duncan Campbell to call us "murderous" in front of a gathering at the Edinburgh Film Festival.

But things are looking up. We were in celebrated company indeed when Luc Montagnier announced that there was no explosion of AIDS in Europe and that it would be wrong to frighten the general public into believing that there was a high risk of catching the disease

This after years of panic-mongering and plague terror tactics in the press. The worst culprits to fuel the machine were our own hack colleagues. Coughing in public, barber's scissors, garbage collection at a lesbian centre, shaking hands with a known carrier, the kiss of life after a road accident, and raw sewage outfalls on beaches were all blamed for transmitting AIDS. When what we have been saying is that that the immune suppression described has AIDS has remained firmly locked into the high risk groups, namely intravenous drug users, blood transfusion recipients, a small percentage of the fast-track gay community, and people whose immune system is compromised through poverty, malnutrition and disease. These conditions can cause severe immune suppression which in turn causes the body to produce high protein levels (autantibodies) in the blood. These are the very proteins which, when raised, test positive in conventional HIV tests.

Since HIV has never been isolated, we argue that the HIV test simply points to a state of immune suppression but does not identify the putative infectious retrovirus HIV.

We heretic hacks have not been proved wrong yet, so next time you hear that the AIDS figures are dropping, remember, it's not because HIV is in check. It's because you can't catch AIDS and most of those at high risk for chronic immune suppression who can do something about it are beginning to get the message and adapting their lives accordingly.

We heretic hacks will continue to snarl until the day comes to bite back.

Lust for Life

It is with great pleasure that I share with Continuum readers various parts of my life before and after my hiv diagnosis. I spent the whole decade of the eighties involved in the music business. I lived with Taka, Chaka Khan's sister, in either Los Angeles, New York, or London. Dance music and discos were how we made a living and there probably wasn't one major club we missed. The stories I could tell involving the dance divas of that era – Sharon Redd, Grace Jones, and Sylvester just to name a few... I had no idea at the time but those years would later serve as preparation for a jump into the big league.

It was late in 1987 that my best friend Greg Alliapoulos and I went on to manage Chaka Khan. He unfortunately would later die in my arms of pharmaceutical poisoning – oh yes, isn't that one of the many names for AIDS?

I had known Chaka for about eight years already, but nothing quite prepares you for the consistent intensity of being with Ms Khan. The three years that followed were like one big whirlwind; I mean if it wasn't Quincy Jones or Stevie Wonder's office calling, then it was a fight with a promoter, another singer, or a label executive. I cherish those years and one day I may write in detail about some of the many stories. I find now, that the strength I developed during those times is part of what serves my courage to deal with the many ramifications of an hiv diagnosis.

In being assertive for the rights of Ms. Khan as an artist and friend, I got much more comfortable using that two letter word, "No". There were many ways I actually learned from watching Chaka's vocal escapades off stage, as she either fired road managers or background singers. I must admit by her being an Aries some aggression just seems to come more naturally. I am one of those people that always found it easier to stand up against injustice for others than necessarily myself; however after the psychological adjustment to the hiv/AIDS madness I've changed. One soon realises that you're going to have to ask the questions from your doctor, you're going to have to read the books, go to the lectures, take the vitamins and herbs, do the exercises and change what needs to be changed in order to be whole, in other words totally take charge. I guess I would simply say, no, it isn't easy but somebody has to do it. This is the approach I took when taking care of Greg in the last year of his life, but sometimes when there isn't anyone else what can you do but rise to the occasion?

It was somewhere in 1991 about six months after Chaka, Greg and myself parted professional company that Greg started to feel fatigued. He went home Christmas holiday, only to soon be hospitalised with pneumonia. Many of you are too familiar with the rest – he was subsequently tested for hiv and put on azt. I began to face the fact then that though we weren't lovers, there still was a possibility I could test positive. I was not lying to myself, I hadn't been some purist or something through all those years dealing with recording artists. I decided to test, it was positive, I was a emotional wreck, and I went home to mother. I kept all this bottled up for about two months until I felt compelled to confront what I then thought was the truth about hiv and AIDS. My family have never been ones to appreciate most of my lifestyle, professional or otherwise, but when it came to basic

Steve Grissom (left), former manager of Chaka Khan and Aileen Getty, says to be informed is to empower ourselves

compassion related to health, they were there. Many years earlier in the the 70s I had developed a growth that was thought to be cancer; it turned out to be a swelling that once lanced disappeared. It was this experience that made me very aware of health and having an holistic approach in life. I became a vegetarian and started to take some herbs and vitamins, but little did I know years from then there would be AIDS..

In the first year after my positive results I continued to buy into the mass media approach to AIDS, but being an avid reader I soon found different viewpoints. I started to question many ideas and I might add I've always had a slight distrust for most authority figures, be they government, doctors, or priests. My views began to be very much in step with HEAL, Continuum, and all the others that doubted the hiv=AIDS hypothesis. I began to study yoga and take many supplements too numerous to mention here. I tried to pass along some of my philosophy to my friend Greg but I guess it just wasn't in the cards for him.

I was in Florida on holiday during the spring of 95 when I got a call from a mutual friend of Greg's and mine. It seemed that Greg's doctor felt he needed 24-hour care and though his family had money, paying five thousand dollars for nursing care was out of the question. There had been a meeting of his friends and family and I was the natural choice to ask for help. What followed in the next six months was simply the most difficult and rewarding experience of my entire life.

I soon realised on arriving that one of the most important things necessary was to keep his business going. I had to stay current with the bills, so in essence I became everything from business manager and public relations agent to nurse, therapist and priest. I am sure far too many of you out there know the feelings and have heard the stories. What has mattered most to me in this overall drama is simply the fact that I tried, I gave it my all. I poured as much compassion out of this heart, with all its faults, as I could give.

At the end his family would have had no problem putting Greg in a hospice, but it was my feeling and his wish for him to die at home.

It was shortly after Greg passed that AIDS activist Aileen Getty, a former client of his, asked me to be her publicist and manager. We had been friends for a while and certainly we had some common goals related to AIDS – however her beliefs were much more mainstream than mine. It was this past summer that we came over to Europe and met with the Princess of Wales, who I must say seemed genuine in her compassion. In doing some of our interviews you know I wanted to say more about this whole hiv hypothesis, but it wasn't possible as I wasn't the celebrity and that wasn't their focus. I will always admire Aileen's courage for certainly as a Getty she could choose not to talk publicly. We are in so many ways programmed in life to follow and not lead, which of course keeps us from knowing our true inner resources. I do feel it is also our responsibility to challenge and question all aspects of this or any other disease.

What has worked well for me throughout these years is simply reading as much as I can in order to empower myself. I continue to holistically enhance my immune system, even as they come up with one new pharmaceutical drug after another. I do adamantly adhere to a balanced approach physically, emotionally, and spiritually. I believe in trying to live in the present, even if it is something which is often hard to do. On many occasions though it has been more than a year since Greg died I reminisce. I allow myself good tears – after all it was a twenty year friendship and another hasn't come along. I say that as a statement of fact not sadness, for life does go on and I am thankful for each day.

I am one of those that doesn't mind saying "There but for the grace of God go I." Please stay well and continue to love yourself.