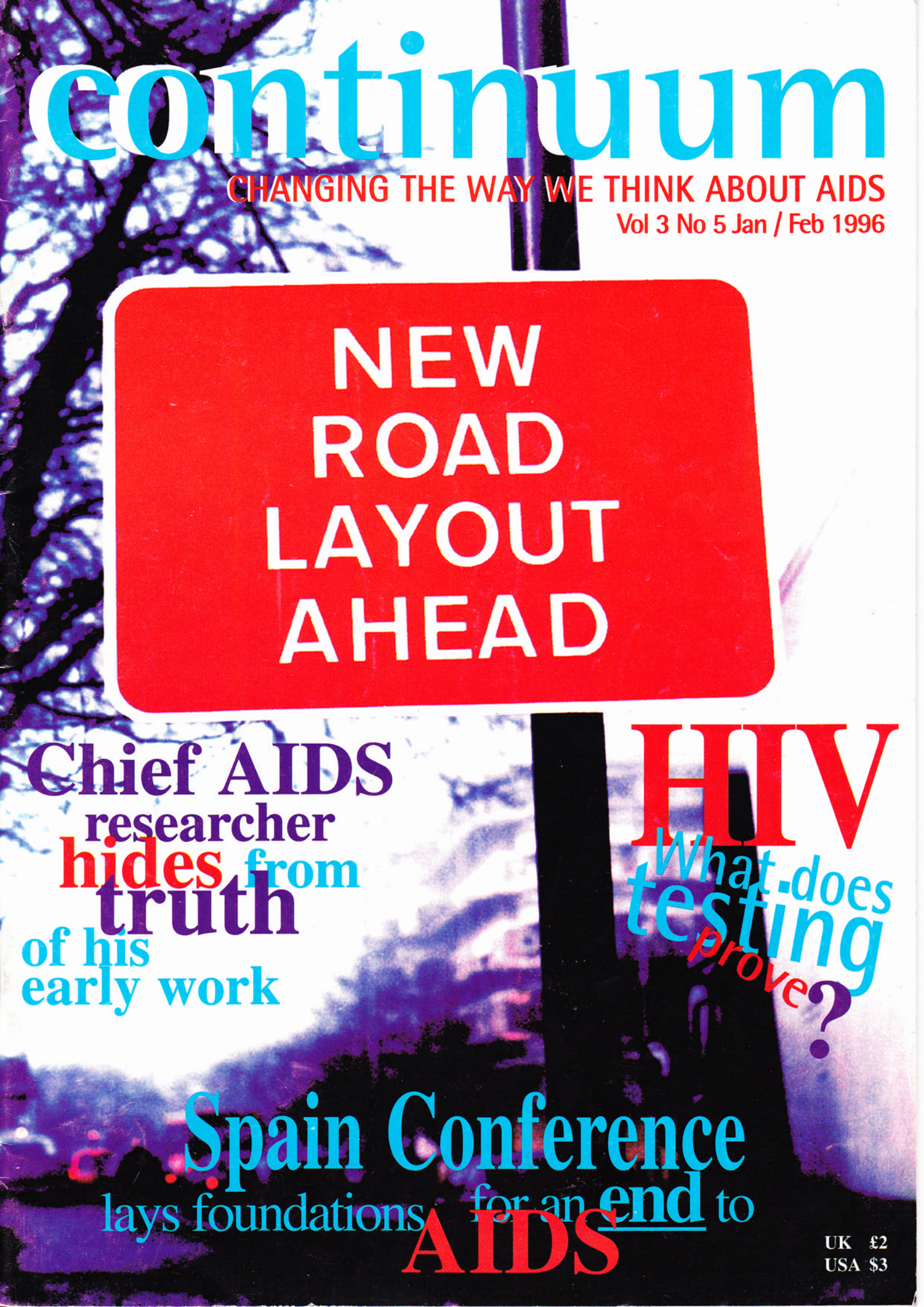
continuum

CHANGING THE WAY WE THINK ABOUT AIDS

Vol 3 No 5 Jan / Feb 1996



Chief AIDS researcher hides from truth of his early work

HIV What does testing prove?

Spain Conference lays foundations for an end to AIDS

UK £2
USA $3

An Open Meeting

Tuesday March 12th, 6.30 - 8.00 pm

at

the Continuum office, 172 Foundling Court, Brunswick Centre
London WC1N 1QE *(near Russell Square tube)*

Continuum is holding an open meeting
to which all our readers are invited.

Come and ask questions, share your experiences
and meet the faces behind the names at Continuum

Please call to confirm attendance on 0171 713 7071

25% Discount coupon on inside back cover

continuum

Vol 3 No 5 January/February 1996

Contents

Changing the way we think about AIDS...

1st WORLD CONFERENCE ON URINE THERAPY

East & West will get together to share their experiences on Urine Therapy - a sure remedy for every ailment. Followers of Urine Therapy, here's a Golden opportunity to visit Goa, India, where the 1st World Conference on Urine Therapy will be held on 23rd to 25th Feb. '96. See and enjoy beautiful Goa and participate on the Conference.

Contact the organisers for details:

WATER OF LIFE FOUNDATION (INDIA)
Post Box No. 176, Panjim, Goa-403001 (India)
Tel: (0832) 223761/221907, Fax: 91 (0832) 220448

OR c/o Continuum at the usual address

DNCB?

If you are using DNCB as a treatment for KS

please contact Tommy c/o Continuum
(usual address and phone number)

He'd like to know of your experiences.

From the edge

DARBYSHIRE PRESSED

Dr Janet Darbyshire of the Medical Research Council, responsible for the Delta trial of combination therapy, was asked to defend the reasoning behind giving the control group AZT. In response she said "Had we known what the results of the Concorde trial would be the protocol for Delta would have been different". Pressed further she explained that Delta was conceived in 1991 when AZT was considered standard treatment for HIV+s.

In 1992 Concorde trial results showed AZT was a useless treatment for asymptomatics, but the MRC felt unable to change Delta protocol to reflect this. She also said that they had been unable to find patients willing to receive no AZT as a control.

Darbyshire was speaking at a lunchtime lecture held at University College London in November.

EPIDEMIC DROPS DEAD

The number of people testing 'HIV+' in Uganda has fallen dramatically said the World Health Organisation at the *AIDS in Africa* conference in Kampala. Figures from the national survey in Uganda show that those aged 15-19 are only half as likely to test antibody positive as the same age group tested five years ago.

It is apparent that the predictions of a continual expansion of HIV will not be realised. This has lead to talk of an end to the epidemic-that-never-was, after a similar decline in Britain and Thailand. Scientists claim the reason for the decline is the success of health education campaigns, which is curious since the most noticeable drop has been among young women attending antenatal clinics.

Is it reasonable to expect that pregnant women are the ones most using safer sex advice?

CRIMES AND MISDIAGNOSES

A woman received a two year jail sentence for injecting her former boyfriend with her blood after he found another girlfriend.

Rhena Ndagga has tested 'HIV+' and is accused of putting his life at risk, which Mrs Justice Steel said was "deliberate, calculating and cruel". One might use the same words to describe the propagation of an unproven theory as the cause of AIDS.

Whatever the motives behind the act Ndagga, a Ugandan refugee living in London, has used the power of misinformation to exact revenge with a consequence more dreadful in thought than in action. So far David Kabagwire has not had a 'positive' test result.

New group pushes Delta cocktail

DRUG MONEY PRESSURE PACT

A nationwide association of providers of care and treatment in the NHS (PACT) is being formed around a steering committee chaired by London immunologist Prof. Anthony Pinching.

After the change in government policy allowing health trusts to switch HIV/AIDS money to different services, and a central government cut in HIV/AIDS spending of 8% last November, the group of interested professionals hopes to pressure budget makers to keep up the levels of money spent on AIDS drugs and salaries.

High on the list of new costs reportedly promoted by PACT will be the cytotoxic drug "cocktail" of AZT and ddC spuriously touted as beneficial following last year's hotly debated Delta Trial. If coercing patients to swallow the drug combination is successful, pharmaceutical company coffers should swell by around £15 million per year. PACT want the government to provide this money.

A Department of Health spokesperson indicated the authorities had not yet accepted the Delta results as proving combination therapy works. A statistician at the Medical Research Council, the government agency running the trial, said the results confirm neither that the two drugs are good for asymptomatic people nor that they are better than no drugs.

PACT chairman Pinching is on record stating that "the problem with AZT is it's side-effects mimic the symptoms of AIDS" so his activism is a surprise, but perhaps the side-effects of budget cuts mimic the symptoms of adrenalin.

HC

UNWELLCOME CASH STRATEGY FAILS

The coordinator of the Herpes Viruses Association appeared in court on January 4th 1996, after almost two years of delayed hearings, accused of blackmailing Wellcome. In a very unusual move the judge at the Old Bailey, London awarded costs to Michael Wolfe of around £4000. The decision came after negotiations between Wellcome and the Crown Prosecution Service.

Wolfe ran the self-help group for people with Herpes from 1985. There had always been an uneasy relationship between the Association and Wellcome, manufacturers of Herpes drug Zovirax (also called Acyclovir), but in 1991 the company approached them offering £36,000 to be spread over three years, which they accepted. Conflict followed over the marketing and claims for Zovirax , a subscription drug Wellcome were relaunching as an over-the-counter cream. The strategy of relaunching old products is a technique referred to as drip-feed marketing and bears a relationship to the way AZT has been marketed.

The launch was set for August 1993. The Association held a press briefing in June 1993 with respected medical professionals present questioning the cream and its over the counter sale, which was reported in *The Sunday Times*.

After the press briefing Wolfe looked for another way of influencing the marketing campaign. He was struck by the effectiveness of AIDS activists willing to put themselves on the line and hatched his own plot to embarrass Wellcome, and it was this that led to the eventual charge of blackmail.

Wolfe claims that his objective was to obtain a cheque from Wellcome as a retainer for promising to stop the anti-Zovirax campaign, and then he would take the cheque to *The Sunday Times* to expose the company.

On the morning of August 1993 Wolfe met with Gary Noon, UK manager of the Wellcome Foundation at a café and prepared the ground for his 'changing camps' strategy. They met again in the afternoon and it was then that Noon claims to have formed the view that Wolfe wanted to blackmail Wellcome and involved the Metropolitan Police. They met again on the morning of August 26th and now Noon appeared to set the agenda by offering £250,000 cash rather than a cheque as Wolfe claims he originally asked for. Wolfe said later that he felt he had to agree to this

This billboard appears on the border of Haiti warning Dominicans as they leave to beware of the dangers of AIDS. However in Haiti, despite infrequent use of condoms, the supposed prevalence of HIV is considered to have remained stable since 1984.

GERMAN HIV MURDER CASE

Two men are charged in Germany with HIV-related crimes. A medical doctor responsible for overseeing the testing of blood donations is accused of murder, and the chief of a pharmaceutical company charged with complicity, after plasma recipients tested antibody positive.

Independent virologist Dr Stefan Lanka has offered to testify in their defence that no murder weapon, no HIV, can be identified. Lanka is aware that false testimony in German law carries a minimum penalty of a year's imprisonment, aside from the force of his own professional ethics.

Such important cases in Germany occur in an increasingly complex political environment. Recent right-wing coverage has asserted that just as AIDS-dissidents are correct, and HIV is a fraud, so claims that there was a Jewish holocaust during World War 2 are fraudulent. While no sane person believes that, refuting it can seem to refute the HIV-does-not-equal-AIDS position once the issues are linked.

Commentators agree it is important to avoid building conspiracy theories as these usually fall well short of reality, and to remain aware of the political agendas of some groups who appropriate the HIV/AIDS phenomenon for entirely different purposes.

HC

Even though his strategy was going badly astray. Meeting again that afternoon Noon handed the money over to Wolfe in the back of his company Jaguar and moments later Wolfe was arrested by the police and charged.

The case rested on the crucial second meeting, of which, unlike the other meetings, there is no tape recording. Noon claims that Wolfe made threats and demanded money whereas Wolfe asserts that Noon agreed to pay him about £200,000.

Legal proceedings that followed carried on for two years because of Wolfe's ill health, partly due to a blow to the head he received a few days before a scheduled court appearance in 1994. In November 1995 his health deteriorated so much that he had to be admitted to a psychiatric unit.

The case raises questions about the relationship between drug companies and self help groups and the accountability of pharmaceutical marketing policies. A final question hangs in the air concerning how the Crown Prosecution Service came to be involved in a case in which the evidence was so insubstantial as to make a conviction unlikely.

MR

SCOTTISH AIDS NO LONGER A THREAT

The director of public health in Tayside, Scotland, has announced that the AIDS epidemic in the region is over.

Dr Donald Coid stated in a local newspaper that the spread of HIV was largely under control and no longer presented a major threat to public health. There were only 16 new cases of AIDS last year compared to 16 cases of stroke each *week* in Tayside.

The release of this encouraging news has been greeted with anger by local AIDS workers who believe that it will promote complacency among people.

They went on to state that "HIV is preventable, strokes are not" making their suitability as health care workers seem questionable.

MR

From the edge

CALL THIS PROOF?

The US National Institute for Allergy and Infectious Diseases has had to produce a booklet purporting to explain how HIV causes AIDS after receiving many queries from people who doubt that conclusion or want ammunition to field sceptical questioners. There's nothing like being market-led.

Called *The Relationship Between the Human Immunodeficiency Virus and the Acquired Immunodeficiency Syndrome* it claims to contain all the documentation for proof of the hypothesis. Wishful thinkers hoping to claim our 'Missing Virus' prize should get their hands on it and start scouring the pages.

STALE VACCINE

The Sydney Cohort of seven blood transfusion recipients thought to contain HIV – some of whom 12 years later remain "long term non-progressors" (LTNPs) – has made news worldwide.

Of the eight infected people, two have since died, one of PCP and one of a non-AIDS cause – and HIV has not been detected in two others! The remaining four are well.

A scientist at Australia's Macfarlane Burnet Centre inaccurately claims to have sequenced "HIV isolates" from these four, saying that a defective viral *nef* gene explains why the individuals remain well. Even so virologist David Ho of the Aaron Diamond AIDS Research Centre reported that he found no evidence of gross *nef* defects in any of 10 other NTLPs he studied, upsetting investors in HIV vaccine technology who hoped they could employ *nef* as a fresh approach.

HYPOCRITICAL OATH

National AIDS Manual's (NAM) *Treatment Update* editor Edward King has apparently confessed to a colleague he's reluctant to take an HIV test.

King is known through various media as a staunch supporter of the HIV=AIDS hypothesis, of the sorts of drugs marketed by NAM funders Glaxo-Wellcome and of HIV testing campaigns.

People are openly questioning King's motivation for urging these courses of action which he does not follow himself.

HIV NOT IDENTIFIED

Continuum reader Matthew Probert reports he called up the Royal Society of Medicine to ask them if it was possible that HIV had been bio-engineered for depopulation.

The external relations office replied that this was "unlikely as HIV had not been separated and identified".

comment

When a supertanker stops in the shipping lanes of, say, the English Channel, it cannot help but plough on for miles and miles after initiating its halt, such is its momentum. We are now seeing a similar thing with HIV/AIDS. Like a skidding juggernaut the HIV hypothesis veers one way and another trying to negotiate the sharp bends and blind corners – the majority of HIV-positive people who are well, the non-specificity of antibodies, the explanation of T-cell artefacts, the failure to isolate the virus. Political and scientific developments worldwide show clearly it's coming to an end.

Pretty soon we will see the insane maltreatment and suffering that have been the AIDS era stopped. Those people experiencing unwellness will find proper consideration of their actual ailments, and the curse of HIV testing itself will cease.

In recognition of this changing map, in London in mid-January an off-the-record dinner meeting took place between editors from three UK gay or HIV/AIDS publications (including *Continuum*), a representative from the Medical Research Council, an international virologist, and two independent critics of the HIV hypothesis. Consensus was found that questions about HIV/AIDS will be best handled in a climate of fuller exchange and genuine co-operation. One great problem remaining is how to achieve a win-win situation. Although it's clear that the antibody diagnosed, the actually unwell, the honest scientists, will benefit from emergence of the truth, upholders of the orthodoxy have everything to lose from the passing of their paradigm. How can they move forward when all they see is loss? This will become a central political question of the months to come.

For those affected directly by HIV/AIDS, more personal questions with more exciting answers – such as: "What do I want as my long-term future?" and "How shall I keep growing and changing for the better?" – are every bit as important and ever more realistic.

Published bi-monthly by

continuum

172 Foundling Court
Brunswick Centre
London WC1N 1QE
Tel: [+44] (0)171-713 7071
Fax: [+44] (0)171-713 7072

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

Founder: Jody Wells
Co-Editors: Huw Christie, Molly Ratcliffe
Sub Editor: Malcolm Manning
Administrator: Tony Tompsett
Advertising: Matthew Probert
Cover Design: Musimbi Sangale
Design & Layout: Malcolm Manning, Tony Tompsett
Research: Alex Russell, James Whitehead

Printed by: PrintKings Trade Services Ltd, 14 Steele Road, London, NW10 7AS Tel: 0181-961 1622

The Jody Wells Memorial Prize

MISSING VIRUS!

£1,000 Reward

Blind romantics still believe HIV causes AIDS. But if 'HIV' has never been isolated, what *is* AIDS?

Never isolated? You bet! A cash prize of £1,000 is offered to the first person finding one scientific paper establishing actual isolation of HIV.

If you or a friendly 'AIDS expert' can prove isolation, £1,000 is yours. In cash. In public.

Interested? Pledge the money to your favourite AIDS charity, why not?

We bet you'll be surprised to discover the truth.

continuum

CHANGING THE WAY WE THINK ABOUT AIDS

To co-incide with the hype around World AIDS Day, *Continuum* placed the above advertisement in Britain's *Pink Paper*, (audited circulation just over 50,000). To date the announcement of the prize has attracted the interest of various organisations and individuals, but claims for the prize money itself from none.

The editor of Britain's National AIDS Manual *Treatment Update*, Edward King, was among the first to enquire formally what was required as isolation in order to collect the prize. Dublin's monthly *Gay Community News* announced the prize as a news story the week after publication of it in the UK and reported "leading AIDS researchers at the Kobler Centre in London said current evidence does not prove that HIV causes AIDS"!

During a live interview on Freedom FM's *Positive Zone*, DJ and *Positive Nation* editor Dominic Gough quizzed Huw Christie about the prize and its implications. And as news travelled internationally, HEAL (Health Education AIDS Liaison), Sydney prepared to place the advert in the Australian gay press, while US dissident Fred Cline posted it on the Internet.

The rules for isolation of a retrovirus were thoroughly discussed at the Pasteur Institute, Paris, in 1973, and are the logical minimum requirements for establishing the independent existence of these minuscule entities, 350 million of which would fit comfortably on the head of a pin. They are:

1. **Culture of putatively infected tissue.**
2. **Purification of specimens by density gradient ultracentrifugation.**
3. **Electron micrographs of particles exhibiting the morphological characteristics and dimensions (100-120nM) of retroviral particles at the sucrose density of 1.16 gm/ml and containing nothing else, not even particles of other morphologies or dimensions.**
4. **Proof that the particles contain reverse transcriptase.**
5. **Analysis of the particles' proteins and RNA and proof that these are unique.**
6. **Proof that 1-5 are a property only of putatively infected tissues and cannot be induced in control cultures. These are identical cultures, that is, tissues obtained from matched, unhealthy subjects and cultured under identical conditions differing only in that they are not putatively infected with a retrovirus.**
7. **Proof that the particles are infectious, that is, when PURE particles are introduced into an uninfected culture or animal, the identical particle is obtained as shown by repeating steps 1-5.**

A woman who claimed to have an AIDS diagnosis died at the end of last year from an overdose of methadone.

Sources reveal the woman, a client at several HIV/AIDS drop-in centres in London, was never diagnosed positive. The autopsy confirmed this.

Shocked reactions to news of the incident were followed by revelations that her claim to have AIDS was suspect. She was a prominent member of charitable organisations in the AIDS field, and some wondered why, over a period of years, she was never in hospital, though she talked frequently of her toxoplasmosis, constant diarrhoea, lack of appetite, peripheral neuropathy, and even bouts of PCP. This from a woman who remained over-weight. On one occasion a woman who had shared her own personal experiences with the deceased, overheard them being recounted as if they were hers.

Sadly no-one felt able to challenge her behaviour, since some in the London AIDS industry were enthusiastic about the contribution she made as 'a woman with AIDS' to various committees and projects.

DEATH NOT DUE TO AIDS

When she died many felt that the truth had been on the verge of being revealed, as she had become a little careless in her manipulation of reality. Having created a situation in which her options were limited she could either: reveal all, admit her deceit and face the consequences; begin to 'recover' from her various claimed ailments and get on with life; or the final option, feign deterioration of health to the end-point of death. Though it is not known whether the overdose was intentional, it seems likely given her in-depth knowledge of drugs and dosages.

So HIV claimed a death, not by its action as a virus, but through the system that has grown around it. As an 'HIV+ woman' and later 'a woman with AIDS' she had access to a wide network of support groups, counselling, holistic therapies, training programmes and state benefits, not to mention the sympathy and attention of AIDS carers.

Had she been able to ask for relevant support in her life perhaps she could have avoided the appropriation of AIDS status. It is a sad and extreme case that illustrates the (sometimes) deadly belief in an unproven theory, and the mores of a society that is most comfortable with offering support when the needy have a label. **MR**

FURY OVER ANTI-HIV AD

Alternative AIDS information and therapy providers HEAL Inc in Sydney Australia sparked controversy by advertising that HIV tests are inaccurate and HIV alone is not the cause of AIDS.

Under a front page headline FURY OVER HEAL, the major gay newspaper *Sydney Star Observer* detailed the worry in high places which HEAL's adverts are causing. Immunologist Prof. Ron Penny insisted that the HIV test "is one of the most accurate tests we have", while Professor David Cooper called HEAL's message "disgraceful".

But the paper also quoted leading doctor of biophysics Eleni Papadopulos-Eleopulos from Western Australia: "There's not one, not ten, not any test that can positively signify HIV infection. That's good news for gay men."

HEAL Sydney director (and former *Continuum* worker) Stuart Bennett says, "I can't take responsibility for people's reaction. I can take responsibility for providing accurate information and for opening up the debate on HIV and AIDS".

Although Penny has advised the New South Wales Health Ministry that it could use the Trade Practices Act to ensure Heal's media advertising does not continue, the Australian Federation of AIDS Organisations suggests: "It's probably inappropriate for us to try and stop people from putting their point of view across." HC

PACKING A PUNCH

The drug Saquanivir received approval from the Food and Drug Administration panel in the US in November.

Described as the world's first rationally designed antiviral drug it's said to give HIV the "one - two punch", perhaps a reference to shadow boxing.

HIV needn't worry since the drug is only as effective as AZT so no unfair disadvantage given to 'infected' cells.

Roche who produce the drug have not yet announced the cost but since they all have families to feed and lifestyles to maintain it will probably be excessive. **MR**

Sideways glance

LIVING PROOF

Living Proof, a conference for long-term survivors, is to be held in London on April 12th and 13th 1996. The questions that come to mind immediately are: what defines long-term survivors and what are they living proof of? Long-term survivors are proof that the death sentence was wrongly given, of that we can be sure. What is interesting to investigate is the list of characteristics shared by those who survive the psychological death sentence that is HIV/AIDS, which includes questioning authority and choosing your own treatments for relevant conditions not for a non-existent virus.

The conference will be held at the London Voluntary Resource Centre.

BAD DRUGS AFTER WORSE

Thalidomide, responsible for severe birth defects in the 1960s is now being prescribed to 'HIV+' people. An obvious case of throwing a bad drug after an even worse one, it is being used for the effects of AZT and other so-called antiretrovirals such as ddI and ddC. Dr Mike Youle of the Kobler Centre in London administers it for mouth ulcers, nausea, weight loss and diarrhoea, all of which are symptoms of antiretroviral use.

It is assumed that to give thalidomide to gay men is safe because they don't usually have children. The way in which thalidomide damages cells is only partially understood and there have been cases of thalidomide victims giving birth to deformed children.

The message is clear: if you want to stay living let alone procreate keep away from the doctors with 'drug cabinet' as their middle name.

THE BANK THAT LIKES TO SAY YES

A bank of 'AIDS-related' tumours has been set up in the US by the National Cancer Institute. The AIDS Malignancy Bank, with repositories around the States will supply "all types of fluid, tissues, cells and blood products" associated with AIDS tumours and each sample will be accompanied by "a high-quality pedigree". Interest rates and a minimum deposit are thought not to apply.

Scientists wishing to make a withdrawal will need proof that they believe without question any theory that has large amounts of grant money attached to it, are unable to conduct research with integrity and are generally untrustworthy. Scientists with respect for professional ethics need not apply.

and I Quote...

"Mum .....I don't need medicine, just lunch everyday with Di."

said Rebecca Handel, shortly before she and her daughter aged 12, both 'AIDS' victims, died. Never a truer word. Reported in the Daily Mirror, *December 1995.*

Nervous Energy

In the BBC2 drama *Nervous Energy* shown as part of the Red Ribbon series on December 2nd there was plenty of hyperactivity but little that ran deep. It was a TV play written by a man who lost a lover to that ambiguous acronym: AIDS. It followed a period of time in the life of a gay man given an AIDS diagnosis, Tom, and his interactions with his lover, friends, ex-friends and family.

The drama began with a display of that energy named in the title, Tom having been on a shopping spree, presumably spending his 'positive pounds', in the spirit of 'shop 'til you drop'. Is this evidence of AIDS-dementia or simply the product of a consumer-society? The boyfriend obviously had difficulty dealing with illness, so his main role seemed to be making sure Tom took his medicine. Cut to the hospital – the doctor was sporting a red ribbon, so either the show was sponsored by red ribbon manufacturers or the doctor character wanted to let his patients know he was AIDS-aware. How comforting!

Tom decided on a spontaneous trip to his roots and hopped on a train to Scotland. (And deliberately left his medication behind which annoyed the boyfriend. My hopes were raised for a happy end, but no, his dutiful boyfriend made a special trip to bring the drugs.)

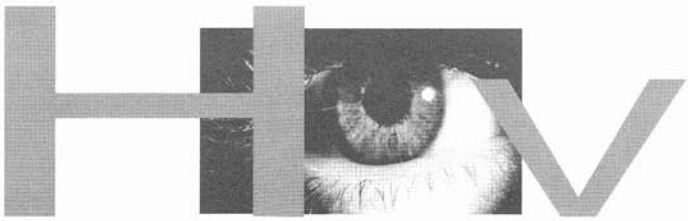
Sitting amongst his family, Dad stoic in the armchair and mum all willing to please, it was clear there'd been some major rift which Tom wanted to forgive them for. At this point Dad let out a gem, which was sadly ignored in the rest of the story. As the family listened to Tom reciting names of medications he'd used, Dad says: "They only want a guinea pig". It was interesting to see the father being portrayed as ignorant and unsympathetic when he was one of the few characters who spoke sense.

If one wanted to hypothesise that AIDS is caused by physical stress (prescribed and recreational drug-use, living life in the fast lane) and psychological stress (family conflicts, unsupportive friendships, a brother who calls you "a little shit" and says "you always were a perverse bastard") then this story offers ample evidence to back up the theory. Strangely it was the unlikeable brother who got the other good line in the piece. When he shouted at Tom: "This has got nothing to do with HIV" the profundity of his words fell on deaf ears.

It was a frustratingly dull and insight-less piece of TV showing that dramatists are as confused as the AIDS scientists about what the real story of AIDS is.

MOLLY RATCLIFFE

A review of the BBC* Red Ribbon *series commemorating World AIDS day



Fine Cut

"In Britain, heterosexual AIDS has presumably never existed," was a conclusion of the BBC *Fine Cut* documentary programme *The End of Innocence*, shown on December 5th 1995.

The programme examined in great and often moving detail the effect of the UK AIDS phenomenon on homosexuals and the part that homophobia plays in public perceptions of AIDS. Drawing on archive broadcast material of health, scientific predictions for AIDS prevalence, and the UK government's AIDS-terror campaign of the mid-'80s, the programme set about demolishing the myth of heterosexual AIDS in the UK, and demonstrating why and how it came about.

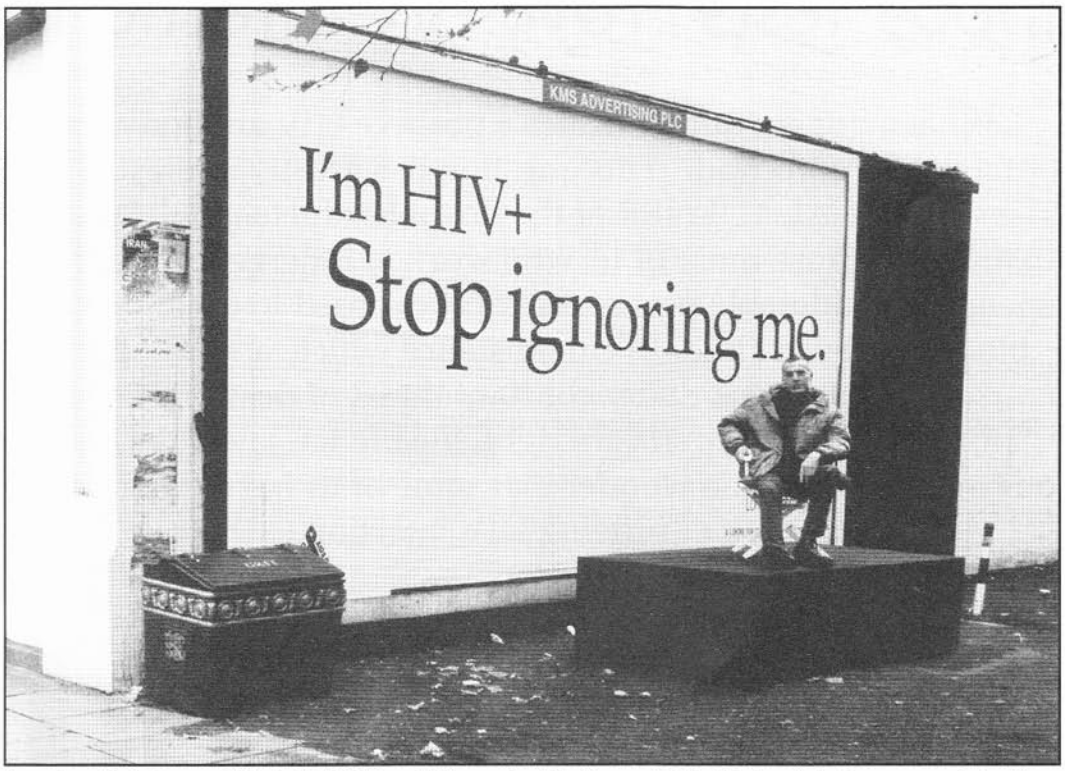
Quoting Public Health Laboratory figures over a ten year period, but not engaging in the wider controversy over HIV and testing, the programme claimed that of the 7,388 heterosexual men and women diagnosed HIV+, 2,928 were infected by drug use, 2,790 were infected from a foreign source, either living abroad or back in Britain, 1,369 were infected by blood products (the vast majority of them hæmophiliacs), a mere 119 from bisexual partners (another myth exploded, in the programme's view), which left a further 182 HIV+ people in the category "none of the above". These, an average of less than 20 cases a year, constitute the totality of heterosexual AIDS in the UK.

Making allowances for human nature, people denying they'd had sex with any of the other categories, or not knowing they had, the number may well disappear completely.

Unusually for the BBC, AIDS establishment figures were shown floundering for explanations for why they persisted in characterising AIDS as a general health threat, when all available evidence showed it to be an overwhelmingly homosexual phenomenon. In particular, homosexual AIDS charities and activist organisations were shown to have embraced the "de-gayed" version of AIDS eagerly, to enhance their fund-raising capabilities at the cost of their credibility, even in the eyes of their own staff.

The programme included interviews with AIDS activists who had come to realise the essential dishonesty in the message they were encouraged to disseminate. "I was going round the country, telling overwhelmingly heterosexual audiences that they were at risk every day of their lives from HIV and AIDS, and they *had* to protect themselves, because AIDS was equally everybody's problem, and it didn't

PHOTO: BARRY WEASER



London Lighthouse World AIDS Day billboard with live exhibit: it's hard to ignore an infection that doesn't exist.

counted were being given experimental drugs that stimulate cells to replicate, and the test he used to count numbers of 'HIV infected' cells gave figures over-estimated by more than 60,000. Ho claimed "once it's infected, that cell's a goner". What he didn't explain was how other cells could be infected by this "goner" when it has been asserted elsewhere that 'HIV' is only infectious in its youth, and then only for a brief period. Our presenters didn't worry themselves about the validity of what was being said; they were more concerned with how well social scientists were mixing with the high-tech crowd.

Robin Weiss of the Chester Beatty Laboratories, London, was keen to explain that drug combinations might ensure that "the virus can't escape" .....or was that the patient? He told of the elusive virus that changes shape to avoid every new drug. Doesn't it occur to him that it's not a virus but polymorphous strands of the body's DNA?

The man from the World Bank said it all when he announced "The World Bank needs to take the lead in the health field". He went on to detail how manual workers in developing countries dying of AIDS were irrelevant to his view of the future global society. In such a vision health is merely a commodity to be bought and sold, not a right of every individual regardless of economic status.

It was left to Jonathan Mann, director of the World Health Organisation's Global Programme on AIDS to speak with some humanity and insight. He suggested that AIDS is a human rights issue that can only be alleviated by the slow and unglamorous work of educating people to respect themselves and one another. A world of people living in a manner that supports their health would be the best way to put World Bank officials and unscrupulous scientists out of jobs: the discomfort they displayed listening to Mann suggests they are aware of that.

If the lack of investigation was disappointing, the blue blob purporting to be HIV that kept appearing on screen was insulting. Does there exist a scientist who will swear on oath that it was HIV?

The programme sadly wasted the opportunity to say something real and instead tried to blind the viewer with pseudo-science.

MOLLY RATCLIFFE

ch

matter whether you were 88 and lived in Harrogate or whether you were 12, whatever, and lived in Surrey, but AIDS was everybody's problem: we are all equally at risk and we all ought to be fearful, the real 'Climate of Fear' stuff," complained one activist.

The programme is significant in at least two ways. One is that the myth of heterosexual AIDS is crucial to theories that assume an infectious agent as the cause. It is on this increasingly shaky foundation that the government's propaganda campaign, some of it still operational, was based. The other is that the *Fine Cut* documentary, both in its length (90 minutes) and the detail of its research, is the first BBC AIDS journalism to be openly critical of the AIDS establishment and to challenge successfully one of its most dubious assertions.

john@blackdog.demon.co.uk

Horizon

I looked forward to the *Horizon* programme *AIDS: Behind Closed Doors*, shown on BBC2 at 8pm on December 4th, thinking it would surely be a challenging look with some investigative reporting and perhaps even accurate information. I was entirely disappointed.

The presenters Susan George and Oliver Morton were at a meeting of 'international AIDS experts' held in London shortly before WORLD AIDS day, and the programme that followed was a summary of the event. George will be known to some as the author of several books on debt in developing countries in which she lays the blame at the feet of big business and rich Western nations. However her critical eye has apparently been totally blinded by what she reads in newspapers and is told by government when it comes to AIDS, if this programme is anything to go by.

One of those 'experts' responsible for the unsubstantiated theory that HIV replicates 'exponentially' and engages the immune system in a continuous battle until the body gives up and gets AIDS, was shown trotting out the same stuff. David Ho was not questioned nor was there any attempt to check his facts. Had that been done it would have revealed that the patients whose 'viral load' he

Do HIV Antibody Tests Prove HIV Infection?

What evidence authenticates a positive HIV antibody test as proof of HIV infection? This question has greatly interested me, says Dr VAL TURNER of the Royal Perth Hospital, Western Australia, because those of us who work in Emergency Medicine spend a considerable part of our lives exposed to other people's blood and body fluids, a circumstance which, according to the experts, places us under constant threat of death from AIDS. Ironically, if the experts are right, the life we save may cost us our own and it's little wonder that some of us have pursued the question of proving HIV infection to the very limits.

Testing, Testing

From the early days of AIDS I was fortunate to collaborate with Eleni Eleopulos, a Biophysicist at the Royal Perth Hospital, John Papadimitriou, Professor of Pathology at the University of Western Australia, and other colleagues. In one of our papers, published in June 1993 in the journal *Bio/Technology*[1], we were compelled to confront many unsettling conclusions about the HIV antibody tests, none of which accord with current wisdom. Some of these I would like to share with you today.

The HIV antibody tests do not detect a virus. They test for any antibodies that react with an assortment of proteins experts assure us are unique to HIV which, almost everyone agrees, is a retrovirus and the cause of AIDS[2]. What happens is this: a sample of blood serum is incubated with a mixture of these proteins in a test called ELISA, an acronym for Enzyme Linked Immunosorbent Assay. The ELISA is positive if the solution changes colour thereby indicating a reaction between the proteins in the test kit and the patient's antibodies.

However, according to many experts, the ELISA is not specific, meaning it may react in the absence of HIV infection. In response to this, testing authorities have developed strategies such as repeat testing of all positive ELISAs and following up those twice positive with a third but different antibody test called the Western blot. In the Western blot the "HIV" proteins, about ten of them, are located at discreet spots in a paper strip, rather like the one your doctor uses to perform multiple tests on your urine. Serum is added and wherever there is a reaction 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 react. Certain combinations of bands are defined as a positive test. It is enigmatic that the location and number of bands required for a positive Western blot vary around the world. They may even vary between laboratories within the same city. In Australia four bands are required, in Canada and much of the United States, three bands suffice. And in Africa two will do. In the US Multicenter AIDS Cohort prospective study involving several thousand gay men, one "strong" band was deemed sufficient. If each of the above indicates HIV infection then HIV must cause different populations of antibodies to appear in different places.

I don't know about you but to me that sounds very odd. But at least it gives some Africans a way out. All an African has to do is have a test in Australia because two bands would not be considered positive here. Nevertheless, in spite of lack of standardisation and other problems such as reproducibility, the Western blot is accepted to be 99.9% specific and if positive is regarded as synonymous with HIV infection. In some countries similar claims are now made for the HIV ELISA without recourse to the Western blot.

The rationale for the use of antibody tests is as follows: the immune system has the ability to detect foreign agents and to respond by producing antibodies which react with those agents. However, this does not work in reverse. By that I mean the observation of an antibody reaction with a particular agent is not automatic proof that the antibody was produced in response to that agent. The problem is that antibodies indulge in casual and indiscriminate relationships. They are in fact promiscuous. Antibodies meant for one agent may react with another agent, a perfect stranger. Or, if you want it put technically, there is ample evidence, some of the best in fact comes from the Pasteur Institute, that antibody molecules, even the most pure, the monoclonal antibodies, are not monospecific and cross-react with other, non-immunising antigens.

Here are some examples to illustrate this most crucial fact. Firstly, in a study of 1.2 million applicants for US military service[3], of the 1%, or 12,000, who had first-time positive ELISAs, only 2,000 were ultimately shown to be also WB positive and thus, according to the authors, HIV infected. That left 10,000 positive ELISAs which must have reacted for reasons other than "HIV antibodies", a fitting testimonial to the problem caused by cross-reacting antibodies.

Secondly, there is the tantalising data reported in 1990 about dogs. Writing in the journal *Cancer Research*, Strandstrom and colleagues reported that 72/144 (50%) of dog blood samples "obtained from the Veterinary Medical Teaching Hospital, University of California, Davis" tested in commercial Western blot assays, "reacted with one or more HIV recombinant proteins [gp120—21/5%, gp41—23%, p31—33%, p24—43%]"[4]. Assuming Californian dogs are not infected with HIV (as did the authors) one must conclude these data are further proof of antibody cross reactivity to many of the "HIV" proteins.

What all this means is that you're not necessarily infected with what your antibodies appear to tell you. This can be brought home by two further examples. Firstly, some AIDS patients have antibody reactions with laboratory chemicals but no-one claims AIDS patients are infected with laboratory chemicals. Secondly, as an example removed from AIDS, the antibody test for glandular fever relies on the fact that patients with glandular fever make antibodies that react with the red blood cells of sheep and horses. But these patients are not infected with animal blood and animal blood does not cause glandular fever. Bearing all these examples in mind it is painfully obvious we cannot pronounce someone infected with what is regarded as a lethal human retrovirus merely because we observe an antibody reaction. Before we pronounce any such reactions indicative of HIV infection and long before we introduce the test into routine clinical practice, we must exact solid proof of precisely why these reactions take place. In doing so we must not forget that biology is not mathematics and despite our clever technology, in biology still we must stoop to the relative ignominy of empirical proofs. Or, as Plato said, "experiential data must always be interpreted in the light of what Nature has revealed".

1 2 3...

In Science we must constantly resist the temptation to stray beyond our data and in that spirit I put it to you there are only two pieces of information which can be gleaned from an antibody test (for mathematical purists it's only one piece of information). Either you see a reaction or you don't. That's all. You don't see antibodies with labels attached saying what produced them. You cannot construe the genesis of antibodies by observing changing colours in a test-tube. The cardinal problem scientists face when ascribing meaning to a set of antibody reactions is how can they tell whether the reaction is caused by a real antibody or a ring in. One whose proper partner is something else but caught in a compromising act?

In this context it is proper for a disinterested scientist to allow for the possibility that there are no real HIV antibodies whatsoever, that they're all pretenders. When the information is only a reaction, and that reaction has more than one possible cause, as is the case with an antibody test, you need extra information before you can ascribe a particular outcome. So, if you want to claim antibody reaction signals a particular outcome, such as HIV infection, first you have to prove it. And just before we get to crunch time consider this little morsel. AIDS patients are exposed to many foreign agents, are known to have antibodies reacting with dozens of different substances and it makes perfect sense that the more antibodies there are, the more chance there will be some that will spoil the test. What this means is that in the very patients you suspect of harbouring a virus there exist the precise circumstances, lots of potentially cross reacting antibodies, which make it imperative to sort out what is really going on.

What's the solution or, more to the point, what's the problem? The problem is how do you know, when you witness an antibody reaction, that is, a positive test, HIV is present too? After all, that's what you really want the test to tell you and the question on the patient's lips is bound to be "Is HIV infection the only cause of a positive test? If there's something else I'd rather have that, thank you very much". In technical terms the patient's hopes are hanging on the specificity of the test.

Let me first explain what is meant by 100% specificity. One hundred per cent specificity means that positive tests only occur in HIV infected people. That's the same as saying positive tests never occur in uninfected people. And that's the same as saying all uninfected people have a negative test. This leads us to the formal, mathematical definition of specificity, which is the number of negative tests in a large group of individuals who do not have HIV infection. If 100% of one thousand people who do not have HIV infection are seronegative the specificity is 100%. If one uninfected person is seropositive the specificity is reduced to 999/1000 or 99.9% by virtue of a lone false positive. Thus, to determine the specificity of an antibody test we need two pieces of data. The numbers of persons with negative tests and the numbers of persons with no HIV infection. By the way, and I'm sure it's obvious, the false-positive rate is (1 minus the specificity). An experiment to find the specificity also gives the false positive rate and vice versa. How should we design an experiment to find this data?

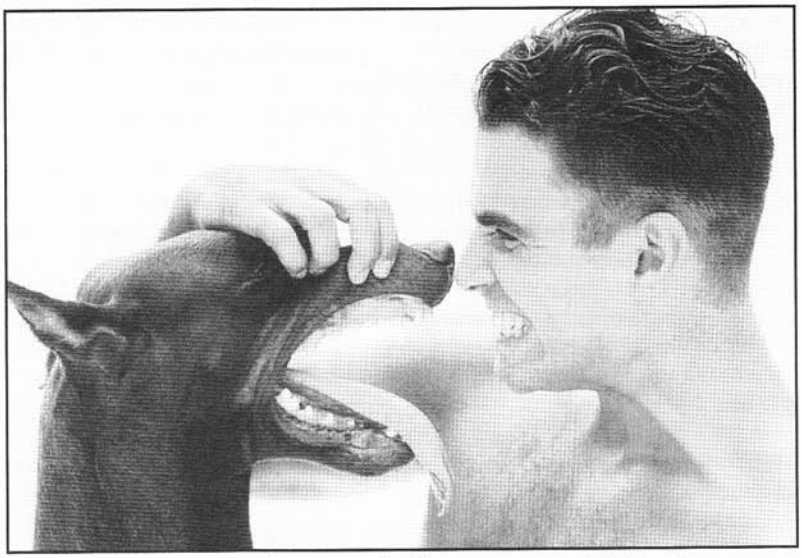
Firstly, since the underlying problem is largely one of deciding between *bona fide* and cross-reacting antibodies, we must include in our sample persons who are likely to have a large repertoire of antibodies to agents other than HIV. The more the merrier. Thus we must include persons who are sick and who have diseases similar to AIDS but not AIDS. Secondly, we need a way of determining the presence or absence of HIV infection. Obviously, this can't be the test because that's what we're trying to validate. When we measure specificity we are trying to find out how often reactions occur in individuals who do NOT have HIV infection. Rather surprisingly, in the AIDS literature, the specificity of the HIV antibody tests has been evaluated by testing for reactions in healthy individuals such as blood donors. These persons are chosen as *de factos* for the absence of HIV infection. Under these circumstances few if any positive reactions are found but this is not necessarily, as the HIV/AIDS experts claim, because the tests are highly specific. In fact, this is the wrong experiment and wrong for two reasons.

What all this means is that you're not necessarily infected with what your antibodies tell you

Firstly, healthy people do not have a large number or variety of antibodies to react in the first place. That goes with being healthy. That's why we put them in the army and let then donate blood. There are simply not enough antibodies available to measure the propensity for unwanted reactions. It's like going to a party where hardly anyone is hogging the Guinness because there's hardly any people. Secondly, good health cannot be used as a *de facto* for the absence of HIV infection any more than good health can be used as a *de facto* for the absence of gall stones, kidney stones, pregnancy, hydatid cysts,

deep vein thrombosis, cerebral aneurysms, pathogenic bacteria or coronary artery disease. The practice, widely adopted by HIV/AIDS experts, of appraising HIV antibody tests by testing thousands of blood donors, also creates an enormous dilemma. If healthy people are regarded as a *de facto* gold standard for the absence of HIV infection, counting the occasional one or two who do react as false-positives, by what criteria can similar or even the same individuals be regarded as infected at some future date? One week such an individual may be tested as a member of a cohort of healthy blood donors and the following week may be tested again when he or she requests an examination for life insurance or attends a doctor for a checkup. Is the test proof of HIV infection or not? Does the outcome depend solely on who you are and which door you knock on?

Back to the problem of validation. We select our thousand people who are sick and let's make sure we include some who have diseases similar to AIDS and let's include a few healthy persons and some cases of AIDS as well. You never know, we might be in for a big surprise. We might find some AIDS patients too are antibody positive in the absence of HIV infection. In fact, if you read May 1984 *Science* papers, where it is claimed HIV was proven to be the cause of AIDS, HIV could be 'isolated' in less than half the AIDS cases. Let us return to our experiment. Most of the people selected will have lots of antibodies and this will give the test a fair run for its money. There'll be a lot more people at this party. But hold on, if HIV causes AIDS, and some of our patients have AIDS-like diseases or even if they don't, even those who are healthy, how do we get past the sticky problem of knowing who is infected with HIV? We don't want to include them in our analysis because we want to evaluate the test when there is no HIV infection. I know by now many of you will have the correct answer. It's obvious isn't it? You have to use HIV itself. You simply divide your blood sample in two. One to test for the antibody reactions and the other to try and isolate HIV. If you want to know what the HIV antibody tests tell you about HIV infection you compare the reactions with what you are trying to measure. Not with pumpkins. The only way to distinguish between real reactions and cross-reactions is to use HIV isolation as an independent yardstick or gold standard.



50% of dog blood samples reacted with one or more 'HIV' proteins

What are the results of such an experiment? How many of an appropriately chosen, thousand patients from whom HIV cannot be isolated at the same time have an antibody reaction? I can't tell you that because, bizarre as it may sound, twelve years since the discovery of HIV and ten years since the development of the HIV antibody tests, this experiment has not been done. We don't know how many positive tests occur in the absence of HIV infection, it might be none, or it might be all of them. Nobody knows. There is no proof of the specificity of the HIV antibody tests for HIV infection.

What if someone decided to do this experiment? Is it feasible? That's hard to say because it depends on how much importance you place on the precision of defining HIV infection. Ultimately this can only be defined by the isolation of a unique retrovirus. The word isolation comes from the Latin word *insulatus* meaning "made into an island". It refers to the act of separating an object from everything else that is not that object. Like solitary confinement.

The rules of retrovirus isolation are now old. All the HIV experts should know them. They were developed in the several decades preceding the beginning of the AIDS era in 1981 and were thoroughly discussed at a meeting held at the Pasteur Institute in 1973 and attended by now leading HIV/AIDS researchers including Barre-Sinoussi and Chermann. These are a set of rules which credibly achieve the aim of separateness. The problem is that no claim of HIV isolation yet presented fulfils either the island concept or follows these rules. None of these claims even fulfils the initial and most basic of these rules, the requirement to obtain an electron micrograph of the material which is present at a sucrose density gradient of 1.16 gm/ml. In fact no claim of HIV isolation *is* isolation. All such claims are based on a set of phenomena ('HIV' proteins such as p24, reverse transcriptase enzyme activity, 'HIV' particles, 'HIV' PCR) detected in cultures of AIDS patients' tissues, none of which is even specific for retroviruses. And without isolation who can say whether the proteins used in the HIV antibody tests are unique to HIV?

Yes, I know that we have all been shown pictures of something called HIV but that should come as no surprise because, in the extensive retrovirology literature, retrovirus-like particles are commonplace. For a start try insects, reptiles, fish and tapeworms. They are also found in the majority of healthy human placentas and while it is true that electron microscopy reveals retroviral-like particles in 90% of enlarged lymph nodes from AIDS patients, the identical particles can also be found in 90% of enlarged lymph nodes from patients who do not have AIDS and who are not at risk for developing AIDS[5]. If the particles seen in lymph nodes from AIDS patients are HIV as the AIDS experts assure us, what are the particles seen in the lymph nodes of patients who are not at risk from AIDS and what is their relationship to the plethora of other particles seen in cultures of tissues from AIDS patients?

Wait on, I hear some ask, what about the polymerase chain reaction or PCR? For those who don't know, this is a new and very sensitive technique for finding genetic blueprints. Surely this can put us straight about the antibody tests? Not so I'm afraid. To perform the PCR you need to begin with a piece of RNA or DNA which you can say for certain belongs to the HIV genome. To obtain the HIV genome first you need to isolate an HIV particle. That's where the HIV genome comes from and that is the only way to know the RNA or DNA actually belongs to the virus. Even the most charitable interpretation of the data available does not show that a unique retrovirus, HIV, has been isolated.

Furthermore, even if one assumes that the RNA and DNA molecules (molecular probes) used in the PCR are from the HIV genome there are still many problems with the use of the PCR to prove HIV infection. For a start, at best, the PCR detects single genes and most often, only bits of genes. If your PCR finds two or three genetic fragments out of a possible dozen complete genes is this proof that you have all the genes? The whole genome? No

it is not, and in fact HIV experts admit that the majority of HIV genomes studied are defective. This means they are incomplete and could never orchestrate the synthesis of a viral particle. Even if all genomes were complete let's not imagine for a moment having the plans means you've built the house. Basic retrovirology teaches us you can carry a whole retroviral genome around inside your cells all your life without ever making a viral particle. And in 1992, in the only study of its type, French researchers found the HIV PCR non-reproducible and the agreement between the PCR and the HIV Western blot was found to vary between 40–100% and was especially poor when fragments of more than one gene were sought.[6] In this study there were several PCR-negative/HIV-positive as well as several PCR-positive/HIV-negative samples. In other words, the two tests don't fit. As for which test proves HIV infection, you pays your money and you takes your pick.

You can carry a whole retroviral genome inside your cells all your life without ever making a viral particle

Finally, a specificity in excess of 99.9% sounds pretty damning, but is it? What if you were found to have a positive HIV antibody test? What is your chance of being truly HIV infected, and not a false-positive? To answer this let's imagine a population of one million people where somehow, by authentic viral isolation studies if you like, we know that 1/1000 is HIV infected. That's the prevalence touted for Australia. Let's also assume that there is definite proof, measured against a viral isolation gold standard, that the HIV antibody tests are 99.9% specific for HIV infection. If the test is also 100% sensitive it will detect all of the 1000 infected people. However, 0.1% (1 minus specificity) of the 999,000 non-infected remainder will also be seropositive. That's another 999 people making a total of 1,999 positive tests, 1000 who are infected and 999 who aren't. If you were randomly selected and found to be antibody positive there is only a 50/50 chance you are actually infected. The test will be wrong half the time. But for those of you arguably somewhat removed from the risk groups that dominate the statistics, we can probably do better. If your prior odds are say, only 1/2000 of being infected, and if we drop the specificity of the test slightly to a mere 99.6%, a positive test will be wrong in 89% of cases, in other words, almost all of the time.

Where does all this leave HIV/AIDS patients. Firstly, the only evidence that HIV is the cause of AIDS is the perception by the AIDS experts of a correlation between antibody reactions and the presence of AIDS-defining diseases. However, for AIDS patients who have had antibody tests and have been diagnosed HIV-infected solely on the basis of these tests, we can argue that there is no proof that even one such patient is infected with a virus call HIV. Secondly, in these cases, the tests provide no justification for the administration of potentially toxic drugs like AZT on the basis of a perceived anti-viral activity. Certainly the HIV antibody tests confirm that certain diseases are AIDS rather than just those diseases but this can be construed as an artefact of definition. The only scientific conclusion we are permitted to make is that in some, but not all, well-defined at-risk individuals, there is a correlation between antibody reactions, whatever their *raison d'être*, and the propensity to develop and die from certain diseases. On the other hand, if you're HIV positive but not in a risk group and especially if you're healthy, any pronouncements on your likely outcome will be severely confounded by knowing you are positive, a situation we might describe as twentieth century bone pointing*. And your health may suffer further from the use of medications administered in good faith to kill a virus you may not have. The failure to verify the antibody tests against the gold standard of virus isolation is a serious omission of scientific method. In the absence of such validation these tests should not be used to diagnose HIV infection.

Addendum

In the entire AIDS literature there is only one study, that of Colonel Donald Burke and his colleagues[3] from the Walter Reed Army Institute, which is widely regarded as the definitive proof of the specificity of the HIV Western blot. Over an eighteen month period Burke and his colleagues tested 1.2 million applicants for US military service. Burke's testing procedure was a progression through two ELISAs and two Western blots. From these data the HIV seroprevalence was found to be 1.48/1000. Burke then retrospectively investigated a highly selected sample of this population in which the seroprevalence was one tenth that of the 1.2 million. This group comprised 135,187 persons aged 17-18 years who resided in rural areas where the cumulative incidence of AIDS was low. Many would assume this group to be no different from healthy blood donors and regard all HIV positives as false positives but Burke and his colleagues' premises were the opposite. Assuming there were true positives amongst healthy, rural American youth and wishing to evaluate the false positive rate and specificity of the Western blot Burke needed to define HIV infection. This was done by performing a panel of four more antibody tests on sera from the 15 out of 135,187 applicants who had already been found twice ELISA and twice Western blot positive. Two of the extra tests were other Western blots and two were similar tests. Any individual positive in all four extra tests, thereby making a total of eight positive antibody tests, was deemed HIV infected. Those who failed any of the extra four tests were deemed non-HIV infected. Of the 15, one failed to complete the panel and thus Burke conceded only one, not fifteen, false-positives. From these data Burke calculated the specificity of the HIV Western blot to be in excess of 99.9%. There are many flaws in this study and they are outlined in reference 1. Here I wish to draw to your attention the fact that an antibody test, even if repeated and found positive a thousand times, does not prove the presence of a viral infection.

References

1. Papadopulos-Eleopulos E, Turner V F, Papadimitriou J M, 1993. Is a positive Western blot proof of HIV infection? *Bio/Technology* 11:696-707.
2. Papadopulos-Eleopulos E, Turner V F, Papadimitriou J M, 1993. Has Gallo proven the role of HIV in AIDS? *Emergency Medicine* [Australia] 5:113-123.
3. Burke D S, Brundage J F, Redfield R R, et al. 1988. Measurement of the false positive rate in a screening program for human immunodeficiency virus infections. *NEJM* 319:961-964.
4. Strandstrom H V, Higgins J R, Mossie K, et al. Studies with canine sera that contain antibodies which recognise human immunodeficiency virus structural proteins. *Cancer Res* 1990; 50: 5628s–5630s.
5. O'Hara CJ, Groopmen JE, Federman M, 1988. The ultrastructural and immunohistochemical demonstration of viral particles in lymph nodes from human immunodeficiency virus-related lymphadenopathy syndromes. *Human Pathology* 19:545-549.
6. Defer C, Agut H, Garbarg-Chenon A, 1992. Multicentre quality control of polymerase chain reaction for detection of HIV DNA. *AIDS* 6:659-663.

**Bone pointing is a traditional, ritualistic punishment practised by Australian aborigines. A bone is pointed at an individual as a method of retribution. That individual soon becomes sick and death within weeks or months is an invariable consequence.*

Dr V. F. Turner can be contacted at the Department of Emergency Medicine, Royal Perth Hospital, Perth, Western Australia..
Tel: int+ 619 2243221. Fax: int+ 619 2243511.
email <vturner@uniwa@uwa.edu.au>

Where did the UK's Western blot go?

Engineering Innocence

"HIV is the embodiment of viral ingenuity."
- Prof. James Neil, Glasgow University.

"There's no better way to dismantle a personality than to isolate it."
- Princess Diana, BBC Panorama, *Nov. 95.*

In the shifting world of HIV there are still two main kinds of antibody test - the ELISA or Enzyme Linked Immunosorbent Assay, and the Western blot, so named as one of medicine's witticisms: Dr Southern designed a Southern blot and the Western blot was named in clockwise contrast although no Dr Western existed. Both HIV tests require taking blood from an individual and seeing if antibodies in it react with test proteins representing the virus. These proteins, huge by molecular standards, are either commercially grown or artificially made. Manufacturers are proud they have learned to reproduce with increasing exactitude the proteins they want.

The Western blot uses up to ten different proteins to test the blood for antibodies. ELISAs are cheaper and quicker and test with two or three.

Many people think that in the UK, HIV testing procedure is first an ELISA, and if it's positive, a Western blot to make sure. A *National AIDS Manual* spokesman gave this opinion as recently as last November. Actually that's quite wrong and has been since March 1992 when a policy paper was published by the national authority that sets testing standards, The Public Health Laboratory Service (PHLS). The paper, called "Towards error-free HIV diagnosis: notes on laboratory practice" turned ELISAs into the only test generally used. Dr Philip Mortimer, head of the PHLS's Virus Reference Division (VRD) was of the opinion in the *Lancet* back in 1991, "Western blot detection of HIV antibodies began as and should have remained, a research tool."[1]

Its overall successor the ELISA has always been very sensitive, meaning good at showing positive when some sort of antibodies are there. That's why ELISAs are screening tests, and useful for checking blood donations. Because of their chemical design – about as complicated in a different way as the design of a short-wave radio – they detect very readily. Not many blood samples with more than background levels of antibodies that could react with the test proteins *don't* do so.

But to be fair the Western blot is no slouch: it's in the same ballpark of sensitivity and it's demanding in a different way. It probes the range of antibodies present in a blood sample. If you had a virus made of 10 antibody-causing proteins, Western blot could show you whether antibodies had been made to all, some or none of them. If it seems strange there could be antibodies to only some, like to half a virus, nonetheless it happens frequently, and varies from person to person, in country to country. For this reason a decision was made over seven years ago in the UK that just three particular proteins reacting on a Western blot would have to be sufficient for calling the test HIV positive. And in 1992 Western blots were quietly eased out of the front carriage altogether. In Western blot language, people didn't consistently have all the viral antibodies. The question of why they didn't was so strange to answer truthfully that it was confusing the procedure of keeping blood donations free from possible virus.

So for the past four years, the more detailed but disturbing Western blot has been confined in the field of HIV to the much rarer task of trying to distinguish whether a blood sample may contain antibodies thought to indicate the presence of a virus called HIV-2. Even then on the whole "the cost of using Western blot to make this distinction is unjustifiably high and the results are often not conclusive."[2] It's recommended only for use in special reference labs where difficult questions can be privately mulled over. Invites the PHLS: "Suspected anti-HIV-2 positive sera referred to the Virus Reference Division can be tested there by a native antigen-based Western blot."[3] Since then, a one-off sequence of three positive screening ELISAs has routinely created anyone's positive diagnosis.

Dr Mortimer recently responded to the resulting question of how reliable the commercial ELISAs for HIV detection are. Specificity is the extent to which a test will always be negative in people who truly do not have the virus. How should the specificity of an HIV ELISA be determined? "The way we have approached evaluation of specificity, using UK blood donors, is to line up as many different kits as possible and run them through the same panel of donors' specimens. If we find a reactivity on a donor specimen in one kit only, or (occasionally) in two kits that use either the same design or type of antigen, we work on the *assumption* that the reaction is NON-specific unless follow-up of the donor reveals a new HIV infection. (This *would* be extremely rare.)" [my italics]. He concluded, "non-specific reactions occur in between 0.1% and 0.3% of most current assays," and claimed "Western blot has very little to contribute to the evaluation process."

The chance of a result being right rests on an assumption? Why would anyone taking a test be content knowing that? Why is it not possible to say of blood donors that the 1000 to 3000 positives per million per type of ELISA are definitely false positives, rather than just assume so? The PHLS's own paper carries the awesome answer: "Experience has shown that neither HIV culture ['growing HIV'] nor tests for p24 antigen [a 'viral

core' protein] are of much value in diagnostic testing. They may be insensitive and/or non-specific..."[4] In other words, the 'viral' proteins themselves don't match specifically with a virus. A culture of HIV may be negative, even though HIV were there, and it may be positive though HIV is not there; p24 antigen tests may be negative even were HIV there, and positive though it is not. This is useless to everybody.

The historic black hole where isolation of HIV should be is why HIV culture and p24 tests are insensitive and/or non-specific. Numerous strange manifestations in the microcosm appear viral so there's a necessary process for genuinely separating what is viral from what is not. Retrovirologist William Blattner spelled it out in 1989: "one difficulty in assessing the specificity and sensitivity of retrovirus assays is the absence of a final 'gold standard'"[5] i.e. some isolated virus.

Multiple antibodies in people in the groups susceptible to AIDS can react with each non-specific protein: lower levels and fewer varieties of antibodies in the wider population produce proportionately fewer reactions. A positive HIV test result, whether in a risk group or the 0.1% to 0.3% at large, is proof only that the non-specific manufactured proteins attracted some kind of antibodies or another. It becomes clear that specific interpretations of HIV ELISAs are impossible. HIV testing of individuals should stop until this ridiculous situation is sorted out. Either they test for the virus or they don't.

Neither the jettisoned Western blot nor the PCR can offer any greater virus-specificity, but with its exposure of the different antibody profiles from individual to individual and community to community, Western blot kept vivid the essential question "what's actually causing these antibodies?" The all-ELISA policy sealed the HIV sector in a maze of mirrors which Dr Mortimer quietly anticipated in 1989: "There can be misleading cross-reactions between HIV-1 antigens and antibodies formed against other antigens...it may be *impossible to relate an antibody response specifically to HIV-1 infection.*" [6] [my itals]

LICHTENSTEIN

In the UK we have been carefully shielded for four years now from the subversive influence of Western blots. In the USA, according to Mortimer, the Western blot remains popular and people would probably sue if told they were HIV positive without one. So it takes more than curious lab technicians and independent virologists to agitate America. In Britain steps have been taken that help avoid that kind of behaviour. "I think it safe to say the approach to evaluation of screening assays has served us well," Dr Mortimer recently commented. ■

HUW CHRISTIE

References

1. Mortimer P, *Lancet* 37:286-287, 1991.
2. Mortimer *et al*, Towards error free HIV diagnosis. PHLS 1992.
3. ibid.
4. ibid.
5. Blattner, W.A., Retroviruses. *Viral Infections of Humans*:545-592. Plenum Medical Book Co., NY, 1989.
6. Mortimer, P.P., The AIDS virus and the AIDS test. *Med. Internat.* 56:2334-2339, 1989.

What's changed?

Reprinted from the leading medical journal The Lancet, *Jan. 20th 1996.*

HIV transmission by donor semen

SIR— In September, 1985, in *The Lancet*, Sydney researchers claimed "convincing evidence for transmission for HTLV-III [HIV]" to four women after in-vitro fertilisation with semen donated by a bi-sexual man.[1] This report still remains the only evidence for HIV transmission by such means and is also considered one of the most important pieces of evidence proving the infectivity of semen. The evidence for transmission of HIV was based on Western blot testing where each individual had the following bands: donor p24/gp41; first woman gp41; second woman p24/gp41; third woman p24/gp41; fourth woman p24. However, the present Australian criteria for a positive Western blot are "reactivity to at least one glycoprotein (gp 41-5, gp 110-120, or gp160) and three other viral proteins of *gag* (p12, p18, p24, p40, p55) or *pol* (p34, p53, p68) origin. A negative Western blot had to show no reactivity to viral proteins; reactivity to viral proteins that did not fulfil positive or negative criteria was considered indeterminate".[2] Thus, by the present criteria for a positive Western blot in Australia none of the four women or even the donor would be considered HIV positive. Neither would any be positive under the criteria set by the FDA and the American Red Cross. In fact, two of the women would not be positive by any criteria anywhere in the world.[3]

According to Fauci, "the least likely explanation for an indeterminate Western blot is that the individual is infected with HIV", and "the most likely explanation is that the patient being tested has antibodies that crossreact with one of the proteins of HIV. The most common patterns of reactivity are antibodies that crossreact with p24 and/or p55".[4] The above data pose these questions: have these five individuals been retested and if so, have they all been found positive and by what criteria; if some or all were not found positive have the authors modified or retracted their claims; if not retested, why not and are they still considered to be infected with HIV; have any of these individuals been treated for HIV/AIDS and if so, with what drugs and on the basis of what tests?

Eleni Papadopulos-Eleopulos, Valendar F. Turner, David S. Causer, John M. Papadimitriou. (Dep't of Medical Physics, Royal Perth Hospital, Perth 6001, Australia; Dep't of Emergency Medicine, Royal Perth Hospital, and Department of Pathology, University of Western Australia, Perth)

References

1. Stewart GJ, Tyler JJP, Cunningham AL, et al. Transmission of human T-cell lymphotrophic virus the III (HTLV-III) by artificial insemination by donor. *Lancet* 1985; ii: 581-85
2. Healey DS, Maskill WJ, Howard TS, et al. HIV-1 western blot: development and assessment of testing to resolve indeterminate reactivity. *AIDS* 1992; 6: 629-33.
3. Papadopulos-Eleopulos E, Turner VF, Papadimitriou JM. Is a positive western blot proof of HIV infection? *BioTechnology* 1993; 11: 696-707.
4. Fauci AS, Lane HC. Human immunodeficiency virus (HIV) disease: AIDS and related disorders. In: Isselbacher KJ, Braunwald E, Wilson JD, Martin JB, Fauci AS, Kasper DL, eds. *Harrison's Principles of internal medicine.* 13th ed. New York: McGraw-Hill, 1994: 1566-618

A Breath of Fresh Air

The 2nd International Meeting on Complementary Medicines was held in Girona, Spain, from December 4th to 10th 1995. MOLLY RATCLIFFE reports.

This seven day conference was organised by the Asociación de Medicinas Complementarias (AMC) of Madrid.[1] Alfredo Embid is the director of the organisation and main person behind the conference. AMC produces a monthly journal, *Medicina Holistica*, on aspects of natural medicines and provide access to a wide range of alternative therapies to people in the Madrid area. Embid is a Traditional Chinese Medicine practitioner and has years of experience treating people, including those with an "HIV" or "AIDS" diagnosis.

Each of the days had a theme. Day seven, Sunday, was devoted to looking at HIV and AIDS, though the subject was included in discussions on other days, particularly in relationship to the helpful effects of certain diets and TCM practices such as acupuncture and qi gong (Chinese self-healing exercises).

I arrived at the conference on the fifth day, tired from a night at Barcelona airport, having been delayed by French air-traffic control problems. I soon felt refreshed by the sea air and fresh herb teas that greeted me. All the presentations except the AIDS day were conducted in Spanish and French so I didn't attend, but I spent the time meeting with people concerned in some way with AIDS, either as practitioners, scientists or by being affected themselves.

The causes of illness are multifactorial and within the power of an individual to change

One person I met with was Lluis Botimas of CORBRA, a Barcelona-based group focused on alternative and holistic approaches to health issues including AIDS, cancer and environmental pollution. They hold weekly meetings in Barcelona and their main tool for change is education.

They have produced a four-page declaration entitled *Losing the Fear of AIDS* which points out that HIV and AIDS have been misreported and misrepresented by the government, scientists and the media, and that not only does HIV not cause AIDS, but has not been proven to exist. They cite inaccurate tests, a bias towards expensive pharmaceuticals and ignorance about the true causes of ill-health as some of the problems with mainstream HIV and AIDS information, and refer to World (propagation of) AIDS Day on December 1st as another way that official terror attempts to reinforce itself. The declaration has been read and signed by over a thousand people, the majority of whom are in Spain.

I was initially perturbed that the AIDS day was last on the schedule, until it was explained that for most people attending it would be the highlight of the week.

Sunday started late – the Spanish not being overly concerned with time keeping. The daily qi gong practice session was the only event that started on time consistently! Since it was a holistic medicine conference it did seem appropriate that participants placed more importance on leisurely consumption of all meals than punctuality.

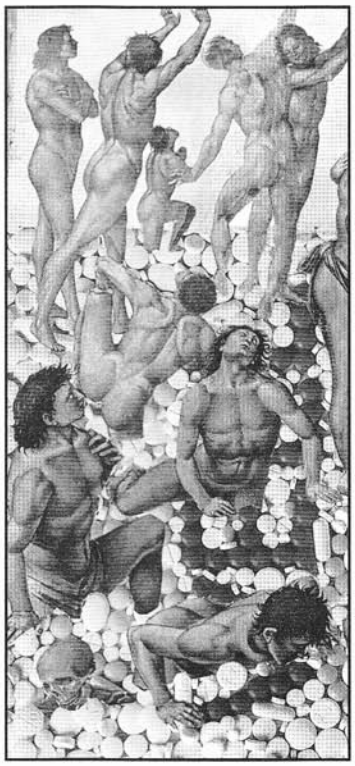
Dr. Alain Bordil began the day with a lecture on the Kousmine method of dietary adjustment and its application to AIDS. This was in French, translated into Spanish, and so my understanding was partial. The principle is that diet can be used to aid the immune system to function. As a doctor, Bordil was concerned with categorising levels of immune competence, then proposing suitable dietary advice. Main tenets he applied were the use of whole grains, legumes, fruit and vegetables and avoidance of meat, dairy products, sugar, drugs and processed foods.

Stefan Lanka, the virologist from Constance in Germany whose work *Continuum* has published on the non-isolation of HIV[2], spoke next on the unscientific mistakes and cover-ups involved in AIDS. From his perspective he was able to explain in detail not only the political and media interests that have led to the ubiquitous HIV=AIDS theory, but also the mechanisms of science and how dubious experiments can get pushed as absolute truths.

Lanka is a tall and dynamic man who expresses himself through gesture and visual expression as much as with precise

terminology. Layer by layer he unrobed the orthodox paradigm of AIDS until it stood before us naked, pathetic, and definitely unconvincing. He discussed conditions such as PCP, the flair in using PCR to detect "virus", false antibody testing methods and in particular the situation of people with hæmophilia; how they have been co-opted into the AIDS picture by selective and biased reporting. He described how manufacturers of Factor VIII, the clotting factor that people with hæmophilia lack, warned about its use due to antibody formation and immune suppression in recipients. It was only to be used when necessary, but has been used (and still is) prophylactically, constantly, and so problems arose.

When it came to the central pivot of his argument, that HIV does not exist except as a misinterpreted cellular phenomenon, Lanka was in his element and like an adept magician took us through the steps of how 'HIV' is produced in a laboratory, using coloured liquids, jars and test-tubes. If HIV was a retrovirus, as has been claimed, you could put cell cultures containing it in a test-tube and centrifuge it and it alone would band at density 1.16, but that doesn't happen - at density 1.16 (its molecular weight) you get a mixture of cellular debris, proteins, particles etc., which does not prove the existence of HIV - in fact it shows the opposite. The climax of his presentation was drinking the 'HIV' mixture, which he did with glee, to demonstrate its harmlessness. Though only the native English speakers in the audience seemed to get Lanka's jokes, he did manage to communicate some complex scientific concepts in a simple and human way. The impact on the audience was tangible and provoked much excited discussion.



Martin Walker, an investigator and author of *Dirty Medicine*[3] who has been researching connections between censorship, profits and disease since the late '80s, spoke about the way that AZT manufacturer Wellcome shaped the treatment and perception of AIDS. Walker covered the subject of censorship on a previous day and it was clear that the audience were ready for a deeper foray into his findings.

He described how, when Wellcome set up the Concorde trial in October 1988 to test the use of AZT in people with HIV antibodies or AIDS, the protocol included these points – that participants:

i) must not have taken other retroviral treatment previously;
ii) must not be using other treatments currently;
iii) may not use any therapy other than AZT, including no vitamin supplements, or holistic medicines or therapies.

The aim was to have HIV-positive people on AZT alone. Concurrent with the setting up of Concorde was the creation of The Campaign Against Health Fraud, with money from Wellcome, which began what can only be described as a witch-hunt directed at holistic practitioners, many of whom were wrongly accused of using fraudulent treatments.

Consequently the community of HIV-positives were at the mercy of Wellcome's agenda in more ways than one. In discussing this work Walker made it clear that he doesn't subscribe to conspiracy theories, but sees the hierarchy of profit over health as a natural result of a capitalist system.

I gave a presentation after lunch on women, AZT, AIDS and pregnancy, drawing on research I've done into the AIDS definition in relationship to women and the giving of AZT to pregnant (HIV-positive) women and their babies supposedly to stop transmission of HIV[4]. The arbitrary inclusion of PID (pelvic inflammatory disease) and cervical cancer in the AIDS definition in 1993 vastly increased the number of women with an AIDS diagnosis in the UK overnight. Considering the unspecificity of the ELISA test used to look for what are vaguely called "HIV antibodies", it is possible that presence of PID or cervical cancer, or susceptibility to them, may cause antibody reactions on the test, creating a misleading link between presence of these conditions and "HIV-positivity".

I went on to discuss how it has come to pass that AZT is being given to HIV-positive pregnant women, re: ACTG0176 trial. The full results of the trial have still not been released, yet AZT is being pushed as a "standard care" in countries that can (unfortunately for them) afford it, and reports leak out of deformities, cancers and low immunity in the infants affected. All to stop the transmission of an imaginary virus.

It appears I was only the second woman to give a presentation at the conference (perhaps due to some unconscious machismo in its organisation) and the audience were appreciative of a woman's perspective. I believe it's important to acknowledge that women are affected by the HIV/AIDS phenomena but to remain clear about the extent and reasons for this. It saddens me to hear women claim an equal right to AIDS as if it were a question of political correctness. Economics are partly the cause: in the US and UK an AIDS definition will get you access to certain state benefits. Women have felt excluded from this because the AIDS-defining conditions did not affect them, so new ones specific to women were added after pressure from certain groups. This is only part of the picture but it's important to be aware of such influences.

Gareth James of Health Education AIDS Liaison (HEAL) London, who is a practising homœopath[5], gave a detailed tour through the failings of the official pronouncements on AIDS. Much of what he said Lanka had covered earlier, though to be taken through again from a different perspective was obviously welcome to the audience, who listened attentively throughout. James' emphasis was on what is therapeutically useful. He eloquently demonstrated that the orthodox model of HIV=AIDS=death is definitely untherapeutic, while the dissident model which supports the patient to see causes of illness as multifactorial and within the power of an individual to change, is eminently therapeutic.

James read out a list of survival characteristics which have been observed in people that have lived with an HIV or AIDS diagnosis for a substantial period of time, providing concrete guidelines about what works. The crucial message was – be empowered. There followed discussion of the therapies, all non-toxic and holistic, available at HEAL in London which will be fully accessible when they have found suitable premises.

The last speaker was Marshall Smith from the USA[6], a successful lawyer who was diagnosed with KS in 1987 and cured himself using visualisation techniques. Smith is a charismatic and entertaining man who spoke from his heart. He described how from 1984 onwards, when he first heard about AIDS, he scrutinised his body for signs of KS everyday, perceiving himself to be at risk as a gay man living in New York. Then came his diagnosis of AIDS after KS was found. He began making changes in his lifestyle and started Transcendental Meditation and visualisation. Describing himself as a natural cynic, when his KS lesion began to shrink, then disappear (and he saved himself

continued on page 30

SPECIAL

Where have all t

Prof. Alfred Häs
US AIDS resear
which revealed


Prof. Alfred Hässig

Last issue *Continuum* published an introduction to the work of Prof. Hässig, the distinguished Swiss immunologist who now directs the Study Group on Nutrition and Immunity in Bern. Following here are a paper which Hässig co-wrote on the activity of CD4/CD8 cells when the body is under stress and an interview with him which explores the context of this work.

The Study Group was set up to examine non-infectious diseases of Western civilisation like cancer, MS and arteriosclerosis, focusing on bridging the gap between Eastern medical procedures and Western science. Their attention was drawn to AIDS when they noticed physicians gave a message of hopelessness to those diagnosed HIV positive, contrary to the Hippocratic oath which states "above all, do no harm".

Hässig's work gives a clear explanation of why people diagnosed HIV-positive might experience T-cell counts that fluctuate or drop: it is part of the body's response to psychological or physical stress, not a consequence of their destruction by HIV. T-cell counting measures levels of T-cells circulating in the blood but not the overall amount in the body tissues. Hässig says that the count going down indicates that, because of stress, they have migrated from the blood to the bone marrow to activate another limb of the immune system. After the stress is over they return to circulating blood.

Incredibly, this mechanism was demonstrated by Anthony Fauci, the current "boss of HIV/AIDS research in the US", way back in the '70s. At the time it was acknowledged to be a ground breaking discovery making a significant contribution to the developing field of psychoneuroimmunology (the study of connections between psychology, the nervous system and immunity).

In 1984 Robert Gallo announced that he'd found HIV, the 'probable cause of AIDS', which he claimed resulted in declining T-cell counts. Fauci remained strangely silent on the effects of stress on T-cells. In time Fauci has risen to the position of director of the National Institute of Allergy and Infectious Disease (NIAID) and is responsible for upholding the HIV/AIDS hypothesis by allocation of money to scientists who tow the viral line. More recently he blatantly dismissed work that relates to his previous findings on T-cell activity. Could it be because it makes a mockery of the HIV/AIDS hypothesis?

The Study Group on Nutrition and Immunity, Elisabethenstrasse 51, CH 3014 Bern, Switzerland.

Prof. Hässig interviewed by MOLLY RATCLIFFE and HUW CHRISTIE

Our focus is Anthony Fauci, Head of the US National Institute of Allergies and Infectious Diseases (NIAID). Could you explain about him?

- In the late 70's Fauci worked at NIAID on neuroendocrine (i.e. hormonal) influences on the immune system. He was interested in what happens to T-cells under the influence of the anti-inflammatory hormone cortisone. He injected people with cortisone and observed that this led to a selective depletion of CD4-cells. They were sequestered out of the blood mainly to the bone marrow and, when the cortisone levels returned to normal, the CD4 -cells (T-cells) came back. [see accompanying article.]

Is Fauci an immunologist?

- No, he is an MD, let's say an immune biologist. He never treated patients, he was more of a laboratory man.

Had Fauci done anything significant before he produced this research?

- No, he was a young researcher about 30 years old, just starting his scientific career studying what T-lymphocytes do. It was new in those days to be able to distinguish T4 helper cells and T8 cytotoxic and suppressor cells.

Was he able to publish his work?

- Certainly. It was controlled, well done work. He wanted to know why the T4-cells go into the bone marrow. He published four papers at that time, and they showed that T4 cells activate the B-cells so that they make more antibodies, i.e. activate the immune reaction. Strangely Fauci ended this aspect of his career the moment HIV was declared to be the cause of AIDS.

Are scientists generally aware of this extensive work by Fauci on hormones and the behaviour of T4-cells?

- No. We have such an overflow of information that a young scientist reads literature from perhaps the last 3 to 5 years, but almost nobody reads literature published in the '70s! Most people think that's completely out of date. Fauci's observations which were peer-reviewed and published in first class scientific literature are not known.

What pressures could have persuaded him to neglect his own work?

continuum Vol 3 No 5 January/February 1996

Back Issues Index and Order Form

Subscription Form and
Covenant Scheme details inside

Copies are available for all back issues of the magazine. However, where we have exhausted our stock of the original copies, we have reproduced the articles from these issues and made them available individually. The index below details the contents of each issue, starting with the most recent.

To order please fill in the form overleaf and return the entire page to:
Continuum, 172 Foundling Court, Brunswick Centre, London WC1N 1QE.
Telephone enquiries on 0171 713 7071

Complete issues

Vol 3, No 4 November/December 1995 32pp

- HIV Watch: Delta – Trials and Tribulations
- Feature: Introduction to the work of Prof. Alfred Hässig on the Stress/AIDS link
- DrugEffects: Acyclovir
- Alternatives: Homœopathy revealed
- Questionnaire: How toxic are you?
- HIV Debate: Why the Hæmophiliac controversy is misleading
- TestingTimes: Examining the Western blot Antibody Test
- Nutrition: The Gerson Therapy - coffee enemas & cancer?
- CounterCulture: Why We Will Never Win the War on AIDS
- Review: The Complete Guide to Urine Therapy
- LifeStory: A Personal Story from one of our readers

Vol 3, No 3 September/October 1995 32pp

- HIV Watch: Absurd Convictions: Murder for HIV transmission?
- Health: Massage, Psychneuroimmunology & the Immune System
- Legal Matters: Selling Poppers may be illegal: the risks explained
- AIDS Babes?: Did Romanian Babies really die of AIDS?
- HIV Debate: Causes of False Positivity in HIV Tests
- HIV Debate: Does the Hæmophilia Study Prove that HIV causes AIDS?
- Interview: The Kobler Centre's Dr Phillipa Easterbrook
- CounterCulture: The Focal Point Hypothesis of AIDS
- Side Effects Info: Pentamidine, a common prophylaxis for PCP
- Nutrition: Organic Food: what it is, why it is healthy & where to buy it
- Book Review: The Stonewall Experiment, by Ian Young
- LifeStory: A Personal Story from one of our readers

Vol 3, No 2 June/July 1995 32pp

- HIV Watch: The latest news from around the world
- HIV Debate: Dr Stefan Lanka's reply to a critic's rebuttal
- Health: Amaroli, the Amber Fluid: Urine Therapy explained
- Imprint Book Review: Dirty Medicine, by Martin J. Walker
- A History of the HIV/AIDS Hypothesis, and its Consequences
- Peter Duesberg visits the Berlin Conference
- Interview: Joan Shenton, Director of Meditel's AIDS Documentaries
- Conference Report: Buenos Aires
- Nutrition: You and Your Colon: How to achieve a healthy bowel

Vol 3, No 1 April/May 1995 24pp

- HIV Watch: HIV tests, AIDS and PCP
- HIV - Reality or Artefact? Dr Stefan Lanka asks questions about HIV
- Health as a Virtue: Extract from Ivan Illich's book
- Imprint: An AIDS Bibliography
- Is Anyone Really Positive? Christine Johnson examines the HIV test
- Continuum Woman: Pelvic Inflammatory Disease and Cervical Cancer
- Health: Preventing Herpes
- Imprint 2: Author's response from last issue's review

Vol 2, No 5/6 November 1994/January 1995 36pp

- HIV Watch: Censorship, Elton John and the Sunday Times
- Continuum Crew: Meet Tony Tompsett, Office Manager
- Supplements: The Importance of Antioxidant Therapy
- Just For the Record: Questions to Keith Winestein, WAD Co-ordinator
- Aromatherapy 1: Essential Oils and how they work
- Interview: Neville Hodgkinson, Sunday Times Science Correspondent
- Imprint Book Review: You Don't Have To Die, by Leon Chaitow
- Blood Medicine: The Risks of Blood Transfusions & Blood Products
- Aromatherapy 2: Healing Properties of Essential Oils
- Continuum Woman: Suffer the Little Children: Babies, HIV & AZT
- Health: Massage, Psychneuroimmunology & the Immune System
- Continuum Crew: A Bit About Molly Ratcliffe, Woman's Editor
- Neenyah Ostrom: Is HIV hiding in our Lymph Nodes?

Vol 2, No 4 August/September 1994 32pp

- HIV Watch: Questions Cow AIDS; and are CD4 Counts back to front?
- Supplements: Zinc and herpes; Bee Propolis introduced
- AIDS Inc: Celia Farber on AIDS Dissent & Morality of AIDS Purists
- Interview: Nick Partridge, Chief Executive, Terrence Higgins Trust
- Continuum Africa: HIV Guinea Pigs (in African languages)
- Jody Wells: How can HIV be Sexually Transmitted?
- Barry Duke: Don't Allow Your GP to Make You a GP (Guinea Pig)
- Supplements: Chlorella, Nature's Potent Detoxifier
- Imprint Book Review: Deadly Deception, by Dr Robert Willner
- Udo Schuklenk: Ethics of Clinical AIDS Trials in Developing Countries

continued overleaf

Complete issues (cont'd)

Vol 2, No 3 June/July 1994 28pp

- HIV Watch: Positively Healthy; AZT & ddI; Johnson's home HIV test kit
- Robert Gallo: Admits he's never found HIV DNA in T-cells or KS
- Continuum Crew: Meet Huw Christie, Researcher and Writer
- Testing 1: Celia Farber on how T-Cell Counting affects our lives
- Health: Diarrhoea: Nutritional Ways to Reduce, Control & Eliminate it
- Testing 2: What Does HIV Testing Really Mean?: Eleopulos reviewed
- Mughal Art: The Naz Project's Exhibition
- Interview: John Campbell, Director of the UK Coalition for HIV & AIDS
- Imprint: Wickers & Bullers, a Black Lesbian & Gay magazine

Vol 2, No 2 April/May 1994 24pp

- HIV Watch: 'AIDS Therapy': causing more harm than good?
- Jody Wells: HIV Dementia, Folic Acid & Vitamin B12 Deficiency
- Organics: Meat: Where to buy it
- Concorde Trial: The AZT Trial Results reviewed and exposed
- Sue Threakell: Man from the Gas Board No. 1
- Travel: Gay Guide to Cornwall
- Drugs: Septrin: Graham Ross discusses the dangers of prophylaxis
- Continuum Africa: Dangers of HIV vaccinations in Africa
- Imprint: The Anarchist AIDS Medical Formulary: Guerilla Immunology

Vol 1, No 6 October/November 1993 24pp

- HIV Watch: Serious & less serious issues around HIV & AIDS
- Nutritional Supplement: Calcium and Selenium
- Nutrition: Fats and Oils
- Interview: Andrew Neil, Editor of the Sunday Times
- Sue Threakell: Shouting Her Mouth Off - Hypochondria
- Drug Side Effects and Interactions
- Who's Zooming Who? 10 Years into the 'AIDS Epidemic'
- Dr Derek Wolfe: Alternatives to Orthodox Medicine
- Imprint: Healing With Wholefoods. AIDS, Hope, Hype & Hoopla
- Fighting Fit & Fighting Back: 10 years on, Jody Wells Interviewed

Individual Articles

No Vol 2, No 1 February/March 1994

G1 - HIV Watch: Positively Hilarious - Continuum Attacked over PCP
G2 - Supplements: The Truth about Vitamin A and Toxicity
G3 - Lynne McTaggart: The Scientific Sham of Modern Medicine
G4 - AZT and the Newborn Child - a Report on the NIAID Study
G5 - Imprint Book Review: Food, Your Miracle Medicine, by Jean Carper
G6 - Interview; John Maddox, Editor of science journal Nature
G7 - Recreational Drugs & Nutrition: How to repair the Damage
G8 - Spirulina: The Benefits of Nature's Richest Food
G9 - Instinctotherapy: Turning HIV On and Off by Diet

No Vol 1, No 5 August/September 1993

E1 - A Western Blot on the HIV Landscape - Press treatment of study
E2 - HIV Watch: Serious and less serious issues around HIV & AIDS
E3 - Shouting My Mouth Off Again: Sue Threakell talks about how her husband died from AZT Toxicity
E4 - Supplements: Zinc
E5 - Side Effects Information: Foscarnet
E6 - Alternatives: Ayurvedic Medicine & Lifestyle Change
E7 - Is a Positive Western Blot Proof of HIV Infection? - Extracts from this important Australian study
E8 - Hope in Dope? - A Case for Legalising Cannabis?
E9 - Imprint Book Reviews: Rethinking AIDS by Robert Root-Bernstein & The AIDS War by John Lauritsen

Individual Articles (cont'd)

No Vol 1, No 4 June/July 1993

D1 - An Open Letter to Les Rudd of the National AIDS Trust
D2 - Health: Amaroli - The Ancient Practice of Urine Therapy
D3 - Side Effects Information: Septrin & Folic Acid Deficiency
D4 - Reprint: Arthur Ashe is AZT Victim (from NY Daily News)
D5 - SNARL Page: Saying No - and Meaning It
D6 - AIDS - Exploring Divisions, Looking for Unity - a Homœopath's view of AIDS
D7 - Imprint Book Reviews: The Food Pharmacy by Jean Carper & The Natural Pharmacy by Miriam Polunin & Christopher Robbins
D8 - Interview: Jeremy Selvey of Project AIDS International
D9 - A Natural History of PCP by Jody Wells
D10 - Lightning Strikes, by Frank Zerox: 3TC Combination Therapy and Self-Test Kits

No Vol 1, No 3 April/May 1993

C1 - Concorde Nosedives: Questions asked following trial results
C2 - Acquired Nutritional Deficiency Syndrome (ANDS): Jody Wells asks Is Malnutrition the cause of AIDS?
C3 - Side Effects Information: Dapsone
C4 - Nutrition: Sweetly Suppressive - Are You a Sugar Addict?
C5 - The Delta Drug Trial: Initial Patient Info. and a reader's opinion
C6 - SNARL Page: AIDS is Dead - Long Live HIV Disease
C7 - AIDS Research & Censorship, by Udo Schuklenk
C8 - News from around the World: Vitamin Deficiency; Hæmophiliacs and Factor VIII
C9 - Imprint Book Reviews: HIV Glossary from Merseyside Body Positive; & Cancer as a Turning Point by Dr Lawrence LeShan
C10 - Reprint: The Prostitute Paradox (from Rethinking AIDS)
C11 - A Natural History of Candida (Thrush)
C12 - Lightning Strikes: report on Wellcome's damage limitation of the Concorde Trial

No Vol 1, No 2 February/March 1993

B1 - The Gospel According To: Review of HIV=AIDS=DEATH theory
B2 - Malnutrition & Ill-health: How to Fortify your Immune System
B3 - Supplements: A Guide to commonly-used supplements
B4 - Let's Get Free of HIV by Jerry Terranova of CureNow/Praxis
B5 - Side Effects Information: AZT
B6 - Supplements: Bee Propolis - general information
B7 - A Natural History of Shingles
B8 - SNARL Page: A Truly Lovely Death - Besotted by Dying & Death
B9 - Project AIDS International's Statement on HIV=AIDS Hypothesis
B10 - Lightning Strikes: BBC2's Public Eye attacks Alternative Therapists

No Vol 1, No 1 December 1992

A1 - Welcome to the First Continuum Newsletter
A2 - The HIV Puzzle: Channel 4's cosy but confused coverage of HIV
A3 - Continuum Questionnaire Analysis & Future Plans
A4 - A Session With the Breakdown Man, by Garry French
A5 - Cough, Splutter, Cough - A Look at Prophylaxis
A6 - Side Effects Information: Acyclovir
A7 - News From Around The World: HIV-Free AIDS; Co-Factors; TB cases increasing
A8 - AIDS & Nutrition : Sensible Advice from Danielle Harris
A9 - Readers' Letters Page
A10 - Thank You from Jody Wells

Why not treat a friend to a year's subscription to the continuum magazine?

Use the form opposite and we'll despatch the next issue to them ⇨ ⇨ ⇨

Back Issues Order Form

Please send me the following Back Issues/Articles of the Continuum Magazine.

I enclose my cheque/P.O. for £/$ ..... made payable to Continuum. (see below for prices)

Name ..... Address .....

..... Postcode .....

Issue No.s:.....

Article Nos: .....

.....

Prices: Complete Issues £1.50 each (US$ 2.50)
Articles: 1 - 10 items - 25 pence each; 20 - 50 items - 20 pence each; over 50 items - 15 pence each

Postage included. Please allow 14 days for delivery, though we will endeavour to despatch your request within one week.

continuum *relies heavily on your individual donations and subscriptions. You can help our work more by covenanting a regular amount, which means we claim back 1/3rd of your gift. See overleaf for details of this scheme and for how to make a donation. Your assistance will be greatly appreciated.*

continuum subscription application

Name: ..... Tel. No.: .....

Address: ..... Fax No.: .....

.....

..... Postcode: .....

Country: ..... Local Authority: .....

I enclose my cheque/postal order (payable to Continuum) for £/$..... for one year's subscription.

If subscription is for a friend, please give your name here: .....

Professionals and Organisations, please also complete below:

Job Title: .....

Name of Organisation: .....

* I enclose my cheque for £/$..... **delete as appropriate* 3/5

* Please invoice me at the following address: .....

.....

Rates: Positive Individuals: UK...£10, Europe...£15, USA/Canada...$30, Australia...$40, Elsewhere...£20.
Other Individuals: Double above rates. Organisations: 2 1/2 times above rates.

To make out a Covenant, please complete both the forms below.
Should you prefer to make a single gift, please use the section at the bottom.
Return form to: CONTINUUM, 172 Foundling Court, Brunswick Centre, London WC1N 1QE

DEED OF COVENANT BLOCK CAPITALS PLEASE

To: **CONTINUUM**

I promise to pay for four years, or until further notice thereafter (or during my lifetime if shorter)* such a sum as after deduction of income tax at the basic rate amounts to:

The sum of £..... each month ☐ quarter ☐ year ☐

from the date shown below:

Signed and delivered ..... Date .....

Your full name .....

Address .....

..... Postcode .....

Please ask a friend to witness your signature

Witness's signature .....

Witness's address .....

..... Postcode .....

official wording

BANKER'S ORDER BLOCK CAPITALS PLEASE

To: ..... Name of Bank

At: ..... Address of Bank

.....

Please pay to Midland Bank plc, 166 Vauxhall Bridge Road, London SW1V 2RB for the account of CONTINUUM (account no. 91107410, sort code 40-06-03):

The sum of: £..... (.....) amount in words

each month ☐ quarter ☐ year ☐

from: (your account no.) ..... sort code .....

starting on (date) ..... until further notice

Name .....

Address .....

.....

Signature ..... Date .....

SINGLE DONATION FORM (If a regular gift is inappropriate, please use this section to make a single gift)

I enclose my cheque/P.O. made payable to CONTINUUM for £.....

Name ..... Address .....

.....

he T-cells gone?

g wonders why Dr Anthony Fauci, head of , seems to have forgotten his early work cell activity in times of stress.

- I think he saw big money and grants on the virological side, so he switched over to that research area. Gallo is the retrovirologist. Fauci had nothing to do with retroviruses in his early days.

It's very stressful to deny previous work that you have been recognised for, wouldn't you say?

- I could never do that. I remember what I have done over 50 years in science and often reconsider it. Fauci hasn't reconsidered. Actually for several years now he has been considered to be the boss of HIV/AIDS research in the United States.

Have you ever met him?

- I have seen him giving lectures several times. He is a very good lecturer – fanatical and persuasive. Fauci is, in my view, an extremely ambitious man and also an organiser. Now he says who gets grants for what, and he's a super-peer-reviewer of AIDS research.

At a meeting on psychoneuroimmunology and neuroendocrine immunology in the spring of 1995 in Belgium, Fauci was present saying: "This type of work is of no use." So now he doesn't believe it?

Of the Mosmann/Coffman work, which is the very basis for understanding the stress-induced switch of the immune system, he said: "This is not valid." Also the work of Daynes, who demonstrated DHEA influence, is practically never cited by the HIV experts.

Had psychoneuroimmunology existed before Fauci did his early work?

- It was born around 1975 in Davos, Switzerland, in the research institute where I was a board member. This I can explain, but what I really cannot explain is why Fauci stopped taking into consideration his early work. He is now the man behind the suppression of all papers critical of the HIV/AIDS thesis.

You think that there is conscious censorship from the top?

- Certainly. You have to see how science today is split into small groups. Lack of communication and interpretation of the knowledge of these groups is a big handicap.

Let's take our group in transplant and transfusion, a dozen leaders world wide and we were the peers. We decided which papers were published. This is partly the problem in AIDS research. HIV as the cause of AIDS is a typical example of linear thinking in medicine.

Reparative medicine is very successful – surgery and diagnostics – yet completely unsuccessful in areas like the chronic Western diseases such as arteriosclerosis, cancer and prevention of disease. People are specialised and go in deep but they have lost the ability to make connections. HIV/AIDS research consists of a large group of people helping each other to get grants. It's supported by the pharmaceutical industry. Wellcome for instance play a key role in favouring this line of thinking and the use of therapies such as AZT.

It's interesting to look at Wellcome. I have a good friend who is a leading haematologist and immunologist, Lady Susan Hollan in Budapest. She visited Wellcome and said: "We should know where this drug goes to in the body. We could use radio-labelled AZT to image its destination in the body." This is theorised by critics of its use to be the bone marrow. They immediately blocked her and stopped contact.

Everything which questions mainstream thinking on the use of this drug is blocked. With the use of AZT there are several handicaps. There is one paper which shows that AZT kills immature thymocytes which are key cells in the immune system. But it is never mentioned. Such companies are dominated by commercial interests. Perhaps Wellcome has an uneasy feeling about their future and that's why they joined to Glaxo. You can imagine if people damaged by AZT asked for compensation it would be a huge amount of money, and you need powerful resources to be able to handle that.

Dr Anthony Fauci

"Fauci is an extremely ambitious man – a super-peer-reviewer of AIDS research"

If you could sit down with Anthony Fauci and ask him one question, what would it be?

- I would ask him what he thinks now about the work he did in the 1970s. You know *Nature Medicine* (an off-shoot of *Nature*) took several months to decide whether or not to publish a paper that we sent them on Fauci's previous research into T4 cells. They certainly sent it to him to ask for his comment, and perhaps he was unable to give a satisfactory answer, so they hesitated .....'Shall we publish it? This is a funny man in Switzerland, we don't know him.....'

As I see it they are in a difficult situation because virologists have nothing new to offer. They keep coming up with excuses, they find constant growth and change in the virus structure, it evades, attacks, strange things, but none of them has the courage to explain properly how these things could possibly be so. ■

Reappraisal of the depletion of circulating CD4+ lymphocytes in HIV-carriers in transition to AIDS

This paper, by ALFRED HASSIG, LIANG WEN-XI and KURT STAMPFLI, was offered to *Nature Medicine*, but after some deliberation they refused to publish it. We reproduce it here in full.

A characteristic for the transition from asymptomatic HIV infection to AIDS-related complex and to full-blown AIDS is the continual reduction in the number of CD4-lymphocytes in the blood while the CD8-lymphocyte count remains practically constant. According to current wisdom, this is because of the increasing destruction of CD4-cells by HIV.

Last year however, Carbonari *et al* showed that apoptotic (apoptosis = programmed cell death)* lymphocytes in AIDS patients consist for the most part of CD8 T-cells and CD19 B-cells.[1] They concluded from this that the phenomenon of *in-vitro* apoptosis might not be related to the depletion of CD4 T-cells in AIDS. Finkel *et al* recently showed that apoptosis occurs predominantly in bystander cells and not in productively infected cells of HIV- and SIV-infected lymph nodes.[2] In their commentary, Pantaleo and Fauci did not wish to give any conclusive answer to this.[3]

In order to clarify the question of the cause of the increasing depletion of CD4-cells in the transition from healthy 'HIV'-carrier to AIDS patient it seems to us to be useful to make a critical review of the studies of this phenomenon which appeared before the first description of AIDS in 1981.

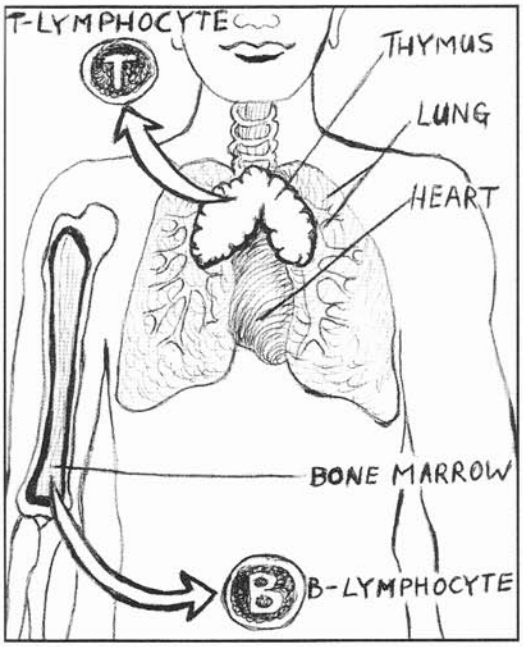
In the mid-'70s Fauci and his working group showed that after the administration of cortisol (a hormone produced by the adrenal glands in response to stress) the body appeared to respond with a selective reduction in the number of CD4-cells. This was found to be because most of this sub-group of white blood cells migrated from the blood circulating in the blood vessels into other areas of the body outside the vascular system.[4,5,6] After the withdrawal of cortisol, the CD4-cells return to the circulating blood and CD4/CD8 ratio returns to normal.

With regard to where the CD4-cells migrate under the influence of cortisol, it has been shown in animal experiments that they are sequestered mainly into the bone marrow.[4,7,8] Following these studies Antonacci and Calvano, from the working group of Shires, showed that a similar depletion of CD4-cells is also seen in burn patients.[9] Calvano also demonstrated that in cases of burns the body's own bioactive cortisol level rises sharply.[10] These investigators concluded from their findings that the sequestration of CD4-cells to bone marrow may be considered as a general phenomenon in any severe and persistent hypercortisolism (an excess of cortisol in the blood) in acute-phase inflammatory reactions in which the whole body responds to an inflammation or injury.

With regard to the direct effect of hypercortisolism on the lymphocytes, it has to be considered that immature CD4+/CD8+ cells** which are produced in the thymus (thymocytes) represent the most cortisol-sensitive element of the lymphatic tissue. They are reduced by increased apoptosis so that the number of these immature CD4/CD8 cells decreases noticeably. Peripheral mature CD4+/CD8- and CD4-/CD8+ lymphocytes are relatively

**apoptosis: a cell shows a surface marker to denote 'altered self' status, and therefore has to be removed by cellular immune reactions. Each day the human body removes about a billion cells which are replaced as part of its housekeeping.*

***CD4+/CD8+ cells are produced in the thymus and show markers for both CD4 and CD8. They are immature precursor cells of CD4+/CD8- and CD4-/CD8+ cells which are abbreviated as CD4+ and CD8+ cells.*



Bone marrow and the thymus are the primary immune system organs. Lymphocytes (white blood cells) are produced in bone marrow. Some become B-cells, while others leave to go to the thymus where they are differentiated into T-cells.

cortisol resistant.[11]

One could now ask whether the temporary sequestration of CD4-cells to the bone marrow during acute-phase reactions can be incorporated into the general concept of the neuroendocrinal control of the immune system. Mosmann and Coffman showed in 1986 that the CD4-lymphocytes can be divided into two cell-groups, known as Th-1 and Th-2 cells (Th is an abbreviation for T-helper cell).[12] The Th-1 cells secrete mainly Interleukin(IL)-2, IL-12 and Interferon(IFN)-gamma, which are chemical messengers which stimulate cellular immune reactions. The Th-2 cells secrete mainly IL-4, IL-6 and IL-10 which stimulate the humoral immune reactions.

The significant step towards clarification of the mechanisms behind production of these chemical messengers known as cytokines was made by the study group around Daynes.[13,14] This group revealed first of all that regulation of the cytokine production of activated lymphocytes takes place in the periphery. Mitogen (a substance which activates cells to divide)- or antigen-stimulated lymphocytes from lymphoid organs of the mucus membranes produce mainly IL-4. Lymphocytes from internal organs produce mainly IL-2.

The decisive factor for the type of peripheral regulation of lymphocyte cytokine production is the production of steroid hormones which are produced locally from inactive precursors. In this process the dehydroepiandrostosterone (DHEA) produced in the cortex of the adrenal glands plays an important role as an antagonist to cortisol. DHEA is the adrenocortical hormone contained in the blood in the highest concentration of all the steroid hormones.

In its sulphated form, DHEAS, it is inactive. By means of steroid sulphatase, DHEAS is desulphated in the periphery and thus transformed into DHEA, the active form. In the lymphocytes the active DHEA causes increased production of IL-2 and IFN-gamma, but not of IL-4. These findings have revealed that the varying concentration of steroid sulphatase in different tissues during the transformation of the pre-hormone DHEAS into active DHEA plays a central role in the production of Th-1 and/or Th-2 CD4-lymphocytes.

In the lymphatic tissue the macrophages are the only cells that have an appreciable quantity of DHEAS sulphatase. Moreover the high concentration of circulating DHEAS is used for the production of androgenic (male sex) and secondarily of oestro- ⇛

From the New York Times, *21 November 1995*

Stress: Immune Cells Rush to Skin to Repel Microbe Invaders

by SANDRA BLAKESLEE

EVERYONE knows stress is bad for you. It weakens the immune system. It increases your susceptibility to infections and diseases like cancer. Drugs that exert their effects on the body's natural stress hormones are medicinal sledgehammers: they may help your arthritis, but they make you feel like Wile E. Coyote after a bad day with the Roadrunner.

But it now turns out that stress has been handed a bum rap, mostly by scientists who study diseases, death genes and other aspects of biological doom. As with most complex systems, there is another side to the story. Under certain conditions, say two neuroscientists from Rockefeller University in New York, a stressful experience can marshal immune cells to travel to distant parts of the body, ready to do battle with any foreign agent trying to breach the defences.

The researchers are Firdaus S. Dhabhar, a doctoral candidate in neuroscience, and Dr. Bruce McEwen, a leading authority on stress hormones and the brain. Some of their research was published earlier this year in *The Journal of Immunology*, and some of it was presented for the first time here last week at the annual meeting of the Society for Neuroscience, a gathering of nearly 23,000 brain specialists from around the world.

Earlier experiments showed that a mildly stressful experience produces dramatic changes in the distribution of the body's immune cells, Mr. Dhabhar said. The number of T-cells, B-cells, natural killer cells and monocytes – all involved in protecting the body from injury and disease – plummets by 50 to 80 percent within a couple of hours after a stressful experience. In the popular view, he said, stress makes the immune system crash.

But after three hours, the immune cells return to normal levels, Mr. Dhabhar said. And that does not compute. The body could not destroy its leukocytes and refabricate them in just three hours, he said. Something else must be happening.

To study the mystery, Mr. Dhabhar is examining the effects of psychological stress on immune reactions in the skin. The skin, he said, is the body's largest organ and the major barrier protecting an organism from the environment. It is a place where immune cells congregate, especially where there is contact with poison ivy, poison oak or certain dyes and cosmetics.

The experiments use two groups of rats. Both get a dab of a chemical (4-dinitro-fluorobenzene, or DNFB) on their ears. This procedure initiatives a moderate inflammatory reaction and is similar to the skin tests used by dermatologists to determine if a patient is allergic to certain substances or to test for exposure to diseases like tuberculosis, Mr. Dhabhar said. Such delayed type hypersensitivity is involved in resistance to certain bacterial and viral infections.

Over the next six days, all the rats develop an immunological memory, akin to a vaccination, for DNFB. Should they encounter the chemical again, their immune systems are primed to begin ⇛

⇐ genic (female sex) hormones.

After what has been said it seems plausible to us to consider the sequestration of CD4-lymphocytes to the bone marrow as a significant component of a stress-induced Th-2 profile of CD4-lymphocytes, because in the Th-2 profile in the bone marrow CD4-cells actively stimulate the B-cells, present there in large numbers, to increase the formation of antibodies.

If one looks into this question further one finds four studies by Fauci *et al* who, during 1976 and 1977, drew attention to the fact that in the case of cortisol-induced sequestration of CD4-cells into the bone marrow, these stimulate the B-cells to increase antibody production. In these studies they anticipated many findings regarding the Th-1 and Th-2 cytokine profiles of CD4-lymphocytes.[15-18]

In order to support our still hypothetical notions it seems to us to be useful to analyse the course of the CD4/CD8 ratio in the transition phase from HIV infection to the development of AIDS together with other parameters for this acute phase reaction, e.g. the body's own bioactive cortisol content or the C-reactive protein content. Following a suggestion by Cottier, in these patients we recommend that the size of the thymus be measured regularly by means of an imaging procedure such as nuclear magnetic resonance.[19]

In conclusion we would point out that studies of sequestration of CD4-cells in bone marrow can provide a clue to the question of long-term survival of individuals judged to be infected with HIV. They may have overcome HIV infection not exclusively by cellular immune reactions as in immunologically healthy persons, but with an additional humoral response in which the production of anti-HIV antibodies has occurred. They then remain in the neuroendocrine Th-1 state and do not induce the transformation into the Th-2 state along with the hypercortisolism required for the development of AIDS, thus sparing the patients this disease. ■

References

1. M. Carbonari, et al.: Detection and Characterization of Apoptotic Peripheral Blood Lymphocytes in Human Immunodeficiency Infection and Cancer Chemotherapy by a Novel flow Immunocytometric Method. *Blood*, 83:1268-1277 (1994).
2. T.H. Finkel, et al.: Apoptosis occurs predominantly in Bystander cells and not in productively infected cells of HIV- and SIV-infected lymph nodes. *Nature Medicine*, 1:129-134 (1995).
3. G. Pantaleo & A.S. Fauci: Apoptosis in HIV infection. *Nature Medicine*, 1:118-120 (1995).
4. A.S. Fauci & D.C. Dale: The effect of in vivo hydrocortisone on sub-populations of human lymphocytes. *J. Clin. Invest.*, 53:240-246 (1974).
5. A.S. Fauci & D.C. Dale: The effect of hydrocortisone on the kinetics of normal human lymphocytes. *Blood*, 46:235 (1975).
6. B.F. Haynes & A.S. Fauci: The differential effect of in vivo hydrocortisone on the kinetics of sub-populations of human peripheral blood thymus-derived lymphocytes. *J. Clin. Invest.*, 61:703-707 (1978).
7. J.J. Cohen: Thymus-derived lymphocytes sequestered in the bone marrow of hydrocortisone-treated mice. *J. Immunol.*, 107:841-844 (1972).
8. M.A. Levine & H.N. Claman: Bone marrow and spleen: dissociation of immunologic properties by cortisone. *Science*, 167:1515 (1970).
9. A.C. Antonacci, et al.: Flow cytometric analysis of lymphocyte sub-populations after thermal injury in human beings. *Surg. Gynaecol. Obstet.*, 159:1-8 (1984).
10. S.E. Calvano, et al.: Changes in free and total levels of plasma cortisol and thyroxine following thermal injury in man. *J. Burn Care Rehab.*, 5:143-151 (1984).
11. J. Gruber, et al.: Thymocyte apoptosis induced by elevated endogenous corticosterone levels. *Euopr. J. Immunol.*, 24:1115-1121 (1994).
12. T.R. Mosmann & R.L. Coffman: Th-1 and Th-2 Cells: Different Patterns of lymphokine Secretion Lead to Different Functional Properties. *Ann. Rev. Immunol.*, 7:145-173 (1989).
13. R.A. Daynes, et al.:Regulation of murine lymphokine production in vivo. III. The Lymphoid Tissue Microenvironment Exerts Regulatory Influences over T-Helper Cell Functions. *J. Exp. Med.*, 171:9790996 (1990).
14. J.D. Hennebold & R,A, Daynes: Regulation of Macrophage Dehydroepiandrosterone Sulfate Metabolism by Inflammatory Cytokines. *Endocrinology*, 135:67-75 (1994).
15. A.S. Fauci & K.R. Pratt: Activation of human B Lymphocytes. I. Direct Plaque-Forming Cell Assay for the Measurement of Polyclonal Activation and Antigenic Stimulation of Human B Lymphocytes. *J. exp. Med.*, 144:674-684 (1976).
16. A.S. Fauci, K.R. Pratt & G. Whalen: Activation of human B Lymphocytes II. Cellular Interactions in the PFC Response of Human Tonsillar and Peripheral Blood B Lymphocytes to Polyclonal Activation by Pokeweed Mitogen. *J. Immunol.*, 117:2100-2104 (1976).
17. B.F. Haynes & A.S. Fauci: Activation of human B Lymphocytes III. Concanavalin A-Induced Generation of Suppressor Cells of the Plaque-Forming Cell Response of Normal Human B Lymphocytes. *J. Immunol.*, 118:2281-2287 (1977).
18. A.S. Fauci, K.R. Pratt & G. Whalen: Activation of human B Lymphocytes. IV. Regulating Effects of Corticosteroid on the Triggering Signal in the Plaque-Forming Cell Response of Human Peripheral B Lymphocytes to Polyclonal Activation. *J. Immunol.*, 119:598-6063 (1977).
19. H. Cottier: personal communication.

Stress: *continued from previous page*

a response, including the swelling and inflammation that result when immune cells rush to the scene.

Next Mr. Dhabhar puts half the rats into a psychologically stressful situation. (It would probably upset humans, too.) He stuffs them into a transparent glass tube. "They hate it," he said. It does not squeeze them or harm them in any way, but sure enough, their immune cell count plummets. Their natural stress hormones – cortisol, epinephrine (adrenalin) and norepinephrine (noradrenalin) – squirt into their bodies.

The other rats are not placed under stress, Mr Dhabhar said. Both groups are dabbed for a second time with the same noxious chemical, DNFB.

The results are dramatic, Mr. Dhabhar said. The stressed animals show an inflammatory response that is three times larger than that seen in the unstressed animals. In the stressed animals, the immune reaction occurs at a faster rate and is significantly higher for up to six days.

To see what accounts for the difference, Mr. Dhabhar examined the ears of both groups of animals at different times. The stressed animals had thicker ears, containing many more immune cells in the skin, than did the unstressed animals.

The researchers concluded that under stress, immune cells do not disappear. They are redistributed throughout the body. They leave the blood stream and go to the bone marrow, spleen, lymph nodes and skin, ready to "do battle," Mr. Dhabhar said. In the stressed rats, they go straight to the ear – the spot primed by the DNFB – park themselves and stand ready to deal with that noxious chemical.

The new research may help explain a familiar human experience, Mr. Dhabhar said. When you are coming down with a nasty bug but have something important to do – be in a wedding, meet a deadline, close a business deal or cope with some other stressful situation – you do not get sick, he said. You stave off the infection until the big event has passed. Only then do you succumb to the bug.

But the stress response is a double-edged sword, the scientists said. As with alcohol, a moderate amount may prove beneficial, but too much is clearly bad. "We do know that chronic stress can suppress immune cells."

In future experiments, Mr. Dhabhar plans to stress animals more and more, to see at what point their immune systems fail to protect them.

In the meantime, the work may help expand on longstanding observation about how some steroids, drugs that are similar to the body's own stress hormones, kill immune cells. Natural stress hormones are bound to tissues in the body, Dr. McEwen said. Plus there are other buffering agents to protect the body from these substances. But the drugs circulate freely in the body and thus do more harm, he said. ■

DuanoXome

DuanoXome is a new drug claimed to be equally effective as previous chemotherapies used to treat Kaposi's sarcoma. We examine the drug and highlight its real effects which are not as widely acclaimed.

In November in London a new drug named DuanoXome was market-launched for prescription to people with advance Kaposi's sarcoma. Its manufacturer NeXstar Pharmaceuticals are creatively promoting it as a preferable, but equally effective alternative to the combination of adriamycin, bleomycin and vincristine (or ABV). But equally effective at what?

Unfortunately not at curing KS: "Median time to treatment failure was 115 days for DuanoXome patients, and 99 days for the ABV patients," and by about 450 days treatment had failed in over 90% of people in both arms of DuanoXome's Phase III trial involving advanced KS in 227 people.

The lure of DuanoXome, which is an anthracycline (referring to its molecular structure) antibiotic, is the new technology used to make it. This enables injection of the active drug, Duanorubicin, into a person's blood in sub-light-microscopic spheres called liposomes, made of lipophilic, or fat-liking, molecules. On its own, Duanorubicin, say the drug's makers, "as is true with most anti-cancer agents...causes significant side-effects, some of which can be life-threatening...".

But the spin is that when Duanorubicin is inside liposomes, they protect the drug from decomposition, minimise its binding to proteins, and somewhat decrease its uptake by normal tissues including the liver, spleen and bone marrow. Incidence of some of Duanorubicin's effects, particularly neuropathy and hair loss, was reportedly reduced in the small Phase II Trial conducted at the Kobler Centre, London, from 1992 to 1994.

Twenty-nine people enrolled, with 14 initially being simply observed and fifteen receiving DuanoXome. The trial protocol available from NeXstar's head office in Boulder, Colorado reveals the identity of the trial centre. Kobler Centre chief Dr Brain Gazzard chaired the panel at the London drug launch but made no mention of his role in the trial, probably alert to the fact that it was in "early" KS for which the drug has now not been indicated.

Dr Lundgren of the Department of Infectious Diseases, Hvidovre, Denmark, in NeXstar's own literature cautions against the general use of the drug: "The degree of immunodeficiency at the time of [KS] diagnosis, as measured by CD4-cell count, has declined substantially over time. [i.e. more people with apparently healthier immune systems have been diagnosed with KS.] The clinical picture may vary from a few cutaneous benign nodes to widespread dissemination, with lymphoedema, respiratory obstruction, and gastrointestinal haemorrhage and pain." He highlights this variation in disease patterns when considering "treatment strategies".

Is it desirable to treat advanced KS with a drug whose dangers in "early" KS outweigh its benefits? The nature of these dangers could hardly be more alarming.

Aside from not curing KS, it matters that the largest section of the Summary of Product Characteristics is entitled Undesirable Effects. Although the liposome delivery method is held to be beneficial: "The primary toxicity of DuanoXome is myelosuppression [suppression of bone marrow where red and white blood cells are made] and as such, close patient observation and frequent monitoring of the blood cell counts is mandated..the use of a cytotoxic [cell-killing] agent decreasing the white blood cell count may cause further immuno-suppression and make the patient more susceptible to...opportunistic infections." In otherwords it may produce the symptoms of AIDS!

The contra-indications continue: "DuanoXome is a bone marrow suppressant. Suppression may occur in patients given therapeutic doses of this drug. Combination of DuanoXome with other cancer chemotherapeutic agents which suppress blood counts is contra-indicated."

In apparent seriousness the manufacturers then claim: "DuanoXome has been safely administered during anti-retroviral therapy with zidovudine (AZT), dideoxycytidene (ddC) and dideoxyinosine (ddI)...", although AZT of course was developed precisely as a cancer chemotherapeutic agent in 1963, and its medium and long term suppression of blood counts is well known.

The Phase III Trial of DuanoXome was specifically of "patients [also] receiving anti-retroviral therapy". A condition of entry to the Phase III Trial was "no prior systemic chemotherapy", though undoubtedly 'antiretrovirals' AZT and its analogues are just that! ddC and ddI are more recent versions of the same cell-killing idea.

In the DuanoXome arm of Phase III, there was a greater incidence of 10 out of 13 opportunistic infections than in the ABV arm, and an equal or less (by just one!) incidence of the other three. The trial report concluded: "Patients were on therapy with DuanoXome longer than with ABV, and this increased exposure time may have caused the observable differences." NeXstar claim that "so far no safety information is available on the combination of DuanoXome with other cancer therapeutic agents", but results of the Phase III Trial certainly look like safety information of one kind or another.

Californian Dr Prakash Gill, principal investigator of the Phase III Trial says: "The favourable toxicity profile of DuanoXome means that therapy can be safely prolonged for years rather than months" – among those relative few who do not progress to "treatment failure" in a matter of months or incur fatal opportunistic infections, that is.

Other listed effects include delayed nausea and vomiting, back pain, flushing and chest tightness, hypotension, headache, fatigue, chills, mucositis (inflammation of mucus membranes), lightheadedness and rarely anaphylactic reactions (hypersensitvity resulting from previous exposure).

Dr Gill's gloss is based on his belief that: "KS is an incurable tumour which eventually kills up to a third of sufferers." But profound questions remain about what KS really is. It does not have metastases (cells being carried to different sites in the body and beginning new growths: all KS lesions originate separately) therefore lacking one of the standard characteristics of a cancer. This suggests one of the most perplexing issues around Duanorubicin.

Although cytotoxic antibiotics are used elsewhere against true cancers, NeXstar state: "The means by which Duanorubicin kills tumour cells is unknown..." and "the specific mechanism by which DuanoXome is able to deliver Duanorubicin to solid tumours is not known." And if they're not really "tumour" cells...?

A variety of effective long-term treatments for KS have been shown, but DuanoXome is not one of them. ■

HUW CHRISTIE

AIDS:

The *Sunday Times* stated on December 10th 1995: "Global drop in AIDS predicted". Steve Connor, their science correspondent, an enthusiastic supporter of the HIV hypothesis since his days with *New Scientist*, states: "Scientists are re-examining their predictions about the AIDS epidemic after discovering that the explosive spread of the virus has declined in Uganda, one of the world's worst affected countries."

Moreover: "The dramatic fall in the numbers of young people being infected in Uganda follows declining rates in Britain and Thailand, leading to hopes that a world-wide epidemic can be reversed." Later, Connor explains that surveillance of pregnant women in Uganda since 1989 showed a 15% drop in the 15–19 age group over a five year period. If they were pregnant, they could hardly attribute the drop in HIV incidence to safer sex, so rather than reversing the epidemic, AIDS in Africa, if it ever existed at all, was a self-limiting epidemic. Any epidemiologist will point out that all epidemics are by their very nature self-limiting. If this were not so, it is doubtful that the human race would still be here today. Curiously, later in the same article, Connor attributes the drop of some 40% in infectivity rates in a rural area of Thailand to condom use amongst prostitutes, and a "relatively small increase in heterosexual HIV infections in Britain" to "government health campaigns".

How could all those epidemiological Mystic Megs have had such dodgy balls, crystal or otherwise?

It may seem ungenerous and unseemly to shoot the messenger who brings good news, but come off it, Steve, and Bang! Luc Montagnier, whose lab first discovered the so-called AIDS virus, admitted to Victoria Macdonald of the *Sunday Telegraph* in June last year that AIDS was no longer a heterosexual threat in Europe, and as I observed a couple of issues ago, when the show gets the bird in Europe and the USA, taking it on a Third World tour won't wash. The fact is inescapable: Peter Duesberg has been right all along when he states that the hallmark of a sound scientific hypothesis is that predictions based on it will be fulfilled. NOT ONE of the predictions based on the HIV=AIDS=DEATH paradigm has ever been fulfilled, despite all the finagling of the epidemiologists and temporising of AIDS 'experts'.

So where did AIDS science go wrong? How could all those epidemiological Mystic Megs have had such dodgy balls, crystal or otherwise? Why do we still believe this totally discredited bunch of silly seers? How did we get to this state where psychological terror is promoted by the abandonment of reason and logic and the pursuit of the profit motive?

Medicine has surrendered to the scientists. Whereas previously the boffins in white coats were useful to confirm a diagnosis by identifying a bug in order to distinguish between one disease and a very similar set of symptoms of another, today the tail seems to be wagging the dog. Doctors have abrogated their rights to the techno nerds, and in so doing, betrayed themselves and us. How can a doctor, who has presumably taken the Hippocratic oath in which he promised not to harm the patient, prescribe drugs like AZT, ddI and ddC? The answer is depressingly obvious – Technology rules O.K.!

Since a device was invented to count T-cells in the late '70s, whereby cells could be stained, counted and differentiated by a laser beam, the T4/T8 ratio became the hallmark of health status. When AIDS was first identified in the early '80s, it was assumed that our knowledge of the immune system was pretty well complete. Robert Gallo promoted a virus – a retrovirus no less – which had a specific preference for T4 cells, part of the cellular arm of the immune system. Subsequent research seemed to show that the virus infected T4 cells because they have on their surface a receptor on to which the virus can lock.

A common misconception amongst virologists was that where evidence of the activity of an enzyme, subsequently called reverse transcriptase, was found, it indicated definitive proof of infection with a retrovirus. This was first observed by Howard Temin and his colleagues in 1970. However, by the late '80s it had been amply demonstrated that reverse transcription is common to most mammalian cells, as well as those of plants.

The other main arm of the human immune system, the humoral arm, makes antibodies in the B-cells to fight invasive organisms. When Luc Montagnier and his team tried to propagate HIV (LAV as they more cautiously called it – Lymphadenopathy Associated Virus) they had difficulty finding a permissive cell

Designer Science, Virtual Virology, & Dodgy Crystal Balls

line, i.e. a cell culture in which it would grow. Before acquiring the CEM cell line (derived from a girl with leukaemia in Boston Children's Hospital in the '60s) Montagnier's team were using pre-cancerous B-cells immortalised by Epstein-Barr virus to propagate LAV/HIV. So it would seem that HIV can infect B-cells as well as T-cells. As Peter Duesberg has observed, HIV is today regularly propagated in laboratories in just those T4 cells which it is supposed to destroy, without apparent damage to those cells. A bit strange for a killer virus! Or could it be that they can only make HIV in co-cultures of T4 cells and known cancerous and pre-cancerous cell lines?

If I'm right in my hunch, then HIV, and the earlier human retrovirus HTLV-I, are merely artefacts of cell-culture technology; a chimera conjured up by state-of-the-art tinkering with aberrant cells. Even the diseases they are thought to cause (AIDS and Human Adult T-cell Leukaemia) are only as new as the technology, unknown to medicine until after the technology could count cells rapidly and viruses could be assumed to exist because a constellation (or even partial constellation) of proteins and antibodies could be detected by molecular biological hocus pocus.

Jay Levy, a leading AIDS researcher in San Francisco, recently and unwittingly gave a clue to where the whole system of virology may have taken a wrong turning. In the September 23rd 1995 issue of *The Lancet*, in discussing the current theory that a newly detected human herpes virus may be the cause of KS, he has this to say: "Herpes virology has enjoyed the spotlight for the past decade, during which three new herpes virus types have been discovered. Evidence for the most recent putative human herpes virus (although not yet isolated in culture or definitively demonstrated by electronmicroscopy) was found using molecular techniques in KS lesions and in B-cell lymphomas of the abdominal cavity. Not since isolation of hepatitis C has a new human virus been *detected solely by molecular procedures*." (My emphasis.)

Levy, the third man to isolate HIV (ARV, or AIDS Related Virus as he cautiously called it) and without any help from the French, admits in the above quote that the new human herpes virus VIII (HHV8) has not been isolated, or photographed under an electron microscope. Thus, all we have is a constellation of proteins suggestive of a herpes virus, not a true isolate. As Eleni Papadopulos-Eleopulos and colleagues, and Stefan Lanka, have shown, HIV has never been truly isolated either, despite the widespread assumption that it has. I suspect that what we are calling HIV is no more than a group of proteins generated by cells that have undergone change, due either to other infections or chemical toxicity from recreational and medical drugs.

It does seem odd that rather than one constant strain of HIV infecting people world-wide, there are now so many 'different' strains, according to risk-group and even country and class. For instance, the Thai strains fall roughly into two groups – those in female sexworkers, and those in drug addicts. Some strains of HIV are considered lethal, others not – e.g. the Sydney transfusion cohort, who have been supposedly HIV+ for over a decade without AIDS.

In the case of HHV8, a clinching factor is considered the presence of this rather common virus in KS lesions in both gay men in the West and Africans, although the pattern of spread seems totally different in both groups. The virus is also quite widespread and the majority of infectees do not get KS. It is supposed that some viruses cause disease, but could some diseases cause 'viruses'? After all, viruses have to start somewhere.

I suspect that HIV is no more than a group of proteins generated by cells that have undergone change

Ever since it was noticed that hæmophiliacs become immunosuppressed after taking their medication – a previously 99% impure blood product called Factor VIII prepared from donated blood and plasma – it was assumed that HIV had contaminated this vital medicine which they need to help their blood clot and prevent internal and external bleeding. It was assumed that gay men, drug addicts and poor people exploited in developing countries had sold their plasma to commercial blood dealers and consequently infected the unfortunate hæmophiliacs.

As early as 1987, whilst researching the Channel 4 programme *AIDS – The Unheard Voices*, I enquired amongst gay men in New York, Boston, Washington and San Francisco whether it was common for gay men to sell their plasma to commercial bucketshop blood collecting agencies. No-one had heard of this being common if it happened at all, and several times I

got the same sort of answer: "Honey, if you're gay in the USA and need bread, you've got other things you can sell!" Whilst gay men were just as public spirited in freely donating blood, it must be remembered that the so-called HIV contaminated clotting factors VIII and IX that were supposed to have infected some 15,000 of the USA's 20,000 hæmophiliacs, as well as countless others from Europe to China in a very short space of time, were made by pharmaceutical companies from commercially derived blood and plasma.

Subsequently, donors were screened for HIV infection, and a double safeguard was introduced in the form of heat-treating the clotting factors. This did not prevent some hæmophiliacs from testing 'positive' for HIV after using so-called safe products. Still I heard people denouncing gay men for infecting what Princess Anne so crassly referred to as 'the innocent victims' of AIDS. Peter Duesberg showed that the age and Factor VIII dosage factors seemed more important in people with hæmophiliac than a single infectious dose. In other words, their deterioration seems to depend on how much of the highly contaminated clotting factor they took, and for how long. This does not suggest the work of a single microbe. It must also be remembered that hæmophiliacs were amongst the first to be given AZT on compassionate grounds as early as 1987 in the USA, and their condition seemed to worsen rapidly thereafter.

The principal supposition about the mechanism of HIV infection was that the virus buds out of an infected cell, and then floats off to infect another T-cell by hooking on to its surface via the cell's CD4 receptor. The coat of the virus is supposed to be studded with little spikes called glyco protein 120 (gp120) which dock onto the receptors. The virus fastens itself to the cell, its membrane fuses with that of the cell and it eventually empties its contents into it. However, as Varmus proved in the late '80s, mature cell-free virus particles shed their gp120 'spikes' and thus in the unlikely event of there being any cell-free, viable HIV particles contaminating the Factor VIII, it would be non-infectious.

It is possible that my hypothetical constellation of aberrant proteins might well have survived in Factor VIII. After all, the clotting factor itself is a protein, and remains viable even after freeze drying and heat treatment. Recent specialist research in Germany, Perth Western Australia and London University has started to question openly whether HIV actually exists, or is merely an artefact of clever technology and pushy microbiologists.

Mystic Mike predicts that AIDS will never be defeated or cured by elimination of 'HIV'. If it exists at all, it is merely a poorly understood, overinterpreted epiphenomenon at most, and it is far better to see 'it' as merely a marker or indicator of cellular disturbance. One current school of thought suggests that 'HIV' can only infect or take root in someone whose cellular immune system is already compromised; that people only make antibodies against 'HIV' after their cellular defences go on the blink. Thus, illogically enough, you can only get the 'virus that causes AIDS' if you already have the illness.

I suggest that the immune system is far more complex than hitherto supposed. It is not there merely to repel invasive organisms – a sort of cellular Immigration Control – but is also an internal police force programmed to regulate cellular behaviour.

One of the first oddities noticed by Montagnier's team in about 1983 was that people with AIDS were generating antibodies against a protein, striated calf muscle actin. These were assumed to be either a contaminant of the cell culture, or antibodies against a constituent protein of the 'AIDS virus'. Subsequently, they were assumed to be part of an auto-immune reaction, whereby the body starts to make antibodies against itself. This gives us a clue.

Lymphocytes contain in their nucleus the complete genome (knitting pattern) of the human body. All the information for the generation of all cells relevant to the organs of the body are contained in that long stretch of DNA. Early in the embryonic development, the mass of dividing cells are differentiated, and assigned their bodily task – heart cells, liver, kidney, muscle, bone, etc.etc. Obviously, the cells must do the jobs assigned to them, and strict demarcation must be maintained, otherwise chaos would ensue. Lymphocytes must only generate proteins relevant to their function; liver cells must produce proteins appropriate to their function; heart cells must....etc. Should any of these cells, which contain the blueprint for the entire body, start to produce atypical proteins, utilising sections of their genomic structure in an aberrant fashion, then I suppose that the immune system is programmed to eradicate them. For example, if a lymphocyte starts to emit the protein known as striated calf muscle actin, which is none of its business, then other immune cells will be programmed to destroy it. Should this get out of hand, then muscle wastage will result from an overzealous and confused immune system.

The scientific explanation for this cellular regulation is apoptosis – programmed cellular suicide. I think it's a little simpler than that. The human genome contains tens of thousands of genes, only a tiny fraction of which are relevant to the functioning of a specific cell. If extra, irrelevant genes are 'switched on' by an invasive organism or a toxic substance, then the cell may start to produce irrelevant proteins, which are recognised as aberrant by the immune system. This is usually described as the immune system distinguishing 'self' from 'non-self'. Whilst undoubtedly the immune cells protect us against invaders, they also protect us against our own delinquent cells. It is just as important that cells be regulated to conform to their allotted role as to protect against invaders.

AIDS will be defeated by a better understanding of the working of the immune system, rather than tinkering with an irrelevant laboratory artefact known as 'HIV'. ■

MICHAEL VERNEY-ELLIOTT

Allicin
the goodness of garlic

It's not often I get excited about a treatment, says JOHN STEVENS, particularly one derived from garlic, one of the smelliest and oldest of medicinal herbs, but when it snugly fits Hippocrates' philosophy of food as medicine and medicine as food, and shows great promise as a major potential player for some of the infections that occur among those diagnosed with HIV/AIDS, then I can't help myself. However, I don't get too excited, particularly as the history of the last twelve years is littered with promising therapies fallen by the way but with garlic, well, you can't argue with history.

One of the great consistencies of folk medicine is garlic. As a mainstay in the medicinal arsenal of many differing cultures this 'stinking rose' has played a role in the therapy of various diseases for as long as records have been kept. An unassuming little plant, historically employed for the prevention and treatment of colds, flu, anaemia, cancers, intestinal infections and parasites, typhoid and cholera, and to facilitate digestion, garlic remains one of Europe's most popular supplements.

Certainly since the early eighties garlic has been utilised by diagnosed individuals as part of their supplement regimes, taken either in raw form (as cooked garlic is said to lose most of its efficacy, though this has been disputed), or as capsules containing cold-aged extract, said to offer the greatest medicinal value. As with other therapies, many unsubstantiated claims have been made as to its use and efficacy.

Despite the overwhelming anecdotal evidence and interest, most of the research into the pharmacological effects of garlic has taken place in China where, perhaps because of medical traditions, modern scientific techniques have been applied to the study of many plant substances. Pharmacological test-tube studies have shown garlic to possess antiviral, anti-inflammatory, antimicrobial, anticoagulant, antioxidant and anticancer properties. As a therapy, garlic has been used in China where orthodox treatment has either been ineffective or too toxic and has shown specific effectiveness when applied intravenously in treating cases of cryptococcal meningitis, cytomegalovirus and candida. Comforting news for holistic practitioners who have been prescribing garlic in their nutritional and herbal programmes.

Of the known 200 constituents of garlic, 33 are sulfur compounds, 17 amino acids (of which arginine has a relative value of 30%) and the rest a host of vitamins and minerals. The main active ingredient however, and the one attracting current attention is Allicin, also known as diallyl trisulphide (Allitride). Allicin is believed to be responsible for most of the suggested benefits of garlic, along with its unique odour.

While Allicin may be new to the West, in China it is the active ingredient used in many of the studies on garlic and has been administered clinically there for a range of conditions from bacillary and amoebic dysentery, cryptosporidiosis, to deep fungal infections. As a therapy its toxicity is low and it is administered either intravenously, orally or as an anal retention enema, according to the medical condition being treated.

Professor Qing Cai Zhang, a Chinese practitioner, runs a clinic on New York's lower East Side that combines both Chinese and Western medicine. With a large HIV/AIDS clientele Zhang's goal is to help those diagnosed survive with the use of herbs and therapies of low toxicity that protect the body's immune functions and reduce viral potency. Allicin, he claims, is his greatest medical asset -- low in toxicity with an established history of use, a wide anti-infectious spectrum, cheap, and employable as a multi-opportunistic-pathogen prophylaxis (MOPPS) to prevent opportunistic infections.

Zhang's belief is that by protecting the respiratory and digestive tracts, most infections can be prevented

For every diagnosed patient who visits his clinic with a T-cell count below 200, Zhang offers Allicin as prophylaxis or treatment for microsporidiosis, cryptosporidiosis and mycobacterium avium complex, three infections for which there is no long-term effective cure, and for oesophagal and vaginal candida. In addition several of his patients nebulise Allicin as a PCP primary prophylaxis or utilise it when suffering from long-term low grade fevers, sinusitis, laryngitis and bron-

continued on page 30

reView

Where else do you ge your informatio about healthy eating

Continuum was invited to attend the recent launch of a new video **EAT - an introduction to nutrition for people living with HIV.** It was to be found seriously lacking in nutritional advice.

Eat is a video made by Dietitians Working in HIV/AIDS (DHIVA). It is presented by Claire Rayner and Kevin Greening and runs for 40 minutes. It is aimed at people who are diagnosed HIV+, their carers and health professionals, although you could be forgiven for thinking that it was aimed at primary school children who want to justify their sweet tooth.

With so much talk of calories I was half convinced that there is a famine going on. All the food that we are usually advised not to eat suddenly becomes the food of choice; put cream or butter in your soup, add cheese to your potatoes, sugar to your tea and ice-cream to your desserts. And keep on snacking.

Is it any wonder that one of the men in the video has put on two stone since being diagnosed positive and talking to his dietitian? There are other ways of valuing food, besides counting calories - check out Peter Cox's *Life Points* for example.

So the theory goes that if you put on weight you'll be OK when you start wasting away. No question of what causes the wasting or what this junk food is doing for you - spot the close ups on McDonald's and friends. The bodies that we walk around in are made from the choices that we make. Should I eat this? Should I not eat this? Should I smoke this? Should I not smoke this? Should I take this toxic drug for a disease I don't have, even though it will give me horrific side-effects?

There was no mention of antioxidants. I admit that they are trying to avoid nutri-babble, but how can they neglect to mention such important immune enhancing nutrients? When they did manage to talk about vegetables (the best source of antioxidants) they recommended the tinned and frozen varieties. Precisely the kind that are lacking in life force, enzymes, vitamins and other antioxidants. I despair.

The mineral bit mentioned abnormal zinc and copper levels. The studies that I have seen show that both these minerals are abnormally low in people with AIDS, whereas most people have low zinc levels with elevated copper. Zinc and copper are antagonistic - too much of one will decrease your ability to fully absorb and utilize the other. So why are both mineral levels significantly low? Well, there is another mineral that is antagonistic to both zinc and copper - iron. So high levels of iron would manifest symptoms of low zinc and copper. In the last issue of *Continuum* (Vol 3, No 4), Dr Hässig said that iron overload (among other stresses) causes the decline of T-cells circulating in the blood as they get sequestered into the bone marrow.

After his lecture at The London Lighthouse I asked Dr Hässig what causes iron overload. He answered that it was the intake of red meat (iron in the red blood pigments). So how can a video, paid for by the Health Education Authority, promote the consumption of red meat when nearly all its other literature says we should decrease our consumption is beyond me. Supposing there was a cure (in their terms), would they want people to die of heart disease and cancer instead?

As for the five food groups that were promoted – vegetables, fruit, dairy produce, meat and grains – aren't they the five advertised by the dairy industry? The ones that put dairy produce in a category of its own. Dairy produce was praised for its calorie content and calcium. Well the calcium is less easily absorbed than when you eat it in green leaves and whole grains, and they forget to mention the possible effects of the other constituents of milk, the cow proteins and hormones, the antibiotics, cow pus, saturated fat and so on.

I think that if someone knows about nutrition then they will ignore the information in the video and not be affected, apart from feeling patronised and a little more cynical than before. If the importance of eating a good quality diet is beyond your awareness then you probably won't change your immune-depleting dietary habits, except maybe to turn down your fridge and stop eating those soft blue cheeses.

The graphics were nice though!

BOO ARMSTRONG

Health warning: This video may seriously damage your health

Healing With Whole Foods - Oriental Tradition and Modern Nutrition

by Paul Pitchford

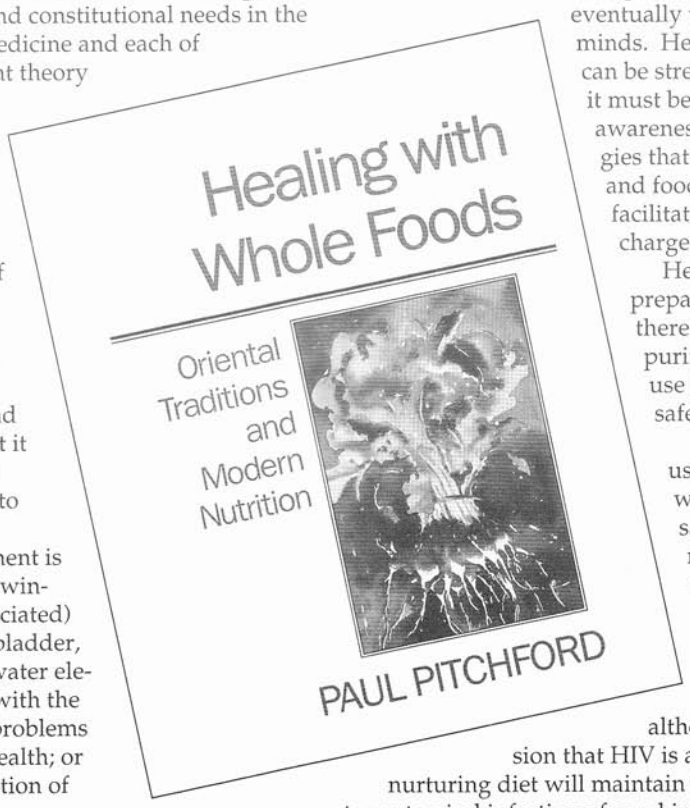
published by North Atlantic Books, 1993.
UK distribution: Airlift Books 0181 804 0400.
UK £19.95 USA $24.95

People often ask 'what is a good diet?', but there really is no universal answer. What would be ideal for an office worker in London may be very different from that for a labourer in the country. We all have unique constitutions and circumstances. This book explains how to assess and meet our different dietary needs.

Paul Pitchford is a healer, teacher and nutrition researcher who has been working for over twenty years on applying ancient oriental wisdom to modern dietary therapies in order to create a unified approach to food.

The book begins by explaining the roots of oriental diagnosis and treatment: how to understand constitutional needs in the light of basic traditional Chinese medicine and each of the elements of Chinese five element theory – fire, earth, metal, water and wood.

Elements are associated with seasons, colours, emotional and physical characteristics, organs of the body and certain foods that influence them. If the expression of an element goes out of balance, everything else will too, and the result may be manifest as dis-ease. In this context the object of understanding the five element theory and oriental diagnostic principles is that it can inform our choice of foods and preparation as a fundamental way to address any imbalances.



If, for example, your water element is out of balance (as it often can be in winter, the season with which it is associated) one may suffer problems with the bladder, kidneys and tissues related to the water element. This might mean problems with the knees, lower back, teeth and hair; problems with hearing, urination or sexual health; or feeling an excess or lack of the emotion of fear.

The solution will be foods that are favourable to the water element, such as warming soups and stews, dark legumes, seaweeds, dark greens like kale and cabbage, and salty foods that draw energy into the centre of the body. The emphasis always remains on balance – having excess salt, for example, rather than strengthening the water element will tip the balance the other way and so weaken it further.

To be able to use this book and benefit from its valuable information it isn't necessary to have prior knowledge of Chinese philosophy. Many of the insights of Oriental thinking are paralleled by explanations from western nutritional research. The two strands are interwoven throughout most of the text, though the Chinese view, at first glance perhaps unfamiliar and complex, is particularly beautiful in its completeness and simplicity.

The book encourages a vegan diet, detailing the healing properties of foods, and products derived from them, with suggestions on when and how to use them. Animal products, dairy, fish and meat, are also acknowledged as valuable for certain conditions, and again the information is backed up with practical advice.

The essentials of nutrition are gone into in detail beginning with a request to 'wear only a hat'. This is a practice from Chinese philosophy, in which a 'hat' refers to an action in a chain of causation. In the context of improving our diet, the first action or 'hat' we wear is the decision not to eat poor quality, unhealthy food, and when we follow this action we wear only one hat.

If we were to choose to eat the unhealthy food, this action would be our first 'hat', and we would need to wear three or four hats in order to combat the effects of that food. The consequent actions might be suffering, using medicine, overcoming the effects of the medicine, etc. If we choose the appropriate action first, then we are freer of worry and struggle. It is lighter and clearer to wear only one hat.

A poor diet, the author states, will eventually undermine the strongest of minds. He's aware that to make changes can be stressful to the body and mind, so it must be done gradually and with awareness. He offers foods and strategies that will assist transitions of diet, and foods that counteract toxins and facilitate mental and emotional discharges.

He also explores the art of food preparation and combining and there is a section on fasting and purification which explains how to use these practices and do them safely.

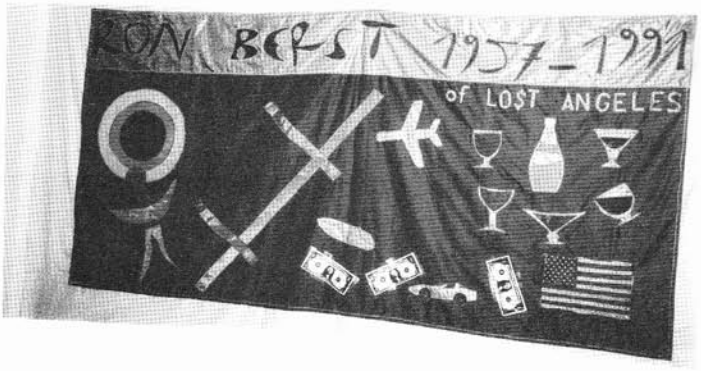
On AIDS he offers extremely useful insights into rebuilding a weak body through diet, and says "people with AIDS can recover in response to good nutrition and a balanced lifestyle". He advocates a renewing diet, the success of which will be greater the sooner it is started, and although he is under the impression that HIV is a threat, he makes it clear that a nurturing diet will maintain the body and strengthen resistance to viral infection of any kind. Solid advice is offered for the treatment of all common problems, including diarrhoea, candida, herpes and skin problems.

He lists herbal formulas that can be used to supplement the effects of a healing diet, but the key concept in this book is that an appropriate diet and lifestyle will create the underlying constitutional strength for a full life.

This book is like a well-cooked, balanced, attractive and delicious meal: it satisfies hunger and stimulates the senses. I heartily recommend it to anyone interested in enjoying life more.

MOLLY RATCLIFFE
with MALCOLM MANNING

Which is the killer – HIV or Alcoholism?



I have seen far too many people die from alcoholism and drug addiction while they thought HIV was killing them. Thankfully I'm not going to be one of them because, one day at a time, I am a recovering alcoholic in a program called Alcoholics Anonymous (AA). Because it is a program tradition, I wish to remain anonymous.

You rarely find alcoholics in bars and clubs, only people who drink too much: alcoholics you find in AA meetings. Alcoholism and drug addiction are twin diseases: they are both progressive fatal illnesses, the final stages of which include: cirrhosis of the liver; œsophagal hæmorrhage; jail, mental and other institutions; and finally death.

After being brutally raped in Hollywood, and at the insistence of my therapy counsellor, I went to my first AA meeting. Until then I had always maintained that I could control my drinking. It was an AA meeting for HIV-positive gay men in West Hollywood, California.

That meeting was the first time in quite a while that I was among people who were interested in helping me without wanting to get into my pants first. I knew I was an alcoholic immediately - at least at a superficial level. It took over a year of being sober and regularly attending meetings to really feel in the deepest part of my heart that I was an alcoholic. It is a process similar to coming out gay, it takes time.

God has given me many gifts and the gift of sobriety is the biggest one. If at this moment the word God turns you off, keep in mind that in AA that means God as you understand him, and actual belief in God is not necessary to stay sober. I also have to do my part to keep this gift and believe me this alcoholic works very hard to stay sober and I AM WORTH IT!

AA is a very simple program. It is comprised of meetings, sponsorship, the 12-step program, and reading the big book of AA. For over 60 years millions of people have found freedom from their addiction to alcohol through using AA. Today I can be in thousands of different cities in 152 different countries and walk into a meeting of AA and have a wonderful support system available to me. Yes I am 'addicted' to AA meetings, but, unlike alcohol and drugs, it is an addiction that works for me.

Today my life has improved dramatically from where I was at when I stopped using. I've started a new sport that I love, started playing electronic keyboard, I am in school studying to be an actor, which is what I always wanted to do, and,one day at a time, I am managing my fear of HIV, sober, totally aware and awake in a way that I have never experienced before.

More importantly I can now see how all of my dreams can come true. Those dreams that didn't have a chance back in my drinking days, because my disease of alcoholism destroyed every single one of them. Now that I know what the problem is, I finally stand a chance.

Sober life is not always wonderful, there are still moments of despair but I can turn it around much quicker than before and decide to be happy. That is how the program helps me. I wouldn't go back to the old drinking days for a billion pounds. This gift is more precious than gold.

Here are the 12 steps of AA. If you don't have a problem with alcohol, just substitute 'drugs' or 'negative thinking' (or whatever you feel your addiction to be) for 'alcohol':

1 We admitted we were powerless over alcohol – that our lives had become unmanageable.
2 Came to believe that a Power greater than ourselves could restore us to sanity.
3 Made a decision to turn our will and our lives over to the care of God as we understood Him.
4 Made a searching and fearless moral inventory of ourselves.
5 Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6 Were entirely ready to have God remove all these defects of character.
7 Humbly asked him to remove our shortcomings.
8 Made a list of all persons we had harmed, and became willing to make amends to them all.
9 Made direct amends to such people whenever possible, except when to do so would injure them or others.
10 Continued to take personal inventory and when we were wrong promptly admitted it.
11 Sought through prayer and meditation to improve our conscious contact with God as we understood Him , praying only for knowledge of His will for us and the power to carry that out.
12 Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practise these principles in all our affairs.

The 12 Steps of AA © by Alcoholics Anonymous

You can contact a helpline for AA in London on 0171 352 3001 daily from 10am to 10pm. The office is staffed by volunteers that can also give you other local numbers for the rest of Britain.

The number for Narcotics Anonymous Helpline in London is 0171 498 9005.

continuum CLASSIFIEDS

Advertising rates:

BOX: £10 per column centimetre (min £20)
LINEAGE: 75p per word (min £10)
PERSONAL ADS: Up to 25 words - £10
(additional words 40p each)

DISCOUNTS: **3 consecutive insertions – 5%**
6 consecutive insertions – 10%

All adverts must be prepaid with order. Cheques & Postal orders accepted payable to Continuum.

All enquiries to Tony or Matthew on **0171 713 7071**

NEXUS MAGAZINE

In the Feb/Mar issue:

- **Urine Therapy:** making a comeback
- **Super-antioxidants** & the benefits of red wine

Plus:

- suppressed technology
- health cover-ups
- big brother conspiracies
- the new world order

Tune into the news you are not supposed to know

Subscription: £18.00 for 6 issues per year
£3.00 for sample issue
NEXUS Magazine, 55 Queen's Road
East Grinstead, West Sussex. RH19 1BG
Tel: 01342 322 854 Fax: 01342 324 574

GENUINE GAY VIDEOS

SAMPLE TAPE & CATALOGUE £5.00 OR
2 FIRST CLASS STAMPS FOR OUR CATALOGUE

To: FIRST PRIORITY (C.O.)
2 RIXSEN ROAD, MANOR PARK
LONDON E12 6RN

New! - Continuum *presents*

a page for **you** to sell your services, let people know what you do or simply meet others

Personal Contacts

WHERE HAVE ALL the sensible people gone? I need to socialise with intelligent, sincere friends, not those whose minds are blinkered. We can talk, read, challenge authority, but let's do it now! A piece of your dissident writing ensures reply. Box 1000.

GAY MAN, 31, diagnosed HIV+, wants to meet other interesting people bored with the standard view of HIV & AIDS. Let's have fun together! Box 1000.

WOMAN, 28, HIV+. Desperately wants to have a baby, seeks like-minded HIV+ man who doesn't care what people say. Photo essential. Box 1000.

Trades/Services

HOLISTIC THERAPIES
If this is what you do,
why not let our readers know?
Reach more clients with this space for only **£20**

SAMPLE ADVERTISEMENT
Spaces like this cost from £10.
Call 0171 713 7071 to find out more.

EXCELLENT MASSEUR
(MTI, IPTI registered)
gives deep tissue massage
Comfortable, safe environment
Refreshments & shower available
Ring Tom on 0171 262 0237
Continuum Reader Discount 25%

do Continuum covers catch your eye?
for graphics and artwork call

Jean Musimbi Sangale
0181 674 3381

Why not advertise your therapy, training course or other business here?
See above for competitive rates

Complementary Therapy Information Group

This is a **self-help group** for people diagnosed HIV+ who are interested in **complementary** and **non-toxic therapies**

Forthcoming talks:

Jan. 30th – Homœopathy
Feb. 29th – Beata Bishop talks about recovery from a terminal cancer diagnosis
Mar. 25th – Introduction to the Immune System

For further information contact Kevin on 0171 731 4482 or Frank on 0171 222 8123.
Talks will be held at The Information Exchange, 369 Fulham Rd. SW10, starting at 5.30pm.

A Breath of Fresh Air *continued from page 15*

the cost of having it removed surgically), his belief in TM and visualisation grew, as did his belief in himself. He had us laughing and crying as he spoke, and the hall was captured by the authenticity of his words.

Afterwards he held a short workshop on visualisation, and encouraged participants to find a picture for themselves of whatever it was that ailed them physically or emotionally. A young woman, looking very sick with purple/black lesions visible on her face, asked for assistance. She said it was fear that ailed her. With encouragement she saw it was black, and changing size and shape, and it was the blackness that was most scary. Several people volunteered a possible solution for her – to visualise a light coming, to banish the darkness.

It was moving to see Marshall draw her into her own process of healing. Though ill and afraid, her courage was clearly visible, as was the real possibility that she could and would heal. Marshall didn't profess to have answers, but he showed that he had constructive ways of dealing with questions, a quality probably familiar to anyone who is a survivor, be it of an AIDS diagnosis, a broken relationship or a lost career.

The staying power of the audience was amazing; without that the day could not have succeeded, hampered as we were with the necessity of waiting after each half-sentence for it to be translated into Spanish.

Afterwards the conference was alive with conversations, many stunned by the new information and inherently hopeful message that it gave. For some the information was not new, as Alfredo Embid has had articles translated and published in Spanish, including pieces from *Continuum*. However the impact of being able to debate and ask questions was enriching.

It was an inspiration for me to meet with so many people committed to disseminating information and working holistically, and to meet the recipients of their work, who are managing to make positive changes in their lives and get on with living, rather then being under a misplaced death-sentence.

I came away enlivened as much by the clean air and food as by the openness and good spirit of the participants, and feeling hopeful about the ability of therapists and AIDS dissidents, from a multiplicity of perspectives, to work together.

The future is ours. ■

References

1. *Medicina Holistica* is available from AMC, Prado de Torrejón 27, Pozuelo de Alarcón, 28224 Madrid.
2. Lanka, S, HIV – Reality or Artefact? *Continuum*, 1995, vol. 3, no. 1.
   Lanka, S, HIV Debate replies to Dr S B Harris, *Continuum*, 1995, vol. 3, no. 2.
3. Walker, M.: *Dirty Medicine; Science, big business and the assault on natural health care*. Slingshot Publications, 1993. BM Box 8314, London, WC1N 3XX.
4. Ratcliffe, M., Suffer the little children, *Continuum*, 1994, vol. 2, no. 5/6, and PID and Cervical Cancer, *Continuum*, 1995, vol. 3, no. 1.
5. James, G., New Perspectives on Homœopathy, *Continuum*, 1995, vol. 3, no 4. (HEAL UK can be contacted on 0181 265 3989)
6. In a forthcoming issue of *Continuum* we will be discussing Marshall Smith and his approach to KS in more detail.

Allicin *continued from page 25*

chitis. Particularly useful for diarrhoea of unspecified cause, claims Zhang, Allicin is used with herbal formulas to treat and re-establish digestive function.

Zhang's belief is that by protecting the respiratory and digestive tracts, most infections can be prevented. Despite his own observations however, he has no data to back up his claims and an earlier trial proposal to the US Office of Alternative Medicine at the National Institutes of Health was turned down. By that time though Allicin had become part of the American 'alternative medical folklore' occupying its place in the underground arsenal of low-toxicity/low-cost therapies and word of its supposed effectiveness reached the eyes and ears of AIDS Research Alliance (ARA), a respected community-based research organisation in Los Angeles. Phase 1 studies using Allicin for cryptosporidium have just been completed and ARA will be providing details officially in January 1996. However, they were able to confirm that a Phase 2 study will commence enrolment early this year, encouraging news for Allicin users.

With little chance of any clinical investigation in the UK into Allicin and no means of influencing the investigative process here, users of Allicin will have to rely on the ongoing work of AIDS Research Alliance to confirm its value. In the meantime, should you wish to use the therapy, it is available from Dr Zhang's clinic and the HEAL Trust of London. Unpleasant to drink and difficult of retain anally, Allicin is not the easiest of therapies to self-administer nor should it be used on the basis of self-diagnosis. If you have a problem get it checked out. That said, according to its supporters Allicin is a wonderful herbal remedy effective in treating some opportunistic infections and an example of herbal medicine's great potential. ■

Allicin is available from:
- Dr Zhang, 141 East 44th Street, Suite 712, New York, NY 10017. Tel: 212 573 9584, Fax: 914 682 4396
- The HEAL Trust, 41c Ramsden Road, London, SW12 8QX. Tel: 0181 265 3989, Fax: 0181 265 3973.

John Stevens is editor of Equilibrium and is a freelance HIV/AIDS writer.

POSIBASE
PO Box 130
London
W5 1DQ
+

POSIBASE
is a database set up to record details of people who have been diagnosed HIV+ and are not taking any special medication such as AZT.

The idea is to record basic information, such as when a person was diagnosed, their current health status and whether they have changed their habits, eg. started taking vitamins.

Brian Parry, who started POSIBASE, feels that people not taking medication are being ignored when drug trials are conducted, and that there is a valuable source of information from this group that may help others in future choices regarding their health.

The plan is to record this information, update it every three months, and publish the results. To join all you need do is write to Brian at the above address, giving the following information.

- name, address, tel. no., date of birth;
- month & year when first diagnosed HIV+;
- general state of health (good, average, poor);
- medication used as prophylaxis;
- any other relevant information. eg, stopped smoking, changed diet, etc.

Do not send any money – stamps make a useful gift. Names and addresses will be kept strictly confidential.

Help others to keep well!

Dear Continuum.....

Dear Continuum,

Just a note to say 'thankyou' for all your hard work with *Continuum*. I look forward to each issue and find it very enlightening, good luck for 1996.

I was diagnosed HIV+ 5 years ago whilst living in Australia. I applied for a residency visa and needed a full medical which included an AIDS test! I had no counselling but worked through it myself. Even though it has been offered on numerous occasions, I have never taken any medication. I use alternative medicine and good nutrition. I reckon I have been positive about 9 years now and healthier than ever!

I had a baby 7 months ago, a 10lb baby girl. I absolutely blossomed through my pregnancy, much to my doctor's disbelief! I was informed of the (so-called) benefits of taking AZT during pregnancy from recent trials. Needless to say I was adamant in my reply, "NO WAY". I actually stopped going to the hospital for my blood count about 2 years ago as I had told my doctor I wasn't interested in the results so it didn't seem necessary to go in the end.

"HIV" has actually changed my life so much for the better. I have grown so much spiritually, met so many wonderful people and accept that it's all part of this strange and wonderful life. I do my best to dispel the fear that surrounds HIV, as I believe this is the way forward. I've run out of paper, so take care.

Love,
Nicola, Merseyside

Dear Continuum,

I have already received and read the four 1995 issues. It is a wonderful magazine, and I support the way the authors think and write about health.

I come to regard AIDS as a degenerative process of the whole body, especially of the immune and the nervous system (neuroimmunodegeneration), as the consequence of a massive chemical and psychological intoxication of a human being. If people really are open, there is so much that they can do to become healthy again. I am a medical student and soon will do my final exam, but in the last six months, when I did my private studies about the many myths and realities of AIDS, I learnt more about health than during my six years of medical studies at the university. Suppression of processes and chemical and psychological intoxication of huge numbers of people are the basic themes in orthodox medicine, and for me there is no doubt, that we have to begin with alternatives as soon as possible. From my personal experience in my work in a psychiatric clinic I sometimes think, that one could also publish a magazine like yours about the suppression and intoxication-medicine in modern psychiatry...

I thank you for your magazine and the opportunity of learning a lot, and I wish you a happy and fulfilled 1996.

Yours sincerely,
Marc, Berlin

Dear Continuum,

Thankyou for sending me the three copies of *Continuum* recently.

It was very interesting to read some of the articles, one article about colonic cleansing I passed on to one of my clients.

Although I have been well aware of AIDS since 1984 when our master Rajneesh first talked about it, I have not come into contact with many HIV positive people. I also had similar insights during my years of relative promiscuity that AIDS is actually more related to causal factors such as: immunisation of babies, degenerate dietary lifestyle, spleen deficiency, e.g. craving as such, seeking distraction (instead of contacting inner emotional self) and, certainly, abuse of recreational drugs.

A few years ago I met a woman whose husband was diagnosed HIV+ and died of AIDS a few years later. She had a child by him and despite regular sexual intercourse she did not get infected, nor did the baby boy. She is still HIV negative now, after 10 years.

Sometimes I think that times have not changed much since the Middle Ages when Pestilence ravaged Europe. Is it the fear of contracting disease, or other oppressive environmental factors that makes us catch the 'bug'?

So many theories are floating around – T-cells, antioxidants – the beauty about life is, it cannot be analysed.

I believe in supporting and strengthening Ki (energy) by, e.g. aerobic exercise such as running. Also to develop the notion of love and sensuality without necessarily 'sex' (or indulgence of it) is important to me. Shiatsu is one way in that direction.

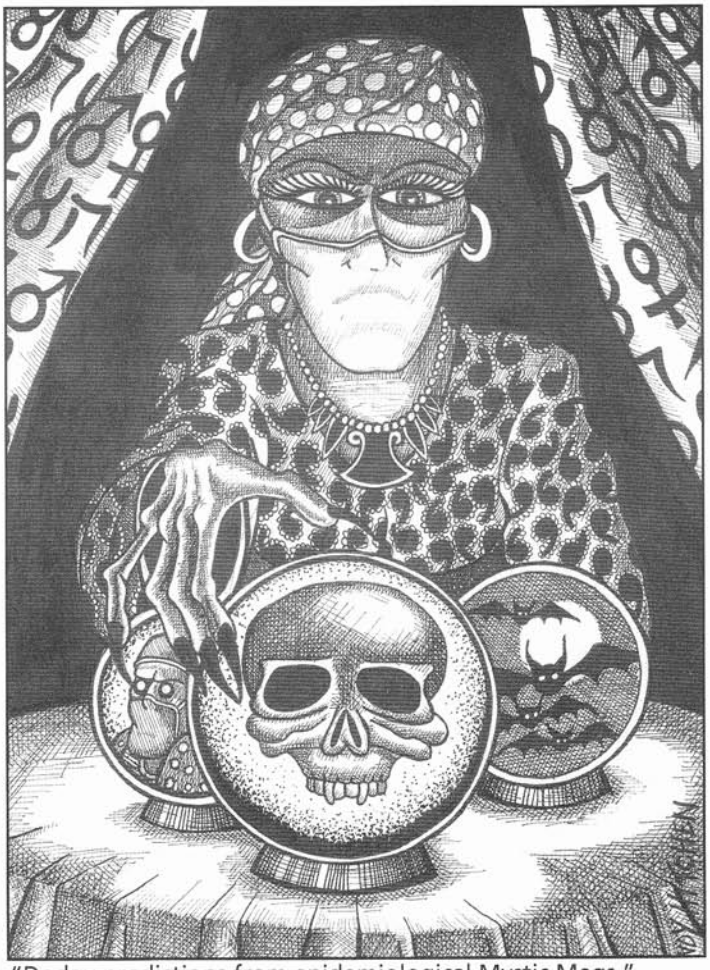
I just attended an assessment with a candidate (HIV+) qualifying for MRSS. What a beautiful experience! I totally support your notion as regards freedom of choice in treatments.

Best wishes,
Shruti, MRSS, Devon

Dear Continuum,

May I say how much I value and enjoy reading *Continuum* and do keep the good work up – the standard of articles is excellent and the way they probe into your thoughts re: how we approach our lives after diagnosis, is a constant stimulus. I don't follow all of them – but most of the 'thinking' and 'changing perceptions' is very challenging and meaningful.

A.H., Dorset



"Dodgy predictions from epidemiological Mystic Megs."
© Andy Hitchen 1996

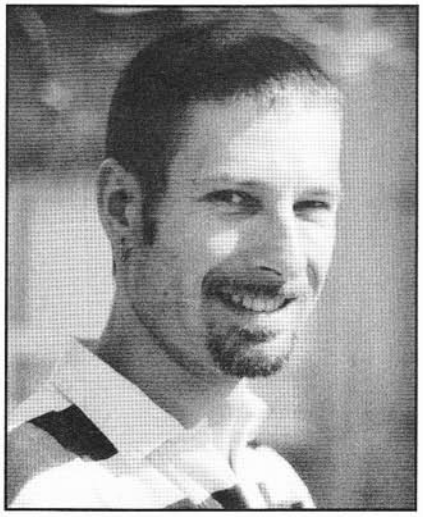
LifeStory

a reader's experiences

Do you want a chance to share your story? Then type it up and send it along to us, or phone 0171 713 7071.

I always feel, when talking about my life, that it all started five or six years ago. Well, that's when the life I know and enjoy now began. But then I remember that what happened before then must have shaped the way I am now.

I was brought up in the country within a very loving family, and because of the rural surroundings and religious environment it took me a while to accept my 'homosexual tendencies' and come out. Anyway, I moved to London to live the gay life, and was thrown in at the deep end – I moved in with my partner, who was HIV-positive and I started learning to cope with his situation and problems. Shortly afterwards I was diagnosed HIV-positive too.



However, something I had read made me determined to 'fight back'. I likened the situation to cancer, as I had heard of people who had overcome the big 'C' and had conquered that illness and were living normal lives. So this devastating news initially didn't get me down. I remember the words I said at the time: "I'm going to live until I'm 70, if I have any say in the matter". Little did I know then how true those words might become.

I carried on with work and with life in general, though I was constantly monitoring my health and my skin, and at the slightest sign of anything I would trot down to the clinic to get checked out. After all, I thought, they know best.

It was not until a couple of years later, on returning from Spain after the breakdown of a relationship, and working too hard to make ends meet, that I came down with flu. It got worse and descended to my chest. My doctor immediately said "suspected PCP" and put me on Septrin, steroids and one or two other things that I can't remember – I know it was 39 tablets a day for about three weeks. The funny thing was that all the tests he did came back negative for PCP, and I never actually learned what I did have.

I was forced to rest, and decided that the time had come, like lots of my friends, to stop work and claim all those lovely benefits. At least that would give me plenty of time to recover and regain my health. So that's just what I did. However, once I got better (pneumonia, bronchitis, etc. aren't that serious if we rest enough) I then started to enjoy the freedom I had. And boy, did I enjoy it! I spent far too much time on the scene drinking, clubbing, drugs and sex, etc. – the type of lifestyle that takes a lot out of us and contributes to the lowering of our immune systems, though I wasn't thinking about that at the time.

Gradually I was getting bored with the 'HIV lifestyle', and it was a candlelight vigil that sparked me into thinking a bit more seriously. I saw a multitude of people who had evidently been affected by AIDS more than I had, and I felt, "I'm fortunate, I have my health – shouldn't I be doing something for the gay community and those who are suffering?" So I decided to do some voluntary work, which gave me a little stability. This brought me in contact with complementary therapies, which I didn't know much about, but thought were very valid as a natural means of dealing with illness.

After a while I read of a need at *Continuum* for an office manager, and got the job (unpaid, but I was on benefits). It was this that really made a big change in my life. I suddenly came across information which I'd never heard before. People were saying that HIV hasn't been proven to cause AIDS, and there are probably good reasons why the gay community, in particular, was being struck down by illness. As a kid, my parents had subscribed to the view that 'you are what you eat', and had put me on fasts and fruit diets when ill. This training was bearing fruit now, in later life, and it all made sense to me.

Now, because of what I have learnt, I am a firm believer that HIV does not cause AIDS. I think the HIV test is so unreliable that a positive result has no real meaning. It certainly doesn't worry me. I think of it as a marker for possible predisposition to illness. So I have made some changes in my diet and lifestyle, as I prefer to take part in maintaining my own health. I am therefore using more natural methods such as vitamin supplements, herbal remedies and holistic therapies to maximise my body's inbuilt defence mechanisms, and I'm sure I'm enjoying a healthy life because of this. For me, this also means taking time out if feeling under the weather to allow my body to repair (as at the time of writing), and preferably without the aid of antibiotics, which I don't believe do any good in the long-term.

The benefits of adopting this change of attitude have been enormous for me – gone is the fear of impending illness and death, the constant worry of whether every cough or scratch is something worse. I don't need to trip down to a special clinic every few months to have my blood checked (haven't doctors heard that T-cells migrate to the bone marrow when the body gets stressed? So why measure them in the blood alone?). Nor do I feel the need to take part in trials for inappropriate toxic drugs aimed at treating a virus which hasn't even been isolated!

All of this doesn't mean that I don't enjoy life – I believe that's very important, but very difficult if you constantly have the fear of death over you. I certainly have a good time, and I still smoke, drink, even do recreational drugs, but I feel that I'm in control – which I didn't when trusting myself to the doctors. It's also very empowering to do work that I feel is useful for me and vital for others. I think we are gradually getting there in reforming the HIV/AIDS story and exposing the scientific fraud for what it is.

On that note, I still haven't had an answer to the question that came to mind a few years ago: why are HIV antibodies so bad when other antibodies are part of the body's natural defence mechanism? If anyone knows, please let me know.

Above all, don't give up – enjoy life and have fun!

Tony

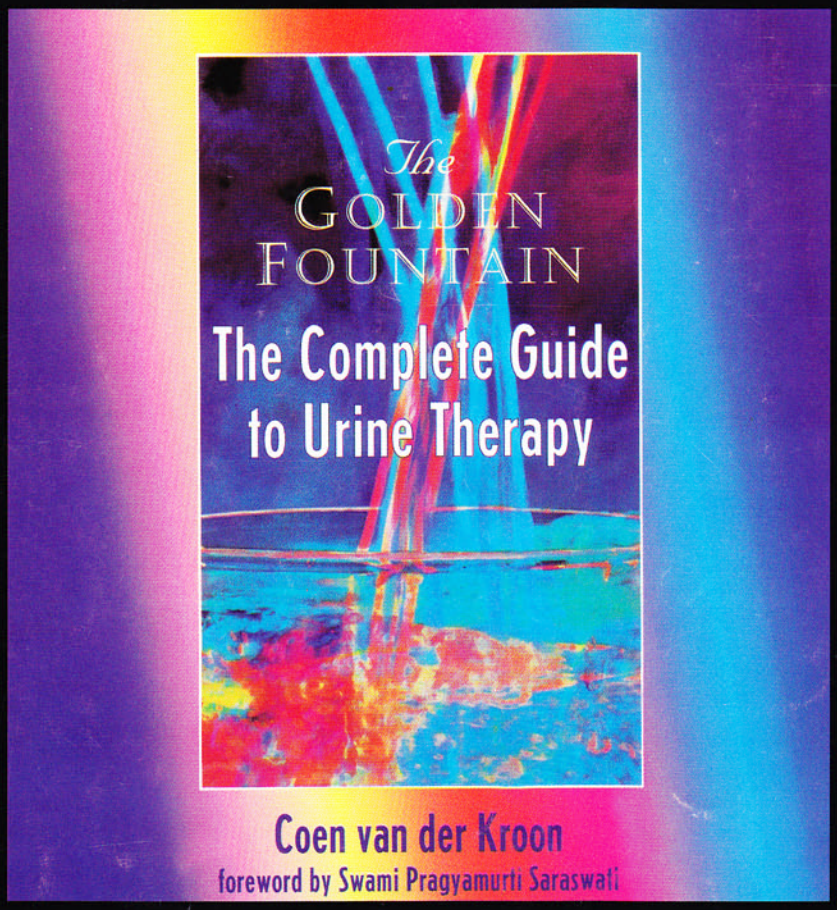
Tony Tompsett

In the next issue of continuum...

- Feature: AIDS in Haiti - where is it?
- SPECIAL: Benefits of dietary antioxidants
- Interview: The Helios Centre
- Health: KS: an in-depth look

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

Changing the way we think about AIDS

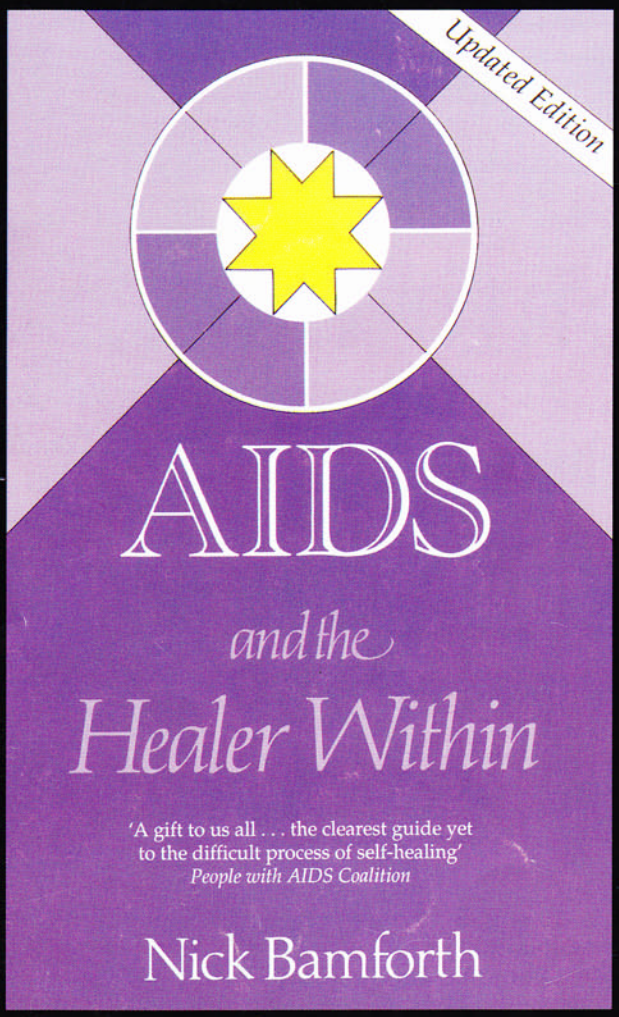


THE GOLDEN FOUNTAIN

- The Complete Guide to Urine Therapy by Coen van der Kroon

"People with cancers, PWA's with parasite infections or KS describe the healing that urine therapy has brought about" - as reviewed in Nov/Dec issue of Continuum.

£8.95 plus £1.00 p+p



AIDS AND THE HEALER WITHIN

by Nick Bamforth

"A gift to us all - the clearest guide yet to the difficult process of self-healing" - People with AIDS Coalition.

£6.95 plus £1.00 p+p

BOOKS AVAILABLE MAIL ORDER FROM

Gateway Books, The Hollies, Wellow, Bath BA2 8QJ

Tel 01225-835127