

SUMMARY OF OUR TESTS FOR DISPATCHES

1. 26 samples ran through the full gamut of our tests. Of those only one sample remained truly negative.
2. Of the seven individuals who tested positive, two were wrongly diagnosed. One was Peter, who tested positive on three different test kits in our tests, and negative on three subsequent NHS hospital test kits. The other was the patient with an autoimmune condition and raised gammaglobulins who tested positive although the patient had no AIDS defining diseases or HIV risk.
3. The specificity in our testing was: 4 wrong positive results out of 202 tests. i.e. $1 - 4/202 = 98.02\%$: false positivity rate 1.98%. This is 20 times the claimed national average for false positive results.
4. If we adhere to the orthodox figure of 99.9% specificity for the tests and choose a population of one million where 1 in a thousand is truly infected (prevalence claimed for Australia) then 1000 will be true positives, and 999 will be false positives, making 1999 positives. So if we were randomly selected and found to be antibody positive there is only a 50/50 chance we would be truly infected. The test would be wrong half the time. And if we take our own test results with 98.2% specificity, 1.98% of the non infected would be seropositive - that's another 19,780 i.e. for every true positive twenty false positives.
5. Our testing revealed 27 results of indeterminate reactivity in one test kit (which were negative on the other two kits). Retesting would increase the false positivity rate manifold, with the obvious implications of unreliability.

POSITIVELY FALSE

OUTLINE FOR DISPATCHES FROM MEDITEL

There are 18,000 HIV positive individuals in the UK. In 1984 it was assumed that a positive HIV test meant that if the patient was infected with HIV he would develop AIDS and would inevitably die.

It is now known that:

1. All HIV tests are not reliable and have no diagnostic value.
2. The orthodoxy openly states that not every individual will progress to AIDS.
3. Leading scientists at the University of Perth, Western Australia (Eleopulos, Turner and Papadimitriou) and the University of Konstanz (Stefan Lanka) are now not only doubting the validity of the tests (ELISA, Western Blot and PCR, polymerase chain reaction) but the very existence of HIV. They maintain that HIV has never been isolated and that the proteins detected in HIV tests are no more than stress proteins expressed, for example, under heavy psychological stress (described as hypercortisolism by Prof Hassig) in many autoimmunological diseases. The proteins can also be derived from cells in the test tubes which are treated with, amongst other substances, cortisones) in order to "produce HIV."

With the death sentence in mind that accompanies HIV, as well as the highly toxic AZT drug therapy given to HIV positive patients, combined with other potentially toxic prophylactic treatments for pneumonia like the sulphonamides Septrin and Bactrim, it is now imperative both on humanitarian and scientific grounds to discover whether those 18,000 UK HIV are truly "positive".

As our programme will demonstrate that HIV tests are invalid and have no diagnostic value, we will be able to lift the death sentence from all HIV positives.

With the co-operation of the AIDS support group CONTINUUM and the SwissBerne Institute of Nutrition and Immunology, we propose to perform three sets of tests:

2.

TESTS

1. To demonstrate genuine virus isolation and how HIV (and no other retrovirus) has ever been isolated.

Dr Lanka will give a brief and clear demonstration of how a real virus is isolated and how whole viral particles can be easily identified. He will then show how this has never been achieved with HIV because like all retroviruses, HIV is only a concept, or a viral misconception.

2. To show how unreliable the HIV antibody test is and how bias can result in false positives. (There is no gold standard against which to measure any test kit).

In order to mislead presumptive diagnosis, we will send a number (the more the better) of HIV positive gay men in the company of a young woman to different labs across the UK. The couple will say they want to get married and want to have an HIV test. This has already been tried in Germany with one couple, and the young man, previously positive, tested negative.

NB: Dr Eleopulos's published papers paper in Bio/Technology describes how her team submitted positive and negative blood samples to 4 standard labs in Australia over 40 different times. The same blood samples were interpreted differently on different occasions by the same lab and by each other.

3. To show how the proteins said to be specific for HIV are derived both from the cell cultures used for testing as well as being endogenous in all of us.

We will send the blood of 10 HIV positive and 10 HIV negative individuals (the latter with known risk factors) to be tested through PCR. Dr Lanka maintains that the DNA sequences found will be the same for both groups, thereby making the antibody negative individuals test positive for PCR. In other words, the stretches of DNA found by PCR are endogenous, occurring as frequently in antibody positives as in antibody negatives.

Through these tests we can prove that the HIV test has no value and that HIV does not exist, because what is said to represent "HIV" is the manifestation of a normal reaction to extreme stress.

EXTRA NEWS

Conversation with Dr Mortimer, head of the National Reference Lab at PHLS

One of our researchers spoke to Dr Mortimer this week and he admitted over the telephone that the issue of standards for HIV testing is "one of considerable arguments that are not entirely reconcilable... We are all very concerned about how specific the tests have been over ten years now, and this is a cause of anxiety to us." Mortimer was particularly worried about the fact that although he lays down guidelines for testing, and is trying to establish a single agreed policy, "independent scientists don't want to follow our reference laboratory guidelines."

Lupus and false positives

Today, I finally managed to speak to Dr Graham Hughes, head of the Lupus Research Unit at St Thomas's Hospital and one of the world's leading authorities on lupus (systemic lupus erythaematosus - SLE). We know that about one quarter of lupus patients test false positive for HIV, and Professor Hässig has long said that lupus patients could provide the key to understanding the immunological breakdown seen in AIDS patients. Dr Hughes, to my delight, is willing to co-operate with us in our blood test runs and would be willing to provide samples of blood from his patients for testing through the Robens Institute.

Wall Street Journal, May 1st, 1996

A front page article reveals the Centres for Disease Control's own admission that since 1987 it has been deliberate policy to exaggerate the extent of heterosexual AIDS in order to garner more funding.

HIV TESTS THROUGH ROBENS INSTITUTE, SURREY UNIVERSITY, AND PRIVATE CLINICS

STAGE ONE

PART ONE

Sending five gay men who have tested HIV positive, dressed straight in the company of a woman, to either a private clinic or private doctor-call service in an area outside London. The couple will say they plan to get married and both want to be tested for HIV. This is to achieve a negative result in the men.

CONDITIONS

At least one week of conspicuously healthy living. A regimen of 8 hours of sleep, started before midnight, fresh vegetables and fruit. No stimulants like coffee, black tea - no alcohol, no smoking. At least two and half litres of water and herbal teas per day (if big person 3 and a half litres per day).

The blood should be taken as late as possible in the day.

This is to achieve a negative result. If they re-test positive, continue with the protocol offered (second ELISA and maybe Western Blot).

PART TWO

Sending the blood of the above 5 HIV positive men and the blood of five gay men who may be considered to be at risk, but have tested negative, through the Robens Institute to three different PHLS labs using different test kits. The blood samples will be sent blind and then resubmitted to those labs under different numbers. We may also be able to send the blood of some of Dr Hughes lupus patients.

This is to see how much the results differ How many of the positives will be negative and how many of the negatives positive.

CONDITIONS

For the HIV positives:

They should continue with the protocol described in Part A. The blood should be taken as late as possible in the evening.

For the HIV negatives:

One week of unhealthy living. e.g. Lack of sleep, red meat, sugar, few vegetables and not much fluid (Dehydration achieved through drinking fruit juices and alcohol).

The blood should be taken early as possible in the morning.

**TWO CASE HISTORIES OF THE TRAGIC EFFECTS
OF A FALSE POSITIVE DIAGNOSIS - ONE IN THE UK AND ONE IN THE
DOMINICAN REPUBLIC.**

HECTOR SEVERINO - Puerto Plata, Dominican Republic

Hector is 28 and looks healthy and strong. Two years ago he had a motorbike accident and seriously injured his leg. He was taken to hospital, tested for HIV, and found positive. Because the surgeon was afraid of being infected with HIV he would not operate on Severino's leg and he was sent home to die. Severino's young wife was so terrified of being infected by her husband that she swallowed a whole bottle of bleach and took a month to die in agony.

Severino's general health is good. He has never had a day's illness but he is now severely disabled and can barely walk on crutches. I was able to give him the money from a London charity to go back to hospital and be tested. In August last year he tested negative for HIV. He has lost his wife, his job and the use of his leg.

GEORGE HAMER - London

For six years George believed he had AIDS. In 1986, at the age of 52 he was found to be positive for HIV in a routine health check. "I was given a death sentence on the strength of one blood test." His family abandoned him and people refused to eat with him before checking with their doctors that it was safe. "I was treated like a leper, like a fiend. When I had dental treatment the dentist wore a helmet with a visor." He became so phobic about infecting people that he would wash his hands over and over again with bleach until they were raw.

Then he decided to be re-tested. He was told that both his original blood sample and his recent one were both negative. The hospital that performed the tests has admitted liability and Hamer is taking legal action. "I want justice and I need to be sure nobody will ever have to go through what I have gone through need justice

FALSE POSITIVE RESULTS IN SCIENTIFIC LITERATURE.

The journal of The American Medical Association (JAMA), 19 August 1988, page 923, Vol 260:

"(ELISA) for the detection of antibodies to HIV is KNOWN to be associated with a certain amount of false-positivity, false positive results have been found more frequently in people with liver diseases, parental drug abusers, hemodialysis patients, and patients who receive multiple transfusions."

"In our previous study, using the first-generation ABBOT HTLV 111 ELISA, 15 (24.2%) of 62 RPR- reactive [people with syphilis] serum samples tested falsely positive for HIV antibody." (1)

"Of 2210 specimens, ten had REPEATEDLY positive reactions by the HIV ELISA; Only one was confirmed a true-positive [sic] by Western Blot." So 9 repeatedly positive samples out of ten were false positives, how many were initially positive the authors fail to mention.

The authors found the following in their Evaluation of the current (third generation) ABBOT HTLV 111-ELISA kit in people who had tested positive for syphilis:

"Of 160 RPR-reactive serum samples, 26 were initially reactive and 11 were repeatedly reactive for HIV antibody. Of these 26 Only six were positive by indirect fluorescent antibody and Western blot. Among RPR-positive [syphilis] serum samples, the HIV antibody false-positive rate was 13 % for initially reactive samples and 3% for repeatedly reactive serum samples." So out of 26 positive results on the ABBOT (third generation) ELISA 20 were false positive. In other words when using the ABBOT (third generation) ELISA to test for "HIV antibodies" in people with syphilis at least 76.9% of positive results are false-positives, so over 3 in 4 positive results are false positives. (2) in every ELISA -

Please note: Gay men in the U.S.A. and the U.K. during the 1970's and 80's had by far the highest rate of syphilis. *in 2nd Syphilis*

The New England Journal of Medicine, 18 February 1988, page 448-449, Vol 318:

The authors reported that they had found the following cross reactivity (false-positive) to core proteins of HIV-1, HIV-2, and HTLV-1 when using the Western blot .

55 % of patients with cutaneous T-cell lymphoma or its predomes were found to have cross-reacting antibodies to HTLV-1, 24 % had cross-reacting antibodies to HIV-1 and 33.3% had cross-reacting antibodies to HIV-2.

41.1 % of patients with Multiple Sclerosis (M.S.) had cross-reacting antibodies to HIV-1, 12.5% had cross-reacting antibodies to HIV-2 and 11.76 % had cross-reacting antibodies to HTLV-1.

12.7 % of randomly selected patients with dermatologic disorders had cross- reacting antibodies to HIV-1, 23.5 % had cross-reacting antibodies to HIV-2 , and 5.4 % had cross-reacting antibodies to HTLV-1.

The authors also reported: " Such antibodies were found in a few cases with generalised warts without underlying systemic disease and in some cases with autoimmune connective disease"

The authors concluded by stating: " thus, an antibody response restricted to HIV core proteins detected by Western Blotting may indicate either an infection with some as yet UNIDENTIFIED virus immunologically related to the known human retroviruses OR an early phase of HIV infection in persons at risk. Against this background, it is important for the laboratory to know whether a person belongs to a high risk group , and consequently to perform additional tests."

The Lancet 28 October, 1989 page 1023-1025:

Headline... "What do Western blot indeterminate^{UA} patterns for immunodeficiency virus mean in ELISA negative blood donors ?

The authors stated that they had found the following supposedly unique and specific "viral proteins" in blood donors who had tested "HIV antibody" negative using the ELISA "HIV antibody" test.

65 % had p 24

20 % had p 55

15 % had p 51

15 % had p 66

15 % had p 17

The authors also noted that ; " 48 % to 64 % of donors repeatedly positive for HIV-1 antibody by ELISA have Western blot indeterminate patterns. The frequency of such patterns in low risk populations is so high as to suggest that, as with ELISA, most such reactions represent false-positive results."

"If W.B.I. patterns were common among individuals non-reactive [negative] on ELISA, it would favour the hypothesis that such W.B. patterns are related to the NON-SPECIFICITY OF THE ASSAY, test artifact, or a common cross-reacting antibody unrelated to HIV-1."

RECORDED FALSE POSITIVE HIV TEST RESULTS

The medical literature is peppered with false positive test results.

The Journal of the American Medical Association, 19.9.88, states:

1. That the standard ELISA HIV test "...is known to be associated with a certain amount of false positivity.....in people with liver diseases, parenteral drug abusers, haemodialysis patients, and patients who receive multiple transfusions."
2. Using the Abbott HTLV III ELISA test, found 76.0% of syphilis patients tested falsely positive.
3. 10 patients, who repeatedly tested positive, were retested using Western Blot of which only one was confirmed HIV positive.

NOTE: Gay men in the USA, according to CDC figures, accounted for 70% of reported syphilis cases in the 70s and early 80s, although they only accounted for 6% of the population.

The New England Journal of Medicine, 18.2.88, dealing with false positivity using the allegedly more precise Western Blot test for HIV core protein antibodies, found cross reactivity with HIV-1, HIV-2 or HTLV-1 in many patients with other non-AIDS-related conditions, e.g.

55% of a group of patients with skin cancer had antibodies to HTLV-1, 24% to HIV-1, 33.3% to HIV-2.

41% of a group of patients with Multiple Sclerosis to HIV-1, 12.5% to HIV-2, 11.76% to HTLV-1.

12.7% of a group of patients with dermatological conditions had apparent antibodies to HIV-1, 23.5% to HIV-2, and 5.4% to HTLV-1.

All the above results were false positives. The authors state in conclusion "Against this background, it is important for the laboratory to know whether a person belongs to a high risk group, and consequently to perform additional tests." i.e. the tests could not determine HIV status objectively.

FALSE POSITIVES IN BLOOD DONORS.

The Lancet, 28.10.89.

The authors noted: "48% to 64% of donors repeatedly positive for HIV antibody by ELISA have Western Blot indeterminate patterns. The frequency of such patterns in low risk populations is so high as to suggest that, with ELISA, *most such reactions represent false-positive results.*"

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