continuum

CHANGING THE WAY WE THINK ABOUT AIDS

Vol 3, No 4 Nov/Dec 1995

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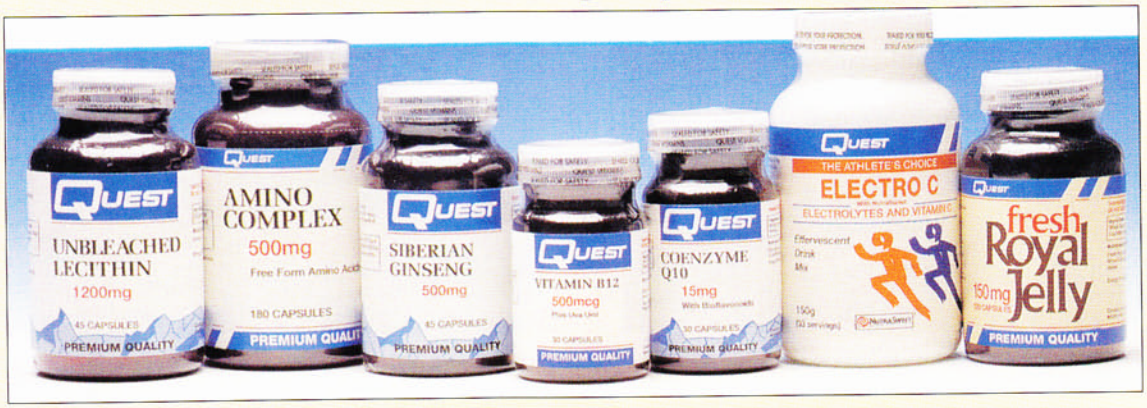

For further details contact the continuum office on 0171 713 7071

THE NUTRI CENTRE HALE CLINIC 7 PARK CRESCENT LONDON W1N 3HE Tel: 071-436 5122/071-631 0156

The Nutri Centre is located on the lower ground floor of the Hale Clinic in 7 Park Crescent, London W1N 3HE. The prestigious (Nash Terrace) crescent is only a few minutes away from underground stations at Great Portland Street, Regents Park and Baker Street.

Clients are often faced with a dilemma when they have been prescribed or recommended a course of nutritional regime by their practitioner or Nutritionist

One often doesn't even know where to begin to find a company which provides all the products he or she needs. It may mean placing orders with a number of different manufacturers whose despatch times may vary. Consequently the institution of the regime is delayed or becomes staggered. Since delay can cause further upset to someone already in distress and staggering can mean that it takes longer for the full benefit of the treatment to be effected and felt (nutrients interact with each other and the regime will have been designed with this in mind) the client may lose heart and motivation.

In an effort to circumvent some of these problems some practitioners have arrangements with certain manufacturer's or else stock the remedies themselves. But time spent in administering the purchase and sale of remedies simply increases the stress load on practitioners and their practices.
For those individuals who do not wish to see a practitioner for any specific illness there is problem of trying to obtain professional advice on the use of vitamins and nutritional products to suppliment their diet.

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The aim of the recently opened NUTRI CENTRE at the Hale Clinic in London is to lift all of these burdens from practitioners and clients. Essentially it stocks or has access to the most extensive range of nutritional supplements – from those you would find in a health food shop, to practitioner products, to exclusive lines, even to the occasional batch made up for specific requirements.

Now clients can visit or contact the Nutri Centre knowing that it can almost certainly provide all the products that have been recommended. And if, with this relative ease of availability a client begins to feel better sooner, the incentive to keep going with the regime becomes stronger and healing is achieved at a much faster rate. Suitably qualified staff are also available to give professional advice on improving compliance of the regime to maximise its therapeutic benefits.

The Nutri Centre operates a prompt and reliable mail order service for those not fortunate enough to live or work within striking distance, and next day delivery is guaranteed. This service can also be extended to ordering "repeats" enabling them to maintain continuity of the Dietary Supplementation Therapy. The intention, therefore, is that clients from anywhere in the country should be able to order their supplies from just one phone call to the centre.

"The Nutrition Centre's influence on the industry as whole will be considerable, and indeed, it is already leading the way in a number of areas..."
Jan de Vries (June 1991)

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The Centre also incorporates a Library/ Bookshop with an extensive selection of books, not only on health and nutrition but also on the whole range of alternative and complementary therapies, self development and psychology, and new age. With no obligation to buy, clients are encouraged to browse- there are plenty of leaflets around advertising courses and seminars relating to lifestyle and health. The Centre is uniquely placed to make a positive contribution to education.

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Natural Health: Ailments, Allergies, Fitness, Slimming & Beauty, Food Combining, General Good Health, Healthy Non-vegetarian cook books, Herbs & Herbal Medicine, Macrobiotics, Natural Food Healing, Nutrition, Parents & Childcare, Special Diets, Vegetarianism, Vitamins & Minerals, Women's Health.

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continuum

CHANGING THE WAY WE THINK ABOUT AIDS

Vol 3 No 4 November/December1995

This Issue

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InBrief

CHIMP FALLS PREY TO MODERN LIVING

Patricia Fultz of the University of Alabama, US, infected a chimp with 'HIV' in 1986 while working for the Centers for Disease Control and Prevention.

Science reports that the chimp, named Jerome, has developed AIDS or rather acute diarrhoea with a low CD4 count. Fultz is not surprised by the news. Neither should she be, since Jerome has been living in Atlanta Yerkes Regional Primate Research Center for more than nine years, subject to stresses and strains from the artificial environment and being injected with blood products from a different species. Who wouldn't get diarrhoea after a lifetime of that?

Though Fultz believes Jerome's bowel movements "will add weight" to studies testing vaccines in chimps, she concludes, "I don't think it will make any difference at all on vaccine development." Nor will it illuminate "human HIV pathogenesis". The main problem being the nine years it took Jerome to get ill.

Now she's looking for a strain of HIV that will cause illness quickly in chimps. She could always give them AZT which would mutate their HIV, speed up disease progression and develop a new market for the drug!

A BID FOR FREEDOM

After the release of preliminary results from the Delta 1 and 2 trials of combination therapy given to 'HIV-positives' and amid widespread distorted reporting of the meaning of the results, a new organisation sprang into being in London in order to curb the damaging effects the misinformation could have on the health of those testing 'HIV+'.

The International AIDS Freedom Network is a campaigning group that has produced a detailed response to misleading reports on the purported benefits of taking a 'cocktail' of 'anti-retrovirals', and takes issue with the suggestion that people should have an HIV-antibody test in order to start on the drugs if the test comes back positive.

The response has been circulated to the gay press and managed to secure coverage in the *Pink Paper*, Britain's most popular gay newspaper, of the ways in which Delta has been over-interpreted. The Network is now preparing to lodge complaints with the Press Complaints Commission on this issue. James Whitehead, of the International AIDS Freedom Network, can be contacted on 0171 402 4948

DRUGS KILLING THE PATIENT, NOT THE DISEASE

LETHAL DRUGS COMMON FOR HIV+ PEOPLE

Incomplete and harmful treatments for TB are killing almost a third of 'HIV-positive' people worldwide [which keeps the AIDS toll rising] the World Health Organisation warned in September, after a meeting of representatives of foreign aid agencies and ministries of health.

There is an effective and affordable treatment for TB called DOTS (directly observed treatment, short-course). If patients are not adequately supervised and fail to take the treatment every day they are unlikely to recover from TB and will remain infectious for longer periods, thereby putting others at risk. WHO estimates that up to two-thirds of 'HIV+'s' who seek treatment for TB are misdiagnosed or treated improperly. When it is used properly DOTS is nearly 100% effective at curing TB in 'HIV-positives' and 'HIV-negatives', and is reported to have no serious side-effects.

Another anti-TB drug, thiacetazone, reportedly can be lethal to HIV+'s, for an unexplained reason, yet it is often administered. In some it causes the skin to become detached from the body, as well as other severe effects. Will skin-detachment become a new AIDS-defining condition?

Dr Arata Kochi, director of the WHO Global Tuberculosis programme, said; "An estimated 266,000 HIV-positive people will die of TB this year. Their TB was potentially preventable and treatable." According to WHO, TB is the main killer of 'HIV+'s' worldwide. The problem is, TB can cause a cross-reaction on HIV-antibody tests, so it's anybody's guess as to whether the HIV+ status is merely an artefact of the presence of TB.

In England and Wales a recent study found that the notification of TB has increased by 12% from1988 to 1992, with a 35% increase in the poorest 10% of the population, a 13% increase in the next 2 poorest groups, and no increase in the remaining 70% of income groups. Incidence was found to be unrelated to ethnic group, homelessness or HIV status.

So why is TB an AIDS-defining condition? Answers on a postcard please.

CLEVER DRUG OR IS IT THE MARKETING?

AZT, commonly described in the annals of AIDS literature as an "anti-retroviral" 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 New England Journal of Medicine by researchers from the University of Southern California reports the use of AZT with interferon-a in 19 patients with adult T-cell Leukemia-Lymphoma. The condition is said to be caused by HTLV-1, 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 but 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.

PHOTO: ALEX HANSON

Continuum co-editor Molly Ratcliffe as Jeanne d'Arc, in costumes by Burnel Penhaul, crowned Alternative Miss World at the Clapham Grand, South London, on 3rd November, before a panel of celebrity judges including David Hockney and on-stage presenters Marc Almond and Jean-Paul Gaultier.

PRETENDING TO FIND NEEDLES IN HAYSTACKS IN DNA TEST

Kary Mullis, inventor of the PCR (Polymerase Chain Reaction), a test used to search for HI Virus is tissue samples, was interviews recently in a Channel 4 programme in the UK on DNA finger-printing (Equinox, Oct 22nd, 9pm).

Mullis, who won a Nobel Prize for his invention, was eloquent in stating his case. He described how the PCR was invented on paper and is 100% accurate, but therein lies the problem: because it is so efficient at magnifying whatever sample you have, any contaminants will also be magnified.

How do you decide which bits are the sample and which, contaminants, if you couldn't detect what was there in the first place? Precisely.

PCR is the basis for DNA finger-printing. In the programme the conclusion drawn was that there have been wrongful convictions of innocent people, where the only evidence against them was a DNA test.

It was most entertaining, in a cruel sort of way, to see the head of the Scottish forensic service squirm in front of the cameras as he tried, unsuccessfully, to lie his way out of having to acknowledge the very real problem of contamination of DNA samples in his own labs.

In this case it was the camera that didn't lie!

NIAID ACTG HIV/AIDS CD4-AZT STUDY

A new study supported by NIAID (Nat. Inst. of Allergy & Infectious Dis.) in the US shows that early AZT treatment "does not significantly prolong either AIDS-free [time] or overall survival" in asymptomatic HIV+'s. Volberding and colleagues who conducted the ACTG study (AIDS Clinical Trial Group) concluded that the results "do not encourage the routine use of Zidovudine" in such patients. Published in The New England Journal of Medicine in August it involved asymptomatics with a CD4 count of 500 or more and compared giving AZT therapy immediately against deferred therapy. The end-points of the trial were overall survival, AIDS-free time, toxic effects and changes in CD4 counts.

Although treatment with AZT slowed the decline in CD4 counts it didn't produce clinical benefits, which demonstrates the uselessness of the CD4 count.

Volberding et al., responsible for the study, were in 1990 behind another ACTG study which was stopped prematurely and claimed to "indicate that Zidovudine therapy... can delay the onset of AIDS when it is initiated in asymptomatic HIV-infected subjects with fewer than 500 CD4-positive cells."

The difference between the two studies is the CD4 counts of trial participants, but since CD4's are notoriously changeable and unreliable, the difference between the two groups is arbitrary.

Volberding is over a barrel - is 499 T-cells so different from 501?

CREATIVITY WILL OUT

A creative response to the Delta Trial came from Brian Parry in London. The travesty of a trial comparing people taking combinations of toxic and unproven drugs inspired him to formulate an idea: a data-base of 'antibody positive' people not on medications, that would monitor their progress. Parry, who was one of the founders of Continuum, had the original idea for the data-base even before Continuum was set up. The imperative for the project grows as the drug-companies fight for profits while dispensing with quality of life. In the absence of other organisatons or individuals interested in the realisation of the idea, Parry intends to go ahead himself. T.H.T. (Terence Higgins Trust) were contacted but did not reply. Enough said.

DOCTOR AFRAID TO SPEAK OUT ON KS

A doctor at Charing X hospital, London has admitted to Continuum that he has a case of K.S. (Kaposi's Sarcoma) in a 'HIV negative' gay man. It's not known what the patient's history regarding drug-use is.

The doctor, who wishes to remain anonymous because he fears the consequences of speaking out, has said that many doctors are aware of major problems with the HIV=AIDS hypothesis but "no-one wants to put their head above the parapet". Like that war metaphor! There are anectodal reports of K.S. in 'HIV-' gay men who have used poppers.

Since K.S. was declared an 'AIDS defining condition' there has been an assumption that HIV causes it. Professional recognition that it can occur in a risk group without the causal agent, HIV, shows the need to step out from behind the HIV-battlements and speak the truth instead.

NEW AUSSIE RULES

Tha Australian Government has accepted the recommendations of the chief health advisor to the World Bank, Prof. Richard Feacham, in formulating its Third National HIV/AIDS strategy: "Federal and state governments should continue to provide education for the general community, but funding should be decreased"; "Federal and state governments should assist the integration of HIV/AIDS into mainstream programmes where appropriate", and The Australian National Council on AIDS should be "retained and strengthened and its mandate should be revised to enable it to deal with aspects of public health that are wider than HIV/AIDS".

Looks like the whole scam of HIV/AIDS is being swept under the carpet of general public health.

Oh well - it had to happen.

Delta's Distorted Results

Reading between the lines of the latest anti-HIV drug trial, Molly Ratcliffe and Huw Christie find that interpretations of figures can be deadly misleading.

On 26th September preliminary results of the Delta 1 and 2 trials were released. The Trials were set up to examine whether taking a combination of antiretrovirals AZT, and ddI or ddC, was more beneficial to 'HIV+'s than taking AZT alone.

Delta 1 participants had never taken AZT before; Delta 2 participants had taken AZT prior to the trial for a minimum of three months and 63% had taken it for more than a year. Results cover the period from March '92 to May '95 because the trial has been stopped early by the International Co-ordinating Committee on the recommendation of the Data and Safety Monitoring Committee. Delta involved 3,214 people from eight countries worldwide including Britain where it has been supported by the Medical Research Council (MRC).

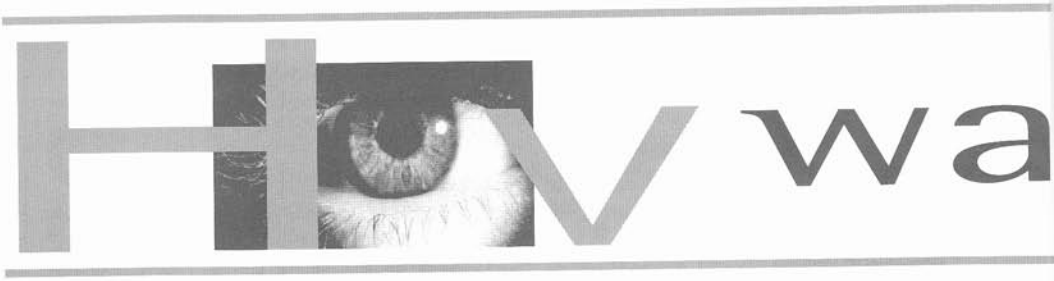
In a press release the MRC state that Delta demonstrates that "two drugs are better than one" because somewhat fewer people died in Delta 1 who took a combination of drugs than who took AZT by itself. 116 of 703 individuals taking only AZT died (16.5%), as did 69 of 720 using AZT with ddI (9.6%) and 82 of 708 using AZT with ddC (11.6%).

In Delta 2, where people had taken AZT longer, deaths were at much higher more uniform rates, and were actually more numerous despite Delta 2 involving only half as many people: 94 of 355 taking only AZT (26%), 84 of 362 taking AZT/ddI (23%) and 96 of 366 taking AZT/ddC (26%) died - a total of 274 deaths in 1083 individuals, or one in every four (25%) compared with 267, or one in eight (12.5%) of Delta 1's. By contrast, the mortality of 'HIV+' hæmophiliacs in another prominent study, over a similar period, BEFORE introduction of AZT, was 4.7%.

These results have been widely reported in the gay and mainstream press as a wonderful breakthrough for 'HIV+'s, a spin provided by a Dr Gazzard, principal investigator in Britain. He went so far as to say, "If you're thinking of starting treatment - and these results should encourage people to get tested and begin treatment - you should start with combination therapy [AZT plus another] not AZT alone."

Two drugs are almost certainly NOT better than one, and since when was the one - AZT - proved to be of benefit? Delta itself shows the opposite - the longer trial participants had taken AZT the more likely they were to be dead. Combination therapy [therapy - from Greek for healing] surely does benefit financially the three pharmaceutical companies that produce the chosen drugs (Bristol-Myers Squibb, Roche and Glaxo-Wellcome) - Glaxo-Wellcome shares have risen by 20p since the trial hype, the *Financial Times* reported. The fact that amongst those taking AZT for the first time, 47 and 34 fewer individuals also using ddI or ddC respectively died suggests mainly that the consistency in death rates improves the longer everyone's been taking AZT. In the absence of raw data (What 'AIDS' illnesses caused the deaths? Which countries were they in? How much drug swapping went on? Which markers on which of the antibody tests were used for 'positivity'? How long had participants lived with 'their diagnosis'? What risk group are they from? etc.) any number of factors could explain the statistical differences in Delta 1. If it is possible (though remote) that some synergistic or antagonistic reaction between the drugs lessens the toxic effects this suggests only a slower poisoning of the patient.

That antiretrovirals - so called - should be given to anyone, let alone those testing HIV+, is the most obvious and intrinsic flaw to mar the *raison d'etre* of the trial. AZT, ddI and ddC are all claimed to act by inhibiting the retroviral enzyme Reverse Transcriptase (RT), necessary for replication. Glaxo-Wellcome say whilst AZT "is a potent inhibitor of the virus RT, it is a far less potent (about 100-fold less) inhibitor of the host cell's DNA polymerases [enzymes]." This ratio is deduced from a single 1984 research paper.



The other claimed action of these nucleoside analogue drugs is that, even though they are inhibiting the enzymes, the enzymes somehow incorporate parts of the drug into DNA - in reality, both viral and cellular DNA - blocking replication. These contradictory modes of action cannot disguise the eventual consequences. AZT, ddI and ddC do not and cannot target 'HIV infected cells', but instead interfere particularly with all rapidly replicating cells; that means the lining of the digestive tract, bone-marrow and skin. Reverse Transcriptase activity, claimed by scientists on the AIDS payroll to be a marker for HIV infection, is actually found not only in all other retroviruses, but also in all living matter. The term anti-retroviral is not a truthful description of the drugs used: cytotoxic, that is 'cell-killing' would be more appropriate.

The Delta Trials had no control group of HIV+ diagnosed people who didn't take any 'antiretrovirals', a control group being a standard of comparison for checking the results of an experiment. The head of the MRC's HIV Clinical Trials Centre, Dr Janet Darbyshire, was reliably

- Anyone for Cocktails?

reported in Britain's *Pink Paper* saying, "It would have been unethical to have a group of people on no medication given the current views of the benefits of AZT." Apparently benefits are in the eye of the beholder. In the same story she says the MRC "never claimed Delta showed taking drugs would prolong life over not taking drugs." To extrapolate from Delta then that "combinations prolong life" *(NAM Treatment Update,* Oct. 95) is grossly misleading and cannot be supported by the available data.

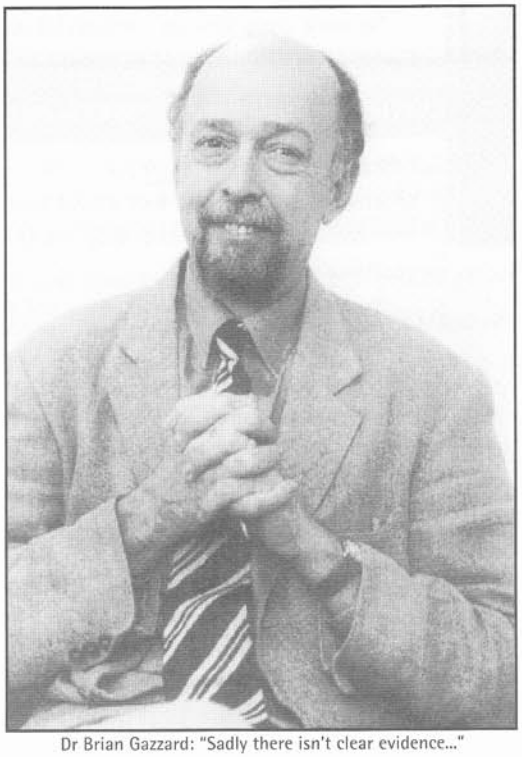
The MRC-supported Concorde Trial results of 1994, in which AZT was given to asymptomatic 'HIV+'s, concluded that AZT was of no benefit in preventing the onset of AIDS (Wellcome employees on the Co-ordinating Committee were forbidden by head office from signing the statement.) A lesser known study, though in fact the largest of its kind, by Lundgren *et al.* showed that "for patients surviving more than two years since starting Zidovudine [AZT] the death rate was greater than for untreated patients who had developed AIDS at the same time." That is, at the LEAST in 'symptomatic' people, AZT noticeably hastens death after two years. The Lundgren study was conducted in 51 centres in 17 European countries and involved 4,484 patients. Why is THIS information not taken on board?

NAM's *AIDS Treatment Update* editor, Edward King, responded to criticisms of Delta by the International AIDS Freedom Network (who took into account the Lundgren study etc.), by saying that, "these [criticisms] are inaccurate, ill-informed and a grave disservice to people with HIV...it's a waste of time to air such misinformation ...when there are genuinely important issues to report, such as whether the NHS will pay the costs of prescribing combination therapy." Fortunately it needn't take a very well-paid classics graduate like King to recognise the cost of this debacle cannot be measured in pounds and pence.

tch

Since only preliminary data from the Delta Trial has been released it is impossible to arrive at detailed conclusions of how individuals were affected. It's promised that fuller results will be released "as soon as possible". Meanwhile, over-eager physicians are promoting treatment options based on scant information.

It's certainly curious that average follow up in Delta was just over two years, when the Lundgren study indicates that it's after two years that mortality from AZT toxicity increases. Was the trial stopped due to these sorts of ethical considerations by the Data and Safety Monitoring Committee? For the MRC's part, its press release states that Delta 2 results "have not directly shown a clear benefit from combination therapy, [but] it is too early to say whether or not those who have already taken AZT may benefit from combination therapy." In other words, when we're expected to believe the results are meaningful as in Delta 1, the follow-up time is fine and dandy. When the results are clearly hopeless as in Delta 2, the follow-up is too short. Either 26 months is sufficient or it isn't. If it isn't (it isn't) why is the world being subjected to headlines such as "Most Important Trial Results Ever"? Could this making-up of the rules as you go along have anything to do with Dr Gazzard's stated worry that money for HIV units is increasingly hard to come by?



Dr Brian Gazzard: "Sadly there isn't clear evidence..."

Side effects, or rather further effects (other than AIDS and death) of the drugs deserve a mention. Most commonly occurring were nausea and vomiting in the AZT/ddI group, and peripheral neuropathy and mouth ulcers in the AZT/ddC group.

Pancreatic abnormalities were more common in the AZT/ddI group. A number of people discontinued treatment because of these effects. Though it is suggested that AZT plus ddI most significantly delays clinical progression or death, those on the ddI combination were most likely to choose to stop treatment because of the "side effects", which might go some way to explaining the lower death rate in this group.

All sorts of concessions have been made by Trial supporters to accommodate the lack of benefits bestowed by the "drug cocktails" (as they are so enticingly described) on longer term users of AZT. King, in *AIDS Treatment Update,* concedes "people who have developed a high level of resistance to AZT from prolonged use are less likely to benefit from AZT and also less likely to benefit from switching to ddI." Dr Gazzard says, "Sadly there isn't clear evidence what AZT-experienced people should do...switching to combination therapy with AZT plus ddI is probably better than continued AZT, although switching to ddI monotherapy may be just as good." Or just as bad? When the group action legal suit against AZT-makers Glaxo-Wellcome, over deaths due to the drug, comes to its conclusion, it will be interesting to see whether these careless commentators can be held responsible for their current abuse of position.

Perhaps the answer is to be so resistant to AZT, ddI or ddC that you never take any of them, or, finding yourself on them, get off as quickly as possible. Nothing in the results of Delta suggests a convincing reason for NOT resisting the drugs. ■

[Anyone deciding to stop taking any medications should do so only under the supervision of a trusted practitioner, as coming off any drug suddenly could cause problems which may otherwise be avoided.]

Too much 'HIV'-research,

An introduction to the work of Prof. Alfred Hässig

by Michael U. Baumgartner

Since 'HIV' was declared the probable cause of AIDS in 1984, this hypothetical virus has been at the centre of the international fight against AIDS. AIDS research is still a synonym for HIV research. Up to the present day, after $35 billion spent for HIV research in the US alone, researchers do not know much for certain about the tenuous relationship between 'HIV' and AIDS. The pathogenicity of 'HIV' - demonstrating how it is supposed to cause AIDS - remains at best highly speculative. Fact is, there is no proof to back up such a claim. All that money would, of course, not have been necessary to realise that a retrovirus does not kill the very cells it needs to survive and replicate in, and therefore could not cause AIDS.

There are still people dying of AIDS. The 'HIV' establishment has failed to come up with a cure for and a vaccine to prevent AIDS. Yet both the US Centers for Disease Control (CDC) and the World Health Organisation (WHO) continue to define AIDS in terms of the presence of antibodies to sub-cellular components claimed to be 'HIV'.

In the absence of these antibodies, the old and previously known AIDS-defining diseases are called by their given names. Up to 1993 the CDC collected 4,621 'HIV-antibody-negative' AIDS cases, (calling them idiopathic CD4 lymphocytopenia.)

In view of the failure of AIDS research based on virology, the Swiss immunologist Professor Alfred Hässig, formerly head of the Swiss Red Cross Blood Transfusion Service, and his colleagues Kurt Stampfli MD and Liang Wen-Xi MD looked more closely into the known and supposed mechanisms leading to AIDS as an acquired weakening of the human immune system.

This change explains the low T-cell counts of people with AIDS

They focus on the relevance of stress-induced weakening of the cellular immunity of the human body. In this article I give a brief account of the publications of these researchers appearing in the October '95 issue of the Swiss *Magazine of Holistic Medicine*.

The authors start by showing that the function of the human immune system is twofold. B-cells originating in the bone marrow produce antibodies, which catch living and non-living structures that are foreign to the body (not-self-structures) when these enter the body through the skin or mucous membranes, and eliminate them in the extra-(outside)-cellular spaces before they can cause disease.

T-cells however, originating in the thymus gland, patrol the intra-cellular areas of the human organism, checking the surface of cells themselves for worn out and virus-infected altered-self-structures and eliminating them. The humoral antibodies produced by B-cells, and the cytotoxic (cell-killing) activities of T-cells are in balance in healthy immune-competent people.

Under the influence of stress the antibody-dependent immune responses are intensified, and the T-cell-dependent immune responses are weakened. That means that in stress situations the defence against the intrusion of foreign living and inanimate material predominates over the internal "clearing up" of cellular immunity.

The concept of stress, introduced in 1936 by the Hungarian physiologist Hans Seyle, states that the multiplicity of psychological,

not enough AIDS-research

toxic, inflammatory and nutritional demands on the human organism all act towards enhancing performance related (fight or flight) metabolism, to the detriment of the recovery phases. Characteristic of reactions to each of the above stress factors is the dismantling of body reserves by switching the vegetative nervous system towards achievement, a process called sympathicotony.

In parallel with this is an increase of the stress hormones adrenalin and cortisol from the adrenal gland. This neuroendocrine change (hypercortisolism) weakens the T-cell immune reaction and leads to the disappearance of CD4+ lymphocytes from the bloodstream into the bone marrow to activate the B-cells. That explains the low T-cell counts of people with AIDS. In chronic stress situations the thymus gland shrinks in just a few days and therefore functions poorly (it can likewise return to normal).

Hässig *et al.* pointed out in their early work the ongoing psychological stress that people with 'HIV'/AIDS are living with. Never before in medical history has the orthodox medical establishment put people living with an alleged pathogen under as much of a threat as happens with AIDS. The constant, clinically inspired propaganda, fanned by the media, of disease followed by an inevitable and painful death due to the stigmatised plague of the century, contributes significantly to the progression from 'HIV infection' to AIDS proper.

According to the urgent Appeal for Action at the UN Human Rights Commission in Geneva in February and August 1993, the responsible medical professionals and health authorities have profoundly violated their ethical principles and that basic human right, the right to life.

Regular use of "recreational" drugs, including tobacco and alcohol, is an important factor in chronic stress according to Hässig *et al.* Abstinence from drugs is therefore seen as an essential part of AIDS prevention. Simply to settle for distributing clean needles is to trivialise the well-documented dangers of drug consumption.

Another important stress factor is the chronic activation of macrophages (eater-cells) due to inflammations causing short lived oxygen compounds (oxygen radicals) and inflammatory mediators to be produced in the body. The inflammatory mediators activate the neuroendocrine stress response. Hässig *et al.* point to the importance of removing the chronic inflammatory activation of macrophages by means of sufficient antioxidants via food and supplements.

The last cause of stress which Hässig *et al.* identify is persistent malnutrition due for example to excessive consumption of sugar and refined food. This causes an instantaneous distress release of insulin from the pancreas which in turn leads to a release of stress hormones from the adrenal gland. As an example, Hässig *et al.* point to the chronic protein deficiency, NAIDS (Nutritionally Acquired Immunodeficiency Syndrome), which leads to the death of around 40,000 children under the age of five years worldwide daily.

Hässig *et al.* differentiate between direct activation of the neuroendocrine stress axis via the hypothalamus, pituitary and adrenal glands brought about by psychological and toxic stress, and indirect activation, brought about by high macrophage activity with the release of inflammatory mediators due to inflammatory and nutritional stress.

Regular use of "recreational" drugs is an important factor in chronic stress

An ongoing stress-induced weakening of cellular immunity has, according to Hässig *et al.*, a negative impact on the defence against pathogens. Viral pathogens and retroviral components will not be properly identified, dealt with and eliminated. Latent infections in the body can no longer be kept under control. An increased susceptibility to otherwise harmless opportunistic infections is the result. Falling ill due to an acquired immuno-deficiency can be the outcome.

Even though Hässig *et al.* seem to accept the existence of an entity called HIV in their work, they have demonstrated a plausible model of AIDS.

I want to end this article by pointing out the three main mistakes of the current approach to AIDS research:

The first grave mistake is due to the inclusion of an 'HIV antibody positive' test result in the diagnosis of acquired immunodeficiency by both the CDC and the WHO. This has led to neglecting the study of diverse stress-induced conditions of acquired immune-dysfunctions. Attention was paid only to HIV and the prevention of its transmission. So-called antiviral therapies like AZT were used to treat AIDS. Such drugs are cytotoxic and long-term use leads to inevitable death.

The second mistake is based on the expectation that a positive 'HIV antibody test' is due to infection with a new retroviral entity called HIV. To the present day HIV cannot be isolated from the human body, which is a necessary precondition for any valid test (the establishment of a gold standard). All of today's 'AIDS tests' are therefore not specific for 'HIV'. That means that all positive test results are false positives.

Hässig *et al.* interpret a positive 'HIV antibody test' as indicating increased activity of the humoral - B cell - immunity accompanied by a weakening of the cellular immunity. Immune competent individuals are capable of keeping such an 'HIV infection' under control with a cellular immune reaction. In that case the antibody test would stay negative.

The third main mistake is the assumption that the decline of circulating peripheral blood CD4+ lymphocytes (while the level of CD8+

continued overleaf

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lymphocytes remains constant) is due to virus destroying these cells. Hässig *et al.* however show that this phenomenon is observed in every instance of a severe stress reaction, eg. the acute phase reaction following injuries and infections. It is due to the sequestration of CD4+ lymphocytes from the blood stream into mainly the bone marrow. The numbers remain the same but they're in different places.

After studying the work of Hässig *et al.* it becomes clear that AIDS might be considered mainly a problem of immunology and not virology. Once again in medical history the focus is misplaced. The consequences of this scientific error are horrifying for all affected. 'HIV+' AIDS patients risk not only being treated incorrectly, but the real cause of any individual's condition goes undiagnosed, is played down and left untreated. Such medical mistakes should no longer occur. They are fatal for the affected, deadlier anyhow than any retrovirus could be. ■

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acyclovir

ACYCLOVIR is known as an antiviral drug and has been used in treatment following diagnoses of herpes, CMV and 'HIV' infections. We take a critical look at its clinical use and its effects.

ACYCLOVIR, an antiviral drug, has been variously used in treatment following diagnoses of herpes virus, and experimentally for Cytomegolavirus (CMV - considered a relative of herpes) and 'HIV' infections.

The drug is manufactured by Glaxo Wellcome (the makers of AZT) and, known as Zovirax or ACV, is standard pharmaceutical over-the-counter ointment for herpes simplex (cold sores) despite it having "little effect on cold sores...at best it offers only marginal benefits and then only when started within a few hours of the onset of first symptoms.."[1]

It is however also prescribed as pills and injections at high dosages as prophylaxis and therapy in 'HIV antibody' diagnosed people, against herpes itself (including shingles), and for its theorised antiviral effect on CMV and 'HIV'.

The label 'antiviral drug' may disguise the fact that it is never claimed acyclovir eliminates even the herpes virus, only that it shortens and/or suppresses symptoms of active infection, and "because viruses perform few functions independently, medicines that disrupt or halt their life cycle without harming human cells have been difficult to develop."[2] Like AZT, ACV is a nucleoside analogue. Via a specific herpes virus enzyme it is claimed to interfere with viral replication "more significantly" than it does with cellular DNA replication.[3]

Have studies of 'antiviral combination therapy' with AZT and Acyclovir, compared with AZT alone, shown overall benefit from its use by 'HIV+'s? Not often: "Median survival was similar in both arms"[4]; "No survival benefit could be seen in various sub-group analyses"[5].

Conflicting reports exist stating that Acyclovir and AZT synergistically inhibit HIV in vitro in the ATH8cell line[6], and conversely that possible antagonistic effects were observed in the C3, Jurkat and CEM T-cell lines[7]. These cell lines are the long-lived laboratory cancerous-cell experiments that are used to produce 'HIV'.

One study of ACV-users concluded that longer uninterrupted use of ACV after an AIDS diagnosis was associated with longer survival: that would seem self-evident - a person could not achieve "longer uninterrupted use" unless they lived "longer". Alarmingly, more conventional advice is that "acyclovir is usually given as single courses and is not given long-term".[8]

Regarding CMV and Acyclovir, "there was no evidence of a significant decrease in CMV disease occurring in the ACV group" and "infections related to herpes virus, but not Cytomegolavirus, were reduced" in two studies.[9,10] (A large proportion of the population are likely to have CMV infection but only in some does it seem to cause problems of the eye (retinitis), and of the nervous system, intestines and sometimes the lungs.)

Effects of Acyclovir can include rashes, gastrointestinal upsets, headache, confusion, fatigue and abnormalities in some blood and liver tests. After intravenous infusion there can be severe inflammation or ulceration at the injection site and neurological abnormalities such as confusion, hallucinations, agitation, convulsions and coma. The combination of AZT with ACV has been reported to cause extreme lethargy.[11] Wellcome's own data lists the following further adverse events observed in clinical practice with oral acyclovir: General - fever, pain, peripheral oedema; Digestive - diarrhoea, nausea; Haemic and Lymphatic - leukopenia, lymphadenopathy; Musculoskeletal - myalgia; Skin - alopecia, pruritus, urticaria; Special senses - visual abnormalities.[12]

This drug appears to have no value: alternative approaches to management of herpes simplex and zoster conditions do exist (eg. see *Continuum* 3/1, 1995) and neither CMV nor 'HIV' are convincingly shown to be ameliorated by it. Concerning the unfounded claim of an anti-'HIV' effect, Dr Margaret Johnson of the Royal Free Hospital, quoted in the National AIDS Manual, said, "I advise anyone with recurrent herpes to take 800mg/day acyclovir and discuss its possible survival effects with other patients, but it isn't something that's at the top of my list".

The reported spectre of variant herpes viruses that have developed resistance to acyclovir[13] - and which in 'HIV+' people are subsequently suppressed with highly toxic foscarnet - should be enough to make anybody seriously question the necessity for this drug in their lives, and to explore better options. ■

HUW CHRISTIE

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New perspectives on Homœopathy

Like cures like

With modern medicine having failed us on many counts, we examine the philosophy behind Homœopathy. Gareth James, a registered homœopath, of the HEAL Trust, explains that this increasingly popular therapy defines health as the ability to constantly adjust to changes within ourselves and our environment, and works on the body's energy system to bring about healing.

An overview of the last millennium teaches us that truths and realities about science and medicine have never been fixed or set. As members of the late twentieth century we now have sufficient historical 'memory' to appreciate that what we believe to be 'reality' during any given era, is neither absolute nor enduring.

Over the last one thousand years we have witnessed revolutions in thought that have completely re-designed what we call reality. We have seen one established 'reality' after another fall away to reveal new founded perceptions that lend greater insight to ourselves and our universe. Reality is not and never has been fact - realities are, and have only ever been 'agreed' perceptions and interpretations - always subject to change and always changing.

Our hi-tech world lends immense credibility to the authoritarian voices of our medical profession. But, however highly skilled we have become at convincing ourselves we are nearing an end point of knowledge, history still predicts that our contemporary medical obsessions will, in time, pass away and join the likes of leeches, daily blood letting and the crude mercury misadventures of centuries gone by. We will move on again.

Already, we can have little doubt that in the virtual-virology world of AIDS, the realities of HIV infection are becoming evermore negotiable. So-called medical 'facts' about AIDS have never enjoyed such an immediate relationship with fiction. Relentless research efforts, with a clear agenda to pin everything on HIV, have repeatedly failed to bring us to any point of certainty. AIDS has not only seriously called into question the one microbe - one disease - one cure, twentieth century medical ideal, but it has also caused us to question the very ways in which we have chosen to interpret health and the disease process.

AIDS has caused us to question how we have chosen to interpret health and the disease process

In the present day, our experience of reality relies upon, and has developed alongside, language. Even our ability to think is dependent upon the use of language and words in our own minds. As is well illustrated in *AIDS and its Metaphors*[1] by Susan Sontag, the use of military terminology in the understanding of disease has persuasively shaped and moulded our entire belief systems surrounding health and germs. We now speak of disease with exactly the same language we use to describe military manoeuvres and political paranoia.

We speak readily of 'the war on AIDS'. Modern medicine has conditioned us to view the body as the 'battlefield'. Germs are the 'enemy' which 'invade' us and against which we have to mount 'defence' strategies. We are encouraged to hand over responsibility for our well-being to the 'military intelligence' of our medical doctors who 'attack' our disease symptoms with the aggressive 'weaponry' of pharmaceuticals. We even credit microbes with the same human attributes of intention and cunning as we would any national enemy.

The use of language creates our realities. The language used to describe illness dictates and determines our beliefs and our truths about the nature of disease. Although metaphors are often useful tools for furthering our understanding of the world around us they may also, by definition, be likening something to something that it is not.

Since the birth of the germ-theory, disease has become named in accordance with the microbes found to be involved in the manifestations of symptoms. The upshot of naming diseases in terms of microbes means we have 'actualised' the processes of disease to the point where we imagine it to be a tangible entity, a 'thing' that we 'get' or 'have'.

For example we say that he or she has 'got' cancer, 'caught' a cold or 'has' AIDS - they are all thought of as objects or nouns. The phrase 'he has AIDS' immediately implies that the complaint is external to the person, the person is removed from being involved in the complaint and that the person has been standardised within this system of disease names.

However, diseases are not nouns - they are closer to being verbs. Diseases are processes that we do, rather than being things we get. In this sense, it would be more accurate to say that he or she is cancering, colding or AIDSing. The structure of our language does not comfortably permit us to apply this way of thinking to the majority of named disease, but it is more logically consistent to view dis-ease processes this way. If we follow this line of thought, then the person is instantly inseparable from their complaint, the exact symptoms of any disease are completely unique to that person and incorporate that person's susceptibility and predisposition, and the notion that disease is something we can 'get' becomes an illusion of language and concept. In this sense there are no such things as diseases - there are only dis-eased individuals.

Modern medicine has also succeeded in separating us out into little bits and pieces, e.g limbs, organs, connective tissues, the nervous system, the blood stream etc. Applying dissection of the body to the manifestations of dis-ease, however, relies heavily on the bizarre

assumption that parts of the human constitution are able to operate independently from one another, and in their isolation are able to contract illnesses that leave the rest of the constitution uninvolved and ostensibly well.

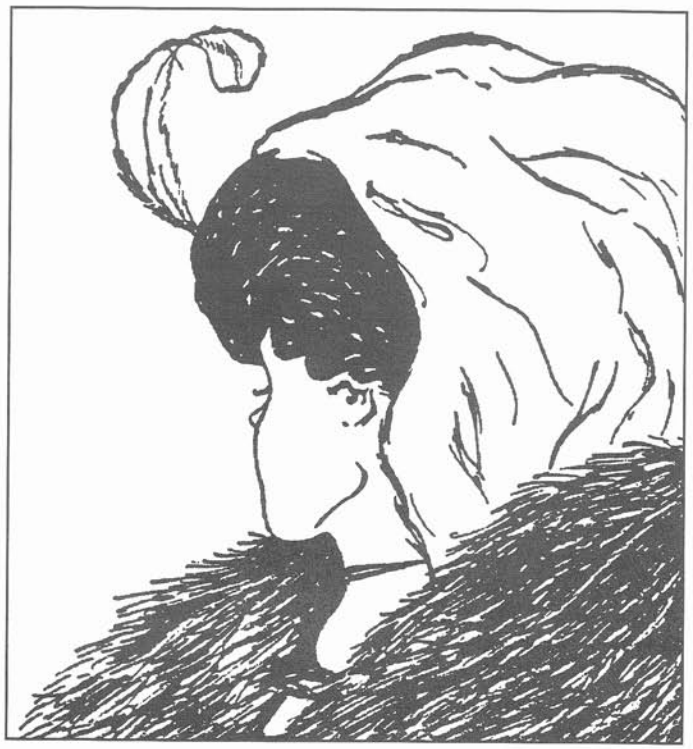
Modern medicine has also teased apart the mental and emotional spheres of the person from the body and recognises no role for these influences in the development of illness. Earlier this year, a joint report published by the Royal College of Physicians and The Royal College of Psychiatrists[2], claimed that a staggering 50% of all illness may have its roots in anxiety and stress.

It is claimed that a staggering 50% of all illness may have its roots in anxiety and stress

There is now no shortage of studies confirming stress and other psychological influences to have a major role in predicting the outcome of microbial disease. The implications for a positive HIV-antibody test result become self-evident. Any medical model which fails to take these factors into account will be fundamentally flawed. How we choose to treat disease is entirely dependent on the ways in which we decide to interpret it - one stems from the other. In the late 1700's, a German physician called Samuel Hahnemann developed the notion that there may be two ways of treating illness dependent upon this choice. The first is the way of 'opposites' or heteropathy - this has now evolved to become orthodox Western medicine.

By its very nature orthodoxy distrusts the body's reactions during disease and believes symptoms to be unintentional, purposeless expressions of microbial attack that signify nothing more than an alien invasion. It prescribes drugs designed to prevent the symptom expressions of the body. For example, if an individual is suffering from acute diarrhoea, it sees diarrhoea as the entire problem in itself and so administers a drug to dehydrate the bowel and therefore stop the symptom. It suggests in no uncertain terms that the body is flawed and foolish in its reactions to the presence of microbes.

The second way of interpreting disease is the way of 'similars' or homœopathy. This model views the body as the finely tuned end product of millions of years of evolution and credits the constitution with intelligence and knowledge far exceeding our own modish scientific trends and fashions. It considers symptoms - which by definition imply a prior cause - to be an intelligent statement indicating where that individual has become dis-eased or 'stuck'. Homœopathy defines health as the ability to constantly adjust to changes within ourselves and our environment. Chronic dis-ease is defined as the inability to adjust to such changes and thus symptoms are considered to be expressions of resistance to change.



Points of View: do you see the old woman or the young woman in this picture?

In contrast to the orthodox medical interpretation, homœopathy believes symptoms of an acute disease (as opposed to chronic) to be a unified effort made by the constitution to return to a state of health and well-being. It is a running joke among teachers that they always get 'flu at the end of term as a delayed reaction to the stresses of the profession. Influenza makes us lie down and stop; we lose our appetites and fast, we kick out mucous and catarrh and often have diarrhoea as part of the purging process. After the dis-ease has resolved, the constitution returns to a state of well-being. In other words, homœopathy views acute disease as an attempt at cure. In this model, microbes are actively employed by the constitution in an attempt to re-adjust and recover. So, rather than viewing microbes as the true 'cause' of acute disease, homœopathy suggests that microbes only 'effect' symptoms when the organism is already dis-eased at some level.

Again, if we reinterpret the example of acute diarrhoea, homœopathic thinking would suggest the body is trying to jettison waste or irritants from the system and so rather than prescribing a drug to contradict the intentions of the constitution, it would give a remedy to assist and resolve the process.

In this sense we prompt a change in reality. If chronic illness is resistance to change and acute disease is an effort to get better with microbes being part and parcel of this phenomenon then they cease to be the enemy. The need to stamp the intruders out with chemical warfare is lost, and all the military metaphors fall away and become redundant mis-conceptions.

So how does homœopathy work? The underlying principle behind the philosophy suggests that 'a like cures a like'. This means that a substance capable of producing a certain set of symptoms in a healthy person will, when taken in a homœopathic preparation, cure a similar set of symptoms shown by someone who is already sick.

For example if someone were to take a toxic dose of Peruvian bark, they would produce physical symptoms akin to those of malaria. If someone who presented with 'genuine' malaria were to take a homoeopathic preparation of Peruvian bark, their symptoms of malaria would disappear. As remedies in a crude form cause the symptoms they cure in a homœopathic preparation, the theory is they actually contain 'information' which can assist the healing powers of the constitution to resolve the process. It is like feeding the body more data as to where it has become 'stuck' in its attempt to get better. The task of the homœopath is to match the symptoms of the person to those of a remedy proving.

Homœopathically prescribed remedies are often talked about as being tiny microdoses of an original base substance. Although this is true in part, it would be inaccurate to describe homœopathy as a chemical level therapy - like acupuncture, it is an energy level therapy. It works with the body's energy system, rather than acting on its chemical physiology. While acupuncture is believed to bring about cure by working with energy flow within the constitution, homœopathy is believed to derive its therapeutic value by working with energy resonance.

Remedies used in homœopathy are prepared by continually shaking and diluting the original base substance (also known as potentising). This often goes beyond the point where there is a single molecule of the original substance left in the final preparation. It is this process of shaking that is believed to give the 'energetic' dimension to the remedies. Kirlian photography is a technology capable of photographing the energy fields which surround everything. The more that remedies are shaken and diluted the more 'energised' they become. Kirlian photography confirms the intense changes in the energy field around a remedy during this process.[3]

Having been diluted to such an extent, the remedies become

Some commonly used homœopathic remedies for 'AIDS' conditions

Finding the right remedy for the person is no easy task and often requires a considerable degree of skill and experience. However, working from a range of practitioners' experience some of the more commonly used remedies for 'AIDS'-related conditions are listed below.
This list is far from comprehensive and does not constitute a specific prescription for these remedies. Always seek the advice of a fully-qualified or registered homœopath who has undergone training specific to HIV and AIDS and who has experience of treating AIDS related conditions.

Aconite
Arsenicum iodatum
Carcinosin
Ferrum phosphoricum
Iodum
Lycopodium
Arsenicum album
Baptisia
Echinacea
Gelsemium
Lachesis
Medorrhinum
Mercurius
Nitricum acidum
Phosphorus
Pulsatilla
Sulphur
Thuja occidentalis
Typhoidinum
Natrum muriaticum
Nux vomica
Phosphoricum acidum
Silicea
Syphilinum
Tuberculinum
X-ray

For further information or to find a homœopath please contact:

The HEAL Trust, 41C Ramsden Road, London SW12 8QX. Tel: 0181 265 3989. Fax: 0181 265 3973

The HEAL Trust is committed to researching the therapeutic benefits of homœopathy in the treatment of AIDS related conditions.

completely non-toxic which is a major benefit making them ideal for use with AIDS. There are no side effects, nor are the remedies addictive as there is no chemical residue to accumulate in the body's tissues. For the same reason it is not possible to take an overdose of the remedy.

To work out the therapeutic value and range of symptoms treatable by the different remedies used in homœopathy, it first had to be ascertained which substances would produce which complaints. During the last century, and to a lesser extent this century, many groups of individuals would systematically subject themselves to taking these substances in order to discover their symptom producing potential. This process is known as a remedy proving. All the symptoms produced were carefully documented and now serve as the major reference works for homœopathic prescribing. Details of the toxicological effects of over 2,000 substances on the human constitution were recorded.[4] The base substances used for these provings included plants, minerals, metals, some animals and certain chemicals.

Another great advantage that homœopathy has over medical orthodoxy is that it is holistic in its approach. It recognises the reality that we are all connected up - mentally, emotionally and physically. We operate as an integrated whole. No 'bits' of us have an independent life of their own. Not surprisingly, it was found that remedy provings would also produce symptoms at all these levels within an individual - some of these substances even induced spiritual dilemmas. Therefore, the therapeutic benefit of the remedies may be used to treat illness at all these levels.

Disease has always been an integral part of our evolutionary process

If we study the remedy proving for the substance *Arsenicum album*[5] we find that at the mental and emotional level it produces: extreme anxiety, tremendous fear, especially fear of death, a despair of recovery and suicidal tendencies. It also has the ability to produce physical symptoms from the emotional state of tremendous fear. These are exactly the kind of mental and emotional traumas brought on by being told you're HIV-positive. Homœopathy considers the impact of an HIV-positive diagnosis to be a major trigger for the development of physical symptoms and would therefore focus remedies of repairing such psychological damage. A recent study at St. Mary's Hospital in London confirms this view.[6] People who already believed they were HIV-positive developed AIDS at a faster rate than those who were unaware of their status. It is worthy of note that at the physical level *Arsenicum album* produces symptoms similar to pneumonia - shortness of breath, bloody sputum, night sweats, weight loss and a sensation of oppression in the chest

Although there are many methodologies or different ways of using homœopathy, holistically prescribed remedies which emphasise the mental and emotional symptoms of an individual often produce the most profound results and are probably considered to be the most effective. However, this method may not always be the most appropriate. For example, if someone presents with an acute painful episode of herpes, then the significance of mental and emotional symptoms is demoted and remedies can be focused on the complaint rather than the person.

From primordial soup to the end product of the human being, we have evolved hand in hand with disease. Disease has been an integral part of our evolutionary process. Over the last 200 years we have profoundly interfered with this partnership to extremes never previously witnessed in our evolutionary history. The discovery of microbes and the medical manipulation of the military model have qualified the extensive use of vaccinations, antibiotics, antivirals and other anti-microbial drugs. As a consequence, we have not only severely disrupted the natural ecology of the body, owing to the toxicity of these pesticides, but we have mutated microbes to the point where they have become totally drug resistant. This aside, homœopathic philosophy suggests there may be even more serious consequences to suppressing the symptoms of disease with chemicals.

Homœopathy believes there to be a hierarchy of symptom expression within the human constitution. If the body is to be credited with the intelligence to know what it is doing, at least to the best of its ability, then the body's healing instincts initially try to localise symptoms to the parts of us that are furthest away from our vital centres. For example, skin eruptions like dermatitis or shingles are considered fairly healthy, superficial expressions of dis-ease. The symptoms are held at our periphery, our skin is where we end. Pneumonia or toxoplasmosis however, are expressions of dis-ease that manifest inside us, they interfere with our ability to function at a fundamental level often being life-threatening.

If our bodies' 'choice' to express dis-ease at the more superficial levels of the constitution is denied or blocked by removing or suppressing symptoms, say for example in a case of herpes treated with Acyclovir, then the opportunity to express dis-ease at that level may

become lost. As it was only the symptoms that received treatment, rather than the cause - which is the dis-eased person - the need to express dis-ease remains. Homœopathic philosophy predicts that one of two things may happen. If the body is strong enough it will re-express symptoms at that level or if the constitution has been sufficiently weakened by the treatment dis-ease expression will be driven deeper and deeper into the body. It is this second phenomenon that homœopaths term 'the birth of the chronic diseases'.[7]

Since the inception of orthodox medical approaches we have seen an explosion in the incidence of cancer, auto-immune illnesses, mental and emotional disorders and in more recent times AIDS. Homœopathic philosophy would argue that suppressing symptoms with chemicals in the name of 'curing' disease may well have been a trade off. We may have swapped the more superficial expressions of dis-ease for chronic, morbid, internal pathologies.

Although the efficacy of homœopathy is now beyond dispute, a recent article in an American medical journal stated that homœopathy had a long way to go before it can prove itself in terms of science. It is far more likely to be the case that science has a long way to go before it develops the technologies needed to recognise the science in homœopathy. At present, the precise energetic mechanisms as to how it works - and indeed how we may gain the greatest benefits from using this therapy - are not as well understood as they might be. However, homœopathy is already recognised as a legitimate system of medicine by act of parliament.

Our current AIDS research and treatment surely epitomises the ultimate application of the militarist medical model. A recent interview with a top London consultant revealed that his ideal prescription for asymptomatic HIV-positive people would now contain no less than *seven* different drugs in combination[8].

If the billions of dollars spent on research mean we still have no reasonable explanation for AIDS in terms of HIV and more importantly no therapeutic resolution or cure for AIDS - despite our most aggressive chemical weaponry - then surely something more fundamental is amiss. It is certainly a paradoxical delusion to imagine that piling ever-increasing amounts of toxic medical drugs into our bodies will eventually produce a state of health. AIDS has not only persistently defied a convincing interpretation within the framework of HIV theory but medical orthodoxy no longer has the tools of the trade.

It may well be the case that modern medicine's unswerving search for that elusive 'magic bullet' has actually back-fired. Not only do the huge amounts of data on HIV stand testimony to the most redundant research efforts ever mounted but our singular 'viral agent' pursuit may have inadvertently revealed some of the greatest flaws in our contemporary medical thinking.

For example, there is still no clearly identified mechanism as to how HIV destroys CD4 cells, no-one develops AIDS at the same rate, AIDS never develops in the same way in any two individuals, different illnesses develop in differing risk groups, the same illnesses have completely different symptomatology, there is no accounting for the AIDS illnesses that are not associated with immune deficiency or microbes, previously upheld medical criteria that prove a microbe is the cause of a disease have not been fulfilled, the 'latent-period' has been constantly adjusted, the AIDS defining illnesses require constant expansion in order to incorporate HIV theory, no other health-risk factors are given any serious consideration, we have made no allowance for the psychological and physiological consequences of programming everyone to get sick and die, we can no longer clearly differentiate long-term medical drug use toxicities from genuinely presenting symptoms, there is no explanation for people who test HIV-positive but don't develop AIDS and the testing kits are not accurate. Most importantly, we have to bear in mind that we have been researching HIV with the clear intention of *proving* it to be the cause of AIDS.

We have been researching HIV with the clear intention of proving it to be the cause of AIDS

Medical orthodoxy has to make the greatest of generalisations in order th standardise everyone within HIV theory and at the same time it has to ignore the discrepancies and anomalies contained in a hypothesis that consistently refuses to offer any long-term health benefits.

With our current model of HIV and AIDS we stand defeated. The militarist medical model does not work anymore. Perhaps the real problem is not the undefeatable foe - HIV. Perhaps the real problem stems from the militarist perspective itself. We are on the brink of another medical revolution. AIDS more than any other illness is hastening the approach of a change in our medical models. Maybe it is time to change 'reality' again. ■

With many thanks to Robert Davidson - lecturer in homœopathy

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The HEAL Self-Assessment Test
How Toxic Are You?

Health Education AIDS Liaison (H.E.A.L.) was founded in 1982 with the purpose of providing information, hope and support regarding natural ways of healing through alternative, holistic and non-toxic therapies. Frank Buianouckas, Prof. of Mathematics at City University NY, in the Bronx, is a founder member. In 1988 he organised the first ever conference to question HIV as the cause of AIDS, entitled "What Really Causes AIDS?" His involvement in questioning HIV's role in AIDS came from seeing so many of his friends die from drug toxicity. He's also a member of Rethinking AIDS.

If there is one thing working against an HIV+ individual's innate capacity and expectation for health, it is the well-publicised equations HIV=AIDS=DEATH. These equations imply a natural progression of 1) testing positive, 2) asymptomatic illness, 3) symptomatic illness, and finally 4) prematurely succumbing to some or one of the 29 AIDS-defining diseases. Accordingly, the simple antibody test for HIV is in itself toxic, imbued with the potential to terrify and destroy anyone claimed to be so infected.

To overcome this psychological barrier it is necessary to change the way one thinks about HIV and possibly about living life itself. A person must first answer the question, do I want to live? If so, a person must then be willing to suspend the belief that HIV is going to kill him and accept the fact that HIV is not sufficient to cause AIDS. The desire to live and the suspension of this deadly belief must both be accepted unconditionally.

HIV is only necessary for AIDS by definition

Let's explore that belief. When a person is vaccinated against polio virus they test positive for antibodies against this virus and are then considered immune to further infection, therefore free from the possibility of disease. Now, in a complete turn around, we are told that having neutralising antibodies against HIV means we are eventually going to come down with some combination of one, two or more of a total of 29 AIDS-defining diseases. These antibodies are no good, we are told, because HIV mutates very often or somehow down the line erupts and the antibodies disappear.

However, it is virtually impossible to recover virus from the peripheral blood of an infected person with antibodies to HIV, hence the antibodies must be neutralising antibodies. The fact remains, nobody has determined how, or even shown that, HIV causes AIDS. It is well-known in AIDS 'scientific circles' that HIV is NOT sufficient to cause AIDS. Remember, AIDS is defined as having one or more of the 29 defining diseases in addition to antibodies against HIV. HIV is only necessary for AIDS by definition.

Worse, the HIV-antibody test (Western Blot or ELISA) is flawed in four distinct ways: a) it tests for antibodies against proteins which are not unique to HIV, b) there is no standard procedure for interpreting whether a Western Blot Test is positive, c) the test is not reproducible, that is, a sample analysed by different laboratories or even the same sample analysed by the same laboratory yields different results, and d) HIV has never been isolated into its pure state. Any 'isolation' has always been contaminated with cellular debris, so there is no gold standard for HIV. It is therefore more correct to say Western Blot positive (WB+) than HIV+. [Ed. note: ELISA HIV-antibody tests are considered more inaccurate.]

Often there is some mention of a low T4-cell count but there are problems with this as a diagnostic tool and it probably should not be used. There is evidence that the stress-related hormone cortisol (hydrocortisone) causes an absolute drop in T-helper cells and a percentage-wise inversion of the ratio between T-helper and T-suppressor cells, just as in AIDS. HIV-positive (WB+ or ELISA+) people often experience profound psychological stress as a result of their test results. These people may also know many friends who have been hospitalised with T4 counts higher than 500 T4/ml of blood. Thus they are led to expect sickness.

Robert W. Maver, F.S.A., writing for the newsletter *Rethinking AIDS*, after reviewing CDC data on AIDS, concluded: "there are virtually NO AIDS cases where the sole infectious agent is HIV."

Professor Luc Montagnier of the Pasteur Institute, at the July 1992

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AIDS conference in Amsterdam, said: "I think that we should put the same weight on the cofactors [as we have on HIV]."

So let's examine the question of 'high-risk'. The majority of gay males diagnosed HIV+ (WB+ or ELISA+) are considered high-risk. Minimally this means that they have exchanged blood with someone who was possibly infected with HIV. But it is extraordinarily difficult to be infected with HIV because there is virtually no free retrovirus in an infected person's blood. 'Infection' occurs only after many exposures. Moreover, infection depends on the individual's susceptibility or predisposition to infectious agents. Just as not everyone exposed to a 'flu bug gets the 'flu, the same is true for HIV. HIV is hundreds of millions of times harder to get than the 'flu. And as mentioned above, there is also a possibility of becoming HIV-antibody positive without HIV. One merely has to raise antibodies against foreign white blood cells or a host of other foreign proteins or substances.

More generally, 'high-risk' implies overuse of medical drugs, abuse of recreational drugs, numerous infections other than HIV, or a host of other problems in the spiritual/mental, emotional, and physical realms. In almost all cases the 'high-risk co-factors' were in place long before infection with HIV. And all of them qualify as severe antigenic stress.

Particularly with the advent of 'AIDS without HIV', these 'co-factors' ought to be considered factors on the way to AIDS. (Of course AIDS without HIV is bizarre since an AIDS diagnosis requires HIV. What it means is that an AIDS-defining disease is present, there is a low T-cell count, the individual belongs to a high-risk group, but there is absolutely no HIV present.) These factors represent a serious toxification of all people who are at high-risk prior to HIV infection.

It is therefore necessary for anybody truly at risk for AIDS who is genuinely interested in preventing it, to eliminate toxicities from their lives. There are toxic substances, toxic thoughts, toxic attitudes and toxic associations. The following questions are to help you decide if there are toxins in your life. The questions are broad and are not meant to diagnose any condition, they are solely for a self-made estimate of toxification. The information may then be used by you to assist your health-care provider. The questions require either a YES or NO answer.

(We must also remember the urgency for people with AIDS to suspend belief in the notion that it is always fatal. It is not. Keeping that in mind, you too can use this instrument to evaluate your level of toxicities.)

The Questionnaire

1. Have you used antibiotics over long periods? Y/N
2. Have you used antibiotics for relatively short periods but on numerous occasions? Y/N
3. Have you used Fluconazole? Y/N
4. Have you used Rifampicin? Y/N
5. Have you used Ethambutol? Y/N
6. Have you used Clofazamine? Y/N
7. Have you used Ciprofloxacin? Y/N
8. Have you used Isoniazid? Y/N
9. Have you used Amikacin? Y/N
10. Have you used Clarithromycin? Y/N
11. Have you used Sparfloxacin? Y/N
12. Have you used Rifabutin? Y/N
13. Have you used Pyrazinamide? Y/N
14. Have you used Nystatin? Y/N
15. Have you used Itraconazole? Y/N
16. Have you used Ketoconazole? Y/N
17. Have you used Amphotericin B? Y/N
18. Have you used ABLC? Y/N
19. Have you used Flucytosine? Y/N
20. Have you used Paramomycin? Y/N
21. Have you used Spiramycin? Y/N
22. Have you used Azithromycin? Y/N
23. Have you used Octreotide? Y/N
24. Have you used Pentamidine? Y/N
25. Have you used Aeropent? Y/N
26. Have you used 566? Y/N
27. Have you used TMP/SMX? Y/N
28. Have you used Dapsone? Y/N
29. Have you used Pyrimethamine? Y/N
30. Have you used Sulfadiazine? Y/N
31. Have you used Clindamycin? Y/N
32. Have you used Piritrexim? Y/N
33. Have you used Fansidar? Y/N
34. Have you used Ganciclovir (DHPG)? Y/N
35. Have you used Foscarnet? Y/N
36. Have you used Acyclovir? Y/N
37. Have you used Trifluorothymidine? Y/N
38. Have you used flagyl? Y/N
39. Have you used Bactrim? Y/N
40. Have you used Tetracycline? Y/N
41. Have you used Doxycyclin? Y/N
42. Have you used Aureomycin? Y/N
43. Have you used Anabolic-steroids? Y/N
44. Have you used Corticosteroids? Y/N
45. Have you used Anti-depressants? Y/N
46. Have you used ACE-Inhibitors? Y/N
47. Have you used barbiturates? Y/N
48. Have you used methamphetamines? Y/N
49. Have you used Mandrax? Y/N
50. Have you used Quaaludes? Y/N
51. Have you used Cocaine? Y/N
52. Have you used crack? Y/N
53. Have you used MDM? Y/N
54. Have you used MDA? Y/N
55. Have you used Ecstasy? Y/N
56. Have you used Special K? Y/N
57. Have you used THC/Marijuana? Y/N
58. Have you used LSD? Y/N
59. Have you used mushrooms? Y/N
60. Have you used Dilaudid? Y/N
61. Have you used Amyl-nitrite? Y/N
62. Have you used Butyl-nitrite? Y/N
63. Have you used mescaline? Y/N
64. Have you used Secanol? Y/N
65. Have you used Tuinel? Y/N
66. Have you used heroin? Y/N
67. Have you used Valium? Y/N
68. Have you used Librium? Y/N
69. Have you used Purple Hearts? Y/N
70. Have you abused alcohol? Y/N
71. Have you used PCP (Phencyclidine Hydrochloride? Y/N
72. Have you had syphilis? Y/N More than once? Y/N
73. Have you had gonorrhoea? Y/N More than once? Y/N
74. Have you had chlamydia? Y/N More than once? Y/N
75. Have you had giardia? Y/N More than once? Y/N
76. Have you had cryptosporidiosis? Y/N More than once? Y/N
77. Have you had Herpes Simplex 1 or 2? Y/N
78. Have you had Herpes Zoster? Y/N
79. Have you been infected with CMV? Y/N
80. Have you been infected with Epstein Barr Virus (glandular fever)? Y/N
81. Have you been infected with TB? Y/N
82. Have you had amoebas? Y/N More than once? Y/N
83. Have you had gay bowel syndrome/irritable bowel syndrome? Y/N
84. Have you had sexually transmitted warts? Y/N
85. Have you had other types of parasites?
86. Have you had thrush (Candida Albicans)? Y/N
87. Have you been infected with hepatitis A or B, or tested antibody positive for C or D? Y/N
88. Have you had scabies? Y/N
89. Have you had alcoholic pancreatitis? Y/N
90. Do you know if you have been malnourished? Y/N Are you now? Y/N
91. Do you or have you suffered anal/vaginal disorders? Y/N
92. Have you had any tropical diseases? Y/N
93. Have you attempted suicide? Y/N
94. Do you think of suicide as an option? Y/N
95. Do you suffer from low self-esteem? Y/N
96. Do you loathe yourself? Y/N
97. Do you suffer from rage? Y/N
98. Do you suffer from apathy? Y/N
99. Are you sexually compulsive? Y/N
100. Are you obsessive-compulsive? Y/N
101. Do you suffer from stress? Y/N
102. Have you been vaccinated for the 'flu? Y/N
103. Have you been vaccinated for hepatitis B? Y/N
104. Have you been vaccinated for polio? Y/N
105. Have you had other vaccinations? Y/N Smallpox, Measles, etc. Y/N
106. Have you or do you use tobacco? Y/N

continued overleaf

If you have answered yes to even one of these questions there is a possibility that you are toxified on the mental/spiritual, emotional or physical plane. You have the choice to seek out a health care professional who could help address these issues. Homœopathic detoxification offers help for the deepest levels of distress. Chinese medicine and naturopathic medicine are also very helpful in detoxification. There are nutritional and herbal detoxifications. You are encouraged to look up any of the drugs mentioned above in, for example, the *British National Formulary* to determine the full range of their side effects.

If you determine that you are toxified, it makes no sense to continue putting toxic drugs into your system, you will only become more toxic and these toxicities are life-threatening. You can empower yourself to go off all toxic drugs (under trusted health-care supervision) and detoxify. Often the results of detoxification are startling. People have experienced improved health (mental/spiritual, emotional and physical) determined by their own improved attitudes and improved laboratory results.

It is essential, however, that you suspend the belief that HIV is going to kill you, and decide that you truly want to live. This is unconditional! HEAL YOURSELF!

There are some caveats:
1) if you are HIV-antibody positive (WB+ or ELISA+) it is impossible to get a diagnosis for any physical condition without having it compromised by your status; that is, if you have a simple rash from some independent condition, the doctor will still blame it on HIV;
2) if you are not HIV+ (WB+ or ELISA+) but you are gay, doctors often lean towards an AIDS diagnosis for anything that may be hard to diagnose or what is ruled out because of their bias towards an HIV/AIDS diagnosis for gay males. An acquaintance recently told me that he had a breathing crisis. He went to a hospital but withheld the information that he is gay. They immediately determined that he had asthma. His own doctor was astonished, since he had been searching for an AIDS condition for four months and asthma had not even been suspected.
Remember - the probability that a person diagnosed with AIDS has a past toxic history is greater than the probability that a person with a past or present use of toxic materials will eventually be diagnosed with AIDS. One reason for this is that each individual's dose tolerance is different . This situation makes it easier to deny the RISK/AIDS hypothesis and fall prey to the naive and deadly HIV/AIDS hypothesis. But denial does not alter truth. Denial can be and is deadly!
A Western Blot or ELISA positive result is a WAKE-UP call not a death sentence! ■

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Back to Nature?

This letter was recevied by Mr Alex Russell, of the International AIDS Freedom Network, in response to his lettters to *Nature* concerning problems in the Darby *et al.* Oxford Hæmophilia paper. Contrary to departing *Nature* Editor John Maddox's dismissive definition of "AIDS-related diseases", research has revealed that NONE of the people with hæmophilia in the study died with KS. If these casual standards of inaccuracy are found at the highest levels of scientific publishing, what hope is there for genuine science?

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19 September 1995

Alex Russell

Dear Mr Russell:

The receipt of the seventh version of your proposed letter for our Correspondence columns prompts me to write to say that I cannot publish any of them.

The reasons are several. First, I am not prepared to allow a research paper that we have published in good faith (and after peer review) to be described as a "press release". Second, the Papadopulos-Eleopulos paper you quote was out of date when published, and carries no weight no. It is no shame that Darby *et al.* did not specify the AIDS-related diseases, because their concern was simply with the mortality of the two groups, but it's clear that they meant Kaposi's sarcoma, etc.

I am sorry to send you this disappointing reply.

Yours sincerely,

John Maddox
Editor

HIV Seropositivity and Mortality in Persons with Hæmophilia - Proof that HIV causes AIDS?

The Hæmophilia Connection

Following publication in September of the Oxford Hæmophilia study attracting widespread press attention, eminent scientist Dr Eleni Papadopulos-Eleopulos and her colleagues in Perth, Western Australia respond. *Continuum* is honoured to present the paper that *Nature* refused to publish.

In a study published by a large group of epidemiologists, of British haemophiliacs *(Nature,* September 7th), it is claimed that "During 1985-92, there were 403 deaths in HIV seropositive patients, whereas 60 would have been predicted om rates in seronegatives suggesting that 85% of the aths in seropositive patients were due to HIV infec- n".

In the accompanying *Nature* editorial it is said that this "thorough dy". "will, for most people, be sufficient proof that the infection V] leads to AIDS". However most people are not scientists and for ntists "suggesting" is not proving.

One can claim that the 85% increase in death rate amongst seroposi- haemophiliacs is due to HIV if, and only if, the study had evidence ch showed that:

The cause of death in the 343 extra deaths in the seropositive patients was AIDS, otherwise one will have to show that in haemophiliacs HIV does not cause only AIDS but all the other dis- eases from which these patients died.

All the patients who died from "AIDS" were infected with HIV.

HIV causes AIDS.

SEASES LEADING TO MORTALITY

ance at table 3 [of the study] where "cause-specific mortality during 5-92" is given, shows that of the 403 deaths in seropositive individu- 168 died from causes other than AIDS. The other 235 died from DS, HIV, etc". The statement that deaths were due to "HIV, etc" is ningless. AIDS stands for Acquired Immune Deficiency (AID) on ne hand and the syndrome (S) on the other. Because the syndrome nstituted from more than 25 diseases and because no other single, tious agent is posited as the cause of such a panoply of distinct and unrelated diseases including infections and neoplasms (growths), it is said that the syndrome is caused indirectly. That is, HIV causes Acquired Immune Deficiency which in its turn leads to the appearance of the Syndrome. It is accepted that in AIDS, 'AID' stands for decreased T4 (helper) cells resulting from their destruction by HIV.

AID

In the study there is no evidence that the 235 patients had a low T4 cell count due to their destruction by HIV or any other agent. In fact, at present there is no evidence that the T4 cells of haemophiliacs or for that matter, any AIDS patients, are destroyed either by HIV or any other agents, or that a causative relationship exists between a decrease in T4 cells and the appearance of the clinical syndrome.[1] In fact no agreement, or even evidence, exists that lymphocytes contain two subsets, T4 and T8 which have exclusive roles, T4 as helpers and T8 as suppressors, a fact acknowledged by immunologists from many institutions including the University of Stockholm and the Institut Pasteur.[2,3]

As far back as 1981 James Goodwin, from the University of New Mexico, wrote: "The T- and B-cell measurers - having run through the sick, the elderly, the young, the pregnant, the bereaved - had finally run out of diseases....And now it's starting all over again, this time with T-cell subsets....Why not let us unimaginative immunologists publish to our heart's content?....My strongest argument is this: Measurement of T and B cells and their subsets in disease has no clinical meaning....But most non-immunologists do not realise this....Non-immunologists have naturally assumed that any subject occupying so much Journal space must be relevant in some way - a logical but incorrect assumption".[4]

SYNDROME

None of the diseases which constitute this syndrome is new or specific to it. The diseases which are rare in the general population and most often diagnosed in AIDS are two: Kaposi's sarcoma (KS) and

Pneumocystis carinii pneumonia (PCP). In fact these two diseases constitute the basis for the HIV hypothesis of AIDS. Although in the *Nature* studies it is not stated how many, if any, British haemophiliacs have died from KS, it is a known fact that unlike gay men, haemophiliacs rarely, if ever, die from KS. The clinical picture of PCP is not specific to this disease; both infectious and non-infectious diseases produce clinical pictures comparable with PCP. Neither can the disease be diagnosed by radiological means.

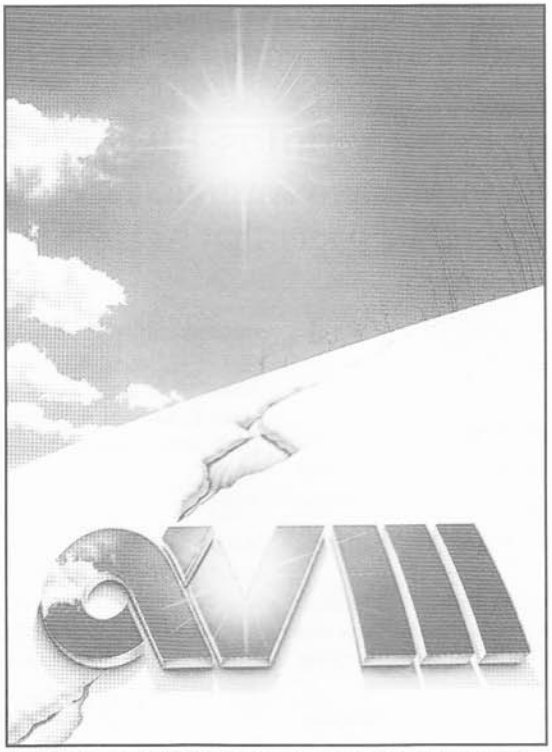
Before the AIDS era, and even in the early 1980's, the visualisation of the causative organism *P. carinii* in Gomori-methenamine salver (GMS) stained preparation of lung tissue obtained by open lung biopsy was considered the only method suitable for a definite diagnosis of PCP. Even with this method "considerable expertise is necessary to differentiate *P. carinii* from other GMS positive entities, particularly yeast".[5] In the AIDS era, the method used to diagnose PCP became less and less specific. Instead of open lung biopsy, diagnosis began to be obtained by fibreoptic bronchoscopy, a much "less dependable" procedure, or bronchoalveolar lavage (BAL). However, "one might expect to find *P. carinii* in the fluid from bronchoalveolar lavage of about 40% of patients with AIDS who present with symptomatic pneumonia caused by other organisms".[6]

Despite the very high level of false positive results obtained with BAL, this procedure is not only used to definitely diagnose PCP but, more recently, as a gold standard for other, even less specific procedures used for the "definite" diagnosis of PCP, such as testing specimens from sputum induction using GMS.[7] In turn this procedure is used as a gold standard for the "definite" diagnosis of PCP by testing sputum specimens with the use of "monoclonal antibodies" instead of GMS, although it is accepted that in sputum specimens GMS "will stain not only *P. carinii* but also host and microbial cells and amorphous debris, which make up a large part of the sputum sample; even in experienced hands, distinguishing *P. carinii* from this background can be difficult".[8]

Another method presently used for the "definite" diagnosis of PCP is the polymerase chain reaction. However, the authors themselves admit that this method, when compared to detection of *P. carinii* in BAL or sputum specimens, as gold standard, is less specific and "most falsely positive samples were from patients treated with immunosuppressive drugs or from HIV-positive patients with CD4 counts below 0.2 x 10^9/l".[9]

Nonetheless, on the basis of these tests, individuals from the AIDS risk groups, including haemophiliacs are diagnosed as having PCP and are treated accordingly. Some studies recommend the use of "empiric therapy for PCP, based purely on" clinical findings. But, "The propensity of patients with PCP to present with atypical clinical finding, the ability of both infectious and non-infectious diseases to produce a clinical picture compatible with PCP, and the toxicity of anti-pneumocystis treatment regimes however, all argue against the use of empiric treatment based on clinical evaluation alone".[5] The toxic effects include "neutropenia, thrombocytopenia, or both",[6] which are of particular significance to haemophiliacs since these diseases were present in high frequency in this population long before the AIDS era, and thrombocytopenia is considered to be a contributing factor in the development of AIDS in haemophiliacs.[10]

In conclusion from the study it is not possible to say how many of the 235 hæmophiliacs died from KS and PCP, considered to be the most specific AIDS diseases; from "mild and moderate diseases", which following the 1985 CDC AIDS definition signified AIDS; from AIDS-defining conditions according to the 1987 CDC definition (according to which a patient could have been certified as dying from AIDS without a definite disease diagnosis or even with no evidence for HIV infection and even with evidence against HIV infection); or from "AIDS" in general whatever one means by it.



Alpha VIII - commercially available clotting factor: "sterile powder for reconstitution."

CAUSE

Of the 343 extra deaths in HIV seropositive hæmophiliacs between 1985-92 only 235 were due to "AIDS, HIV, etc". To account for the other 168 extra deaths one will have to assume that either:

(1) In hæmophiliacs HIV does not cause only AIDS but all the other diseases for which the 168 patients died.

(2) In the AIDS era two, or more, new pathogens appeared in hæmophiliacs, HIV which caused the 235 deaths and the other(s) which caused the other 168 diseases.

(3) The extra deaths in hæmophiliacs, including the 235 who died from "AIDS, HIV, etc." were caused by agents other than HIV.

The only evidence which one can find in the study for a causal role of HIV in hæmophilia deaths is that most of the deaths occurred in seropositive hæmophiliacs. However, as it has correctly been pointed out in the editorial, "It is well known that no amount of statistical argument can by itself prove that a disease is actually caused by the agent with which it is statistically associated". Indeed before one can claim that "85% of deaths in seropositive patients were due to HIV infection", one must satisfy two conditions:

(1) Present evidence that the "seropositive patients" were actually infected with HIV, that is, the antibody tests are HIV specific.

(2) Prove, by direct evidence, not by association, that the "85% of deaths" were caused by HIV.

There are two major problems in using "seropositivity" to diagnose HIV infection:

(i) The only way to determine the specificity of the antibody test for HIV infection is to use viral isolation as a gold standard. This has never been reported and in fact there is ample evidence that the tests are non-specific.[11] That this is the case in hæmophiliacs is acknowledged by very well known HIV/AIDS researchers.[12-14] Even the CDC accepts that a positive test in hæmophiliacs is not proof of HIV infection. "It is possible that antibody to LAV is acquired passively from immunoglobulins found in factor VIII concentrates.... Likewise, it is possible that seropositivity is caused not by infectious virus but by immunisation with noninfectious LAV or LAV proteins derived from virus disrupted during the processing of plasma into factor VIII concentrate".[15]

(ii) According to the authors of the epidemiological study, "A reliable test for HIV antibodies became available to Hæmophilia Centres early in 1985. Among those who were alive on 1st January 1985, 78% of potentially infected severe patients and 52% of moderate/mild patients had been tested by December 1985, rising to 90 and 74% respectively by January 1993. One thousand and twenty severe patients and 207 moderate/mild patients were found to be infected....The median estimated date of seroconversion was October 1982 for severe patients and December 1982 for moderate/mild patients".

Before 1987 a positive ELISA with or without a WB was considered proof of HIV infection. However, it was realised that many individuals (4000/6000) [67%] in one study[16], who had a positive ELISA did not test positive when the WB was performed. This was interpreted as evidence that the WB was more specific than the ELISA, and since 1987 many, but not all, laboratories use ELISA only as a screening test and WB as

confirmation. But in addition to the fact that the specificity of the WB has never been determined, there are many other problems associated with the use of this test to prove HIV infection, so much so, that according to Philip Mortimer, "Western blot detection of HIV antibodies began as and should have remained, a research tool".[17]

Among the many problems associated with the WB is the arbitrary introduction of criteria as to which WB pattern means HIV infection. At present these criteria vary between continents, between countries and even between laboratories in the same country. The criteria have also changed over time. It is of pivotal significance that the criteria used to define a positive WB before 1987, by which time most of the hæmophiliacs were tested and were found to be positive, would not satisfy even the "least stringent" criteria presently used to define a positive WB result.

The study gave no evidence that the hæmophiliacs were even infected with HIV

IN CONCLUSION

(1) The study presented no evidence that the 235 seropositive hæmophiliacs died from AIDS, whichever definition is chosen, merely the bold assumption that they died from "AIDS, etc.".

(2) The study presented no evidence that the excess deaths in the seropositive patients were caused by HIV, or even that the hæmophiliacs were infected with HIV.

(3) The most one can claim from the evidence presented is that the finding of a positive "HIV antibody" test, whatever that signifies (but certainly not HIV infection of hæmophiliacs via factor VIII), indicates an underlying abnormal propensity to develop a number of illnesses which may prove fatal.

(4) The study, more than anything, highlights the urgent need to:

(a) Determine the meaning of a positive "HIV antibody" test in hæmophiliacs;

(b) Determine the effects which factors associated with "HIV antibodies" may have on the health of persons with hæmophilia. These include lifetime exposure to factor VIII and impurities in clotting concentrates, prophylactic and therapeutic anti-bacterial and anti-viral agents, AZT, blood transfusions, steroids and also the psychological impact of a diagnosis of HIV seropositivity.[18,19]

In any scientific debate both sides have obligations, the antagonist to question when there is indisputable evidence that contradicts the received wisdom; the protagonist to answer these questions rather than simply to suppress them. One such question rises from the following laboratory data:

1. There is unanimity that gpl20, a component of the knobs on the surface of HIV, is an absolute prerequisite for "HIV infection";[20,21]
2. Such knobs are found only in immature (budding) particles which are "very rarely observed", and are absent in cell-free HIV[22,23] thus rendering cell-free HIV non-infectious.
3. According to Professor R. Penny, Australia's leading HIV/AIDS expert, "HIV is rapidly inactivated in discarded needles and syringes";[24]
4. Levy and his colleagues have shown that the titre of HIV in plasma of HIV-infected individuals three, six or twelve hours after phlebotomy (drawing blood), "dropped from up to 500 TCID/ml to 0" [TCID=tissue culture infectious dose];
5. In January 1994, the CDC communicated the following experimental data and conclusion:

"In order to obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory grown virus...the amount of virus studied is not found in human specimens or anyplace else in nature,...it does not spread or maintain infectiousness outside its host. Although these unnatural concentrations of HIV can be kept alive under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the number of infectious viruses by 90 to 99 percent within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other body specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to that which has been observed - essentially zero".[25]

Since: (a) in most instances, if not all, the time between phlebotomy and conversion of pooled plasma to factor VIII concentrate is considerably greater than 3 hours; (b) factor VIII is made from plasma which is cell-free; (c) the late 1970s factor VIII has been supplied as a dry powder which may spend weeks or months waiting use; how can one reconcile the above facts with the view that hæmophiliacs are infected with HIV via contaminated factor VIII concentrates? ■

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HIV Positive? - It depends where you live

Take a look at the criteria that determine a positive HIV test result

The HIV antibody tests do not detect a virus. They test for any antibodies that react with an assortment of 'virus-proteins' that experts assure us are unique to HIV.

According to AIDS-experts, the ELISA test is not very specific and may react in the absence of HIV infection, and thus if positive is repeated, and if still positive warrants a third, but different, test called the Western blot. In the Western blot the 'virus-proteins', about ten of them, are located at discrete spots in a paper strip. Serum is added and whenever there is a reaction with some antibodies a colour change occurs which shows up as a dark band. The test is read by noting which bands show up, in other words, which proteins are reacting. Certain combinations of bands are defined as a positive test.

It is most peculiar that the location and number of bands required for a positive Western blot VARY around the world, and may even vary between laboratories within the same city. In Australia at least four bands are required, in Canada and much of the USA three or more. And in Africa two will do. If each indicates HIV infection then HIV must cause different populations of antibodies to appear in different places. Does that not sound very odd? Can HIV navigate? But at least it gives some Africans a way out: all an African has to do is retest in Australia because two bands would not be considered positive there.

Nevertheless, in spite of lack of standardisation and other problems such as reproducibility, the Western blot is promoted as greater than 99.9% specific, and if positive is regarded as synonymous with HIV infection.

A Martian might be forgiven for wondering whether wine-tasting was less subjective. ■

Western Blot "virus proteins"	Africa	Australia	U.S. Food & Drug Admin	U.S. Red Cross	CDC (1)	CDC (2)	CON[1]	MACS[2]	UK
ENV gene: p160, p120, p41	ANY 2	1 OR >	1 OR >	1 OR >	p120/ p160 AND p41	p120/ p160 OR p41	p120/ p160 OR p41	ANY 1 Strong OR 3 Weak bands from: p15, p24, p32, p41, p45, p53, p55, p64, & p120. Score '1' for each weak band, and '3' for each strong band - total of '3' or greater is positive	1 OR >
POL gene: p68, p53, p32	OPTIONAL	ANY 3	p32	ANY 1			p32 OR		p31 (sic)
GAG gene: p55, p40, p24, p18			p24	ANY 1		p24	p24		p24

HIV + Western Blot Test Criteria in various centres around the world
With thanks to Dr Val Turner

1) Consortium for Retrovirus Serology Standardsation
2) Multi Centre AIDS Cohort Study (USA)

The Gerson Therapy

"A Coffee Enema? Now I've heard everything."

In 1978 an article was published in the peer-reviewed journal, *Physiological Chemistry and Physics*, (Vol.10 No.5) which stated that: "The high potassium, low sodium diet of the Gerson therapy has been observed experimentally to cure many cases of advanced cancer in man".

Cancer, like AIDS, is known as a disease of toxic stress whose increased occurrence appears to correlate with environmental and nutritional post-war pollution plus emotional and mental stresses. Both diseases are spoken of as apparently incurable and your best hope according to most doctors is to take chemotherapy, alone or in combination with other drugs.

Putting more poison into an already toxified body doesn't make sense. Gerson's therapy works by getting rid of all the toxins and putting back the nutrients needed to repair the body - and nothing else.

Putting more poison into an already toxified body does not make sense

The average person trying to get his or her body to work better needs to improve the health of their cells. By controlling the amount of salt found in individual cells, one controls the water content which affects the way cells function, the health, energy, production capabilities and ability to stay alive and in normal balance.

The best trick our bodies know is how to be us, which is a pretty clever one really. We have trouble being ourselves when the environment encroaches into our space. We yield and lose the barrier between ourselves and the environment when we are poisoned by it. The same is true of individual cells: what a cell does best is be itself. When the cell is infiltrated by components of what is normally its exterior environment it will lose its health.

Dr. Cope, who wrote the 1978 paper, also wrote: *"Pathology of structured water and associated cations in cells (the tissue damage syndrome) and its medical treatment."* In it he explained that when cells are injured there is a unifying set of occurrences, irrespective of the type of cell or cause of injury. First the cell will lose potassium, second the cell will accept sodium, and third, the cell will swell with too much water.

When a cell has too much water (cellular œdema) the environment becomes inappropriate for the manufacture of energy. For a cell to function normally it needs enough energy in order to take in nutrients and get rid of wastes. The energy it uses is ATP (adenosine triphosphate), made by burning sugar in the cells. Without it no reactions can occur, our cells die and then we die. Cope did not describe this cell pathology until 1977, but Gerson observed it clinically in the 1920s. He was actively correcting these imbalances by eliminating sodium from the diet, supplementing a high potassium diet with extra potassium, and removing from the bloodstream the toxins which inhibit normal cellular enzyme functions, metabolism and respiration.

Gerson observed that when someone is on a high potassium, low sodium diet, the first thing that happens is that very large quantities of sodium comes out in the urine. Because sick people got better when they dumped sodium in their urine, Gerson wanted to increase the effect and prolong it. He found that by eliminating dietary protein he could cause more of what he called "Natrium Ausschluss", sodium flooding out in the urine.

But hang on, haven't we been told that extreme protein restriction will compromise immunity? So believed Robert Good, ex-Chairman of Pathology at the University of Minnesota, known as the most published pathologist in western medical literature. Good carried out experiments to prove it and predicted failure of at least serum immunity. What he saw was something he was unprepared for. Not only did serum immunity remain stable, but lymphocyte activity, especially T-lymphocytes, became tremendously active, nonspecifically active, and remained so for a long period of time. His findings support the therapy Gerson advocates.

The Gerson therapy is undertaken for about 18 months, during which time you can do little else. Everyday you drink 13 freshly squeezed organic juices of carrot, carrot and apple and green leaves, and eat a very simple pure vegetarian diet. You also have coffee enemas every four hours.

We all know that coffee is bad news, but when taken as an enema (check Gerson books for details) it dilates the bile duct so more toxins can be released from the liver. Coffee enemas also stimulate, by 600-700% above normal, an enzyme system in the liver, glutathione-S-transferase, which is capable of removing from the bloodstream a vast variety of free-radicals like no other substance can. It is one of the reasons why people get a buzz out of coffee or feel lousy until they have their first cup. That it causes opening of the bile ducts explains why some people find drinking coffee to be a laxative.

The coffee enema is held inside the bowels for 12-15 minutes, during which time all the blood in the body circulates through the liver at least five times. The water in the enema stimulates the visceral (gut) nervous system which is what controls peristalsis, the movement of food through the intestines. Because you have toxic bile being released way up in the small intestine, it is really important that you help it to move through the intestines to a point where it can come out.

The coffee enema is the only pharmaceutically effective choleretic in the medical literature that is repeatable many times daily. [Diuretics cause urination. Choleretics cause bile flow.] They are safe and effective but you do need to talk to someone with experience first. Coffee enemas remove from the blood ammonia-like products, the toxic-bound nitrogen, and they could be effective at removing residues of poppers.

The lifestyle that one would need to adopt to go on the Gerson therapy is very intense and requires constant support. It's obviously not a therapy for everyone and would need a lot of thought before embarking on, but the principle that you can repair your body, however diseased, is definitely one worth learning from.

So what can you do? Eat no salt (500mg in every slice of bread and watch out for hydrolysed vegetable protein and vegetable stocks, etc.) and increase your potassium intake by eating more vegetables. If you can afford a juicer then get one so that you can obtain the potassium (and other nutrients) from vegetables without having to eat pounds and pounds of them. You need to be careful if you have low blood sugar - consult a nutritionist. It's dangerous to have coffee enemas without juices or juices without coffee enemas. The two must be carefully balanced or the result will be an electrolyte imbalance in the body requiring hospitalisation. ■

BOO ARMSTRONG

Books for reference:

A Time to Heal, by Beata Bishop, Hodder & Stoughton, 1985 (a personal account of the Gerson Treatment)
A Cancer Therapy - Results of 50 cases, by Max Gerson, pub. Gerson Institute, California, USA, 1986 (a more scientific discussion of the work).
See also: *Journal of Alternative & Complementary Medicine*, Oct. 95: "Research proves benefits of Gerson Therapy."

For equipment needed to follow the Gerson therapy contact:

Wholistic Research Company, Bright Haven, Robin's Lane, Colworth, Cambridge, CD3 8HH. Tel: 01954 781074.

Helpful advice available from:

Mrs F. Gwynne. Tel: 003535455114 (11am - 1pm, 7.30 - 8.30pm, Mon-Sat) Fax: 003535455671.
Also Newsletter available from above, entitled "*A Coffee Enema? Now I've heard everything.*" Costs £1.

Scientists were still looking for and somehow actually finding microbial causes for scurvy as many as 323 years after the real cause was first discovered to be a lack of vitamin C. Over the centuries several other serious diseases have been wrongly attributed to infectious agents. Could it be that we are seeing a similar situation with regard to AIDS? Volker Gildemeister reviews some examples.

Medical misdiagnoses - truth or dare?

Why We Will Never Win the War on AIDS

When I first came across a full account of the AIDS story in about 1988 it appeared that the AIDS fiasco was an unfortunate one-off derailment of the scientific process.

Something seemed very wrong with the official story that antibodies were, strangely, the predisposing cause of a disease [*they are non-neutralising, you see*], the predicted explosion was even then clearly not occurring [*just you wait, there's a very long incubation period*] but to cap it all, there was no HIV actually in semen [*yes, but there is provirus*].

But what is a provirus? Do coughs and sneezes spread viruses or proviruses, and do other proviruses spread diseases? No, of course not. So, a whole new set of rules had been invented for AIDS - a bit suspicious to say the least.

There can be no reasonable expectation that HIV/AIDS researchers will ever see the error of their ways. Things were pretty bad in the 'old days' when the printing press was still a novelty and a letter far away, like Italy, might take a month; then 'hot' news like how to stop sailors developing scurvy took 200 years to get around. At that time there weren't even any vested interests or careers propping up the whole speculative story of HIV, which is little more than the result of Gallo's lively imagination and his craving to be a celebrity.

Things have got slightly better since then, but not much: it took just 10 years from 1984 for Barry Marshall's theory that stomach ulcers were caused by a bacillus, *H. pylori*, to travel from Australia round the world, but as the patents for drugs like Zantac and Tagamet had not yet run out, Marshall couldn't be allowed to be right. Witches and heretics have been burnt at the stake, draculas have had stakes driven through their heart, conscientious objectors have been imprisoned, Communists have killed themselves following the collapse of their cherished views, but no AIDS researcher will ever pay the price for 'just following orders', as a lot of Hitler's cronies did at Nuremberg and thousands of lesser trials.

Every youngster knows that lack of vitamin C causes scurvy, ie. that it is a nutritional deficiency. This was first demonstrated to be so by an English admiral in 1593, but it was not till the 1930's that it was finally admitted that another nutritional deficiency, in this case of vitamin B_{12}, was the cause of pellagra, so tenaciously is the idea imprinted on the medical mind that every dread-disease is caused by a microbe of some sort or other. What hope, therefore, is there for a handful of AIDS-dissenting voices bleating in the wilderness?

"There can be no reasonable expectation that HIV/AIDS researchers will ever see the error of their ways"

Stubborn adherence to a wrong theory was never due to genuine lack of information. On the contrary, it was always noticed quite early on what the true cause was. It was just pig-headedness, yet believers fought tooth and nail to uphold the wrong view. And what was the wrong view? Invariably a bug, or ideally several of them - presumably, safety in numbers. That having been so when nothing,

except at most vanity, was at stake, there is clearly no possibility whatever that the present authoritarian view that HIV causes AIDS will ever be revised. What would happen to the careers of all the people whose entire reputation rests on the theory? They would be sued from now till kingdom come for negligence. What would happen to the pharmaceutical companies who would be demonstrably guilty of manslaughter, so glaring are the sins of omission and commission committed in evaluating the safety and efficacy of all the current AIDS drugs.

The first recorded account that scurvy was infectious dates from the mid-15th century, and was based on none other than the trivial observation that a number of monks at a single monastery began to suffer from it. There could be no explanation other than infection, could there?

Sailors were particularly prone to scurvy because of frequent periods of enforced deprivation of fresh food. Because it was thought to be infectious, any sailor found to have the disease suffered the harsh fate of being cast ashore on the nearest island in the vain hope of ridding the ship of the source of the trouble. By 1753, ie. just over 150 years after the English admiral worked it out, another English admiral furnished a new proof, yet it still took another 40 years for it to become accepted. Sailors were then issued with lime juice, and that was an end to it, or so you would have thought.

As if all this were not horrifying enough, the mania for finding a microbe for every disease sometimes actually caused disease: pasteurising, ie. heating milk kills off probably harmless microbes, but in the process destroys vitamin C naturally present.

As already noted, although by 1750 Admiral Lind had clearly proven the role of citrus fruit in preventing scurvy, that did not prevent the American Pediatric Association from asserting as late as 1898 that this was not so, and they had found a 'new' bacterium instead. Still worse, various Continental scientists were in 1916 *still* searching and finding(!) various bacteria that caused scurvy. Who would credit it?

Another vitamin deficiency disease is beri-beri which does not feature much in English medical history (but caused havoc elsewhere) leading to degeneration of the entire nervous system, and hence paralysis and death. Its cause is lack of vitamin B1 contained in the nuclei of mainly wheat and rice. Wherever refined cereals were used 'epidemics' of beri-beri followed.

Despite the lack of detailed knowledge of the chemical constituents of any foodstuffs at that time, an observant Japanese naval surgeon correctly identified the source of the problem, and tested out his theory by force-feeding the crews of ships with differing diets. He published his results in *The Lancet* in 1885, but because it was not *fashionable* at the time to consider factors other than microbes, his results were simply ignored. Some critics all-knowingly just said he was wrong, without adducing any evidence, and left it at that. Sounds familiar?

At the same time the Dutch in Java undertook intensive investigations of their own, because of the new practice of eating polished rice. Various army doctors quickly 'sussed' out the pernicious effect of this practice, but concluded nonetheless, this must be wrong, and redoubled their efforts to find various germs and fungi, which they did - many of them, but of course, none that actually caused the disease.

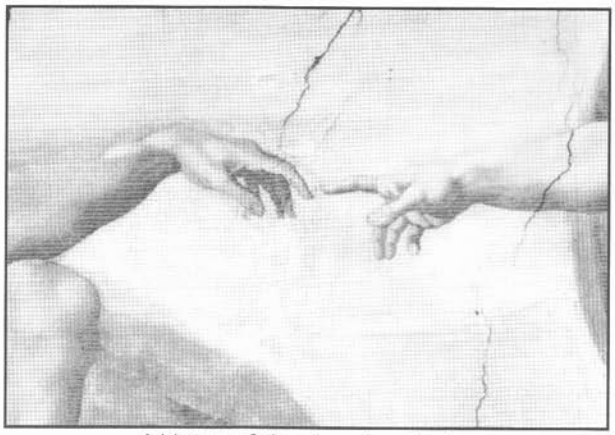
As these things went the outcome of this particular horror story was rather bland: by 1911, after 'only' 30 years of wilfully barking up the wrong tree, the issue was settled by actually isolating the vitamin that was causing the problem. It was hard to argue with something you could actually point to and show to be responsible. Right to the very end though, doctors were still 'treating' the disease with arsenic and strychnine, more commonly used to see off old ladies and rats, respectively.

"The mania for finding a microbe for every disease sometimes actually caused disease"

The worst by far in terms of cases of mistaking a dietary deficiency is pellagra, again largely unknown in the UK, because we don't much go in for maize. But things were very different in Italy and America.

The symptoms of pellagra, a vitamin B12 deficiency, are rough and peeling skin with splotches of reddish pigmentation followed by nerve disorders, dementia, wasting, diarrhoea and finally death. This clearly not very nice disease was treated as if it were an infection: by bloodletting, administering quinine and arsenic. These measures nowadays seem mind-boggling, but this was only about 100 years ago. The real cause of pellagra was the absence of an essential amino-acid, niacin, which happens not to occur in maize. It was for this reason that only the very poor who could not afford to eat anything else, were affected.

A French doctor, Hameau, thought it was caused by a disease transmitted by sheep, merely because there was a disease in sheep with vaguely similar symptoms, whereas an Italian doctor thought a mould growing on maize was the culprit. In 1881 another Italian doctor, Majocchi, identified a bacterium growing in mouldy maize as well as in the blood of patients, and decided that was 'it'. Unfortunately for him, in other parts of the world the same mould was found on potatoes, as well as frequently in perfectly healthy human intestines, so it was clearly back to the drawing board.



A history of theories of contagion

Another bacterium was discovered by Carraroli, then there was Ceni who blamed it on a maize fungus. In 1904 Ceni found two new candidates which ostensibly caused the disease. The volume of Ceni's research gave several scientists quite a hard time refuting all these inconsequential findings. He was clearly something of a Robert C. Gallo of the time, always finding things which didn't do anything. The fungal spores, it turned out, caused neither pellagra nor any other disease in animals nor could they be found in some of the patients who were supposed to have died of the disease. Next came Tizzoni, he found two strains of bacteria. He was clearly the John Maddox of the time, always declaring that the matter was now 'settled', forbidding further discussion so as not to upset the correct thinking going on, which didn't lead anywhere.

Matters only got really serious when the disease spread to America. The problem was an outbreak in a lunatic asylum in Alabama. The Public Health Service headed by Dr Lavinder mobilised Americans to believe that there was a disease that could spread out of control, which would affect everyone, rich and poor alike. He must have been the equivalent of our Nick Partridge and the THT, forever forecasting the breakout from existing risk groups, which never happens!

Dr Lavinder had the novel idea of using arsenic *and* mercury to treat patients. Any halfway sane English schoolboy would recoil in horror at administering such well-known lethal substances to anyone, and one can only wonder why Dr Lavinder did not try out cyanide and strychnine as well. Perhaps that omission led to his temporary sacking, because he only lasted one year and was replaced by Dr Long who had the bright idea that the disease was brought on by lack of hygiene. He had obviously stumbled upon a catastrophic, idiopathic breakdown in potty training in the Deep South. He found an amoeba-like microbe in the intestines of most of his patients. An English doctor, Louis Sambon, announced that the disease was transmitted by insects, either flies or buffalo gnats, which was pretty shrewd, considering - there must have been quite a lot of different beasties buzzing about, and he plumped for the wrong ones. Despite his reputedly sophisticated powers of observation, he failed to notice that unlike malaria, pellagra did not spread out of its risk groups. Even in epidemic areas only very poor farmers were affected. Ultimately, in 1912 stable flies (but no gnats) were officially blamed for pellagra. People who refused to accept such patently suspect waffle were described as "pernicious," compared with those who disbelieve the HIV story nowadays who are called "irresponsible."

"People who refused to accept such waffle were described as pernicious"

By 1913 Lavinder was back at the helm of an official commission enquiring into a cure, and was up to his old tricks of injecting blood from pellagra sufferers into monkeys, which, apart from administering systemic poisons, was his 'great idea' during his previous stint at the job. It is not recorded whether he administered any other poisons - just in case they might do the trick, nor whether the monkeys developed horrible immune diseases or even kuru, as might be expected from having human blood injected into them.

In 1914 something rather unusual and sensible happened. Dr Joseph Goldberger who until then was just an ordinary member of the commission, became its head. He noticed that doctors and nurses in epidemic areas never 'caught' pellagra, and linked it to the very different diet of their patients - a contemporary analogy would be noticing that no prostitutes ever get AIDS (unless they use drugs) but plenty of doctors and dentists do! He drew the inescapable conclusion: he changed the diet of the sufferers completely, and cured them. For his pains he was bitterly attacked by fellow doctors - the mind boggles.

In desperation Goldberger injected himself, his wife and 14 co-workers with samples of blood, faeces, mucosa and other body fluids from pellagra patients, but none of them contracted the disease. This demonstration of his clinical point as well as his courage swayed hardly anybody. Where ignorance is bliss, it's folly to be wise. The infectious theory of pellagra only became a dead letter when niacin was synthesised in the mid-1930's, but poor Goldberger was dead by then. Quite a lot of people will still have to die of AIDS at that rate.

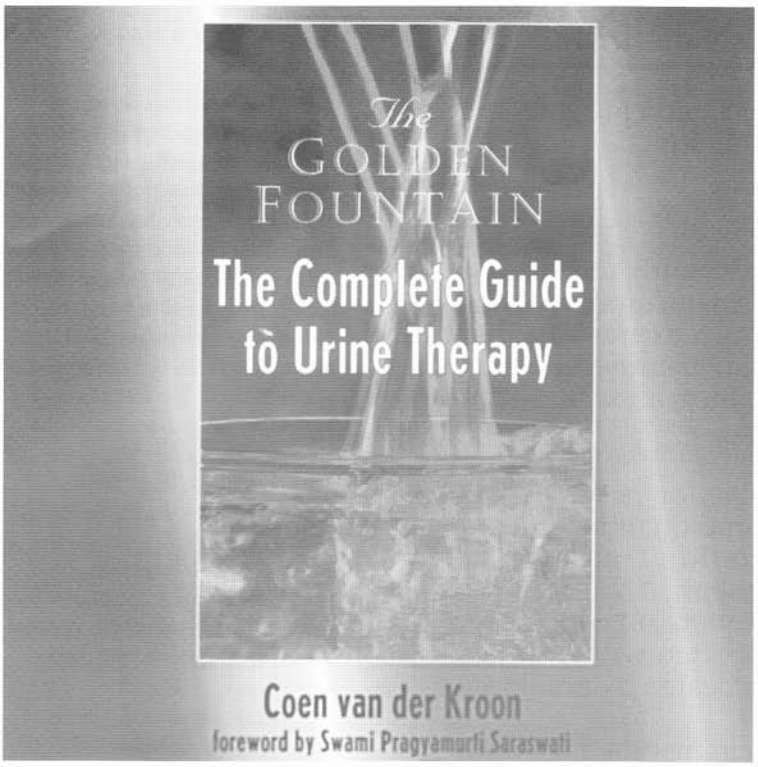
Old hands amongst us may remember one of the last modern 'spectaculars', (ie. other than last year's major outbreak of plague in India which claimed 50 lives, or this year's of Ebola fever in Zaire which did 20 or so) when in 1976 microbe fanatics discovered a new epidemic among participants at a get-together in Philadelphia of 'Dad's Army', the American Legion. There were 4,000 or so taking part, of whom 182 fell ill and 29 died. So-called painstaking detective work by the CDC identified a 'new' microbe, *Legionella*, in the air-conditioning system of the convention centre hotel, and went about their business of alarming the whole of America and the world of the non-impending calamity. There were, however, immediate problems with their 'work'. Firstly, for 29 out of 4,000 septuagenarians to die, who had imbibed particularly heavily (it was a special occasion, the Bi-Centennary celebrations), many of whom had had kidney transplants, was hardly exceptional. Secondly, 10% of the victims had no detectable amounts of *Legionella* in them. Some of those who fell ill had not even been in the hotel that was the source of all the trouble, and none of the hotel staff contracted the disease, even though it was supposed to be a new microbe.

The list of inconsistencies grows yet longer. There was no secondary infection at all, ie. no wife or family member of a victim contracted the disease, nor did any doctor or nurse attending them. It subsequently turned out that *Legionella* can be found all over the US, not just in Philadelphia, and in cooling systems, shower heads, humidifiers, swimming pools, lakes and mud-flats.

There was an official House of Representatives enquiry into all this nonsense, but it changed nothing. The CDC kept its head down for a bit, and remains completely unrepentant. Remember, Russian and German scientists were still looking for and somehow actually found microbial causes for scurvy in 1916, although the real cause was first discovered in 1593 and 1753 - not bad going.

What can one say except giggle nervously at the logic of those, who following the Concorde Study, admitted that AZT by itself doesn't do much good, but according to the recent Delta Study, persuaded themselves that the same amount of AZT works wonders if given with a smidgen of ddC (the same sort of poison incidentally - an indiscriminate DNA chain terminator - as AZT itself). When will AIDS researchers and doctors ever start thinking? We've clearly still got a long way to go before the HIV theory of AIDS goes out of fashion. Perhaps gays, famous as trendsetters, will give a lead, and start ridiculing such arrant nonsense. It cannot have escaped their attention that it's always the same old story - "too early to be sure but very promising, more research urgently needed", but always disappointment and failure.

This brief overview was inspired by Bryan Ellison's exquisitely written book WHY WE WILL NEVER WIN THE WAR ON AIDS published by Inside Communications, 190 El Cerrito Plaza, Suite 201, El Cerrito, CA, USA 94530 at $20+p.p.



The Golden Fountain

The Complete Guide to Urine Therapy

by Coen van der Kroon

The Golden Fountain is a carefully researched and clearly presented guide to urine therapy. Coen van der Kroon writes from the wealth of his experience and makes reference to a myriad of information sources.

The book's attraction lies not only in its clarity, but also the humour that he brings to the subject, coupled with an obvious enthusiasm. To some, urine therapy is bizarre and its practitioners crazy. Van der Kroon doesn't ignore such prejudices but tackles them head on, putting forward a convincing and reasoned argument as to why we should seriously consider its proven healing effects.

He puts this therapy into perspective by going back to our origins, describing how every child floats in amniotic fluid (a fluid consisting mainly of urine) for nine months in the womb. The foetus drinks and breathes in this solution which facilitates growth of the lungs. It poses no threat to the foetus and is beneficial, yet it's considered to be a dirty substance by most people. If a foetus is operated on while in the womb, the wound will heal leaving no scars. A similar operation conducted after birth would have severe scarring: urine's effectiveness in wound healing is well-documented in this book.

Van der Kroon's own introduction to urine therapy established his subsequent enthusiasm. While staying in an Indian ashram he cut his foot badly. Worried about the consequences of the tropical climate on the wound he applied antiseptics, but to no avail. After a week a Dutch woman suggested he apply a urine-soaked cloth to the wound. Though sceptical, in desperation he followed her advice, and within days the wound had begun a swift healing process.

From then began his quest to understand what was still to him an eccentric practice. He drew inspiration from Morarji Desai, former Prime Minister of India, in good health aged 99, which he himself attributed to drinking a glass of his own urine daily.

Urine therapy is an ancient practice and the book documents its uses in various cultures, archaic and modern: Eskimos use it as medicine and shampoo, in ancient Greece it was used for wounds, and Romans washed textiles with it, to whom it was also a commodity to be traded. From that time comes the phrase 'money does not stink'.

It's not only antiquity that makes it a valid therapy for today. Van der Kroon draws references from a variety of sources that demonstrate its effectiveness, including lucid personal testimonies of those who are using urine therapeutically. People with problems ranging from minor skin complaints to cancers, and 'PWAs' with parasite infections or KS describe the healing that urine therapy has brought about.

Individual constituents of urine are detailed, along with why they are useful when re-introduced into the body, backed up with references to scientific studies. Explained are some theories of how this therapy works, physically in terms of the enzymes, hormones and urea etc. that are re-absorbed into the body, by stimulating immunity, bactericidal and virusidal effects and on the psychological and spiritual level, opening one up to the body's own healing abilities.

There are fascinating revelations on the use of urine extracts in commercial cosmetic products. An excellent topic to enliven any conversation!

The Golden Fountain is a book capable of convincing the most cynical with its rational explanations. There are no sensational claims or wild assertions and statements are supported by references.

In addition it contains practical advice and an index of diseases with general treatment suggestions outlining how to use urine therapy most effectively.

Are you ready to go with the flow? Sip it and see! ■

MOLLY RATCLIFFE

Published by Amethyst Books, 1996. £8.95
ISBN 0-944256-73-2

Coen van der Kroon is working on a new book to be published in Germany. He's very interested in personal testimonies from people using urine therapy, especially those with a positive 'HIV antibody' result or an 'AIDS' diagnosis. Testimonies should be written, giving details of how you discovered urine therapy, what complaints you used it for and what results you had.

Send to: C. van der Kroon,
c/o Continuum (usual address)

Call our office and speak to Molly for more details.

editorial

One of the problems with Western allopathic medicine is its lack of a definition of wellness. With the body and its functions divided into diagnostic sub-sections, we generally miss the concept of a healthy unifying process.

In this issue we explore a different model of health and disease, that of the well-established art of homœopathy, which presupposes that our bodies strive for well-being, sometimes expressing their distress while doing so. A whole new world of understanding awaits those who come fresh to these ideas of integration and stimulation.

Striving to be well, or secure, or comfortable, or powerful, too often takes the form of undermining these same qualities in competitors - as if the spring of satisfaction couldn't possibly be enough for all of us to share. So comes combat. And from our human strategies for battle come some unfortunate orthodoxies in medicine - eradicating the enemy within, most often with chemical weapons, halting the march of a disease, being beaten by an illness.

The war on AIDS? It has turned into a war against the HIV-diagnosed, nowhere more clearly than in the very hospitals that entice us in. They have become the Mururoa Atolls of AIDS: test (the patient, the drugs) and see how well-contained an apocalypse you can create.

An example of the detachment that the Western medical model has cultivated towards life and humanity is this chilling exchange between St. Thomas' Hospital, London's HIV Unit Consultant Dr Caroline Bradbeer, and a dissatisfied visitor: "You're just pissing in the dark, aren't you?" Dr Bradbeer: "Yes, but it's a fascinating academic experiment."

But there is progress towards sanity. More people trust their own abilities to heal and grow than ever before. In a world frequently poisoned on various levels, developing towards responsibility and wholism may become an irresistable tide.

continuum

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Dear Continuum,
My condolences to those of you who were close to Jody, it is a great and sad loss, but as you say, the greatest tribute to him is the continuation of such an excellent publication.
Never lose faith in what you do and remember what a beacon in the wilderness you provide!

Yours,
Steve Noakes, East Sussex.

Dear Continuum,
I wish to express my sincere sympathy to you all for the sad loss of Jody Wells. May he rest in peace!
He was an inspiration to us all and we shall continue to fight in his memory.
I was very privileged to meet Jody at the Continuum Christmas Lecture and I hold him in the highest esteem. He will be dearly missed.
I wish you all every success for the future.

Yours,
John McNally, London

Dear Continuum,
I met Jody Wells soon after he had started the magazine. I've never known anybody like him and will never ever forget him. I feel a tremendous sense of loss, and hope that wherever Jody is, he is at peace and happy.
Thank you for everything, will drop you a line again. Keep up the good work.

Love,
Farouk, South Africa.

[Ed. Many thanks for these letters and the others expressing your feelings about the loss of Jody. This magazine, which he began, continues through your interest and support.]

Dear Continuum,
Many thanks for sending me a few issues of continuum magazine, and also for taking the trouble to discuss the

....Dear Continuum.....

HIV/AIDS matter with me over the telephone.
As I said then, and I should like to restress it, I have not been tested for HIV, and I don't consider myself to belong to a social group "at high risk" from developing the alleged illness. That is to say, I'm just a boring white, middle class, meat-eating, heterosexual, non-drug using male!
Rather my interest was sparked by two things: the contradictory allegations in the media, and also the panic that has engulfed the world for the past decade. As a lay research psychologist (but so were all the best!) I am concerned and fascinated by the psychological effects that the terror of AIDS has had upon ordinary people.
My own brief enquiries in my home town of Basingstoke lead me to the impression that a significant number of young, single, heterosexual people are denying themselves many of the pleasures that perhaps they should be enjoying due to an excessive paranoia of AIDS. Not to mention the shunning, hatred and fear which accompanies "HIV-positives".
I telephoned the government-run AIDS helpline, and asked if AIDS could be contracted from mosquito bites. They replied that it couldn't. However, when asked why it couldn't when I believed it could be caught from a dirty needle they amended the theory of dirty needles to one of "syringes containing blood". Oh yeah, like sure IV drug users are using syringes containing blood? At no time did the AIDS helpline reassure me that HIV is a THEORY and not a FACT (like smallpox or yellow fever are FACTS). This I find significant.
I read Stefan Lank's paper, and Steven Harris' criticisms etc. with interest. I also read the other articles in the magazine and I for one am convinced that:

1) HIV is a myth;
2) AIDS is not an illness, but a death from one of 29 known illnesses;
3) AIDS is a reslut of poor diet/hygiene/health;
4) AZT etc. is not the answer, better to eat more green vegetables.

And as such the campaign on education should be aimed more at eating a natural balanced diet (sorry veggies, but you're not natural! Watch out for the B_{12} deficiency). And on better hygiene, surely anal intercourse must be risky due to the presence of large numbers of bacteria in excrement? If my beliefs prove to be well-founded, then the motto "don't die of ignorance" takes on a sickly, ironic tone...

Yours sincerely,
Matthew, Basingstoke.

Dear Continuum,

It was great to meet you all today and thanks for making so much time. I had only expected an hour!
I love the consolidating effect Positively Healthy has had on my philosphy and in some ways, on my life. So too, finding the same words spelt out in Continuum for an even wider audience, hopefully.
My only anxiety is that the generals, who lead this battle with understanding AIDS and its complexities, may get so caught up by the stimulus of the 'front line debate' that they forget to tell the 'foot soldiers' how the battle is being fought - and won! You and I will never die from AZT or ddI; or; or; or; but many others are and will die because:

a) they haven't accessed your information banks;
b) they don't understand your "language" - terminology;
c) they've been so frightened and brainwashed by that initial, frightful, misinformed prognosis onslaught - that apathy and acceptance of death sentence is their uninformed choice (I fear this is the majority).

I wonder how many of this group understand the words "HIV doesn't exist" - having already programmed themselves to die from IT?
We will win this battle, I have no doubt, and the world will be richer for it - but let's not forget the foot-soldiers!

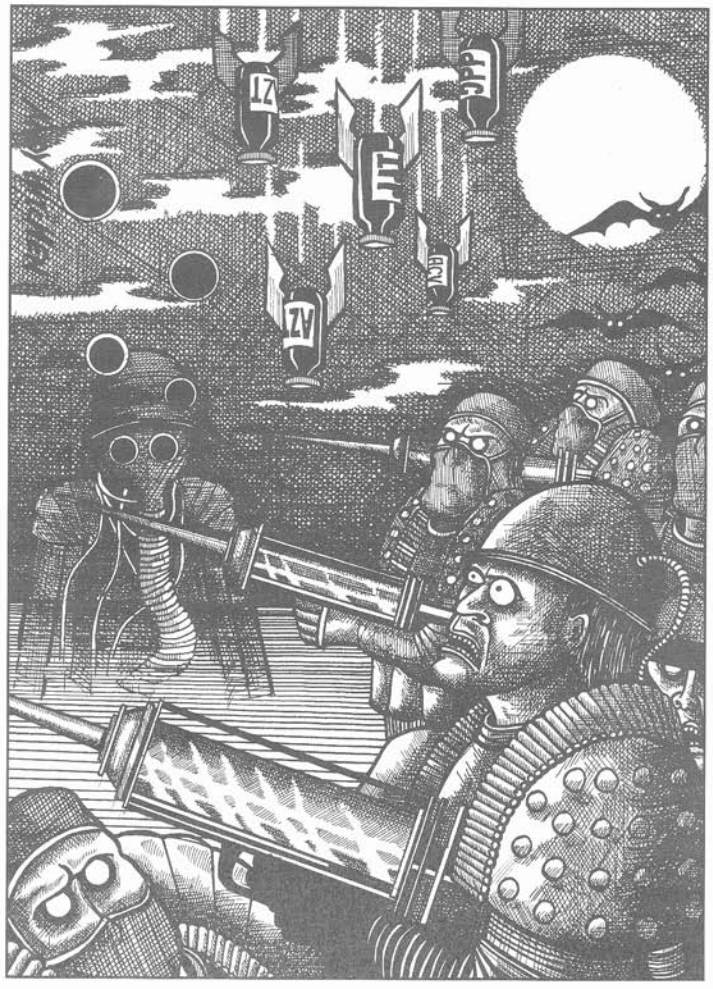
Love,
Granville, London

Dear Continuum,

At long last - some truth about poppers, in the Sep/Oct Continuum. I have been struggling to come off poppers for almost ten years. Now that I've been given an HIV+ diagnosis I feel the need is urgent, Until I read page 10 of Continuum I was, I feel, being kept in the dark. Thank you for some truth!
Do you know of anyone out there who takes this problem seriously? Is there anyone who really knows what poppers can do and is doing?
Every fortnight I chat to a lovely lady at Drugs Advisory, I see a psychologist, I occasionally see the (lovely) doctor at GUM - but nobody seems to know much about the long-term harmful effects. I use 20-30 mls a week and the 'enabling effect' of poppers leads me into harmful self-abuse/sexual mutilation. I am desperate to know more.
Are there any doctors, scientists or self-help groups dealing specifically with poppers misuse? I would be so grateful if somebody could advise me.

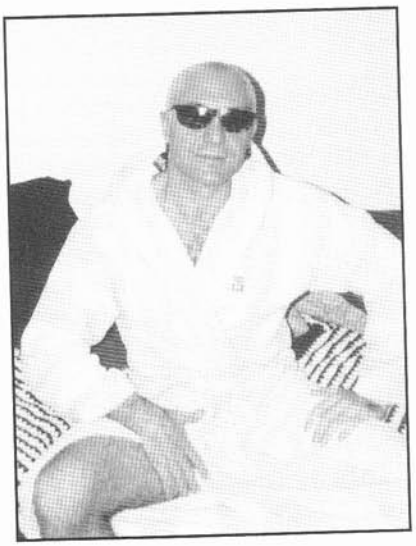
Yours sincerely,
(Name and address supplied)

[Ed. Try making contact with Positively Healthy (0181 878 6114) or Narcotics Anonymous (Helpline 0171 498 9005 or check your local directory). We are also sending you a leaflet on Poppers by Project LSD. Hope this helps you.]



by Andy Hitchen

LifeStory – a reader's experiences



Born in Italy, I've been living in London for the last 15 years. I'm 34, and had a positive test in March 1992.

I was brought up, as most of us Italians are, in a Catholic environment full of conflict. Funnily enough though my mother is a Catholic, my dad is a staunch Stalinist; I remember him saying to us kids that when the day came for him to retire he would go and live in the U.S.S.R. You can imagine, being in the middle of it was very confusing and heavy to deal with as I grew up. I can relate that situation to the one I'm in now, with the orthodox dogma on one side and 'HIV heretics' on the other. Not surprisingly, I'm on the side of the heretics. I don't believe that HIV is the cause of AIDS.

I could write about all the disillusion I've felt, the betrayal, the questions that have never been answered by the so-called 'medical profession', but I think that a lot of other people have done it before me and will do it after me. Sounds bitter? Yes, I'm bitter, I'm angry, I'm furious. About what? About the greatest fraud in the history of human-kind.

From one side I hear that they know what the culprit causing AIDS is, they know how to slow it down, eventually they'll know how to destroy it. On the other side they say that what's been called the culprit is an innocent passenger, blamed and used as an excuse for a series of deadly poisons to be given to all-too-willing recipients. The corporations pushing the HIV=AIDS hypothesis are making a fortune; the people fighting it or just questioning it are being humiliated, losing their jobs, tainted with the charge of being irresponsible mad-men. The perfect illusion has been created. HIV is the so-called enemy, something for people to fight against, without it involving taking control of our lives and our actions. I'm talking about you, me, all of us being used as laboratory rats for their sick experiments and dirty drugs.

I've had my share of problems since my diagnosis. I'm only human and I have my doubts. I'm trying to take control of my health now after years of attempting to annihilate myself through senseless drug-taking and a semi-promiscuous sex-life. Does this mean I'm attacking the hard-fought for right of liberty, to do as we please in the name of sexual politics? Have we been saying that freedom is being able to sleep with anything on three legs, or is the right to destroy ourselves with a bunch of pills with stupid names? Is that what makes us 'Gay'? Thanks, but no thanks, I'll go back in the closet. I won't be a 'willing target' for all that anymore.

Right now I'm taking a combination of antioxidants and shark cartilage specifically for my K.S., which I've had for 1 1/2 years. My eating habits are quite healthy except for occasional chocolates. I smoke herbal cigarettes (ha, ha) to relax me. Well! Nobody's perfect. I've completely stopped taking hard drugs like I used to (I've taken everything except heroin; the list is far too long to include here). I'm still waiting for a sex life, but I'm in control and make my own choices.

I started urine therapy in September '93. I was very lucky to be introduced to it by a wonderful woman called Swami Pragyamurti. I think if anyone has changed my life it is she. I'm not saying I've discovered a miracle cure, but I've certainly found something that is not only very effective but also is side-effect free. With uropathy I've successfully cured recurrent attacks of athlete's foot, thrush, skin rashes and acne. Since I've been using it my energy level has increased and the hair on my head, where once it was thin, has grown thick. If I feel a bit down I increase the dosage and in a short time feel better. I haven't had a cold or 'flu for over a year. I used it while I took a course of antibiotics and the side-effect I usually get of skin rashes didn't appear. I used it on my K.S., successfully at first. Then I was prescribed steroids for weight gain and the K.S. exploded, from two lesions to thirty. Later I found out from a French study that a possible side-effect of steroids is worsening of K.S. lesions.

I believe I should try a period of fasting on urine. The lesions in my mouth are almost completely gone and gum problems or mouth ulcers are things of the past. My blood count (platelets) is normal (I don't care about T-cell counts), and my liver and kidneys function perfectly, which is amazing considering all the abuse with drugs in the past. Maybe that's another effect of urine therapy. You should see the faces of the doctors when I tell them I drink my own urine! It works on a spiritual level too. After all, I'm drinking my own 'poisonous' body fluids. Wow, what a trip!

Back home we have a story about St. Thomas, with whom I share more than my name. St. Thomas was the only saint who couldn't believe that Christ had been resurrected until he'd put his finger in the wounds. Only then would he be convinced that it was indeed Christ. Let's say that I will never believe HIV can cause such a destruction of the human body as is AIDS without it having even been isolated.

A final thought to leave you guys and dolls out there with: I don't know what is going to happen, but what the hell, it may never happen!

Love life,
Yours,

Tommy Perry.

If you would like to have your personal life story featured here on this page, please contact us on 0171 713 7071. Who knows, what you have to say may be instrumental in helping someone else to make an important decision about their life.

In the next issue of continuum...

- Feature: A look at the Healing Centre in London and their holistic approach to AIDS
- SPECIAL: 2nd International Meeting on Complementary Therapies in Spain, taking place in December
- Interview: Prof. Alfred Hässig discusses the U-turns on AIDS by Anthony Fauci, Director of the NIAID
- Health: Allicin: The newly-available garlic extract with remarkable therapeutic benefits

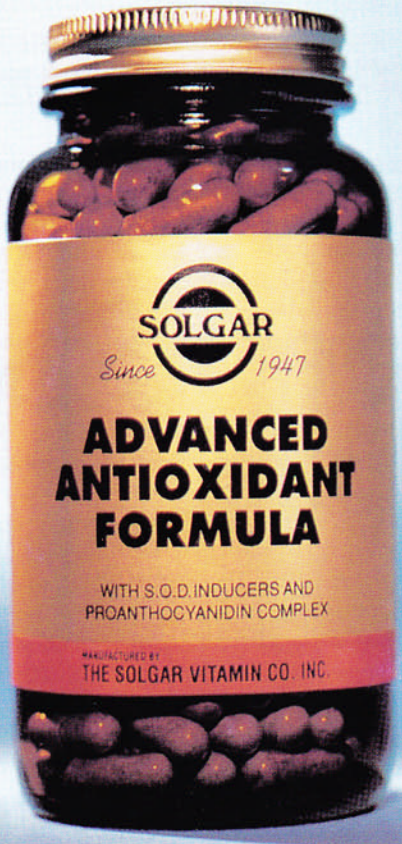
plus: News, drug effects, personal story *and more*

Season's Greetings

to all our readers

See you in the New Year

92.4%* of NURSES want to know more about complementary medicine. *But* who can they trust?



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