CONTINUUM

a magazine by the living for the living

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why CONTINUUM?

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

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

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

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

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

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

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

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

focus

features

PHOTO: H. Armstrong Roberts, 1991

AIDS – the first global dogma. The Barcelona conference proposes 'The Year 2000 Without AIDS' (see p. 20)

news

regulars

changing the way we think about AIDS

AUSCHWITZ RETURNS

Health officials in San Francisco want to identify everyone who is HIV-antibody positive, and force them to have drug therapy. Among those pushing for enforced treatment is the city's health director Sandra Hernandez who believes it has "great potential for curtailing the further spread of the HIV epidemic itself".

RADIO ACTIVE

Scientists in Florida are trying to silence a radio station broadcasting dissident advice to people diagnosed HIV-antibody positive. WLQY, which serves Miami's 155,000 Haitian community, has successfully persuaded many of its listeners to give up harmful anti-viral drug therapy.

• *See Letters, page 38*

SPANISH SUPPRESSION

A Spanish TV channel has axed a televised AIDS debate rather than give into "blackmail" by government officials to censor dissident views. The officials had threatened to pull out if government-funded TVE-1 showed a programme by French filmmaker Djamel Tahi questioning the role of HIV, and interviewing Dr Eleni Papadopulos-Eleopulos.

AFRICAN DEBATE

The London-based magazine *New African,* which circulates 50,000 copies a month worldwide, has continued its campaign challenging establishment views on HIV and AIDS. Deputy editor Baffour Ankomah told *Continuum* there was more to the debate than the establishment allowed, and they agreed with Neville Hodgkinson's book that "deception and half truths are killing more people than the disease itself".

BLOOD WEAPON

Criminals in Ireland are increasingly using blood allegedly infected with "HIV" when threatening their victims. In the latest incident, drug dealer Michael Cahill escaped while on his way to Cork Prison after threatening his guards with a syringe. He was due to begin a four-and-a-half year sentence.

BATTLE BILL

Robert Gallo, the discredited US researcher who wrongly claimed to have discovered HIV, has been ordered to pay all costs after losing a libel action against French newspaper *Le Monde.* The French Supreme Court of Appeal ruled the paper had made every effort to corroborate its 1991 article that Gallo had used material discovered by Luc Montagnier for the US HIV test.

US clinician advises patients to delay therapy

Drugs stampede invalidates trials

A leading AIDS doctor has called for a halt to all drug therapy programmes to give scientists a chance to evaluate results using proper clinical trials.

Donald Abrams, Professor of Medicine at the University of California, San Francisco, told a small group of medical students how trials were being undermined because patients were jumping from one drug to another as soon as a new one came along.

As a result, even the effectiveness of the current protease inhibitors had not been definitively proved, because they had not been properly tried out against a placebo. And he surprised his audience by telling them how little solid, clinical research there was even behind AZT and the other nucleic chain terminators.

Abrams, who is also director of the world's oldest AIDS programme at the San Francisco General Hospital, said while he echoed current belief that protease inhibitors offered the best hope of extending life, he was not necessarily a cheer-leader for anti-viral therapy.

"I have been one of the people who's questioned, from the beginning, whether or not we're really making an impact with HIV drugs and, if we are making an impact, if it's going in the right direction," he said.

Abrams spent the first half of his lecture describing the problems during the 1986 testing and approval of AZT, and how the placebo trials were suddenly abandoned half-way through because of statistically significant differences in deaths between the two group.

He blamed the "very powerful rhetoric" of the emerging community of AIDS activists, who demanded an end to clinical trials and the immediate handing out of drugs.

"Somebody should write a book about the impact of that decision on HIV clinical trials history," he added, "because everything changed because of that demand."

He said the tragic farce of past AIDS research and therapy involved people who thought they were doing something useful but were actually wasting time and valuable resources.

He pointed out that even now, researchers trying out new drugs were using viral load testing, a method which itself had not actually been licensed, to evaluate them.

"We're approving drugs on the basis of their impact on a test that's not yet been approved," he said.

While urging scientists to avoid making the old mistakes, he predicted the ongoing development of new drugs would induce study participants to drop out, undermining the value of the results.

"I have a large population of people who have chosen not to take any anti-retrovirals since I've been following them – since the very beginning," he said. "They've watched all their friends go on the anti-viral bandwagon and die, so they've chosen to remain naive [to therapy].

"More and more, however, are now succumbing to pressure that protease inhibitors are 'it'. We are in the middle of the honeymoon period, and whether or not this is going to be an enduring marriage is unclear to me at this time, so, I'm advising my patients if they still have time, to wait."

Establishment backs dissident viewpoint

Following research into the needs of those diagnosed HIV positive, a joint collaboration between Britain's Positively Healthy and the Kingston and Richmond Health Authority has resulted in the design and launch of the Park Project, the UK's first community based AIDS prevention project intended to help prevent progression from an HIV diagnosis to AIDS.

The first official initiative to endorse the view that HIV diagnoses do not necessarily lead to AIDS, the project is holding a series of interactive workshops for people interested in taking greater control of their own healthcare needs. The workshops will be held in conjunction with healthcare providers and peers, and are open to all people.

The outcomes of the project include increasing self-empowerment with the development of peer support strategies, increasing the quality of life by taking international models of excellence and implementing them locally, and developing local services. Particular emphasis will be placed on therapeutic models in the alternative and complementary field of medicine which may be unfamiliar to participants as well as conventional drug therapies. The data collated from the workshops will inform local healthcare providing services.

The workshops will be introduced by Martin Weaver, Public Health specialist at Kingston and Richmond Health Authority and delivered by Cass Mann, founder of Positively Healthy, the world's longest established gay men's holistic AIDS charity, and John Stevens, founder of Equilibrium.

Further details are available from Cass Mann on 0181 878 6443 or Martin Weaver on 0181 390 1111

On the road to re-election, US President Clinton greeted gay and lesbian community leaders at a White House breakfast. He and Health Secretary Shalala have since promised to prioritise research into an "AIDS vaccine", though leading scientists argue it's impossible

Legal death threat will force hand of Germans

Top German AIDS analyst Karl Krafeld visited London in October to talk on the historical roots of AIDS, and the campaign of careful legal actions forcing the German parliament to rethink its position. Describing AIDS as "the first global dogma", he urged a transition from cultures of belief to a culture of understanding.

London's Pink Paper reported Krafeld had "sent the president of the German parliament, Reta Suessmuth, a death threat for which he was arrested and taken to court." But in fact he was examined by a state lawyer over a letter to Suessmuth that the parliament, in rejecting a technically valid Petition, is now on record as having lied over documents discrediting the HIV/AIDS hypothesis, a betrayal which, he wrote, some people might violently object to. The state lawyer found Krafeld acted legally and had no case to answer. Parliamentary Petition Group leader Christa Nickels ordered Krafeld be examined by a psychiatrist, who found no evidence of irrationality.

Krafeld then used the German constitution's "Right to resist" clause permitting direct violent action against state officials who abuse human rights or threaten the lives of citizens, by informing Nickels that citizens including himself were legally empowered to take any necessary steps to prevent further abuses. This action is pending.

Citing the enormous investment of intellectual energy in over 100,000 scientific papers about the discredited HIV/AIDS hypothesis, Krafeld states, "The transition to a culture of understanding proceeds through the creation of a law-abiding society, which is capable of liberating humane energies, especially scientific energies... The transition from belief cultures is not possible without radical belief or confidence traumas. The fear of these confidence traumas has the effect of removing the right to life from future generations."

Authorities in Krafeld's home city of Dortmund have held a series of meetings with AIDS analysts to try to improve health and education work in their region.

Italian study undermines AZT

An Italian study into the effects of AZT has revealed the same short-term effects in HIV-negative-diagnosed individuals as in their positive-diagnosed counterparts, indicating the drug has no specific action against the putative HIV.

Eighteen people, who were later confirmed as being 'HIV negative', took the drug believing it would inhibit replication of the virus, which by subsequent accounts they never had. Nevertheless, the patients experienced short-term increases of up to 30% in the counts of their circulating T-cells, consistent with the short-term increases seen in diagnosed people.

The study, reported in AIDS, Oct 1996, supports the view of an increasing number of doctors that the apparent increase in immune function in some people starting AZT is a response to the toxicity of the drug, and does not translate into real clinical benefits as the extra cells are not functional.

The Concorde trial found 25% higher mortality in people taking AZT long-term than in those taking no medication.

AIDS FIGURES

The number of people dying with AIDS diagnoses in England, Scotland and Wales has fallen for the first time since 1986. The figures for 1995 were 1,231, a drop of 105 on the previous year, and bring to total of deaths in ten years to 8,376.

SURGEON CLEARED

A Glasgow surgeon has become the first in Britain to be allowed to continue practising after going public over his HIV-antibody-positive diagnosis two years ago. Renowned ear, nose and throat specialist, Professor George Browning, has permission to perform "remote" surgery using long-handled instruments.

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BOXER RETURNS

Former US world heavyweight champion Tommy Morrison has returned to the boxing ring in Japan saying he wanted to do his bit to erase the fear of AIDS. He has been banned from boxing in the US after testing positive.

KS TREATMENT

Researchers in the US claim a hormone derived from the urine of pregnant women is proving successful against Kaposi's sarcoma (KS), although it is unclear whether the cancerous skin lesions come back. They say the hormone, injected directly into the tumour, triggers the cancer cells to die, although exactly why remains a mystery.

POT LUCK

San Francisco's top AIDS researcher Donald Abrams has won California State approval to experiment with cannabis in treating people with AIDS and other wasting diseases. The ruling, which has also been passed in Arizona, allows cannabis to be prescribed by doctors in appropriate cases.

TOO HASTY

Sussex University's John Abraham says the US drug approval system is weak. The people supposed to monitor problems are the same as those that grant the licences and "might be reluctant to admit they are wrong"

COCKTAIL HANGOVER

US scientists want to find out why protease inhibitor drug cocktails fail to live up to their high expectations. They admit latest studies show the drugs are ineffective in an increasing number of patients and claim this is because the "virus isn't giving in without a fight" and continues to mutate and evade the new combinations.

C O M M E N T

If this is a festive season, let it also be a season of communication. While there may be none so blind as those who will not see, many of the adherents to the orthodoxy on HIV/AIDS simply have not encountered those doorways of logic and honest information that reveal the essential dimensions missing from the standard view of AIDS. It would be a Scrooge indeed who believed that with access to fresh perceptions very many people would not want to usher an era of enlightenment into the gloomy arena of AIDS and its many facets.

Said Plato, "Medicine may be regarded generally as the knowledge of the loves and desires of the body, and how to satisfy them or not; and the best physician is he who is able to separate fair love from foul, or to convert one into the other; and he who knows how to eradicate and how to implant love, whichever is required, and can reconcile the most hostile elements in the constitution and make them loving friends, is a skilful practitioner." (*Symposium*)

Since the publication in our last issue of the papers demonstrating the non-isolation of HIV, things have been slowly and fundamentally changing. This will undoubtedly continue as consideration of the implications spreads worldwide. The respected international newsletter *Reappraising AIDS,* published in the US, reported the publication of these "eagerly-anticipated" works, and *Continuum*'s presence on the Internet henceforth will prove an ever wider forum for discussion, exchange and progress.

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A paper presented at the XIth International Conference on AIDS in Vancouver (1996) by PJ Easterbrook, M Troop, RL Goodall and B Gazzard entitled 'The effect of modifiable lifestyle factors on disease progression in long term HIV-1 infection', has recently received some coverage in the HIV/AIDS press.

Dr Easterbrook has a background in clinical medicine and subsequently worked in epidemiology, however she is not a virologist, as she explained in an interview with Continuum magazine (Vol 3, no 3, p16/7, Sept/Oct 1995). Dr Easterbrook works for the Kobler Centre, which is the GUM clinic of the Chelsea and Westminster Hospital. Given hospital bias toward conventional medical treatment, the question must be asked as to the ability of Easterbrook et al to maintain an objective approach in the research and analysis of 'lifestyle factors' necessary for this study.

I believe the conclusions to this study to be incomplete and misleading. These were:

"This analysis confirms the findings of several previous prospective and case control studies that lifestyle, at best, plays only a minor role in influencing the rate of HIV disease progression. In particular we found no evidence for a 'healthy' lifestyle effect in HIV-infected non-progressors (NPs) or conversely a cluster of adverse lifestyles among rapid-progressors (RPs). An interaction between biological factors, such as genetic susceptibility, viral strain, and immune response therefore prevails as the predominant explanation for long term non-progression."

The study participants, all diagnosed as positive for antibodies theorised to indicate infection with an ambiguously isolated retrovirus conventionally supposed to cause immune deficiency by as yet unexplained mechanisms, were given a questionnaire to determine their general medical history (including STDs), sexual preferences and sexual activity, use of recreational drugs, tobacco and alcohol, nutritional intake and use of vitamin supplements, sleep pattern and level of physical activity, use of conventional and complementary therapies and social activities. The median time since diagnosis of the 186 study participants was 10 years and they were asked to complete detailed information on the above categories, for the two years preceding and for each year following diagnosis. Due to such reliance on the fallibility of the participants' long term memories, the data obtained must be of questionable accuracy.

The study, in considering only the association between lifestyle and delayed or rapid disease progression, totally overlooked the association between lifestyle and quality of life. Quality of life is arguably the most important factor for HIV diagnosed individuals.

The Toronto Survey (Palliser Health Authority, September 1996) on Complementary Therapies found that 78.5% of people living with an HIV/AIDS diagnosis use complementary therapies at every stage of recovery or illness and these people were, on average, more satisfied with every category of complementary therapy than with conventional drugs.

The Easterbrook et al paper presented no data on nutritional intake and use of vitamin supplements nor on the use of conventional and complementary therapies with no explanation as to why. This is a significant oversight for a study of this nature, particularly as many studies have shown the benefits of nutritional therapy and diet in the management of immunity, and also, several studies have shown the declining levels of many nutrients in antibody diagnosed individuals at risk of decreased immunity who do not have any nutritional therapy.

Easterbrook et al's study becomes further misleading by not analysing those lifestyle factors that may have contributed to the group of RPs actually progressing to an AIDS diagnosis. It has never been proven that a retrovirus HIV is the cause of AIDS, but a significant decline in an individual's immune system, represented as 'AIDS', is always associated with candida. This micro-organism often overruns the gastrointestinal system when an individual has been subjected to repeated courses of antibiotics, normally as a result of allopathic treatment of STDs or PCP prophylaxis/treatment. Candida however is usually very successfully treated with nutritional therapy which has a significant impact on the individual's quality of life.

Easterbrook et al's study assumed that when lifestyle factors were fairly common, proportionately between NPs and RPs, they

Study of long-term survivors proves to be useless

Jerry Castro

had no bearing on disease progression or non-progression. This is flawed, as almost all study individuals took alkyl nitrites (poppers) which mainly USA studies have shown with varying certainty to be causally associated with anaemia, strokes, heart, lung and brain damage, arterial constriction, blood de-oxygenation, thymus atrophy, KS and chronic reduction of T-cell ratios associated with severe immune dysfunction. The fact that the NPs had not progressed to an AIDS diagnosis does not mean that the use of extremely toxic compounds like nitrites had no bearing on the disease progression with RPs; it is quite probable they did.

NPs represent approximately 5% of total antibody diagnosed individuals. These individuals appear to have very strong constitutions and favourable genetic characteristics that permit them to indulge in unhealthy lifestyle practices with relative impunity (so far). Furthermore, probably the most important lifestyle factor of all, the use of antiretroviral drugs, was not included and analysed in the Easterbrook et al study.

The fact that 87% of RPs used antiretroviral therapies (presumably mostly AZT) and yet only 47% of NPs used antiretroviral therapies, and then only briefly during the Concorde Trial, is extremely significant. There is little disagreement now as to the long-term ineffectiveness of drugs like AZT, and there is growing evidence as to the damage an individual's health sustains through the use of such highly toxic drugs. It may be that the use of antiretroviral drugs contributed to disease progression in RPs and that NPs relative avoidance of these drugs contributed to their lack of disease progression.

The relatively new field of psychoneuroimmunology (PNI) has clearly demonstrated the interconnectedness of immune and neurological systems. Various PNI studies have demonstrated an impact on the immune system by stress and depression. Antibody diagnosed individuals may therefore expect to benefit from adopting well established stress-reducing techniques such as Tai Chi (Qi Gong), meditation, Yoga and relaxation methods. This field of PNI was omitted from the Easterbrook et al study.

I believe it to be sufficiently important to warrant listing out the main characteristics of long-term survivors of an antibody diagnosis taken from PNI studies by G Soloman, L Temoshok, A O'Leary and J Zich in the Annals of the New York Academy of Science #496: 647-655; R Nielsen: Long Term Survival Skills, Seattle Treatment Education Project. 5:1 February 1993; Callen M (1990): Surviving AIDS: Callen M (1992): AIDS: A different view, Amsterdam Conference, De Rode Hoed, 14th-16th May.

My recommendation for anyone diagnosed as infected with HIV, is to treat the conclusions of the Easterbrook study critically and with extreme caution and to carefully review their own lifestyle practices.

Long-term survivors are people who:

1 develop a sense of personal responsibility for their health;
2 experience a 'healing' relationship with their primary health care provider;
3 want healthcare practitioners they can trust, and expect to be treated as equals and collaborators – will change practitioners if not satisfied;
4 are verbal, talkative – communicate well when discussing their condition with healthcare practitioners;
5 stay informed about conventional medical treatments in order to understand their limitations and harmful side effects;
6 do not give in to disease – maintain a holistic approach to health whether during diseases or good health;
7 have a sense that they can influence their own health outcome;
8 have a commitment to life in terms of 'unfinished business', unmet goals or as yet unfulfilled experiences and wishes;
9 feel optimism for the future – feel that good times are ahead;
10 are satisfied with the quality of their lives;
11 are not obsessed with CD4 or viral load counts;
12 have dealt with or healed their own emotional wounds – they have good coping mechanisms;
13 are pragmatic and realistic – take each day as it comes
14 find new meaning in their life as a result of an HIV diagnosis;
15 have a sense of meaningfulness and purpose in life
16 engage in physical fitness – exercise, dietary and nutritional therapy work;
17 have had previous experience of coping with a traumatic event;
18 become altruistically involved with other affected persons;
19 refuse to perceive an HIV diagnosis as a death sentence and maintain a healthy scepticism toward the meaning of the diagnosis;
20 develop a personalised means of actively coping that they believed had beneficial health effects;
21 are assertive and are able to say 'no';
22 have the ability to withdraw from taxing involvements and to nurture themselves;
23 are sensitive to their bodies, including psychological needs;
24 are able to communicate openly about their concerns;
25 do not use AZT or any other toxic substances;
26 use as many alternative or complementary therapies as are necessary to maintain good health or to recover from disease.

(A few points on this list have been amended to bring it more up to date and in line with current holistic thinking)

Unfounded Assertions

Huw Christie

The London Sunday newspaper The Observer has published an apology over a story attacking former Sunday Times Science Correspondent Neville Hodgkinson, who from 1992 to 1994 reported the growing scientific controversy about the meaning of so-called HIV-antibody tests, and the misgivings of African health workers about the Western perception of an "AIDS epidemic" on their continent. For several years before that he had reported the orthodox view of HIV/AIDS. Since 1982 he has belonged to a Buddhist spiritual movement called the Brahma Kumaris, founded in 1937.

The Observer Review's front-page article by Mick McGovern, whose sister is a member of the same spiritual movement, alleged Hodgkinson was averse to the world of 'scientific rationality' because of his association with the spiritual movement, and reported Hodgkinson has been accused of endangering lives "by undermining health advice designed to reduce the transmission of HIV". Though McGovern suggested a bizarre cultist subjectivity compromised Hodgkinson's research and reporting on HIV/AIDS, at no point did he himself offer any evidence either that HIV causes AIDS or that HIV exists. Since 1987, a growing number of scientists have challenged the view that HIV causes AIDS, and some have demonstrated great ambiguity in all claims that the virus has even been isolated. Some indeed have questioned this since 1983.

Hodgkinson's thoroughly referenced book AIDS – the Failure of Contemporary Science: How a Virus That Never Was Deceived the World was published earlier this year, a fact reported in the Observer article. To date, no review of the book either has attempted to address its scientific and political arguments, but one of its implications – that the vast amounts of money spent on antiviral drug research by multinational pharmaceutical companies have been perhaps far worse than useless, given the acknowledged toxicity of 'antiretroviral' drugs – indicates the context for the Observer's attack, some months after the book hit the shelves.

Historically The Observer courted a close relationship with the advertising budget of Wellcome in the days when AZT was new in the AIDS market. Aware that their sales depended on supportive articles, Wellcome worked through the medical and science correspondents of the large papers to promote the HIV theory of AIDS and the promising nature of their own product research. Because newspapers like The Observer depended on advertising for revenue, there was an understandable reluctance to sing from a dissonant songsheet – who pays the piper calls the tune. The declining Observer was among the most pro-Wellcome of publications. When Hodgkinson's departure from the orthodox line signalled the possibility of a more general unprofitable trend away from drug company influence, he endured a growing campaign against his reporting from those whose financial interests were at stake. The Observer's overall financial viability nonetheless worsened despite its adherence to the lucrative pharmaceutical line, and the paper is now a lame charger in the Guardian stable.

McGovern thought nothing of rewriting his primary source

In his attempt to depict Hodgkinson as pitting himself in principle more or less naively against a demonised establishment, McGovern did not balk at misrepresentation. In a paragraph which required specific apology he wrote "Then, crucially, in a passage that prefigures the crusading zeal of his book, [Hodgkinson] writes that the 'arrogance that characterises...the scientific establishment may have to take a considerable knock before we open the door to a different way of thinking and feeling'." The original text was in fact considerably more instructive, such that the Observer's full apology read,

> "In an article headlined 'Sunday Times science editor awaits flat earth' that appeared in our issue of 6th October, we wrongly quoted an extract from an article written by Mr Neville Hodgkinson.
>
> The quote should have read: "The arrogance that led to such unfounded assertions may have to take a considerable knock before we open the door to a different way of thinking and feeling." Mr Hodgkinson has also asked us to point out that he refutes the use of the term 'flat earth' as that does not accurately reflect the views of himself and the Brahma Kumaris. We are happy to clarify his position and apologise for the error in the quotation."

One wonders no less why Mr McGovern, in the process of writing his article, thought nothing of rewriting his primary source than why he found the phrase "unfounded assertions" so expendable.

Concurrent with their apology, The Observer published the following letter by Neville Hodgkinson himself under the heading "Search for an ideal and truth on AIDS:"

> *"For too long, science and spirituality have been regarded as incompatible. Mick McGovern (October 6) furthered this false conflict in his article about my recent book on AIDS, when he suggested that the book's conclusions should be distrusted because of my 15-year association with the Brahma Kumaris World Spiritual University.*
>
> *The Brahma Kumaris is not a cult, but a well-respected charitable organisation dedicated to teaching spiritual knowledge – that is, a way of understanding who we are, and how we fit into a wider scheme of things, made real through inner, subjective experience. It is true that the introspective practices involved differ from the*

Britain's Observer apologises over misleading article

scientific method, with its systematic sharing and analysis of externally observed facts. But it is not true that the one must rule out the other. The two ways of knowing are complementary.

I do not await a flat earth, contrary to the article's assertion, but I do subscribe to unfamiliar ways of thinking, involving an ideal world, an ideal self, and a loving relationship with a Supreme Being (conceived as a non-physical, infinitesimal point of light – not a hairy man, as in your picture). I find such ideas nourish me, in ways that help me to see the world more dispassionately and I hope objectively, as well as giving me a yardstick by which to set about improving my character.

Science has helped sweep aside religious dogmas that obstruct both reason and humanity. However, science falls into the same trap as religion when it denies validity to ideas and experiences outside its own scope. Since it commands such respect, these denials may contribute to a kind of spiritual deprivation.

The resulting sense of emptiness leads to a loss of higher values, essential for holding together society. It can make people vulnerable to false prophets. It can also damage the scientific method itself, when an unrelentingly outward and analytical focus prevents recognition of the scientist's own subjectivity.

My book, AIDS: The Failure of Contemporary Science, argues that this has happened in AIDS science. It presents evidence that the original work claiming isolation of HIV was inadequate; that procedures which should have identified those inadequacies did not operate; and that a kind of censorship operated subsequently which grew more intense as the case for a reappraisal of the HIV theory grew stronger.

Beverly Griffin, Director and Professor of Virology at London's Royal Postgraduate Medical School, has said in a testimonial for my 'thoroughly researched, well-argued' book: 'The emotional response to the HIV story by the scientific/medical community never ceases to amaze.'

I believe this response owes more to hurt pride and misplaced compassion as well as defence of a multi-billion dollar industry, than to genuine concern for truth, and that it is costing lives."

Neville Hodgkinson, Oxford

The Observer's ease with unfounded assertions has yet to evaporate however. In the November "Observer Encyclopaedia of Our Times" supplement, editor of the Lancet (see Focus), Dr Richard Horton writes of "Andrew Neil's cynical and scurrilous campaign in the Sunday Times against the notion that HIV was the cause of AIDS. He exploited the genuine scientific uncertainty about how HIV destroyed the body's immunity for purely commercial ambition. Magazines still exist solely to challenge belief that HIV causes AIDS. One is Continuum. In the September/October issue, the mere suggestion that HIV existed was called 'fascistic'". Scurrilous and cynical? The unmindful Horton (his article opens with "Who remembers Rock Hudson? He is mostly forgotten now, I suppose.") is referring to an interview with leading intellectual Noam Chomsky, in which it was asked "Because of the enduring questions over whether the theory of the existence of retroviruses deserves to be held, may we not argue that the 1986 adoption of the finite term HIV by the International Committee for the Taxonomy of Viruses was a fascistic imposition?" Chomsky was cautious: "We have to investigate the facts, no trivial matter."

Horton defends the "belief" that HIV causes AIDS

While few would disagree with that, Horton's record at the Lancet is consistent with his position stated in the Observer – he defends the "belief" that HIV causes AIDS. Says Chomsky later in the same interview, "What I see when I look around me [is] highly irrational beliefs about the physical world (let alone the world of human life and society.)" Horton's phobia against investigation, and his faith in HIV, besides costing lives, is precisely the sort of cultist phenomenon that the Observer imputed to others.

It was Alonzo Clark who last century remarked, "The medical errors of one century constitute the popular faith of the next." The serious mainstream media have just three years to redress the balance of their reporting of the complex and at times emotive issues around "HIV"/AIDS before Clark's assertion becomes founded in all too present fact.

Pneumonias & Lung Diseases

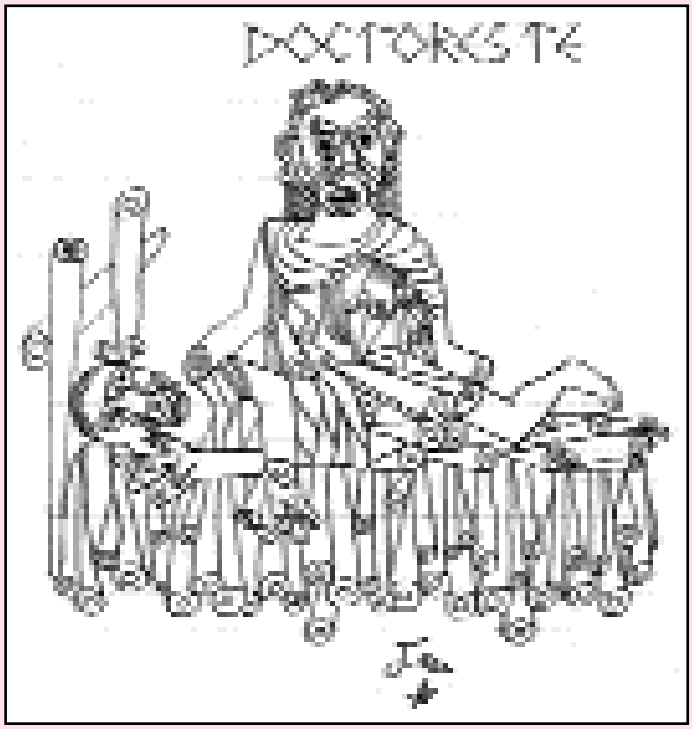
PCP accounts for the majority of Western AIDS diagnoses – yet the diagnosis of AIDS can be given on the basis of a presumptive diagnosis of PCP alone. A positive "HIV"-antibody test is not even necessary. Is this definition alone creating a hothouse of fear and, with its assumptions, distracting patients and doctors from recognising the real processes of risk? In particular, the revelation that PCP is not an opportunistic infection challenges itself the wisdom of drug prophylaxis.

In 1996, the respected British medical journal *The Lancet* began publishing a series of special articles about HIV and AIDS, addressing various aspects from vaccines to the nervous system. All the articles rashly assumed that an isolated retrovirus called HIV causes AIDS.

In the following article, Dr Heinrich Kremer responds to one such article, by Dr Miller, on "HIV-associated respiratory diseases". In a knowledgeable and inquisitive manner he brings into unrelenting focus the deeply disturbing way in which damaging medication has helped create rather than cure the problems of PCP and other conditions.

Pneumonia is a frightening prospect for anyone, treating physicians included. Undoubtedly prevention is better than cure. But does this involves a fresh commitment to look behind the plague-mongering to the sensitivity of our biological systems, and the pressures of present and cumulative chemo-toxicity?

Huw Christie



Doctoreste* by Jean Cocteau (1889-1963)

**** Orestes – in Greek myth, the vengeful brother of Electra***

Acquired Iatrogenic Death Syndrome (AIDS)

by Dr. med. Heinrich Kremer

"Progress comes from individual creation and imagination, not from the narrow dogmatism of a burgeoning AIDS establishment."
—Lancet editorial, July 6, 1996

It was one of the early pioneers of modern medicine, the German physician Rudolf Virchow (1821-1902) who, at the height of his career, said he wanted to become an MP in order to see to the completion of Berlin's antiquated sewage system, otherwise he could not successfully fight tuberculosis. How right he was! Only 100 years ago one worker in three died of tuberculosis. But until about 1950 tuberculosis had become rare in Western industrial countries, practically without recourse to drugs, which only became available towards the end of the 1940s. Above all, improvements in hygiene, living conditions and nutrition were instrumental in curbing tuberculosis of the lung.

Nowadays, however, there are modern successors to Virchow's causes of tuberculosis to surprise us, namely,

> "the association between HIV infection and tuberculosis is well described ... Tuberculosis in an HIV-infected individual is an AIDS-defining illness ..."

This claim is one of the many assertions by Dr Miller in his article "HIV-associated respiratory diseases," which he divides into eight infectious and four non-infectious diseases: Infectious: 1) Upper respiratory tract infections, 2) Acute bronchitis, 3) Acute sinusitis, 4) Bacterial pneumonia, 5) Pneumocystis carinii pneumonia, 6) Mycobacterium tuberculosis, 7) Mycobacterium avium intracellulare, 8) Fungal pneumonia; Non-infectious: 1) Kaposi's sarcoma, 2) Lymphoma, 3) Non-specific interstitial pneumonitis, 4) Lymphoid interstitial pneumonitis.

Now, it turns out to be something of an advantage for me as a medical doctor to have kept away from conferences and not to have much beyond schoolboy English, because I had to check up on the exact meaning of 'association' and 'associated' in the Oxford Dictionary, to find that they mean 'connection in the mind' – in other words, we are dealing with a suggested mental, rather than causal, connection between HIV and respiratory disease, as well as between HIV and tuberculosis. Does Dr Miller want to lecture us on ideology rather than biology? Not at all, Dr Miller quickly explains:

> "tuberculosis is a potent stimulator of cell-mediated immunity, activating HIV production in lymphocytes and monocytes/macrophages latently infected with HIV, which brings out the spread of HIV infection to other cells."

It dawns on me why tuberculosis – 1.7 billion infected worldwide, 600 million cases annually, 2 million deaths, of which 95% are in developing countries; in Western countries less than 0.05% of the population is affected by the disease, of which more than 95% are homeless, alcoholics, IV-drug users, asylum seekers – "is an AIDS-defining illness". Up till now AIDS-defining illnesses were supposed to be the consequence of alleged causative HIV infection. It now seems that diseases which first have to rouse "dormant HIV" from CD4 lymphocytes and macrophages are also part of the AIDS collection.

This means every disease process which has in any way reacted with thymus-matured immune cells (T-cells) can henceforth be renamed an "AIDS-defining disease", if it can simultaneously be

"associated with HIV." There are no limits, therefore, to what can be done in the virtual, toytown world of AIDS, since in practically all serious diseases there is some contribution of cell-mediated immunity.

Dr Miller grabs this opportunity by the throat and lists all "HIV-associated respiratory diseases," and observes that

> "the clinical features of upper respiratory tract infections, acute bronchitis and acute sinusitis are the same in HIV-infected individuals as in those without HIV, but their frequency is increased."

So saying, Dr Miller has deftly dealt with three of his eight "infectious HIV-associated respiratory diseases."

Bacterial Pneumonias

But it gets more serious when Dr Miller classifies as the fourth HIV-associated disease group "bacterial pneumonia".

> "The spectrum of bacterial pathogens is similar to that of community-acquired pneumonia in the non-HIV-infected population."

In this disease group, too, Dr Miller offers an intellectual prop to the "HIV-association":

> "bacterial pneumonia occurs more frequently in HIV-infected individuals than in the general population and is especially common in HIV-infected intravenous drug users."

Indeed, in the general population in Germany, for example, less than 1% of the population is affected by bacterial pneumonias. IV-drug users suffered more frequently from bacterial pneumonias long before AIDS came along for reasons well known to the venerable Virchow – unsatisfactory hygiene, malnutrition, bad housing etc., etc. (see above). The really important point, however, Dr Miller conceals from us: IV-drug users classified as "HIV-infected" suffered from bacterial pneumonias, as a comprehensive study in Berlin has shown, whereas non-bacterial pneumocystis carinii pneumonia (PCP) the most frequent "HIV associated respiratory disease" in Miller's list (and the most frequent "HIV-associated disease" or "AIDS-defining illness" altogether in the West) does not to all intents and purposes feature at all in IV-drug users who are not homosexual.

We can now see more clearly why bacterial pneumonias that are on the official list of AIDS-indicator diseases in adults only if they occur more than twice a year, have to be wangled in under the guise of 'HIV-associated.' Without the creation of "HIV" no-one would ever have dreamt of the need to diagnose IV-drug users as "AIDS," because PCP and Kaposi's sarcoma, the most common "AIDS-indicator diseases", do not occur in non-homosexual IV-drug users in Western countries despite a laboratory finding of 'HIV-positive.'

Why does Dr Miller conceal these facts in his Lancet article? Dr Miller lumps together everything which in patients labelled "HIV-positive" could be called respiratory tract diseases. Because the introduction of a new cause for these long-known diseases from the same long-known causes, in the very same long-known categories of persons, would seem rather untrustworthy, he makes these 'old-timers' among the common respiratory tract diseases the driving force of the newly invented "HIV" infection and lumps them together as "HIV-associated disease" or "AIDS-related processes" as he likes to call them. That these patients are thereby exposed to an increasing number of pharmaceutical drugs does not seem to worry Dr Miller unduly, as his treatment of PCP, the fifth of the eight "HIV-associated" diseases in his list shows.

Pneumocystis carinii Pneumonia

Strangely, pneumocystis carinii pneumonia turns up here as a "genuine" AIDS-indicator disease under the conditional heading of "HIV-associated respiratory disease." Has Dr Miller lost faith in the orthodox belief in "AIDS"? Not at all, he quickly goes on to explain:

> "P. carinii remains a common respiratory pathogen in individuals with AIDS."

Miller again uses the idiosyncratic phrase "in individuals with AIDS." A doctor's diagnosis of PCP alone is entirely sufficient according to the most official AIDS definition to say "this patient is an AIDS case" or "this patient has AIDS." And this attribution of "AIDS" due to the diagnosis of PCP alone, establishes 40% of all clinical "AIDS cases" and about 80% of all "AIDS deaths" in Western countries.

The official definition of the authoritative American CDC has since 1987 remained unchanged – an AIDS diagnosis is justified even if only a presumptive diagnosis of PCP exists, and in the absence of any laboratory suggestion of "HIV-positivity," and without any noticeable decline of immune cell values in blood serum.

Thus, PCP was from the beginning synonymous with AIDS, even without the 'S' (for Syndrome, of another 28 diseases) and without the 'ID' (for immune-deficiency, interpreted from decrease in CD4 lymphocytes in the bloodstream), and without the 'A' (for Acquired "HIV infection"). Naked PCP therefore is the seed of "AIDS". Everything else Dr Miller and his colleagues associated, as "connections in the mind".

In plain language, if there are other good reasons for the occurrence of PCP in homosexual patients, the "HIV-associated diseases" just melt away as yesterday's snow.

In this respect Dr Miller comes up with a genuine surprise. Miller explains in considerable detail that according to the latest research findings, the pathogen responsible for PCP is an airborne fungus and not, as thought up till now by AIDS doctors, a unicellular animal parasite. This implies an enormous difference from the diagnostic and therapeutic point of view: and in the real case of an individual patient, this reclassification can mean the difference between forecasting life and death. Until now epidemiologists assumed PCP was a case of zoonosis, ie. a ubiquitous animal, prevented by cell-mediated immunity from breaking through the body's immune barrier and causing devastating pneumonias. This assumption was seemingly based, according to Dr Miller, on the finding that 90% of children and adults in Western countries had antibodies to P. carinii without contracting that form of pneumonia. But now it turns out the essential assumption – that the presence of antibodies indicates the presence of the pathogen – was fundamentally mistaken:

> "P. carinii *cannot be detected with DNA amplification or monoclonal antibodies in bronchoalveolar lavage fluid or necropsy lung tissue of immunocompetent individuals and low levels of P. carinii are detected in the lungs of only 20% of immunosuppressed HIV-positive patients with respiratory episodes and diagnoses other than* P. carinii pneumonia."

The conclusion is, therefore, that "HIV" was invented in order to explain the apparent fact that CD4 lymphocytes in ostensibly 'hitherto healthy' individuals could suddenly no longer hold in check the pneumocystis protozoa which had been there all along. The simple explanation which the now shattered HIV/AIDS theory led to, was: "HIV" is transmitted in semen, blood and blood products to the recipient, "HIV" destroys the thymus-matured CD4 lymphocytes, the pneumocystis protozoa escaped their dead guards and kill their up till then healthy host. "HIV" was invented in order to explain the apparent fact that CD4 lymphocytes in ostensibly 'hitherto healthy' individuals could suddenly no longer hold in check the pneumocystis protozoa which had been there all along. According to this nightmare scenario anyone with "HIV" in his CD4 cells dies.

But suddenly now, everything turns out to be completely different:

Pneumocystis protozoa cannot escape from the CD4 immune cells, because pneumocystis protozoa are not there. Instead, since P. carinii is a fungus, is not transmitted in semen or blood, and is passed on through the air. This fungus, as Miller informs us, can

be disposed of easily in 80% of "immune-suppressed HIV-positive patients with respiratory episodes and diagnoses other than P. carinii pneumonia," without leaving a trace, and leaving in the rest of these "immune-suppressed HIV-positive patients" just "low levels" of P. carinii (whatever that may mean).

So, what has the laboratory finding of "HIV-positive" got to do with P. carinii pneumonia? What conclusions does Miller draw from his newly discovered findings? Answer: none. Miller simply reports the fact and carries on treating his patients as before:

> "The regimen of first choice for primary and secondary prophylaxis of P. carinii pneumonia is co-trimoxazole, 960 mg once a day or three times a week. ... For treatment, first choice is high dose co-trimoxazole (100 mg/kg per day of sulphamethoxazole and 20 mg/kg per day of trimethoprim) in two or four divided doses, orally or intravenously, for 21 days."

The important point arises – how does the metabolism of a unicellular animal (protozoon) which normally just vegetates as a harmless opportunist in the undamaged environment of a lung differ from the metabolism of a unicellular fungus – an external "recycling specialist" – which, even in "immune-suppressed patients" apparently thrives only when suitable growth conditions are present in the lung? Miller, unsurprisingly, is silent on that question.

Another question is who or what is responsible for the substrate, the suitable growth conditions, for P. carinii in the lung? "HIV"? The patient? Or his treating doctors?

The imaginary retrovirus "HIV" or a shortage of CD4 cells (allegedly massacred by "HIV") cannot be decisive for creating the special environment in the lung which enables P. carinii to multiply freely. Miller himself observes that

> *"many immunosuppressed HIV-positive patients do not have in the lung any P. carinii or show only traces of it."*

The question arises, therefore, whether cell-mediated immune deficiency, the laboratory finding of "HIV-positive", and the production of the substrate for P. carinii could not all be traced back to a systemic change in the body's metabolism. Miller provides an important clue by mentioning that administration of corticosteroids to rats can provoke PCP. Experiments of this kind date back to the 1950s which Miller does not mention, after what was later called PCP was first recognised in the 1930s in premature babies. Similar symptoms of atypical non-bacterial pneumonia (as opposed to typical bacterial pneumonia) were diagnosed in the 1940s in children and adults in famine conditions. So, what do the steroid-treated rats, the premature babies and the starving children after the Second World War have in common? (Note: PCP was at the time practically unknown in the United States).

The premature babies hardly stood a chance before modern treatments came along. They suffered from their immature lung cells a highly acute oxidative stress which in turn led to massive hypercortisolism. They mostly died from bacterial infections. These could be controlled more successfully after the introduction of the first broad-spectrum sulphonamide, prontosil, at the end of the 1930s. But then they died instead from PCP. Although the sulphonamide, which is a folic acid antagonist, [i.e. prevents the building of folic acid] successfully halted the production of bacterial proteins and hence bacterial reproduction itself, at the same time they raised the catabolic stress [see footnote]. Because the necessary maturation of CD4 lymphocytes (T-cells) in the thymus gland is very susceptible to hypercortisolism and systemic oxidative stress, the task of T-lymphocytes to dispose of the extremely increased turnover of cells became practically impossible: and the resulting decomposition products of the catabolic metabolism especially in the lungs which are particularly susceptible to oxidative stress, built the special conditions for the ubiquitous airborne spores of P. carinii to thrive in.

These rather complex patho-physiological processes (unknown about, of course, in the 1930s) would also explain the PCP seen in rats which had been treated with corticosteroids while under antibiotic treatment.

Hypercortisolism induces a characteristic 'famine metabolism', which leads to complicated systemic changes in growth and decay of the body at the molecular level, and provides the substrate for the highly specialised Pneumocystis fungi to grow on.

If this vital emergency condition, under constant stress factors, becomes a fixed lasting condition, as in the starving children of post-war Europe or in parts of Africa today, thymus-dependent cells (T-cells) decrease. In the normal course of events these T-cells have to get rid of 10^{12} spent body cells a day: by halting the maturation of T-cells the table becomes richly set for P. carinii and other microbes to thrive. These unwelcome scroungers can only be chased away from this paradise of theirs, by abolishing the fixed emergency conditions that created it. This explanation is confirmed by the animal experiments quoted by Dr Miller – 75% of P. carinii were found to have been disposed of within one year of ending the artificially induced hypercortisolism.

So, what could Dr Miller have learned from this brief glance into the history of PCP to benefit his patients, ostensibly stricken with "HIV-associated respiratory diseases"? First, that PCP and the fungal pneumonias could thrive very happily before AIDS came along – and long before any hypothesised retrovirus (which is not supposed to have existed before 1978) could have been involved – under the systemic environmental changes in the lung due to excessive situations of oxidative stress under a persistent catabolic level of metabolism.

Secondly, Dr Miller could have learned that the common factor between the phenomena called "CD4 cell immunodeficiency", P. carinii growth conditions, and the laboratory finding of "HIV-positive" can be found in the fact of excessive forced oxidative stress.

The construction rules of the "anti-HIV antibody test" lead also to this conclusion. Dr Gallo and his colleagues brewed their test soup from already overstimulated CD4 lymphocytes obtained mainly from the serum of PCP patients as well as from cells of a particularly division-prone leukaemia cell line, spiced this with powerful oxidising agents, called mitogens, added a generous dash of hydrocortisone, and incubated it thoroughly. They then fished out of this brew a mixture of proteins which they ascribed to a hypothetical retrovirus, HIV. It follows that these proteins (antigens), released under the oxidative stress in the test-tube, will necessarily bind to their complementary proteins (antibodies) from the serum of patients who had themselves, due to patho-physiological processes, formed proteins analogous to the test antigens from Gallo's brew. Antibodies found in HIV-positives are therefore to be seen as nothing other than increased levels of auto-antibodies against endogenous proteins which have been produced as a result of highly increased cell-turnover under chronic oxidative stress.

Thirdly, Dr Miller could have learned from all these findings that these laboratory artefacts known as "HIV-positives", represent anything but the presence of a transmissible mass epidemic due to semen and blood.

The annual incidence of the false diagnosis "HIV-associated diseases" for the whole population of Germany is 0.002%. This result contradicts eloquently the absurd apocalyptic predictions of AIDS doctors. The official annual rate of new infections in the general population in Germany of the clinical misdiagnosis "HIV-associated P. carinii pneumonia" is practically 0.00%, and among gays amounts to just about 0.05%. This true rate, differing starkly from the predicted rate, is well within the range of other epidemiological burdens of other population groups, eg. the annual incidence of lung cancer in all smokers is 0.1%. On the other hand, the annual rate of miscarriages due to folic acid shortage in mothers is also around 0.1% (and is strikingly close to the incidence of folic acid inhibition following medication with co-trimoxazole, of which more below.)

Medical Treatment

Perhaps the most important lesson for survival of those affected is the question: what is the effect of the medical treatment on the

CATABOLISM – metabolism that breaks down complex substances in the body (opp. ANABOLISM)

Heinrich Kremer, Dr. med.

Born in 1937 he qualified with a medical degree in 1965 and then studied Sociology, Psychiatry and Politics at the free University of Berlin.

Between 1968 and 1975 he was the Medical Director of the specialist clinic for juvenile and young adult drug offenders for five counties, including Berlin, Bremen and Hamburg. Whilst in this role he introduced the first clinical protective vaccination programme against Hepatitis B and the first clinical HIV-test cohort in the Federal Republic of Germany. The specialist clinical knowledge he gained led him to make a fundamental critique of the orthodox "HIV causes AIDS" theory of illness.

Since then, as a freelance consultant, he has published in the field of social medicine such titles as *How serious is AIDS-medicine*, *To have fear and to make fear* (1990), a documentary film *The AIDS Rebels* (1992, co-author Fritz Poppenberg), *World Myth AIDS* (1994) and *Attention AIDS-Medicine: Mortal Danger* (1996, co-author Dr Stefan Lanka).

In 1996 he became a member of the Study Group on Nutrition and Immunity, headed by Prof. Alfred Hässig from Bern, Switzerland, and initiated, with Dr Stefan Lanka, the Research Group for Investigative Medicine and Journalism *reg!med*.

development and course of "HIV-associated" P. carinii pneumonia.

Dr Miller is quite revealing in two respects of this without seemingly being aware of the consequences this entails. First, he is perplexed

> "despite the widespread introduction of effective primary and secondary prophylaxis, P. carinii pneumonia remains a common respiratory pathogen in individuals with AIDS and continues to account for almost half of all respiratory episodes."

Without in any way justifying the alleged efficacy of his primary and secondary prophylaxis, he defines his preferred mixture of co-trimoxazole with seemingly precise milligram amounts as a multi-purpose-weapon prophylaxis against prokaryotic and eukaryotic unicellular life forms in three domains of life at the same time: against fungi (including P. carinii pneumonia), protozoa (including toxoplasmosis gondii) and "bacterial infections."

> "The regimen of first choice for primary and secondary prophylaxis of P. carinii pneumonia is co-trimoxazole 960 mg once a day or three times a week; this may also afford some protection against bacterial infections and against reactivation of cerebral toxoplasmosis."

The curious reader also gets to learn from Dr. Miller, 15 years after being first reported by the CDC (June 1981) about the failure of treating homosexuals with co-trimoxazole who had PCP (two out of five died), but nothing of the mechanism of this chemotherapeutic agent (often wrongly prescribed as an 'antibiotic').

Co-trimoxazole (better known under its trade names Bactrim and Septrin) contains a combination of sulphamethoxazole, a sulphonamide, and trimethoprim, a cytostatic agent which is also used to treat leukaemia in the same form, ie. to destroy white blood cells! Sulphamethoxazole inhibits the synthesis of folic acid which is essential to life, by substituting the para-amino-benzene (PABA) moiety, so that the enzyme responsible for folic acid synthesis is consequently blocked.

Trimethoprim inhibits conversion of folic acid into the biologically active form of tetrahydrofolate by blocking the enzyme dihydrofolate reductase. Without tetrahydrofolate, essential precursors for new DNA cannot be synthesised. For example, the nucleoside uridine has to be methylated by methylentetrahydrofolate to form the essential DNA building block, thymidine triphosphate (TTP). This is the same component that is displaced with the notorious cell poison, azido-thymidine, better known as AZT, Zidovudine or Retrovir. Co-trimoxazole, therefore, works in a different way, but with a similar result to AZT, as a DNA blocker!

The consequences of inhibiting essential metabolic pathways for growth, cell differentiation and division are fatal. The synthesis of essential nucleic acids, proteins and enzymes develops faultily, or ends completely.

Cell Damage

This treatment with combined trimethoprim/sulphamethoxazole (=co-trimoxazole) is especially serious for the functioning and fine structure of mitochondria in nucleated (eukaryotic) unicellular and multicellular species (protozoa, fungi, plants, animals, humans). Mitochondria – so-called organelles – are the major suppliers of energy in human cells (except in red blood cells). They are endosymbionts (former bacteria with a double membrane). They contain remnants of their ancestral genome. This mitochondrial DNA (mtDNA) is irreplaceable in the synthesis of protein subcomponents of the respiratory chain. For respiration, activated electrons in the respiratory chain from nutrients using oxygen are built into the universal energy source for the entire cell, adenosine triphosphate (ATP).

If the synthesis of precursors of DNA is harmed through chronic or high dose treatment with co-trimoxazole the mitochondrial DNA is damaged and altered which in consequence impairs mitochondrial proteins, as well as the proteins of the respiratory chain, and ATP production therefore decreases. This leads to increased oxidative stress and to an increase in toxic oxygen free radicals. A vicious circle is set up once the ATP levels reach a critical low, and if the special molecules which normally remove harmful oxygen intermediaries are all used up, then further DNA damage arises. The cell initiates programmed cell death, because the ion pumps which regulate the balance of the flow of manifold molecules of building supplies and working materials into and out of the cell necessary to maintain cell function, fail for lack of fuel in the form of ATP.

Incidentally, DNA blockers such as co-trimoxazole and AZT, fundamentally damage predominantly the mitochondrial DNA, because the mitochondria cannot repair any mismatches or breaks in their DNA unlike the much longer and specially protected double-stranded DNA in the cell nucleus which can. DNA in the nucleus is passed on by sexual reproduction and is recombined, whereas mitochondrial DNA is propagated asexually through the maternal egg cell, which means that mutation errors are not corrected but conserved. The mutation rate of mitochondrial DNA is 5-10 times higher than for nuclear DNA. The nuclear DNA, being surrounded by its own membrane is physically better shielded, as well as benefiting from protective proteins and enzymes from any damaging effects of the metabolism than is mitochondrial DNA, which in bacteria is scattered loose throughout the cell plasma, and in several copies.

The above basic facts of cell biology apply, of course, with greatest force in rapidly maturing cells with short half-lives, especially the thymus-matured lymphocytes (T-cells), whose job is not only to recognise and, with the help of other immune cells eliminate, foreign proteins, but also to remove altered self-proteins without causing inflammation. If this cannot be done adequately because of infectious, toxic, nutritional, psychological or other overload, the body enters a state of emergency: the B-cell system is stimulated to produce antibodies and autoantibodies as well as macrophages and many inflammatory mediators and the entire metabolism is transformed. Over the short term, the body can deal with such a state of emergency. If this state persists, however, a chronic maturation deficit of T-lymphocytes (T-helper cell deficiency) arises, and the now permanently changed environment

becomes the feeding ground (substrate) for the recycling activity of fungal parasites (in Greek, parasite means unwelcome scrounger) and as a consequence of B-cell activation, specific autoantibody profiles make the "anti-HIV antibody test" turn positive, just as in some autoimmune diseases such as rheumatoid arthritis and lupus erythematosus.

Under these conditions of highly acute state of emergency such as is found in "immune-suppressed patients," it does not require the wisdom of Solomon to see that the treatment methods of Dr Miller and his colleagues will induce precisely that which they seek to avoid, namely, an Acquired Immune Deficiency Syndrome (AIDS) induced through wrong medical practice.

Why does Miller apparently not know anything of the special vulnerability of mitochondria to co-trimoxazole? Does he not know that in wanting to stop fungi, protozoa and bacteria prophylactically, he simultaneously attacks the driving force of all body cells, the mitochondria, as well, since they are former bacteria themselves?

Dr Miller comments ruefully

"as many as 25% of patients receiving prophylactic co-trimoxazole develop adverse drug reactions ... 50% of patients receiving treatment doses likewise develop adverse reactions."

But Dr Miller describes only the massive "side-effects" of short term therapy, though he appears to be genuinely surprised by their intensity in "HIV-associated diseases."

"There is no clear explanation for such a pronounced increase in adverse reactions to co-trimoxazole which is about 20% greater than seen in the general population."

It is a pity that he does not give some thought to the long-term use in prophylaxis of folic acid inhibitors like co-trimoxazole (let alone in combination with AZT (zidovudine), ddC (zalcitabine), ddI (didanosine), D4T (stavudine), 3TC (2'-deoxy-3'-thiacytidine), the newer protease inhibitors (saquinavir, ritonavir, indinavir, neltinavir) or the newest non-nucleoside reverse transcriptase inhibitors (delavidine, nevirapine and others.)

Are not the long-term damaging effects of using combined folic acid inhibitors really the major cause and not the consequence of what Dr Miller and colleagues perceive to be "HIV-associated disease?"

Drug History

Co-trimoxazole was brought into clinical use in the early 1970s, ie. more than 20 years ago. Individually, sulphamethoxazole and trimethoprim inhibited the growth of pathogens only, whereas both together as co-trimoxazole killed off a wide range of microbes.

This was of great significance in the treatment of multiple infections of a minority of homosexuals in the large Western metropols. The purpose of treatment in most cases was simply to suppress as quickly as possible the wide spectrum of microbial growth encountered. Co-trimoxazole quickly became the wonder drug with specialist doctors and their homosexual patients in Western metropols; this double-action folic acid inhibitor was used not only to treat but to forestall (incredibly, often by self-administration), unthinkingly, in exactly the same way as nowadays Dr Miller and his colleagues do, too – moreover, in far too high doses and for far too long a time – especially against the often refractory urinary tract and intestinal infections, and atypical pneumonias in this group of patients.

A literature search since 1970 does not come up with a single publication about the "side-effects" of co-trimoxazole on the functioning and fine structure of mitochondria, nor on the connection between T-cell deficiency itself and co-trimoxazole; yet there has always been ample evidence in the literature for the damage caused to all white blood cells (including lymphocytes) in various groups of patients, even during short-term use of co-trimoxazole! The only investigation of up to 45 days after beginning treatment with co-trimoxazole was conducted in Britain by the General Practice Research Group in 1988-93. Since folic acid reserves in man can last up to 4-5 months, significant damage to patients with "HIV-associated infectious diseases" often manifests itself only after long-term prophylactic use exceeding eight weeks, which is then interpreted as AIDS symptoms.

Surprisingly, until the appearance of AIDS in 1981 there were no reports in the medical or pharmaceutical press about the damaging effects of co-trimoxazole use amongst homosexuals, although the "side effects" in this group should have stood out like a sore thumb, because of the high dosages and duration of treatment. The matter was obviously declared a taboo subject until P. carinii fungi as a recycling agent began to run amok in the lungs of these patients, sometimes after they could not be controlled even with high doses of co-trimoxazole (as was first reported by the CDC as long ago as June 1981).

Instead of at least by then asking themselves what the damaging consequences of chemotherapy in this group might be, all those concerned indulged in a fit of collective mental repression regarding the interpretation of the symptoms they were witnessing, which later on became rationalised as a "new lethal syndrome due to a new pathogen."

Egged on by a prurient media relishing plague fantasies, the medical establishment transformed a set of new and old symptoms into an apparently uniform disease process using the codes "AIDS-related processes" and "HIV-associated diseases" which supposedly resulted as a wide chain-reaction of the primary effect, a virus invasion, which anyone could catch through sex and blood.

This interpretation had the tremendous advantage over more mundane explanations that neither the doctor nor the patient had to question their own role in the dynamic of the case history; the new syndrome started, so to speak, a-historically. The pharmaceutical industry could exploit the ensuing fear of death with impunity, instead of initiating a fundamental reappraisal of unphysiological chemotherapy and treatment, involving the testing and use of ever more powerful combinations of highly toxic mixtures on a global scale, financed by all of us, in a seemingly heroic battle against a "plague threatening humankind."

The world's largest manufacturer of co-trimoxazole has meanwhile confirmed in writing that there have never been any investigations into the effect of folic acid antagonists on mitochondrial integrity. Strangely enough though, the indications (recommended circumstances under which to prescribe a drug) at least in Britain and America for co-trimoxazole, have been severely reduced, because of frequent side effects during short term use (cf. BNF, FDA guidelines). Excepted from this change: special indications of prophylactic and therapeutic high doses and long-term use and in frequent intermittent therapy (itself a long-term use because of cumulative damage) were expressly permitted for "HIV-infected" patients and "PWAs".

In this light, the concerned statement of Dr. Miller

"despite the widespread introduction of effective primary and secondary prophylaxis, P. carinii pneumonia remains a common respiratory pathogen in individuals with AIDS"

becomes a self-fulfilling prophecy.

In the early 1980s the use of co-trimoxazole had reached the very high annual incidence of 5% of the population, about equal to that of alcoholism, while use of co-trimoxazole by homosexuals in Western countries (the taboo subject), in particular in metropols and in the neighbourhoods of specialised practices and clinics must have likely been, and continue to be, considerably higher. It was recommended to restrict the general indication of the drug, because of the high level of damage to blood cells, (including lymphocytes) while, gruesome to relate, the prophylactic and therapeutic indication for already immune-suppressed patients, stigmatised as "HIV infected" and "PWAs", were relaxed.

If the number of CD4 cells necessarily declines because of DNA blockage and mitochondrial damage through co-trimoxazole (because of increased cell death and inhibition of maturation) then "AIDS" will be diagnosed, and the range of DNA blockers and mitochondria killers constantly enlarged. The blind zeal of virus hunters leads them to use ever more frantic chemistry without, as Dr Miller shows, ever stopping to think about the vital basic

conditions of the intertwined biospheres of our bodies. The patient will go through all the stages of AIDS described in textbooks, and at the end of it, all the participants will feel bitter at having lost the battle, at great sacrifice against a fickle enemy, despite calling on all means available; the patient will have dutifully suffered a ritual death for the sake of a plague-hungry society; the frustration of the doctors and their companions in death will have been transformed into aggression against those who have insisted all along on a genuine re-evaluation of their actions.

Pre-existing Immune Deficiency

If the premise of an inexplicable immune deficiency affecting hitherto completely healthy individuals had turned out to be true, then the virus-AIDS theory could have been a reasonable working hypothesis. But because AIDS (according to the official CDC explanation) is supposed to be a serious disease of acquired immune deficiency without pre-existing or induced immune deficiency, it has to be stated quite unequivocally that such AIDS cases have never been found up till now, except in the form of a medical mantra of plague propaganda, because in all verifiable cases, demonstrable immune-suppressive disease and/or treatment have always preceded them.

There has never been a need, therefore, to explain an inexplicable immune deficiency, because the causes were there for all to see. And a new virus was entirely redundant for an understanding of the disease process, irrespective of whether the suggested retrovirus HIV existed or not. For example, the annual incidence in Germany of AIDS in the population as a whole is just 0.002%, and amongst homosexuals 0.1%. Intriguingly, more than 60% of all "AIDS-cases" in a population of 80 million occur in the immediate vicinity of six large university clinics in six towns, which rather supports the view that AIDS should be called an "Acquired Iatrogenic Death Syndrome."

Furthermore, according to Dr. Jäger (in a live interview), one of the leading German AIDS-authorities, (President of the Curatorium for Immunodeficiency, Munich) in the period from the ostensible beginning in 1981 to 1996, there has not been a single case of male or female HIV infection in the age group 14-20 (not even in homosexuals!), although every school kid has had the exact opposite drummed into him, which is proof that the advocates of HIV/AIDS are by now unwilling to separate fact from fiction, even for the sake of the patients entrusted to their care.

Plague Mania

Dr Miller really should have another look at Virchow's writings in order to understand why TB had practically lost all its horrors in Western Europe without use of chemotherapy, and why now, in his own words

> *"multiple drug resistant (MDR) tuberculosis has emerged as an important clinical problem in HIV-infected patients in the USA."*

Dr Miller fails to mention, however, that chemotherapy for mycobacterium tuberculosis and mycobacterium avium intracellulare (Nos 6 & 7 in his list of "HIV-associated infectious diseases") also require high levels of folic acid, thereby inducing a relative shortage of folic acid, ideal conditions for DNA mutation to occur. In Africa by the way, in a different mycobacterial disease, leprosy, the anti-HIV antibody test reacts positive as well.

Because African AIDS (apparently 90% of all AIDS cases worldwide) is as a rule nothing other than old well-known clinical conditions such as TB, malaria, hepatitis, diseases caused by worms and 'slim', (all the result of poverty, hunger and inadequate hygiene, in the sense that Virchow meant), there the "HIV-associated respiratory tuberculosis" in Dr Miller's terminology, turns out to be just plague-mongering. As Dr Miller rightly says

> *"TB is a potent stimulator of cell-mediated immunity"*

but he doesn't say that if the store of immunity is constantly being used up, and, for all the reasons explained above not properly replenished, then a deficit does indeed arise, resulting in an "Acquired Immune Deficiency Syndrome". However, even in such cases, immune-suppressive disease and/or treatment have preceded the appearance of the syndrome; it is not a case of independent AIDS in the CDC sense, which requires an explanation based on "HIV association". The HIV association is, as far as this elementary disease process is concerned, exactly the reverse – a life-threatening "connection in the mind" which has led to a collective plague mania, which has completely lost sight of the true causes of disease.

Anniversary

It might be appropriate to mention that the German medical profession these days is commemorating the 50th anniversary of the Nuremberg Doctors' Trials, during which doctors stood accused of crimes committed under the Nazis. Amongst other things one can see in the transcripts that experiments were performed on concentration camp inmates including homosexuals using sulphonamides to treat infectious diseases that had been induced specially for this purpose. Sulphonamides were used knowingly to cause death in innocent victims. Nowadays the chemical cudgel of sulphonamide + trimethoprim (=co-trimoxazole) + AZT, etc. etc., is hurled about (of course, only with best intentions and not to be compared with the crimes of doctors in Nazi times).

The lethal effect of AZT on mitochondria has by now been amply proved; an analogous effect of long-term use of co-trimoxazole is equally plausible. Does it not occur to anyone, bearing the Nuremberg Trials in mind, that it is high time to discuss the ethical consequences of the "virtual medicine" currently practised, which under the pretence of an imagined global epidemic, force-feeds highly toxic drug cocktails to terrorised patients, on the basis of a laboratory artefact.

What Dr Miller and colleagues clearly find hardest to do, is to question their own doing. Anyone who uses co-trimoxazole, AZT etc. etc., which we know very well induce immune deficiency in the long run, to combat immune deficiency, is put in the same position as someone in the 19th century prescribing blood-letting to treat anaemia, knowing full well that millions perished as a result of that treatment. Just 10 days' use of co-trimoxazole can, as has been observed in some instances, result in anaemia. Nonetheless, Dr Miller and colleagues continue to advocate co-trimoxazole as the "prophylactic treatment" of first choice – until the patient dies.

Since the life-threatening consequences of this long term iatrogenic intoxication with co-trimoxazole, in complete analogy to the no-longer-to-be-denied consequences of long-term AZT use, are not ascribed anymore to the Co-trimoxazole-treatment itself (alone or in combination with AZT) but are misinterpreted as the predicted "HIV-associated infectious diseases" and "AIDS-related processes", Dr. Miller arrives at the unbelievable [suggest: breathtaking] conclusion:

> *"in patients with adverse reactions, desensitisation to co-trimoxazole is successful in as many as 80% of cases."*

What Dr Miller does not say is that mortality due to PCP, as a fraction of the total number of AIDS deaths in the Western world is despite (or because of?) medication with co-trimoxazole also 80%!

...To be continued.

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THE AIDS CULT

and its seroconverts

part 1

Ian Young

"Purposely, the twenty-something boys, who have never known a sex life without AIDS, fatalistically expose themselves to HIV as a test of ritual manhood."

—Jack Fritscher, *Mapplethorpe: Assault with a Deadly Camera, 1994.*

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

—*Book of Common Prayer*

At the local gay bars and dance clubs, the raves and fetish nights and "AIDS fundraising" events, a new style of body ornament is becoming fashionable. Young gay men are beginning to sport tattoos, usually in block letters on the upper arm, that spell out HIV, followed by a minus sign. The idea, of course, is that when (when!) you seroconvert, you pay a follow-up visit to your tattooist, who changes your minus to a plus. Simple.

The convertible (one way only!) tattoos signal an unsettling phenomenon that is only now beginning to be acknowledged. An astonishing number of young gay men whose sexual activity began only after the implementation of the "Safe Sex" and "AIDS Education" programs of the 80s and 90s, are seroconverting – testing positive for antibodies, widely believed to indicate risk of AIDS. One estimate has it that one in three twenty-year old gay men will be HIV-diagnosed or dead of AIDS by the age of thirty. According to the psychologist Walt Odets, many of them accept AIDS not only as a possibility for themselves, but "as a destiny about which they can do very little."

A pair of recently published books, Odets' own In the Shadow of the Epidemic: Being HIV Negative in the Age of AIDS[1] and William I. Johnston's HIV Negative: How the Uninfected Are Affected by AIDS[2] explore this new insouciance about seroconversion and offer some disturbing insights into contemporary attitudes. Odets is a clinical psychologist and psychotherapist; Johnston is the facilitator of a discussion group for gay, antibody-negative men. Working independently, they have amassed considerable evidence of what Odets describes as "a psychological epidemic among uninfected gay men."

Now in its fifteenth year, the protracted AIDS crisis has had an impact on everyone in the gay community, diagnosed and undiagnosed alike. Odets writes that he sees "innumerable examples of psychological problems among gay men that seven years ago would have been unusual and noteworthy, but are now so common that they pass almost without comment." Many gay men are afraid to become close to anyone, as either lover or friend, for fear any intimate involvement will be terminated by early death. As one man put it, "I've never thought about having a relationship for more than a couple of years, because I've never dated anyone who was going to live longer than that."

Odets' and Johnston's books are the latest additions to a growing body of literature documenting the complex varieties of "survivor guilt" now experienced by increasing numbers of gay men. Both authors discuss the finding that in today's breezy, out-of-the-closet gay ghetto, antibody-negative men tend to be profoundly clinically depressed, anxious, disoriented, hypochondriacal, uncertain about the future, sexually dysfunctional, deeply demoralised and psychically numb. Many abuse alcohol or drugs, and their physicians prescribe them millions of dollars worth of tranquillisers, sleeping pills, anti-depressants and sedatives every year. More and more undiagnosed men, Odets finds, now "live in nearly every detail like a dying man – disoriented, piecemeal, and with no assumption of a future."

From his years of intensive talks with friends, patients and clients, Odets concludes that this widespread, endemic depression has its origins not only in the current health crisis, but also in "a destructive mix of old developmental problems" that have usually begun in childhood. Substance abuse is often chronic, reflecting mood disorders, loneliness and stress; in this, antibody-negative gay men probably differ little from their antibody-positive brothers. We may now be starting to recognise longstanding patterns of psychoimmune disturbance in a second generation of gay men – a generation that has come to sexual awareness during the AIDS era.

A few years ago, when conservative commentator William F. Buckley, Jr. suggested that PWAs should all be forcibly tattooed (on the arm and/or the buttocks) for instant recognition, there was widespread disgust at the idea and embarrassment that the apparently urbane Buckley would suggest it. Now, such tattooing is available on a voluntary basis and there is no lack of takers. After a decade of propaganda about Safe Sex, a sizeable cohort of young men, becomes eligible every year for HIV+ tattoos. Bill Buckley's American Auschwitz Theme Park is almost here, and no boxcars will be required.

One effect of the ubiquitous official warnings about "risk behaviour" and "vectors of (AIDS) transmission", is that more and more gay men now believe their body fluids to be dangerous, and "define certain behaviours, such as anal sex or oral sex, as unsafe in and of themselves, without regard to whether one of the people involved had HIV...It is common," writes Odets, "for gay men now to say that anal sex is 'unsafe' even when practised by two antibody-negative people." William S. Burroughs is fond of quoting one survey that found most people believe you can get AIDS from anal intercourse, whether or not HIV is present.

Anxieties about gayness now frequently express themselves as fear of viral contamination

Anxieties about gayness, about sexuality, and about intimacy, now frequently express themselves as fear of viral contamination, an ostensibly rational reason to avoid what has always been problematic. When HIV is identified with feared (and unconsciously desired) homosexual intimacy, the result is a powerful draw toward seroconversion. The undiagnosed men interviewed in both these books repeatedly express the view that antibody-positives live richer, more complex, more "authentic" lives, get more attention, are better able to take risks – including, significantly, the "risk of intimacy" – and that only with such risk-taking can life be meaningful and full.

This perceived link between antibody-positive status and emotional fulfilment is one of many factors now propelling gay men toward seroconversion. These pressures emanate from the AIDS Establishment's group assumptions about gay men, assumptions which are more and more clearly reflected in the ghettoised gay community itself. And it is the power and diversity of the pressures to seroconvert that constitute the central, disturbing message of both these books.

After the Reagan administration pronounced in 1984 that HIV was the sole cause of AIDS, lucrative patents on HIV-antibody tests were granted to leading AIDS researchers and an aggressive international promotion campaign for HIV-antibody testing began. At first, most gay and AIDS advocacy groups considered testing to be dangerous and oppressive. In the mid-80s, people entering the "Test Sites" (a term eerily reminiscent of "nuclear test sites") often had to make their way through lines of vocal gay demonstrators. Governments and pharmaceutical companies then directed a light dusting of money to selected recipients and the protests died down. Soon a broad consensus developed that testing was a virtue, a civic duty, and the smart thing to do.

Testing positive, in the current wisdom, leads to "early intervention," by which is meant the prescription or administration of large quantities of pharmaceutical products – the so-called "antivirals" and so on – principally nucleoside analogues whose devastating "side-effects" often replicate AIDS symptoms. Whether subsequent illnesses are caused by the inevitable "progress" of the virus, or by a self-fulfilling prophecy is debatable.

The quotations and first-person accounts by antibody-negative men in these studies suggest that while an antibody-positive test result was originally looked upon as a calamity, this is no longer always the case. This is partly because some PWAs are learning how to take care of themselves and are living longer, and partly because a growing number of gay men see an HIV+ diagnosis and AIDS not as something that can or should be avoided, but as, in Johnston's words, something "fundamentally linked to gay identity". Certainly it has been represented to them that way. Heterosexuals and lesbians are told, "AIDS doesn't discriminate!" But gay men have come to perceive it as an inextricable part of their "community," their "identity," and their future. One female-to-male transsexual told his therapist that his transformation to a gay man would only be complete when he had contracted HIV! I have heard gay men repeat the homophobic joke: "GAY stands for Got AIDS Yet?".

In the 70s and early 80s a ghettoised consumerism (fast food, fast drugs, fast sex, quick-fix medicine) was packaged and sold as "the Gay Lifestyle". Now AIDS is increasingly presented as the new Gay Lifestyle. In the gay community of the 90s, everything revolves around AIDS.

This AIDS-centred vision of community life has even made its encroachments on lesbian society. In 1994, after the founder of the British organisation for lesbians with HIV, Positive Strength, revealed that her claim to seropositive status was false, AIDS activist Simon Watney spoke of "an imaginary epidemic (of) fantasy AIDS" among British lesbians. Lesbian writer Robin Gorna wrote that "although there are many gay men who also lie about their HIV status, it seems that some lesbians feel unable to articulate their own issues alongside the horror of AIDS. If you are a young dyke, your identity is all tied up with AIDS, yet it's not your stuff." She added that there was no evidence to suggest lesbian sex poses any significant AIDS risk: lesbians with AIDS, she said, tend to contract it from drug use and/or sex with men, which she described as "still a taboo subject in the lesbian community."[3] In all the fracas about how many lesbians get AIDS, Gorna's remark that many gay men lie about having HIV seems to have been overlooked.

Walt Odets draws our attention to the attitude, widespread in the gay community, that only PWAs and antibody-positives have a right to express strong feelings. He recalls that when he voiced his concerns about the emotional well-being of antibody-negative gay men, he found it was considered inappropriate for antibody-negatives to "experience feelings about their own lives worthy of discussion or worthy of the concern and attention of others." The feelings of those regarded as "uninfected" are widely felt to be "selfish, inappropriate, or simply ridiculous." Often, antibody-negatives are even seen as The Enemy; one man, on the steering committee of a "mental health" conference, when told of an antibody-negative discussion group, retorted, "That's like Germans getting together...to congratulate themselves on not being Jewish!"

Society has never made the well-being of gay men a priority. On the other hand, if you have AIDS or are antibody-diagnosed, a range of social services, support groups, medical benefits and other perks becomes immediately available. Suddenly, attention is paid. Variations of the same phrase crop up again and again in the sentimental AIDS literature: "I never knew how

Ian Young *was born in London. His involvement in the gay movement, as activist, writer and publisher, began in the 1960s. His books include the ground-breaking gay psychohistory* The Stonewall Experiment, *as well as poetry, literary anthologies, bibliography and history. Director of a communications consultancy firm and a frequent contributor to the gay press, he lives in Toronto and Banff, Alberta.*

much I was loved until I got AIDS." It makes a great ad slogan, if AIDS is what you're selling.

In the urban gay ghettos of the 80s and 90s, a whole AIDS Culture has emerged – an "AIDS Community" based on an ever-shifting melange of medical and subcultural assumptions. This new blood brotherhood is beginning to form a kind of Inner Order within the exoteric conglomeration of the lesbian and gay scene, and a growing number of glossy magazines now devote themselves to the perks and pleasures of the Positive Lifestyle. And one "comes out" into this Lifestyle in one way only: by seroconverting. Seroconversion is the ritual that all who would join the cult must endure. Those who have lost friends, or, especially, one or more lovers, to AIDS may claim honorary membership. The cult's unofficial badge of honour is a looped red ribbon, usually pinned to the chest, or rather to the coat. Originally a fund-raising favour, the "red ribbon" is now commercially available in many stylish designer forms: one can choose from ceramic, dyed leather, or 24-carat gold encrusted with red stones. Elizabeth Taylor is one of the few who can afford a diamond and ruby "ribbon". Of course, fashion is fickle and the red ribbon is already coming to be regarded as somewhat passé, not to say kitsch.

Under the pressure of protracted crisis, the transformation of signals, policies and identities has been relentless. In the 80s and early 90s, the figure of the AIDS activist, the seething ACT-UP clone, body pumped under the white political T-shirt, head shaved, concentration-camp style, became, for a while, a symbol of erotic resonance, a sexual icon. Having exhausted itself in unfocused anger, the fashion is less popular now than it was.

The ongoing roster of AIDS dead (lots of blank space left on that memorial, how thoughtful) constitutes the raison d'etre of this new, prototypically postmodern, community. Obituaries and funerals are its social glue; its chief dramatic form is the memorial service. Every two weeks, when the new issue of Xtra! comes out, everyone turns to the obituaries first. The Toronto version of this Canadian gay newspaper combine (for it has cloned itself) publishes an annual roster of AIDS dead, under the banner headline "Proud Lives." Deaths from non-AIDS-related causes are relegated to a separate, less prominent, section bearing the mundane and rather dismissive tag, "Other Losses." antibody-positive decedents are sometimes placed in the "Proud Lives" section, even if they committed suicide or fell off a mountain. If you're positive, there's only one way to die, and we're going to hold you to it.

The overshadowing of all other gay issues by the AIDS agenda (first pointed out by Darrell Yates Rist) and the frequent dismissal of the concerns of the undiagnosed, have understandably generated widespread feelings of "disenfranchisement" among uninfected gay men. These feelings are reinforced when the undiagnosed are told to behave as if they were infected: "Be good. Have Safe Sex" – even if they are in a monogamous relationship with an "uninfected" partner! Walt Odets suggests that these injunctions have been ineffective in promoting safety and psychologically disastrous.

Within the urban gay community, the undiagnosed now constitute what William Johnston calls a "psychic minority" – one that appears increasingly eager to Think Positive and join the psychic majority, the AIDS/HIV Community. Though it would have been inconceivable only a few years ago, a positive HIV-antibody test result, or even an AIDS diagnosis, now frequently results in a decrease in anxiety! The acute stress of the testing ritual is released by a positive result. Now, at least I know the worst – and I'll never have to be tested again! (Negatives are encouraged to come back.) The director of one health service agency reports that individual "crisis responses requiring urgent counselling" were generated by negative test results at a three-to-one margin over positive ones!

Scattered through these two books are various responses to being told of a negative test result: "All my friends are positive – how can I relate to them?" "Everyone's going to be very angry at me." "I feel like I'm being left out of the great event of our time." "I hoped I would be positive so it would give me an excuse to go back out and drink and drug." "I feel as if I won't really have come out until I'm HIV-positive." "It's a lot simpler to think about AIDS than about being gay." "Guys who get AIDS get a lot more attention." And, my own favourite: "Shit! I'm going to have to go to work tomorrow after all." Every two weeks, when the new issue of Xtra! comes out, everyone turns to the obituaries first.

Elizabeth Taylor is one of the few who can afford a diamond and ruby "ribbon"

One gay man told me recently that when he revealed to an acquaintance that he was antibody-negative, he received the sneering (presumably rhetorical) reply, "How come? Didn't anyone want your tired old ass?" A gay student, who was relieved at his negative test results, nevertheless made a wryly revealing comment about the whole process and everyone's attitudes to it: "For once," he said, "I was glad I failed a test."

One contributor to William Johnston's book describes a gay man who eventually seroconverted after many attempts: he "had a beatific glow on his face when he found out he was positive. He had been expecting this for so long, and finally the desired outcome was achieved." (His lover, he feared, was about to "dump" him if he remained stubbornly negative.) This new attitude – utterly unforeseen by either the pundits of AIDS Education or its consumers – leads Odets to ask whether counsellors "unconsciously suggest that a positive test result is more 'important' than a negative (one)?" The language used suggests they do; certainly they focus almost exclusively on preparing their clients for "positive" results.

The man with the beatific glow is one of a growing group of gay men who see their "progress" (this is the official term[4]) to seroconversion and on to AIDS as somehow desirable or inevitable. For the burgeoning cohort of seroconverts, the assumption of antibody-positive identity represents an all-important rite of passage in their lives as gay men. A beatific glow is a characteristic feature of religious conversion experiences, and in many ways, these men resemble the freshly inducted members of a cult.

There is a growing perception that for a gay man today to be HIV-positive is, well, positive. Connotations as fundamental as those suggested by the words "positive" and "negative" are deeply imbedded in our interpretations of the terminology we use. People do not easily transpose black and white, or accept a positive result as negative. Nor can the frequent use of the word "status" be considered inconsequential; we are lectured about our antibody "status", the subliminal suggestion being that testing positive, becoming "Body Positive," and adopting a "positive attitude" involves gaining a positive status, becoming worthy of concern.[5] The phenomena of the courageous, positive seroconvert and his neurotic, negative twin have evolved out of the

bizarre, dogmatic logic of HIV fundamentalism – what Walt Odets calls the "contradictions, inconsistencies and anomalies" of AIDS.

Odets writes that "a return to unprotected sex among gay men after about 1988 is now widely recognised." Why in 1988, four years after the announcement of HIV as the cause of AIDS? My own experience from periodic visits to New York City, an AIDS epicentre, is that the years 1987-88 constituted the height of what the novelist Andrew Holleran has succinctly called "The Fear". Christopher Street was emptier than it has ever been and many gay men were afraid even to kiss. Protracted, inhibited grief and paralysing terror seemed, even to a visitor, to be causing all sorts of neuroses and a kind of mass mental breakdown. If the "return to unprotected sex" began in the late 80s as Odets believes, it may well have begun as a reactive symptom of that breakdown – an heroic defiance of fear by stoically embracing what was believed to be inevitable.

Just as the health crisis was about to be recognised, the poet and novelist George Whitmore wrote that we engaged in so many of our "rebellious" acts (dangerous sexual scenes, crawling around on all fours on the floor of the Mineshaft at four in the morning) to show that we could do these things "without flinching" – that we were not, after all, sissies. John Rechy endowed sexually promiscuous gay men with "heroic" qualities, calling them the shock troops of the sexual revolution. Is the same defensive need to prove one's masculinity, one's courage, and one's "in group" status now helping to create the phenomenon of the seroconvert?

Survivor guilt often involves the feeling that one should not have survived – and even the hope that one will not survive. The urban gay lifestyle is designed for youth, and for those committed to that lifestyle, the loss of youth may seem more terrible than a fatal illness. Michelangelo Signorile wrote in a recent column that "far too many gay men say they actually fear growing old in a gay world that puts the young and buffed on a pedestal while treating the over-35 crowd like lepers." He tells of one young guy who has unsafe sex because "he doesn't want to live to be 50. He doesn't want to be another aging queen, being jeered at by people like himself." Another man said he felt so "beneath" the men he was attracted to that he'd "do anything" for them, including have unsafe sex.[6]

Survivor guilt often involves the feeling that one should not have survived

Walt Odets concludes that "for some, the self-destructive aspects of unprotected sex are important incentives to practice it. This," he emphasises, "has nothing to do with complacency, nor will traditional AIDS education address it."

The AIDS System now entrenched in the urban gay ghettos has aggressively promoted HIV-antibody testing ("the AIDS test"), and most available AIDS Education has been oriented toward encouraging people – particularly gay men – to "get tested." Former presidential candidate Bruce Babbitt described the system as a "voodoo health policy" animated by the idea that "if we keep sticking needles into people and taking blood tests, the disease will go away." The apparent non sequitur only begins to make sense if, unconsciously, it is not so much the disease but the seropositives who are being wished away, with the AIDS System constructed as a wish-fulfilment around the group fantasy, and camouflaged as medical services.

"There are two ways to find out," read a slogan on the outside of an envelope one gay man received in the mail: "You can get tested. Or you can get sick." Even though AIDS was nowhere mentioned, he "knew right away what this cryptic message meant." It felt, he said, "like an assault." The letter was from Project Inform, a group that began as a dissident AIDS advocacy group and quickly devolved into what one commentator called a "power broker, coordinating sections of the AIDS industry with the appropriate government agencies." In a letter to the San Francisco gay paper the Sentinel, one reader described Project Inform as a "pharmaceutical pimp."

Extensive sections of Johnson's HIV Negative are contributed by various "uninfected" gay men. And Odets' book, the more analytic of the two, contains many briefer quotes drawn from the author's extensive counselling experience. Among the remarks: "Negative men are like my family: they have no feelings." "What I know is that I am going to follow my heart, and I think it's leading me to the (kind of) understanding that having HIV gives a person." "They will have a cure for it by the time we get it." Another remark I have heard repeatedly is "If I test positive, I can start taking care of myself."

There is a common feeling that to try to stay negative – to "struggle" to stay negative, as one man put it – is simply too difficult, too destructive of any joy in life. This is hardly surprising when the rules of "safe" behaviour are at once so stringent and so slippery. Is oral sex safe? Is rimming with a dental dam OK and if it is, why should we want to do it? Should I worry about that sharp pizza crust that might cut my lip and let the virus in? Am I condemned to stay around and watch all my friends die?

In the shadow of such conundrums, becoming positive seems to some like a doorway to intimacy, light and love, and life with AIDS, for all its horrors, begins to appear more rewarding, or just simpler, than life without it. Whatever the respective merits of these questions, the mental soil in which they grow is fertile ground for a positive choice.

Part 2 of this essay will be featured in the next issue of Continuum, *and an expanded version of the whole article will appear in* The AIDS Cult: Essays on the Gay Health Crisis, *edited by John Lauritsen and Ian Young (Asklepios, Box 1902, Provincetown, MA 02657-0245, USA.)*

Anal sex & AIDS

a dissenting view

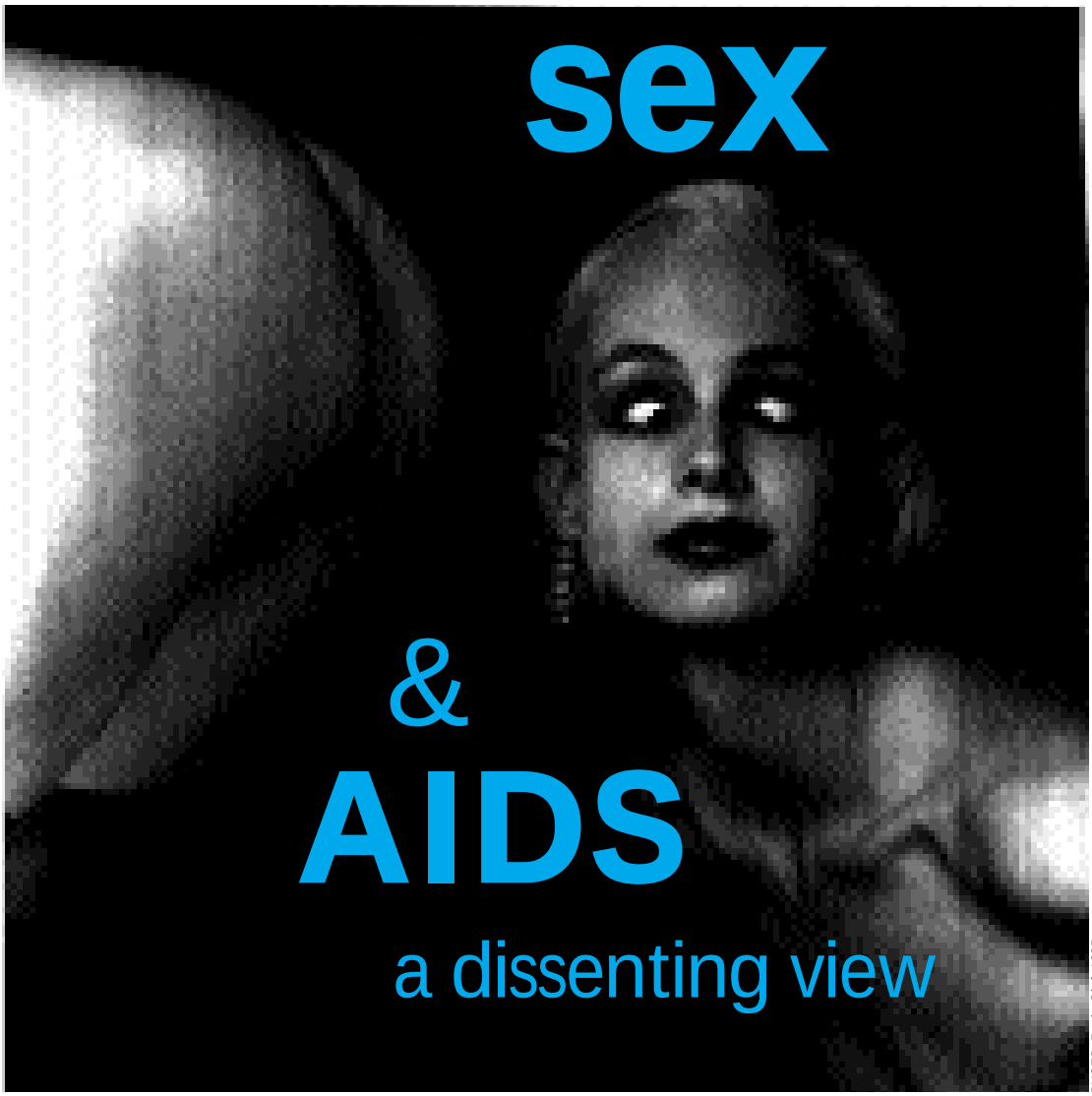

PHOTO: Erwin Olaf, 1985

Fred Cline

Since early on in the AIDS "epidemic it has been widely asserted that there is a correlation between gay men who practice passive anal sex and AIDS.[1]

The argument is that AIDS is induced by the direct immuno-suppressive action of semen in the anus and by the deleterious effects of sexually-transmitted diseases (STDs) and other infections more easily than through the mouth and throat (fellatio) or vagina.

This so-called scientific evidence is based on a correlation first made in the Multicenter AIDS Cohort Study, 1988.[2] Correlation, however, is not proof of causation.

Peter H Duesberg, on the other hand, in his paper "AIDS acquired by noncontagious risk factors" states that: "The probable reason for the higher AIDS risk associated with receptive anal intercourse is that this sexual practice directly correlates with a two-fold enhanced use of nitrite inhalants and other aphrodisiac drugs that facilitate anal intercourse."[3] On numerous occasions he has personally restated this position to me up to the present.

I am not able to argue the point that semen in the anus is directly immuno-suppressive since I am not a scientist. Peter Duesberg, however, has pondered this and come to the conclusion that even if it is mildly immuno-suppressive there is not sufficient quantity to cause a general immune collapse such as we find in full-blown AIDS, even taking into consideration those men who might practice passive anal sex compulsively.

It is generally assumed that anal sex is the riskiest form of sexual behaviour for passing on HIV. This may be so. Being an AIDS dissident, however, I believe that HIV either is a harmless passenger virus of does not exist.[4, 5] Leaving aside HIV, we are, therefore, only dealing with people who are ill for whatever reason.

The evidence that I have for anal sex not directly leading to illness is

Kimberley Bergalis testified before Congress that she was a virgin!

based on personal circumstantial evidence from an active gay life lived on three continents and numerous textual references to widespread anal intercourse practiced around the world.

The most important reference I have been able to find for this practice amongst heterosexuals is "Heterosexual anal intercourse" by Bruce Voeller.[6] Some very interesting facts emerge from this study.

First of all let us look at the prevalence of anal sex in the heterosexual population in the US. "According to the 1987 US census figures, the American female population between ages 15 and 64 years is about 81.6 million. Based on the estimate that 10% of women engage with some frequency in anal intercourse, roughly 8 million women are involved."[7] He concludes that "This startling number of women at risk through anal intercourse probably exceeds the number of homosexual men at similar risk..."[8] What then accounts for the vast difference in the number of AIDS cases between the two groups?

Furthermore, "25 percent of teenage girls [in the US] engage 'in rectal intercourse...to avoid pregnancy or to retain their virginity.' But the risk for ...'AIDS' is the same as for females who do not practice anal intercourse – almost nonexistent."[9]

It is interesting to note that Kimberley Bergalis in the famous Dr David Acer case was found to have venereal warts on the anus upon being autopsied.[10] These can be contracted only by anal intercourse. This, in spite of the fact that she testified before Congress that she was a virgin! Perhaps vaginally she was.

In many areas of the world anal sex is practised as a means of birth control. It would only seem logical that in China, a country of well over one billion individuals that restricts its married couples to one child, this would be the case, especially since we have abundant evidence in the poetry, liter-

ature and art of China of anal coupling.[11] Furthermore, in this study the author contends that "surviving literature [from China] depicts anal intercourse as the preferred form of homosexual intercourse."[12] China is still, in spite of the influence of Communism, one of the most traditional and unchanging cultures on Earth. It is therefore fairly certain that anal intercourse is still widely practised there, and in the light of their huge population, the actual number of rear-end encounters could exceed those of the US. In spite of this, we find practically no AIDS in China and China still suffers from a growing population.

Even more starting are the statistics on heterosexual anal intercourse in Brazil. "In a survey of some 5,000 households, over 40% of those interviewed in rural Brazil considered anal intercourse a normal part of sexuality, and over 50% of urban citizens in Rio de Janeiro did."[13] The author further

This taboo has distorted objective treatment of the subject until recent times

opines that this is probably due to the widespread acceptance of this practice since prehistoric times. One can only guess at what the total number of anal encounters might be in this situation, since only those who admit to it are counted. Suffice it to say that it has been almost universally practised in Latin America from prehistoric times to the present.

There is a curious taboo against speaking of anal intercourse although, at this point, I hope you are convinced that it is very widely practised. This taboo has distorted any objective treatment of the subject until recent times.

We should further note that in popular culture only gay men are thought of as participants in back-door acrobatics. Recently, a famous actor was quoted as saying he did not get along with gay men because they "took it up the ass." Although he regretted this outburst, we can be grateful to him for highlighting this very important misconception.

According to a recent survey done in the UK, the most frequent sex acts performed in the gay population are as follows in descending order of frequency: (1) self-wank, (2) wank/other, (3) suck, (4) fuck.[14] The average of those who "fuck" is set at around 6%.[15] Similar studies have revealed this pattern in the US and other developed countries. If, then, only 6% of the gay population engage in anal sex on a regular basis, and, if, indeed, we only represent 10% of the population, it then becomes abundantly clear that most anal sex in almost all societies is straight anal sex.

Straight men are not supposed to engage in receptive anal sex. My experience and various other sources would tend also to lay this myth to rest. Need we remind ourselves of what happens in all-male groups, such as prison or the armed forces? Steve Zeeland in his book The masculine Marine: homoeroticism in the US Marine Corps documents, through confidential interviews, that there is widespread anal sex amongst Marines who do not consider themselves homosexuals.[16] Marines, to a surprising extent, he concludes, are notorious bottoms!

Lastly, I would like to quote Voeller again, who refers to a study of the Siwan of Africa: "all men and boys engage in anal intercourse...and males are singled out as peculiar [ie. queer? FC] if they do not indulge in these homosexual activities."[17]

Voeller also disabuses us of the canard that a tearing of the tissue in the rectum, contributes to disease: "Fear about anal intercourse is bolstered by a widespread viewpoint that it is accompanied by severe trauma to the rectal and anal walls, commonly including bleeding. These notions find slim backing in fact, rape and force excepted."[18] With the abundance of new lubricants, this should no longer even be considered a problem.

My conclusion is that semen deposited in the anus during intercourse does not contribute to illness because this practice has been so widespread both geographically and historically.

Although avoiding passive anal sex without a condom has become one of the cardinal rules of "safe sex" in the gay world, I have come to doubt, because of the aforementioned facts, the effectiveness of this practice in preventing "AIDS" even though it obviously prevents the transmission of STDs. The myth has become so widespread that one of the leading gay poets in an interview is quoted as saying: "I do not practice unsafe sex, which to me is not practicing anal sex."[19] In espousing this point of view I am therefore going against current prevailing myths in the gay community.

Those gay men who have regular medical checkups for venereal disease, who do not use hard drugs such as poppers and amphetamines, and who live a balanced life with some attention paid to their health, should have no more problem with anal sex than their heterosexual brothers and sisters who are apparently going at it in this manner with no ill effects.

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The Spanish conference looks ahead: 2000A

Causes, mechanisms & nor immunity treatment of th under the AIDS umbrella

A conference, organised by C.O.B.R.A., was held in Barcelona on the 18-20th October featuring Dr Heinrich Kremer. Reporter Juan Luis Lopez de la Fuente studied journalism and photography in Barcelona before teaching and working as a freelance photographer for Spanish and international press.

COBRA:

An organisation which offers solutions for ending AIDS

COBRA was constituted in June 1990 in Barcelona (Spain), via information received by independent journalist Andreas Faber-Kaiser and an initiative of Kim Mititieri, COBRA's current president, and Lluís Botinas, co-ordinator and spokesman of the organisation. COBRA has always obtained and provided information about different views of AIDS treatments, cancer and other serious illnesses. It was the first organisation within the Spanish state which explicitly denounced AZT-Retrovir as a poisonous drug incompatible with life and as the primary cause of death for people labelled with an HIV or AIDS diagnosis.

Since 1990, discussion of biologist and biochemist Dr Mirko Beljanski's studies has encouraged many people to value COBRA's information booklets. Although these were initially based on the official postulates of AIDS, Beljanski's' products proved beneficial with no toxic reactions. Participation of this controversial French doctor did not stop COBRA providing other relevant information based on further serious scientific studies, advice and experience of doctors, therapists and affected individuals who proposed an alternative vision of the terror instituted by officials.

This quest provided COBRA with knowledge of such scientists as Dr Peter Duesberg, Dr Rubin, Dr Eleni Papadopulos-Eleopulos and Nobel laureates Dr Walter Gilbert and Dr Kary Mullis. At a therapeutic level the organisation offers useful methods, in particular those of Dr Beljanski, Father César, traditional Chinese medicine, visualisation, breathing techniques, nutrition, geobiology, risotherapy (laughing therapy). In the past six years COBRA has undertaken weekly talks about AIDS and cancer while providing workshops on different therapies.

COBRA's sources of information have led the organisation to depart from believing the viral cause for AIDS, to current scientific studies by Dr Papadopulos-Eleopulos and Dr Lanka which demonstrate the non-existence of the HIVirus. Another step forward has been Dr Heinrich Kremer's conference.

These influences clearly place the organisation against the tide of orthodox information. COBRA questions the official version that HIV=AIDS and the promotion of toxic treatments with nucleoside analogues (AZT, ddI, ddC etc.) and protease inhibitors, and was the first organisation to launch a peaceful demonstration in Barcelona to challenge the purported "AIDS-epidemic" in November 29, 1995.

For these reasons, not only does this unique organisation within Spanish territory not receive funding from government authorities, but it has been either forgotten or slandered by the Health Authorities, the media and other "responsible" agencies for campaigning against AIDS. Lluís Botinas, an economist with a PhD in sociology, explains this kind of marginalisation: "We can assume that there are more people living off AIDS (scientists, doctors, AIDS organisations workers, conference organisers, laboratories, pharmaceuticals, chemists, etc.) than people dying with an AIDS-diagnosis. The moment AIDS ceases to be a threat, these people will have to find another job".

Dr Kremer's message

PHOTO: Juan Luis Lopez

For the past 30 years Dr Heinrich Kremer has acquired extensive experience especially in the treatment of drug-addiction, and his latest investigations not only open the way to treating immunodeficiency but can also be applied to other illnesses included under the AIDS acronym (eg. KS).

His work as a practitioner and scientist has involved examination of mitochondrial mutations. Mitochondria are an essential part of the cycle of cellular function. From Kremer's analysis of mitochondria we can understand the cellular respiratory process when, with the synthesis of the ATP molecule, energy is provided for cell functions. Also, the formation of more than one hundred proteins needed for the cell nucleus and cytoplasm is encoded in the 37 mitochondrial genes. If mitochondria are damaged by chemo-therapies and/or antibiotics, they cannot repair their DNA-mutations and these are transferred from mother to child.

Towards the end of the conference there was time for questions and Dr. Kremer – characteristically kind and friendly – responded to inquiries which in many instances alluded to non-toxic treatments of immunodeficiency illnesses and others under the AIDS umbrella. This helped clarify concepts.

D without AIDS?

n-aggressive
e illnesses included

PHOTOS: Enrique Hernandez

An evaluation of the conference

The three day conference was attended by about 40 people. Information revealed in COBRA's survey showed 16 were therapists, of which six were allopaths or university doctors of medicine and biology. The rest were homeopaths, naturalists, Gestalt, reflexologists, fitotherapists, etc. The remaining participants included diagnosed individuals, relatives, university students and people keen to know the mechanisms and causes of illnesses related to immunity.

The information introduced throughout the conference was positively evaluated by almost all participants. Conversely some people missed a more expansive explanation of suitable treatments.

The media's great service in promoting the HIV=AIDS hypothesis OR *Their deaf ears to COBRA*

Since 1992, the Spanish magazine Medicina Holistica, edited by Alfredo Embid, has given important information about AIDS dissidents and COBRA contributes to its distribution. Conversely, the results of COBRA's attempts to inform through the media have been polarised. On one hand, there is a list of journalists working in the Spanish territory who include in their programmes and pages articles and scientific papers by dissident analysts. Today, this list is headed by the above magazine and by Mas Allá de la Ciencia, (Beyond Science) both published in Madrid. In another list, there is a series of journalists who in spite of being aware and interested in publishing COBRA's communiqués are unable to do so because these disturb the official environment in which they work. In other words, they experience censorship of the type of vision of AIDS they project.

Outside these journalists' circles, we find those who clearly explain that they only disseminate information about the HIV/AIDS hypothesis filtered through official agencies. Allegedly, they want to pay the least attention possible to press articles on dissident scientific papers. At worst, they do not offer their readers and viewers the opportunity to know the reality of far more promising and heterodox sources of information than those widely published. This group is led by a small number of journalists who monopolise most of the Catalan media market and similarly, this happens with the rest of the Spanish territorial media, reaching approximately 95% of the population.

COBRA invited all these journalists to attend a briefing the day before Dr Lanka's seminar last April. Although there was a minor response, the interest shown by two independent journalists – belonging to the first list above – and a national radio journalist – belonging to the second list – was satisfactory. Beyond these, with deaf ears once again the great media moguls ignored an important event to find out the dark areas of AIDS.

A week before the recent October conference, the press provided a surprising piece of news. On October 14th the Spanish National TV had to stop broadcasting an AIDS debate produced by ARTE (French-German TV channel). During the programme NightTheme, AIDS: The Hope, four documentaries were scheduled including Djamel Tahi's AIDS: The Doubt. Among the guests on this programme were to be: Rafael Nájera, head of Carlos III Institute of Retrovirology & Research, Francisco Parras, Secretary General of National Plan Against AIDS, José Torres, Chairman of FASE (Spanish Anti-AIDS Foundation) and Jorge Gutiérrez, Chairman of the organisation Apoyo Positivo ("Positive Help"). Prior to this programme they had been sent a copy of Tahi's documentary as background information for a planned debate. Once at the studios, Rafael Nájera argued that should Tahi's programme be broadcast, he would leave the discussion. The director of the programme, Victoria Martinez, refused to cancel it and this led to these five guests' departure from the studio. If the five "AIDS officials" were in disagreement with the contents of the programme, at least they could have given some reasons. The fact that there was no dissident present who could have even defended the programme's views, helps us to understand the lack of argumentation and scientific rigour of their stance, and their zeal for censorship. With information, to ignore is another form of censorship, and the censors were these so-called subject specialists, obviously adherents to the HIV/AIDS/Death hypothesis.

On October 19th COBRA took the opportunity of the presence of Djamel Tahi, Dr Stefan Lanka, Continuum magazine and Dr Heinrich Kremer's conference in Barcelona to call a press conference with a view to offering the transmission of Tahi's film and to responding to relevant questions. This no doubt would have untangled recent events, but once again the absence of the media showed how waxed their ears have become such that they regurgitate only orthodox information.

At long last an AIDS debate in Spain

"We should also be aware of our extraordinary priviledge, which offers us opportunities that are not available to the great mass of poor and struggling people throughout the world – opportunities to inquire, understand and act."

—Noam Chomsky,
Continuum magazine, Sept/Oct 1996

COBRA's organisation is accustomed to being forgotten by "top" journalists but we do not renounce our objectives, namely the creation of a favourable climate to carry out public and scientific debate about causes and mechanisms which will allow the dismantling of AIDS.

As a result of sending publications such as Rethinking AIDS, press articles and media fax-sheets to various press departments, a journalist, Miguel Calzada (Mikimoto), responded, who broadcasts from Monday to Thursday at mid-night on Catalan National TV. On October 2nd, he prepared an interview with Lluís Botinas exploring the views of more than 400 dissident scientists and explaining that virologist Dr Lanka clearly demonstrates the non-existence of the HIVirus [the only proof offered being a photographic trick]. Lluís Botinas proposed the publication of these photos. The interview lasted 15 minutes substantiated by Lanka's images of his own virus isolation, the Ectocarpus siliculosus virus (EsV), from an eucariotic marine algae, as an example of rigorous science.

Criticisms of this programme were swift, and after a few days journalists and AIDS organisations, including the politician Ignasi Riera, took the issue to the Catalan Parliament saying "this type of information is banal and frivolous: It creates social unrest, it disconcerts and misinforms all those affected and the public at large". After much pressure Mikimoto had to offer another interview five days later to an orthodox doctor so the truthfulness of the previous scientific analysis could be denied and the HIVirus could once again be promoted as the causative agent of AIDS.

This is the first time ever that a journalist in the whole of the Spanish territory dedicated an interview to exposing the views of an ever increasing number of scientists who dissent from the official version. And it was the first demonstration of photographic proof that the HIVirus is not genuine, to which the official doctor did not have anything else to propose. Instead he showed the fictitious image of a computer virus. This video-image is in fact distributed by IRSI La Caixa Foundation, a large banking corporation, that also sponsors the Science Museum of Barcelona where the fictitious photos of the virus are on view to the public.

Conversely, the magnificent work of this journalist has been rewarded with the cancellation of his programme as from January next year. And COBRA, in media terms, has been discredited and criminalised for no valid reason. Despite such defensive action and such proud ignorance, this TV appearance may have sped up the beginning of a scientific debate that would inform the public through the public media.

It is realistic to believe these issues and this debate are inevitably going to gather force – in Spanish territory it is only a matter of time.

Stefan Lanka, Continuum and Djamel Tahi: a bridge for an international meeting

Dr Kremer's thorough explanations offer a common point of reference to all analysts who demand a re-evaluation of the great artifice called AIDS. His presence together with Stefan Lanka, Djamel Tahi of France, *Continuum* magazine of Great Britain, two Swiss participants and COBRA from Spain, allowed for an international meeting from which a "Plan For the Year 2000 without AIDS" was agreed. A proposal was made to celebrate in June 1997 in London a world gathering of critical analysts and dissidents where a common course of action will be proposed, especially for the forthcoming XII International AIDS Conference in Geneva 1998.

Dr Lanka accompanied Dr Kremer in Barcelona and has become a regular face at COBRA since December 1995 and the subsequent Barcelona conference in April 1996. This type of meeting is essential because it allows an exchange of ideas and experiences as well as helping to recharge our energies – a necessary task which requires the collaboration of dissidents and affected individuals in order to be able to offer the knowledge and research to the majority of population.

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Ecstacy ?

Rafael Ramos

At this time of the year it is remarkable how people abuse their health with copious amounts of sweet food and alcohol. Most extraordinary is to watch homosexual no less than heterosexual club-goers speed up the gluttonous process with heavy drug-taking, freeing themselves of daily chores and social constrictions, invoking Christmas and partying without remorse. Hypocrisy and commercialism have turned this Christian festival, along with its peaceful myth of godliness and its religious imagery, into icons for cult hoards following extremes of consumption. At least since the era of the ancient Greek god Dionysus, such cults have come and gone, united in the energetic pursuit of euphoric extremes. Their aim is ecstasy, ecstasis, which can mean anything from 'taking you out of yourself' to a profound alteration of personality.[1]

Ecstasis

Ecstasy, the contemporary recreational drug, has become the smartie white god who by very simple means produces pleasure and liberation, for a short while, allowing people to transcend barriers, creating the illusion of freedom. It can in some circumstances dissolve fears and remove inhibitions, allowing communication and energy to flow. But how many people ponder the underlying reasons for this urgency to overcome barriers and awkwardness? And how many forget wider aspects of health, not questioning the consequences for their physical or mental reality, preferring to become near hypnotic instruments of this chemical?

Assuming that 'E' is ingested in its 'purest' form, MDMA – which is rare in the commercial party scene where it is now generally manufactured to contain other drugs like amphetamines, LSD, ketamine (Special K), caffeine, ephidrine, triprolidine, etc. – it is believed that it facilitates an openness of the heart allowing love to flow – the reason why it has often been referred to as the 'love-drug'. The sensation may extend to a pervasive loosening-up, freeing tempered emotions. The combination of the drug with rave music and dancing can produce an exhilarating trance-like state, perhaps similar to that experienced in tribal and folk dance or religious ceremonies.

It also seems that a universal effect of the drug is to remove male sexual aggression, contrary to the effect that excessive alcohol may have, and to bring out the feminine qualities in men. This phenomenon may explain why gay clubs today, where 'E' is common, are becoming increasingly popular with women, lesbian and straight, who find themselves in a more congenial environment. Both the ecstasy and the female presence attract growing numbers of straight men to these venues while making them behave less aggressively than they might elsewhere. Another social effect of 'E' is to break down barriers between homosexuals and heterosexuals. Women feel free to hug one another and gays are as likely to be hugged by straight women and men, without harassment or hostility. People feel more loving than passionate and unusually sensitive towards each other.

Used as an aphrodisiac, 'E' can be regarded as the libido poppy-pill of the 90s' club-culture. Ian Young describes recreational drug abuse as a tendency to recreate "inappropriate emotional bonding" by which people believe they are falling in love. This quick-fix method of breeding emotions is not necessarily matched by sexual sensations or orgiastic desire: but when it happens, the effect of believing that you're experiencing different forms of love and affection with a sense of sexual engagement is a complex impulse that can lead to frustration or misleading the person you're with. In the right environment, passionate emotions can be enhanced with a trusted partner. At times the chill-out period after raving becomes the ideal occasion for long, slow or fulfilling sexual experience.

'E' as a chemical compound has a profound effect on most people and does not always suit everyone. The ideal scenario would be to be able to let go of unwanted attachments, particularly fear and anger, expanding towards a space of love and freedom. However, this is unlikely to take place if the overpowering urge to celebrate is being thwarted and repressed by the insulated, overheated and overcrowded atmosphere of most clubs. As many people have probably noticed, the 'loving' effect of 'E' becomes weaker the more one takes it. Increasing the dosage in order to regain stimulus can lead to increased toxicity.

Awareness of harmful effects allows people to take responsibility

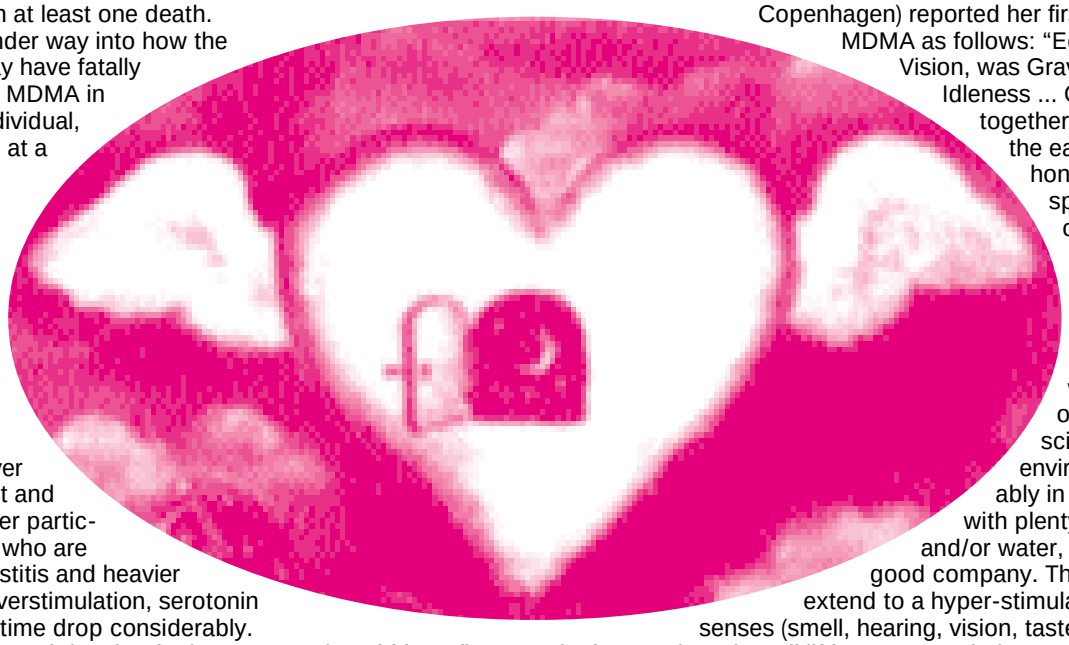
Can we demystify the rise of ecstasy in homosexual and heterosexual drug culture? Project LSD (UK) estimate half a million people in the UK take ecstasy each week. Outside of statistics and media hype about moral concerns on the use and dangers of 'E' as an illicit class-A drug, questions about safety play an intrinsic part in understanding its biological functions. Raising awareness about possible harmful effects allows people to take responsibility for themselves and practically deal with

body

potential health risks.

After being swallowed, the 'pill' is quickly digested in the stomach, reaching the brain, and the bowel area where most of the dose – 65% – will be metabolised, passing through the kidneys and the liver soon after, thence excreted in the urine. A small percentage – some 7% – stimulates the brain where the natural chemical serotonin, an amino acid neurotransmitter, and a potent oxidising agent, is released allowing the flow of information around the brain, altering your mood – similar to the effects produced by adrenaline.[2]

Having absorbed the drug, your body can overreact and start sweating and overheating. Dehydration, nasty headaches, stomach cramps, vomiting, muscular pains and jaw tightly clenched are signs that the drug's demands to let go are inappropriate for the individual at that time. Interactions between Ecstasy (or other amphetamines) and protease inhibitor drugs have been implicated in at least one death. Investigation is under way into how the drug Ritonavir may have fatally raised the level of MDMA in the body of an individual, who recently died at a night club, by 23 times.[3] Although the effects of dehydration inside the body have not been properly understood, the National Drugs Helpline gives a list of possible damage to: the liver and kidneys, heart and genitalia – the latter particularly for women, who are prone to suffer cystitis and heavier periods. Due to overstimulation, serotonin production will in time drop considerably.



A person on 'E' and dancing for hours on end could beneficially sip about half a litre of water an hour – alcohol is not advisable, nor is more than three litres of water in an evening. Also antioxidants, eg. vitamins E, C and B, or NAC, will help the body to counteract after-effects. Only knowing the level of serotonin produced would allow specifically accurate levels of such supplementation. Seeking the advice of a nutritionist is recommended.

mind

The most unpleasant 'hangover' effects are mood swings, confusion, tiredness, sometimes paranoia and depression, and a tendency to interpret situations out of proportion. Although MDMA is not known to be addictive 'E', as a cocktail drug, together with the associated life-style of all-night raving and peer group pressure can lead to psychological dependency . One of the disturbing fears about 'E' is that it may be causing mental dysfunction or permanent brain damage, often associated with sustained abuse. It has also been suggested that it destroys nerve endings or synapses, and in extreme cases could lead to irreparable brain damage.

It is difficult to identify the dangers of ecstasy in spite of it having been originally prescribed to people undergoing psychotherapy. Its medium-to-long-term (lifetime) effects have never been assessed. Psychoanalysts like CG Jung state: "The separation of psychology from the premises of biology is purely artificial, because the human psyche lives in indissoluble union with the body". The reason people under the influence of MDMA feel warm, energetic, and friendly to the point of euphoria is complex: the mind/body, subjected to belief and custom, produces an agreeable delirium of freedom, but free from what and from whom? The fallacies of social and emotional freedom become like an opiate for a person locked in the prison of identity and psyche.

spirit

Powerful impacts of spiritual awakening with ecstasy use have been experienced by many people from San Francisco to Amsterdam – (in that city MDMA's purity can be checked). A woman in Christiania (the flower-power quarter of Copenhagen) reported her first experience of MDMA as follows: "Ecstasy was a Vision, was Gravity, was Love-in-Idleness ... O Eros, drawing together the moon and the earth!"[4] This honest account of spiritual freedom coincides with those who have used the drug as a device to let go of insecurity, and connect with the glories of the unconscious – in a safe environment, preferably in the countryside with plenty of fruit juices and/or water, music and in good company. These accounts extend to a hyper-stimulation of the senses (smell, hearing, vision, taste and touch), with the impression of a veil lifting to unmask the true ego and the soul. Spiritual exploration using MDMA may be an acceptable way of letting-go of unwanted attachments, and self-exploration – gentle 'teacher' that can remind people who they are. The ensuing challenge may be to turn to the many emotions learnt into actualities: to practice letting go of fear in the midst of normal daily life.

Too often ecstasis can be indulged in with the conviction that, in the process of indulging, one is leading to a 'higher life'. What can be dangerous about the need for recreational drugs in order to create 'healthy-loving-feelings' is that you get conditioned to cheap solutions, instead of deep ones. What seems clear in fact, is that many people take ecstasy assuming that they will enrich their experiences if they explore new avenues. What they do not realise is that 'it' is nearly always sold containing a concoction of other chemicals. In this Christmas quest for celebration and freedom or deeper realities, it would be most irresponsible to forget that there are many paths up the mountain, and what goes up must come down. In reality it doesn't matter which path you take, so long as you do not squander your health.

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Corticosteroids

Corticosteroid drugs – often referred to simply as steroids – are derived from, or are synthetic variants of, the natural corticosteroid hormones formed in the outer part (cortex) of the adrenal gland situated on top of each kidney. Release of these hormones is governed by the pituitary gland.

Corticosteroids have two types of effect: glucocorticoid and mineralocorticoid. The glucocorticoid effects include the maintenance of normal levels of sugar in the blood and the promotion of recovery from injury and stress. The main mineralocorticoid effects are the regulation of the balance of mineral salts and the water content of the body. When present in large amounts, corticosteroids reduce inflammation and suppress allergic reactions and immune system activity. They are distinct from another group of hormones, the anabolic steroids.

Although corticosteroids have broadly similar actions, they vary in their relative strength and duration of action. The strength of mineralocortocoid effects also varies.

Why they are used

Corticosteroid drugs are used primarily for their effect in damping down inflammation, whatever its cause. Topical preparations containing corticosteroids are frequently used for the treatment of many inflammatory skin disorders. These drugs may also be injected directly into a joint or around a tendon to relieve inflammation caused by injury or disease. However, when local administration of the drug is not possible or effective, corticosteroids may be given systemically, either by mouth or by intravenous injection. An important use of oral corticosteroids is to replace the natural hormones that are deficient when adrenal gland function is reduced as in Addison's disease. In these cases, drugs that most closely resemble the actions of the natural hormones are selected and a combination of these may be used. Corticosteroids are commonly part of the treatment of many disorders in which inflammation is thought to be caused by excessive or inappropriate activity of the immune system. Such disorders include rheumatoid arthritis, inflammatory bowel disease, glomerulonephritis (a kidney disease), and some rare connective tissue disorders such as systemic lupus erythematosus. In these conditions they relieve symptoms and may temporarily halt the disease.

Corticosteroids may be given regularly by mouth or inhaler to treat asthma, although they are not effective for the relief of asthma attacks in progress. Some cancers of the blood (leukaemias) and of the lymphatic system (lymphomas) may also respond to corticosteroid treatment. These drugs are also widely used to prevent or treat rejection of organ transplants, usually in conjunction with other drugs.

How they work

Given in high doses, corticosteroid drugs reduce inflammation by blocking the action of chemicals called prostaglandins that are responsible for triggering the inflammatory response. They also temporarily depress the immune system by reducing the activity of certain types of white blood cell.

How they affect you

Corticosteroid drugs often produce a dramatic improvement in symptoms. Given systemically, corticosteroids may also act on the brain to produce a sense of well-being and, in some people, a sense of euphoria. Troublesome day-to-day side effects are relatively rare. However, long-term treatment carries serious risks.

Risks and special precautions

Given in low doses by mouth for the treatment of Addison's disease, there are few risks associated with these drugs. Expected adverse effects from higher doses depend on the drug used and the duration of treatment.

Drugs with strong mineralocorticoid effects such as hydrocortisone may cause water retention, swelling, particularly of the ankles, and an increase in blood pressure. Because steroids reduce the effect of insulin they create problems in diabetics. They may even give rise to diabetes in susceptible individuals. They can also cause peptic ulcers. Since corticosteroids suppress the immune system, they increase susceptibility to infection. They also suppress symptoms of infectious disease. With long-term use, steroids may cause a variety of adverse effects including acne and increased blood pressure.

Long-term use of steroids suppresses the production of the body's own corticosteroid hormones. For this reason, treatment lasting more than a few weeks should be withdrawn gradually to give the body time to adjust. If the drug is stopped abruptly, the lack of corticosteroid hormones may lead to sudden collapse.

People taking corticosteroids by mouth for longer than one month are advised to carry a warning card for two years. In the case of an accident, their defences against shock may need to be quickly strengthened with extra hydrocortisone. C

Source

The British Medical Association's *New Guide to Medicines and Drugs, 1995.*

Knowing your... Immune System

Boo Armstrong

There are two things about the immune system which everyone has had instilled upon them and which we all now accept. Firstly, your immune system is directly related to your genitals which are completely separate to the rest of your body, as witnessed by the birth of genito-urinary clinics attached to every hospital. It has also been given to us as a fact that you can tell what state your immune system is in by counting the number of T-cells that you have in any given millilitre of blood and monitoring them closely.

The immune system is in fact an immensely complicated and intricate mixture of many bodily functions ranging from the lymphatics to the large intestine. T-cells certainly count for something but they are not the definitive measure of our state of health, especially when measured in isolation with little thought given to the bone marrow which makes them or the thymus gland which activates them, let alone the nutrients which you need in order to keep these reactions happening.

Reductionist thinking has led us to believe that one part of our body is separate from another and as Alexis Carrel said in Man the Unknown: "Medicine has separated the sick human being into small fragments and each fragment has its specialist. When a specialist, from the beginning of his career, confines himself to a minute part of the body, his knowledge of the rest is so rudimentary that he is incapable of thoroughly understanding even that part in which he specialises." So if we can't trust the specialist who can we trust? The person who knows us best and is aware of what we really eat and how many cigarettes we did smoke on Friday night is us. Me. You. The person who has walked around inside your body for your whole life. So, armed with the knowledge that your immune system may not be functioning at its best (you have after all been told that you have too many antibodies or some strange bits of protein lurking in your blood), now is the time to learn what your immune system really is and how you can look after it.

Imagine a little undersea world with sturdy seaweed and plant life

Your immune system is what enables you to resist and overcome infection. It is an essential requirement for survival since we are surrounded by little creatures of the parasitic, viral and bacterial kind which are always trying to invade our personal space.

When you are thinking immune system, think lymph, whether that is lymph vessels, lymph nodes or lymphocytes. These are good words to arm yourself with if you don't know them already. So what is it all about?

As your blood circulates, providing nutrients and oxygen to all parts of your body, it will accumulate toxins, so you need some kind of waste disposal system to cope with them all, which is where your lymph comes in. Unfortunately (for some) lymph does not have a heart to pump it around, however a piece of beautiful design work by mother nature means that you do not need a separate pump for your lymph. Lymphatic vessels are situated intricately alongside blood vessels so you can rely upon your heart to move your lymph around. This is great if you regularly exercise and if you do not, then think about it seriously – it's great for depression and apathy too, once you have managed to throw yourself into that swimming pool or put on your dancing shoes. So you need your heart to pump in order to move your lymph around your body, or you can move it manually which is where skin-brushing and lymph drainage massage come in.

A skin brush is made from natural (non-animal) bristle which you brush quite firmly in long strokes all over you body – always in the direction of your heart. From your hands, up your arms, up your legs, over your head and don't forget to concentrate on your lymph nodes – especially under your arms and around your groin. You can look in any anatomy book to find out where your lymph nodes are.

As dirty lymph flows from your tissues through the lymph vessels it will eventually get to a lymph node. These are situated in the best place to deal with toxins as the lymph flows from your tissues. They create an environment in which lymphocytes can accumulate and deal with infections.

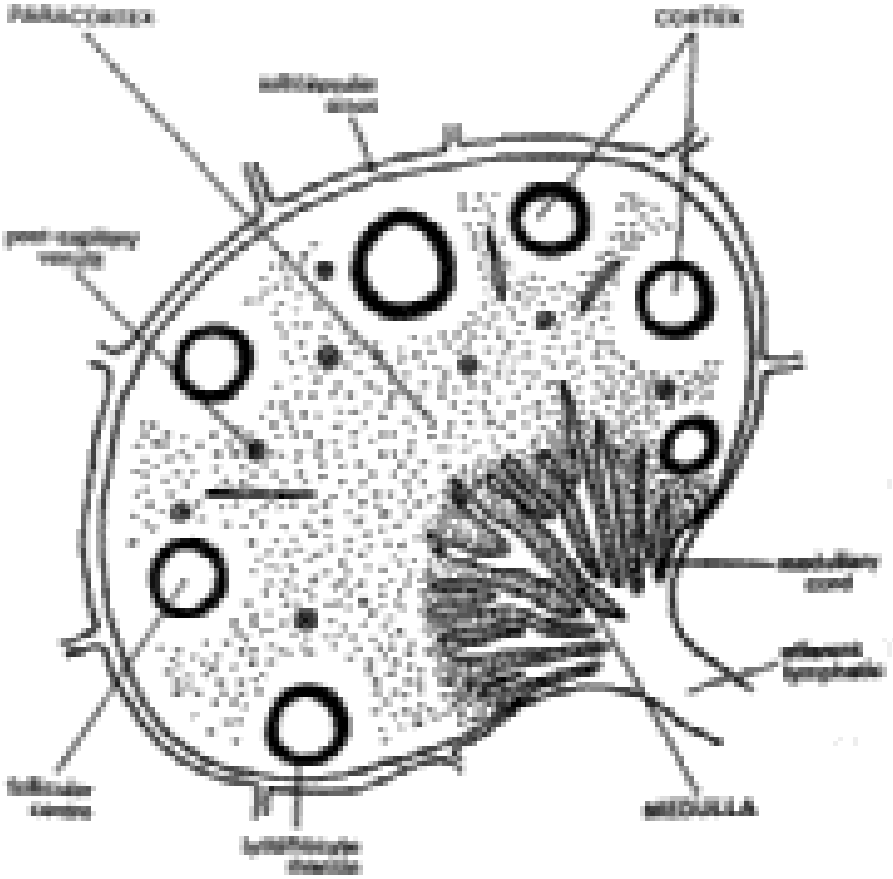
Imagine a little undersea world with sturdy seaweed and plant life creating an environment for little fish and plankton to swim about in. This is what it looks like in your lymph nodes. You have reticular fibres, made of protein, which join together and create a delicate meshwork around blood vessels, glands, nerves, etc. Within this environment various important cells can move around and attack any unwanted nasties, these immune cells are free to move all over your body but concentrate themselves in these areas.

Having a swollen gland or lymph node is a sign that your body is working and is responding to a localised infection. Gentle circular massage on any swollen glands will usually encourage the cells to be active and move around, getting rid of toxins.

The cells which do this are macrophages, scavenger cells which remove bacteria and other foreign bodies, and plasma cells. A single plasma cell can synthesise and pump into the blood 2000 antibodies per second. A group of active plasma cells may produce approximately one hundred, million, trillion antibodies per second.

It is interesting then that more antibodies to HIV are found in the lymph nodes than in the blood. Or is it?

Your spleen is an organ of your immune system and is full of plasma cells, macrophages and white blood cells. White blood cells, also known as lymphocytes, enable us to cleanse our internal environ-



Functional architecture of a normal lymph node

ment of bacteria, viruses, cell fragments and foreign rubbish of many kinds. They are made in the bone marrow, along with the red cells. B-cells (B for bone) produce antibodies which are used to eliminate living and non-living structures that are foreign to the body.

T-cells are another kind of white blood cell. They are also made in the bone marrow but do not become active until they reach the thymus gland (T for thymus). These cells are primarily responsible for cleaning up inside cells. It is an interesting anomaly that the thymus (according to the Oxford Reference Concise Medical Dictionary) is at its largest during puberty and then gradually shrinks as the functional part gets replaced by fatty tissue. "In infancy the thymus controls the immune response to microbes and foreign proteins (accounting for allergic response, autoimmunity and rejection of organ transplants)."

So if the thymus stops working when we get older what exactly is supposed to activate the T-cells which we produce in our bone marrow? One great method for getting your tired thymus to work again is to talk to it. Not verbally but physically. Put your thumbs in your armpits and stretch your hands across the front of your chest. Where your middle fingers meet should be right above your breast bone, the bit of bone which sticks out the most. Tap that area in a waltzing rhythm for a few minutes, a couple of times a day, in order to restimulate your thymus. Not quite sure why it's a waltz that the thymus likes, but I do have it on great authority!

In healthy, immune-competent people, B-cells and T-cells are in balance. Under stress B-cell immune responses are intensified and T-cell dependent responses are weakened. This means that under stress the body concentrates on getting rid of foreign materials and not on cleaning up our internal environment. It also means that T-cell numbers decrease under stress.

Stress-induced weakening of immunity weakens your defences against pathogens

Stress increases the production of adrenaline and cortisol from the adrenal glands. High levels of cortisol weaken T-cell immune reaction and under chronic stress the thymus gland will shrink in a few days and function poorly (it can also return to normal with the help of zinc, vitamin C and multi Bs – read next issue's article to find out more).

Anything which overstimulates your adrenal glands will contribute to your immune depletion; such things are smoking, sugar, coffee, drugs (especially steroids), lack of sleep, poor nutrition and emotional stress.

Modern medicine, and some have said modern life, is not kind on the immune system. The amount of immune-depleting factors that we have to deal with will depend on the choices that we make regarding the food we eat, the drugs we take, how we deal with stress and some factors which are beyond our control, such as someone we love dying, where we live, the amount of money we have and whether or not we are accepted in our society because of our lifestyle, sexuality or colour.

Surgeons like to cut out parts of your immune system, such as your tonsils and appendix. These are both areas where white cells like to hang out and they are essential in helping your digestive system deal with the influx of bacteria which you take in with your food. Steroids, antibiotics and anti-inflammatory drugs directly suppress the immune system, affecting immunity worse than any other system. Steroids stimulate your adrenals, anti-inflammatories suppress the natural reaction of your immune system in trying to deal with infections, and antibiotics kill, indiscriminately, all of the bacteria in your intestines including the helpful ones. This allows harmful bacteria to grow in their place as well as moulds and fungi, such as candida. When candida takes hold in your intestines it makes the mucous lining very permeable which results in over exposing the immune system to foreign antigens. Vaccinations are also bad for immunity and put your immune system into a state of constant alert which is exhausting for adrenals and very mineral-depleting.

All of this ongoing stress-induced weakening of immunity weakens your defences against pathogens which will not be properly identified, dealt with and eliminated. Latent infections in the body will no longer be kept under control which results in an increased susceptibility to otherwise harmless opportunistic infections.

Over-working the immune system causes a lot of damage, unnecessary hard work and the unproductive use of nutrients which are often in scant supply anyway. The foods which generate the least toxins and are therefore the easiest to deal with are whole, unrefined foods. That is, food that looks like food – whole grains, vegetables, fruit, pulses, and not the kind of food that has spent the last three months on various production lines having chemicals added and nutrients stripped away. You also need these foods in order to support your immune system, not just for harm-minimisation.

Read next month's article to find out which vitamins are specifically good for improving your immune system, and the one after will focus on minerals, but until then a little taster is to eat your greens every day.

The significance of infection with parenterally transmitted hepatitis viruses in the pathogenesis of AIDS

A. Hässig, H. Kremer, Liang Wen-Xi, K. Stampfli

"Research is fundamentally a state of mind involving continual re-examination of the doctrines and axioms upon which current thought and action are based. It is, therefore, critical of existing practices."

—Theobald Smith (1859-1934)
American Journal of Medical Science, 1929

Amidst increasing reports of "an evolving epidemic of Hepatitis C infection", scientific researchers at the Study Group for Nutrition and Immunity in Bern, Switzerland have investigated the relationship between diseases of the liver – hepatic diseases – and the signs generally attributed to infection with HIV.

Distinguished Swiss immunologist Professor ALFRED HASSIG and his colleagues have found revealing relationships between viral hepatitis and the diagnosis of HIV infection. In this new paper they discuss in exact detail the nature of their work, and the conclusions and questions that arise from it.

Huw Christie

AIDS is characterised by an acquired deficiency of the cellular immune reactions.[1-3] In subjects with a healthy immune system a balance exists between the cellular and the humoral reactions.

In stress reactions the organism responds to the many physical and psychic stresses in a uniform manner, whereby activation of the neuroendocrine stress axis, hypothalamus-pituitary-adrenals, combined with sympathicomimetic activation of the autonomous nervous system, plays the central role. The increased secretion of glucocorticoids associated with this, accompanied by a simultaneous decrease in the production of dihydroepiandosterone (DHEA), limits the life-threatening acute-phase reactions due to endogenous mediators of inflammation. Here, the raised cortisol level causes a persistent weakening of the cellular reactions associated with the T-cells. This leads to a multiplication of numerous micro-organisms that are normally kept under control by a healthy organism. In the pathogenesis of AIDS this mechanism favours the many types of inflammation that occur due to latent infective pathogens and opportunistic micro-organisms.

AIDS is also characterised by its predominance in certain risk-groups such as homosexuals, drug addicts and recipients of blood products contaminated with viruses. Here the question arises concerning the extent to which parenterally transmitted hepatitis viruses in these groups can complicate the transmission of infections between individuals. This is of topical significance in that the positive anti-HIV antibody reactions against gp 120 and its peptides in patients with lupus erythematosus disseminatus have shown that the anti-HIV-antibody test detects humoral antibodies presumably with anti-actin activity, so that the assumption that it is strictly specific for the detection of HI viruses is not upheld.[4,5]

Viral hepatitis

Today, five different hepatitis viruses are known, all of which belong to different virus families.[6] Hepatitis A and hepatitis E are transmitted orally, via the faeces, while the B, C and D types are transmitted parenterally, mainly by blood-to-blood contact between individuals. Hepatitis A and hepatitis E can as a rule be completely cured, whereas the B, C and D types pass into a chronic carrier-state and in the long-term can cause inflammation of the liver, cirrhosis and liver cancer.

The parenterally transmitted forms of hepatitis are characterised by the simultaneous presence of viruses and antiviral antibodies in the blood. This shows that in these forms of hepatitis the immune reactions are not in a position to eliminate the pathogens. This is probably mainly due to the fact that the antigen structures of these viruses are closely associated with endogenous structures, so that the immune reactions assume the character of autoimmune reactions.

Viral hepatitis in the AIDS risk-groups

Homosexuals are to a large extent infected with hepatitis B and hepatitis C viruses.[7] In this connection it should be remembered that in the Seventies the working-group of Szmuness obtained hepatitis-B antigen particles from the blood of New York homosexuals and, after chemical treatment, used these as a vaccine against hepatitis B.[8] This vaccine obtained from blood plasma is still used today. However, it is now being replaced more and more by vaccines produced by genetic engineering.

With the introduction of sensitive methods for the detection of hepatitis B viruses in blood donors towards the end of the Seventies, it was thought that the problem of transfusion hepatitis had been largely overcome. But this was not the case. Many recipients of blood and blood products developed non-A, non-B hepatitis. For the clarification of this problem we are indebted to three American working-groups who showed, in 1978/1979, that the pathogens of non-A, non-B hepatitis can be transmitted to chimpanzees which then develop a clinical picture similar to that occurring in humans.[9-11]

Using the latest methodology based on molecular biology, the working-group of Bradley was able to demonstrate the genome of this virus, now known as hepatitis C, and to show that it belongs to the family of the flaviviruses.[12] Before the introduction of effective virus-inactivating procedures in the manufacture of large-pool preparations of Factor VIII and Factor IX, all haemophiliacs who received such preparations became infected with hepatitis C.

Many drug addicts with blood-to-blood contact through exchanging syringes are infected with hepatitis C viruses. They suffer from extremely frequent chronically recurrent episodes of this disease.[13]

To summarise, it is seen that the various groups at risk of contracting AIDS are largely infected with parenterally transmitted hepatitis viruses.

Autoimmune reactions in diseases due to parenterally transmitted hepatitis viruses

Chronically recurrent disease due to parenterally transmitted hepatitis viruses frequently causes humoral autoimmune reactions. This is the case especially in chronic cases of hepatitis C.[14] There are also cases of autoimmune hepatitis in which antibodies against hepatitis B and hepatitis C cannot be detected.[15]

The principal antibodies appearing in parenterally transmitted hepatitis are those against microfilamentous cellular proteins belonging to the actin group. Investigations of the autoantibodies against this group of cells have shown that they can be divided into many different specific categories, which display no cross-reactions. In a recently published study, Senécal, who has thoroughly investigated this group of autoantibodies, differentiated between filamin, myosin, a-actinin, actin, tropomyosin and short-chained myosin.[16] In the analysis of 172 serum samples from patients and 29 from normal healthy subjects, he found 57 different reaction profiles.

It seems to us to be obvious to classify the autoantibody activity in the anti-HIV test, which is observed in patients with lupus erythematosus, into the many different specific categories against microfilamentous cell proteins. The many different reaction profiles of this group of autoantibodies explain why the positivity of the anti-HIV autoantibody components against gp 120 and its peptides correlates closely, but not completely, with the positivity to hepatitis-C-virus antibodies. In spite of the fact that at that time all the haemophiliacs who received non-virus-inactivated Factor VIII and Factor IX concentrates had been infected with hepatitis C, the proportion of anti-HIV-positive haemophiliacs is 60-70%, at the most.

Relationships between retroviral envelope proteins and endogenous proteins

As we demonstrated in our earlier study on Open questions on the specificity of anti-HIV antibodies, clarification of the relationship between retroviral envelope proteins and endogenous proteins is of central importance for AIDS research. Since the patenting of the anti-HIV test, a controversy has existed in this respect between the working-groups of **Montagnier** on the one hand and **Gallo** on the other.

In the first description of the Hi viruses by the working-group of Montagnier, they mentioned the possibility that "the 45 k protein may be due to a contamination of the virus by cellular actin, which was present in immuno-precipitates of all the cell extracts."[17]

In his book, Virus Hunting[18], on Page 288, Gallo writes as follows: "We later learned that the Pasteur Institute had also filed a patent some months prior from ours in that its stated aim was a test for AIDS rather than a blood test designed to protect the blood supply. The French test had three problems: (1) only 20 percent of AIDS patients' sera scored positive in the studies they had reported and in the studies they submitted in their patent; (2) they could not find antibodies to the envelope of the AIDS virus, only to the core, and detecting antibodies to both, but especially to that component of the envelope called GP41, is a key to a successful blood test; and (3) they had not produced the virus in a cell line; consequently, the amount of virus was very limited; and any commercial production would have to devise ways to pass the virus every few days into a fresh sample of a newborn's umbilical-cord blood. No large-scale blood test was really possible. Also, they had not supplied compelling evidence for the virus as the cause of AIDS, nor did they attempt to argue the case, though I do not know whether this is important in patent law."

It seems to us to be a matter of urgency today to re-assess this controversy.

What role do filamentous proteins of the cellular cytoskeleton play in the exocytosis of viruses with a cellular envelope?

Viruses without a cellular envelope are released by cytolysis. This involves a specific activation of the immune system, whereby the viruses are completely eliminated from the organism. Effective vaccines are available against such viruses. A typical example of this group is the poliomyelitis virus.[6]

Viruses with a cellular envelope are released through the cell membranes, by budding. During this process endogenous structures are incorporated into the viral envelope; this gives the extracellular virus limited protection against immune reactions. In contrast to those without a protein envelope, the viruses with a protein envelope are not completely eliminated from the organism by the immune reaction. In fact, a life-long equilibrium exists between these viruses and the specific immune reactions directed against them. The manufacture of effective vaccines is mostly impossible. Typical examples of this group of viruses are the herpes viruses.[6]

The hepatitis viruses A and E have no cellular envelope; the hepatitis viruses B, C and D do have a cellular envelope. This largely explains the difference in the course of the disease between the hepatitis viruses that are transmitted orally, via the faeces, and those that are transmitted parenterally, as described above.

Already in 1977, with the example of the breast-tumour virus in the mouse, Damsky et al.,[19] showed that as this virus passes through the cell membranes the viral nucleoids interact with contractile cell proteins. These investigators also drew attention to the fact that at least part of the actin that is always present in washed virus preparations originates from microfilaments of the host cells. In the same year the monograph, Virus Infection and the Cell Surface, published by Poste and Nicolson appeared, in which, in a series of reviews, well-known authors present the state of knowledge at that time regarding the linkage of viral structures with endogenous structures of the cellular surface.[20]

This speaks very much in favour of the view that in the controversy between the working-groups of Montagnier and Gallo concerning the development of an AIDS test, described earlier, the cautious attitude of the French group regarding the assessment of the viral specificity was justified. According to the present state of knowledge, the actin content of their cell extract is based on the binding of viral proteins with actin of the host cell.

This view also receives a very considerable support through the findings of Arthur et al.[21] These authors showed that HIV extracts obtained in density gradients contain more protein from cell-surface structures of the histocompatibility proteins (MHC Class 1, b_2M and HLA DR) than gp 120.

These cellular proteins are closely bound to the proteins of the viral envelope. As self-structures of the cells surfaces they do not form antibodies directed against them. These are apparently formed only against altered self-structures of preapoptotic cells.

Mechanisms of immune defence against viruses with cellular envelopes

As the viral components of the cellular envelope are linked to endogenous structures, namely proteins of the cytoskeleton, the complete immune elimination of these viruses from the organism is, as has been said, impossible. The immune reactions against these viruses are to be understood as autoimmune reactions. With this group of viruses the aim of therapy is therefore limited to the prevention of inflammatory autoimmune diseases. As we explained in our previous work, here the principal aim of the treatment is to suppress the systemic inflammatory activation of the macrophages, as is manifested in stress-induced acute-phase reactions. The primary objective is therefore to eliminate the oxidative stress situation responsible for acute-phase reactions.

Since 1983, **Papadopulos-Eleopulos** et al have drawn attention to the fact that in AIDS a continuous oxidative stress situation, namely oxidation of the cellular sulphydril groups, plays the principal role.[22] The oxidation of these groups causes the polymerisation of proteins of the cytoskeleton, namely of actin, on the cellular surfaces. This leads to a weakening of the cell membranes and the formation of blisters on the surface of the cell (blebbing).[23] In this condition the cells are no longer capable of maintaining the concentration gradients of ionised calcium inside and outside the cells, and they suffer apoptotic cell death. This leads to the activation of intracellular nucleases and proteases, so that with increased apoptosis fragments of DNA, RNA and proteins reach the extracellular space in large amounts.

This mechanism mainly involves the lymphocytes. Their increased apoptosis in the periphery, in combination with the sensitivity of young thymocytes to hypercortisolism, leads to the rapid involution of the thymus in acute-phase reactions. In persisting oxidative stress situations the formation of cells in the thymus becomes exhausted. As a

result of this there is an increasing weakening of the cellular immune reactions, which are no longer in the position to efficiently remove the continuous accumulation of apoptotic cellular debris.

This view of the pathogenesis of AIDS is supported by recent studies which show that in AIDS the increased cell turnover in the thymus leads to ageing of the cells released into the periphery.[24, 25]

Conclusions

The attempts to bring the pathogens in infections due to viruses with cellular envelopes under control by means of chemotherapy have failed. This is due to the fact that systemic autoimmunisations can only be brought under control by correction of the neuroendocrine and immunological situation of persistent oxidative stress situations. The most practical means of achieving this is through the use of polyanion- and polyphenol-containing dietary supplements.[26]

As the experience with lupus patients has shown that the anti-HIV-antibody test shows increased titres of humoral auto-antibodies, and as on the other hand the viral infection in AIDS can be plausibly explained by the parenteral transmission of hepatitis viruses, it seems to us to be time to reassess the pathogenesis of AIDS from these two points of view. Because of the high risk of infection with parenterally transmitted hepatitis viruses, it is advisable to objectively continue and extend the preventive measures regarding blood-to-blood contact among individuals belonging to the various risk-groups.

Summary

In view of the restriction of AIDS to risk-groups such as homosexuals, drug addicts and recipients of virally contaminated blood products, the question arises as to the extent to which parenterally transmitted hepatitis viruses can explain the transmission of the infection between individuals in these groups.

In this connection it has been shown that homosexuals and drug addicts are to a large extent infected with hepatitis B and C. The same is true for haemophiliacs who have received non-virus-inactivated large-pool Factor VIII and Factor IX preparations. Since the anti-HIV-antibody test often proves positive in patients with lupus erythematosus disseminatus, the question arises whether the autoantibodies against the microfilamentous proteins of the cytoskeleton that frequently appear in patients with hepatitis could be responsible for a positive result in the anti-HIV-antibody test. In fact there is much to indicate in the case of viruses with a protein envelope, such as parenterally transmitted hepatitis viruses, that endogenous microfilamentous cell structures are incorporated into the envelope, which makes the immune elimination of these viruses impossible.

Since the experiences with lupus patients have shown that the anti-HIV-antibody test does not detect exclusively antigens of the HI viruses, and that on the other hand the viral infection in AIDS can be plausibly explained by the parenteral transmission of hepatitis viruses, it now seems to us to be time to reassess the pathogenesis of AIDS from these two viewpoints.

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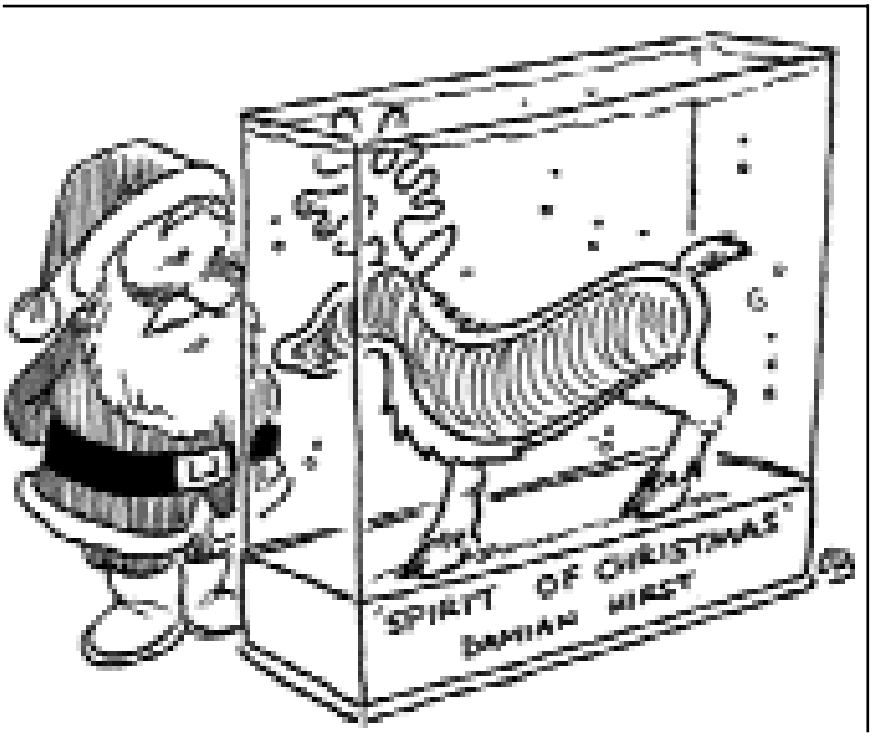

Toxic Sludge Is Good For You!

Lies damn lies and the public relations industry

John Stauber and Sheldon Rampton

Common Courage Press, USA, 1995

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Tel. USA +1 (207) 525 0900. Price $16.95 (£12.75) plus p+p

Martin Walker

In contemporary society, the distance between business and its consumers, like the distance between governments and their citizens has become a yawning chasm. This space which might in a better world be filled with organisations of accountability, is in developed societies inhabited by a mass of irredeemable chancers, engineers of fact and feeling, who produce nothing and live off the labour of others.

When the product leaves the factory, or the policy leaves Washington or Whitehall, it still has an endless journey; to be reinvented, packaged and addressed to its most likely consumers. Toxic Sludge is Good For You! Lies, damned lies and the public relations industry is an American book which provides nuts and bolts information about what happens within the grey space between the production of corporations and their retailing propaganda in the community.

PR companies differ from advertising agencies and other promotional organisations in that as well as promoting products or services, one of their functions is to issue negative information about anything which might threaten the companies they represent.

Toxic Sludge! is what all good campaigning books should be, a handbook for guerrilla warfare in the contemporary world of corporate power and consumer engineering. It explains in detail the ploys and gambits used to censor the information which citizens need to make rational choices in a society dominated by power and prejudice. The book talks in real terms about the journalists who make up the news before they report it, about the scientists who help sell expert solutions to problems about which they are ignorant. The book has a whole chapter on spies and agents provocateurs ... Yes we are talking about business as usual in America.

Perhaps the most important thing Toxic Sludge does is to place dirty tricks, fraudulent science, covert disinformation and destabilisation in the context of apparently legitimate business. It reminds us, unwilling as we often are to accept it, that we now live in a world where governments are often at war with their citizens and corporations often at war with their consumers. A world where politicians, who are meant to fight the corner for their constituents, stumble about like moles on a motorway buffeted by vested interests and professional lobbies.

Toxic Sludge describes the birth of the public relations industry as it emerged from the secret services of American foreign and domestic policy organisations, irrevocably linked to the CIA and other covert intelligence programmes. It re-enforces the industry's contemporary involvement with intelligence by dedicating one of its longest chapters to the lies we are told about arms sales and manufacture.

We will have to wait a considerable time before the British equivalent of Toxic Sludge is written. Our investigative journalists can be counted on the fingers of one amputated hand (with apologies to Paul Foot and John Pilger) and the Left has failed to develop a critique of multi-national corporations and the power vacuum which is being created with the dissolution of the nation state.

Today in Britain, everyone has a public relations company. Health trusts and local authorities employ them. This would not be a problem if PR was simply about singing the praises of Skegness or promoting a specialism in sciatic nerve surgery, accentuating the positive has always been a legitimate sales practice. But what if the trust has a higher than average post-operative mortality rate or Skegness decides to dump nuclear waste, from Spain, offshore. The PR company is then brought in to either: present the matter in a positive light; divert attention from the critical circumstance; or attack the critics, destabilise their organisations and even silence outspoken participants. None of these things can be done without lies, destabilisation and disinformation. In contemporary society scientists, doctors and statisticians play a major part in such campaigns.

Which brings us to why readers of Continuum should be interested in this book and this subject. AZT was licensed in Britain in 1987 despite the fact that no clinical trials had been carried out in this country. By 1990, the drug was making over £200 million a year for the Wellcome Foundation, it was selling across Africa, Asia, the Caribbean and in most European countries. The runaway success of the drug had nothing to do with any effect or lack of effect, nor was it linked to the pseudo-scientific rhetoric which underpinned its licensing – AZT has probably killed more people than viruses. Nor did the constantly rising sales of the drug have anything to do with the actual number of people who were to contract AIDS-related illnesses. The sales success of AZT, despite its clinical failure, was almost entirely to do with the strategies used by the public relations companies employed by Wellcome.

These companies launched wave after wave of positive publicity using tame professionals – scientists, doctors and journalists – to set up front organisations, write articles, appear at medical forums and speak at conferences. Companies hired by Wellcome flooded consultants' surgeries, hospitals and professional medical bodies with literature, videos, lectures and free technical help. Meanwhile at other levels, these companies in co-operation with other smaller ones, began disinformation campaigns about alternative medicine, immune system therapists and those who insisted that AIDS was not solely a viral illness. In Britain and America men and women who have developed AIDS-related illnesses have never had access to the full information about their condition, or a fair chance to choose the kinds of therapies which might help them survive. While the pharmaceutical companies and the economic system under which they operate, are ultimately responsible for this, it was the public relations companies and their sorcerer's apprentices from orthodox medicine and science which policed the grey zone between legitimate business and the lower depths of dirty tricks and disinformation, who truly engineered the social construct of AIDS.

In the post-industrial world of the twenty first century, all consumers will need to be versed in the lies and virtual constructs of PR companies, the dirty tricks of private enquiry agents, and the false promises of front organisations, if they are ever to change anything. Toxic Sludge, together with a handful of other books published over the last five years, begins this process of education.

Viral Load and

–why they can't be used

SPECIAL FEATURE

"Biotechnology's version of the Xerox machine"—that's what Forbes magazine called the polymerase chain reaction (PCR). This revolutionary technique enables a scientist to take a sample containing a minute amount of DNA and replicate that DNA sequence until there are a million copies instead of just one or two.

Kary Mullis, inventor of PCR, won a 1993 Nobel prize for his billion-dollar invention, which has become indispensable to any genetics lab. It is ironic that one of the first applications of PCR was to detect HIV, considering that Mullis himself doesn't believe his invention is capable of this. Mullis states the problem is PCR is too efficient – it will amplify whatever DNA is in the sample, regardless of whether that DNA belongs to HIV or a contaminant. And how do you decide which part of the amplified material could be HIV and which part the contaminant(s), if you couldn't detect HIV in the sample without using PCR?

One of the main arguments against the HIV/AIDS hypothesis is that, when employing traditional methods of virus detection, HIV has never been inferred in significant amounts in people with AIDS. Virus culture, for instance, has been adequate to find other viruses, but not HIV. Why not? When virus culture is employed to detect HIV, HIV is never seen or even looked for in the cultures. Its presence is measured by very indirect methods: assays for detection of reverse transcriptase or a p24 protein, neither of which is specific for HIV. Indirect methods would not be necessary if a significant amount of HIV were there to begin with.

In other words, if a meaningful amount of HIV were present, the time-honoured laboratory techniques should be able to find it. They can't. Now we need not only PCR, but continuous modifications and improvements on PCR, in order to try to find HIV.

This is how the idea of "viral load" came about, inspired by two spates of scientific papers that claimed HIV is busily replicating by the billions: initially, papers claiming HIV was "hiding in the lymph nodes,"[1,2] and more recently, the Ho and Wei papers.[3,4] The latter studies attempted to measure "viral load" at a given point, after which "antiviral" drugs were administered to the patient. The drugs were supposed to prevent replication of any new HIV, and the viral load would decrease accordingly. However, within a few days, the remaining virus would mutate into a form resistant to the drugs, and in a few weeks the viral load would return to its pre-treatment levels. Applying a mathematical formula to this dynamic, the rate at which the virus replicates was allegedly determined.

Hence was born what I call "Dr. Ho's kitchen sink theory". According to Ho, billions of copies of HIV are being made every day, which infect billions of T4-cells. These T-cells are destroyed not by HIV, but by the immune system. They are replenished every day, but over the years, the immune system loses ground and HIV finally wins. This process was likened to a sink with the drain open, the water pouring in from a tap (new T-cells being made) at a slightly lower rate than it drained away (infected T-cells being destroyed).

It is most important to note that the viral load studies all rely completely on PCR and related techniques. This article will discredit PCR as an accurate method of determining HIV infection, which will in turn cast doubt on any conclusions about HIV that have been made based on PCR techniques.

SOME BASICS ON DNA

PCR takes advantage of certain fundamental properties of DNA. DNA (as well as RNA) is a *nucleic acid,* and nucleic acids are composed of nucleotide "building blocks". DNA exists as two complementary strands arranged in a double helix formation (two intertwining spirals). These strands are made up of many nucleotides hooked together to form a long chain of DNA.

The nucleotide molecule has three different parts: the phosphate and the sugar (which form a backbone or a ribbon-like structure), and the base. There are four types of bases: A, T, C, and G (adenine, thymine, cytosine, and guanine). These bases are attached to the backbone, which is wound in the familiar double helix.

The bases on one strand bind to the bases on the other strand, and this gives DNA its stable double helix structure. (Think of the two strands as forming a zipped-up zipper.) The distinct nature of an organism's DNA code depends on the order, or sequence, of the bases along the DNA chain.

There are special rules about how bases form chemical bonds with other bases: an A will only bind to a T, and a C will only bind to a G. A base on one strand binding to a base on the other strand is called a "complementary base pair". This rule of complementary base pairing is what gives DNA its ability to replicate itself exactly.

Each time a cell divides, it has to make a copy of its DNA for the new cell. The DNA double-strand first "unzips" itself into two separate strands. Each single strand serves as a *template,* or pattern, from which to make a new copy of its complementary strand. (So, strand #1 serves as a pattern to make a new copy of strand #2, and vice versa.) The single strand then incorporates new nucleotide building blocks from the surrounding medium according to the rule of complementary base pairing. In other words, an available A on the single strand will grab onto a T nucleotide, a C will grab a G, and so on until the entire opposite strand is duplicated. At the end of this process, the two original strands zip themselves up again, and the two copied strands serve as DNA for a new cell.

the PCR d to prove HIV infection

by Christine Johnson

How PCR works

The theory of HIV says it, like other suggested retroviruses, contains RNA but no DNA: when HIV is said to infect a cell, the reverse transcriptase enzyme is thought to transform the RNA into complementary DNA, which is then inserted into the host cell's DNA.

Therefore, if PCR is used to analyse human tissue for the presence of HIV, it would be looking for only a short segment out of the entire cellular DNA strand. This short segment represents the genetic material proposed for HIV, that in theory has been incorporated into the DNA of the cell. (Viral load studies try to look for cell-free HIV. Even here, PCR is only looking for part of HIV's entire proposed genetic package, or genome, not an entire virus.)

PCR works in the following fashion:

Step 1: Heat the template
A long piece of DNA containing the smaller fragment to be copied is heated. The two strands can be "melted" apart at elevated temperatures, and will slowly come back together upon cooling ("annealing"). The two separated strands are complementary to each other. They serve as *templates* for the new strands.

Step 2: Add the primers
Something called a *primer* is necessary for the next step. Primers are nucleotides that form a short sequence of new strand. Primers are designed to be complementary to a known sequence which is part of a larger sequence, and thus where the primers will bind (or hybridise) is known.

The primers attach to each end of the DNA segment that is to be copied (the segment that represents HIV's proposed genetic material). The primers serve two purposes: a) to mark each end of the targeted segment so only that segment will be amplified, and not the entire strand, and b) to get the duplication process started. The new strands are built block by block by the action of an enzyme called *polymerase.* The polymerase builds a new DNA strand alongside an existing strand. The polymerase will not work unless the old strand (the template) already has on it a few nucleotides forming a short sequence of new strand (the primer). (If you ever see a reference to "template-primers," this is what they're talking about.)

In other words, the polymerase can only form a new strand if the new strand has already partially been formed. In nature, when your own DNA is duplicating itself, other enzymes called DNA primases build the primer onto the old strand.

Once the polymerase gets going, it crawls along the single DNA strand (the template) adding to it the nucleotide building blocks one by one. The primer ends up being part of the newly-made strand.

In nature, polymerases pull the DNA strands apart while they build the new DNA strand. This is how duplicate copies of DNA are made so that cells like blood and skin cells can divide into two new cells, a process essential for life.

Step 3: Amplify
Once again, after melting and then annealing the primers, the polymerase enzyme copies the DNA beginning at the primer, making a new copy of each target segment. This process is repeated for as many as 30-40 rounds. During each cycle, the amount of segments doubles, so two segments become four, four become eight, then 16, etc. By the end of the process, approximately a million copies of the original segment have been made. Now you have a whole lot of DNA, where originally you had only a minuscule amount. This is why PCR is referred to as being able to find a "needle in a haystack."

Obviously, it is necessary for the primers to be specific to HIV. Whether the PCR will make an amplified product (a "positive PCR") depends on whether the primers you add match part of the DNA in the target specimen.

Below, we will see that the specificity of the primers for HIV is in doubt. Even if the primers were specific to HIV, if similar sequences are present in the target, the primers, under lax conditions, will form hybrids with (or bind) related sequences that are less than a perfect match.

They will then prime the polymerase, which starts the amplification procedure, even though no HIV was present to begin with.

USING PCR TO FIND HIV

A problem for the HIV hypothesis was that, even with the use of standard PCR, researchers could not find much, if any, HIV in persons with AIDS diagnoses. To resolve this paradox, the authors of the new "viral load" papers came up with two modifications of PCR, which they claimed were much more efficient at finding HIV. These were the QC-PCR and the branched DNA test (bDNA). And suddenly – *eureka!* – billions of copies of what was believed to be HIV were found. The contradiction here seems to have escaped the authors of these papers: Why would such powerful new tests be needed at all to find a microbe that is present in the billions? Traditional methods should suffice.

QC-PCR

This is the test used in the above-mentioned papers by Anthony Fauci (Pantaleo) and Ashley Haase (Embretson), which claimed HIV was "hiding in the lymph nodes." These papers were accepted as fact, even though QC-PCR was, and remains, an unvalidated technique.

Mark Craddock, of the University of Sydney (Australia), explained the principles of and problems with QC-PCR as follows:[8]

"PCR mass produces fragments of DNA. You start with a small amount of DNA and after each PCR cycle, the amount of DNA you have is between one and two times the amount at the beginning of the cycle. Thus, the amount of DNA you have to study increases exponentially. The fact that the PCR is an exponential growth process means that experimental errors will also grow exponentially, so you need to be very careful about what you do with the process.

"A number of people have decided that it should be possible to estimate the amount of DNA present in a sample by using PCR. This is the so-called quantitative competitive PCR. The idea is to add to the sample to be estimated a known amount of similar but distinguishable DNA and amplify both together. The assumption is that the relative amounts of the two products should stay the same, and hence you can work out the size of the sample you started with by knowing the ratio of the two, determined by observation when PCR has produced enough of both to measure, and how much control DNA was added.

"What is absolutely crucial is that the relative amounts of the test DNA and your known control must remain exactly equal. Close is not good enough. The slightest variations will be magnified exponentially and can produce massive errors in your estimate.

"The difficulties in using PCR quantitatively were pointed out by Luc Raeymaekers in the journal *Analytical Biochemistry* in 1993. He noted published papers on QC-PCR contain data that show that the fundamental assumption that the relative sizes of the samples remain constant is not met in practice. Despite this, HIV researchers continue to use PCR to quantify viral load. There is simply no way of knowing whether a given estimate is correct or is 100,000 times too high!"

Todd Miller calls QC-PCR the "latest fad in science" and agrees that if the relative amounts of your test DNA and your known control are not equal, there is one thing you can say for sure about the estimate of your starting target (the amount of proposed HIV RNA in the patient's blood sample): It *will* be wrong.

How did QC-PCR, with all its flaws, become an acceptable HIV test? Miller explains:

"The way this situation has manifested itself in modern science is like this: First some people spend a lot of time trying to get this test to work, and if they're lucky, end up publishing papers about caveats in the procedure. Second, others happen to get the test to give them an answer that "makes sense" and publish their data as a significant contribution to the field. Third, because of its relative newness and arcane nature, it remains as quasi-accepted with many passive sceptics and a few users. However, most who use it are more interested in their own pet phenomenon than in the mechanics of the reaction."

bDNA

BRANCHED DNA PCR

This is the test used in Ho's paper. Though it is not, strictly speaking, PCR, it is referred to as such since it incorporates PCR-type technology. The difference is that bDNA amplifies the signal, not the target. That is, regular PCR makes more of the target so you can find it, whereas bDNA sort of shines a bright spotlight on it so you can see it better. Project Inform was kind enough to send me the following explanation of how bDNA works:[9]

"Copies of a DNA probe are attached to the wall of a small laboratory vessel; then the sample is put in. [A DNA probe is a small piece of DNA complementary to the target DNA sequence.] This probe binds to a certain part of HIV RNA, if it is found in the sample, holding the RNA in the vessel. Then another DNA probe is put in; one end of this attaches to another part of the HIV RNA. The other end of the second probe has many branches and each branch ends with a "reporter" chemical that, under certain conditions, will produce light, which can be detected by laboratory equipment. Each molecule of HIV RNA can attach to one of these branching structures and hold on to a small number of light sources, not just one. In this way, very small amounts of the target RNA can be detected, without the need for PCR amplification."

In his initial paper, Ho gave no data on the protocols for this test or whether it was reliable. The reader was referred to two other papers that were "in press". So, no data was available at that time to anyone who wanted to verify this method. The data obtained from bDNA was confirmed by QC-PCR, the details of QC-PCR being set out in a reference authored by four co-authors of the Wei study, hardly what you might call independent or objective researchers. In the tradition of HIV research, unproven theories and faulty studies are accepted without question and incorporated into the "conventional wisdom" before being properly validated. By then, the damage is done, and if subsequent flaws are discovered it hardly matters.

The mechanics of bDNA are complex: Five different hybridisation reactions are going on. Hybridisation is a standard technique wherein a DNA probe is put into a sample and will bind to any complementary segments it finds. It's another indirect test, and it has a lot of problems. According to molecular biologist Bryan Ellison, "The only time molecular biology works is if you purify things first. There's always the possibility of cross-reactions, especially when you put your probes into a big soup of proteins" (which is exactly what the target blood sample is).

Duesberg pointed out the following: After making the appropriate adjustments to his calculations, Ho himself later found that more than 10,000 viruses inferred by the bDNA assay used in his *Nature* paper would actually correspond to less than one infectious virus, leading one to wonder what it is that is actually being measured on these tests.[10] Yet these speculative and unvalidated papers have been accepted as gospel truth!

In Ellison's mind, Ho's study is "Pure fantasy. There's never been a paper that shows viral load."

The Problems with PCR

THE ACCURACY OF PCR HAS NEVER BEEN VERIFIED BY A PROPER GOLD STANDARD

To find out if any diagnostic test for HIV infection actually works, it is necessary to verify the test with an independent gold standard. The only proper gold standard for this purpose is HIV itself. In other words, the results of your experimental test, whether it's PCR or anything else, must be compared to the results of virus isolation in each sample tested. If virus is actually found in each patient with a positive PCR, and no virus is found in each patient with a negative PCR, then you could say PCR is extremely accurate for detecting HIV.

The concept of virus isolation as a gold standard is particularly important in the case of HIV, since HIV has been extremely difficult, if not impossible, to define in genetic or molecular terms. Even if anyone had ever accomplished virus isolation for HIV[11], it has never been used as a gold standard for any HIV diagnostic test, including PCR. As it stands right now, bDNA uses QC-PCR as a gold standard; QC-PCR uses regular PCR as a gold standard; regular PCR uses antibody tests as a gold standard, and antibody tests use each other. I have noticed time after time that studies which are "verifying" an HIV antibody test will invariably state that they evaluated the performance of their test on samples which were known to be TRUE-POSITIVE or TRUE-NEGATIVE. How did they know this? It's simple: Without a gold standard, they didn't.

It is sometimes argued that "studies have shown" these tests to agree with each other or confirm each other's findings, and therefore they must be correct. This is not rigorous scientific thinking. Sometimes you can get the results of different tests to agree with each other, but that does not prove anything – no more than it would prove if five criminals all agreed that they were somewhere else when the bank was being robbed.

Eleopulos says the following about the importance of gold standards: "The use of viral isolation as an independent means of establishing the presence or absence of the virus is technically known as a gold standard, and is a quintessential element for the authentication of any diagnostic test. Without a gold standard, the investigator is hopelessly disoriented, since he does not have an autonomous yardstick against which he can appraise the test he is aspiring to develop.... Only by this means can we assure patients that a positive HIV PCR is only ever found in the presence of HIV infection, that is, the tests are highly specific for HIV infection."

Even well-known AIDS researcher William Blattner has conceded that "one difficulty in assaying the specificity and sensitivity of human retrovirus assays (including HIV) is the absence of a final 'gold standard.' In the absence of gold standards for both HTLV-1 and HIV-1, the true sensitivity and specificity for the detection of viral antibodies remain imprecise."[12]

Mark Craddock states QC-PCR is unverified and probably unverifiable. He asks, "If PCR is the only way that the virus can be detected, then how do you establish the precise viral load independently of PCR, so that you can be certain that the figures PCR gives are correct?" All this has apparently been lost on AIDS researchers, as it is regularly recommended that PCR, particularly QC-PCR, be used as a gold standard for other HIV tests.[9,13]

Specificity means how often a test will give negative results in people who are not infected. A test's specificity rating reveals the level of false-positive results to expect when using that test. Without a virus isolation gold standard, the true specificity will never be known. Even using concordance with antibody tests as a gold standard, PCR was not found to be very specific for HIV.[6]

THE SPECIFICITY OF PCR HAS NEVER BEEN DETERMINED

Citing a proficiency study involving five laboratories with extensive PCR experience, Sloand states that the average specificity was 94.7%.[14] Specificity was as low as 90%. Numbers in the 90s may sound good, but in reality, this is not the case. The number of false-positives compared to true positives is dependent on the prevalence of HIV infection in any population being tested[15] – the lower the prevalence, the more false-positives.

Sloand comments that if the specificity levels achieved in this study were applied to the potential blood donor population" (blood donors now consisting of members of the low-prevalence general population), then "...for every true silent infection detected, 1800 uninfected donors would be classified as PCR positive and 3500 as PCR indeterminate. Thus PCR is clearly not suitable for routine screening of transfused blood" and by inference, any low-prevalence population. At a specificity of 90%, I would say it wasn't suitable for testing any population.

In a FAX I received from the Centers for Disease Control (CDC) in 1994 regarding PCR, they stated that "Neither its specificity nor its sensitivity is known," and that "PCR is not recommended and is not licensed for routine diagnostic purposes."[16]

In a nutshell, "The specificity of any form of PCR, for the HIV genome, has not been determined."[5]

PCR PRIMERS ARE NOT SPECIFIC

According to Eleopulos, Turner, and Papadimitriou, "The minimum requirement for [interpreting that a positive PCR signal, or hybridisation in general, proves HIV infection] is prior proof that the PCR primers and the hybridisation probes belong to a unique retrovirus, HIV, and that the PCR and hybridisation reactions are HIV-specific." Turner told me: "The PCR genomic arguments require isolation of HIV as absolutely essential. Otherwise how does anyone know the origin of the nucleic acid?"

Eleopulos disputes the reality of a distinct HIV genome. Conceding its existence for the sake of argument, she offers the following evidence to demonstrate PCR is nonspecific for HIV:[17]

- There is no way to be sure the "HIV" nucleic acid probes and PCR primers are specific to HIV because: most, if not all, probes used for hybridisation assays, including the PCR probes and primers, are obtained from "HIV" grown in tissue cultures using cells (called a cell line) taken from a patient with T4 cell leukemia, a disease which Gallo claims is caused by a retrovirus similar to HIV – HTLV-I. And recently a retrovirus is claimed to have been isolated from a non-HIV-infected cell culture using another cell line. Thus the standard cell lines used to grow HIV have been shown to indicate other retroviruses. Since even the well-established method for isolating retroviruses (which to date has never been done for HIV) cannot distinguish one retrovirus from another, one cannot be confident that "HIV" nucleic acid probes and PCR primers are indeed specific for HIV.
- Proposed HIV genes hybridise with the structural genes of

HTLV-I and HTLV-II, two other human retroviruses. This means that if the probes find genetic material from these other retroviruses, they will stick to it and give a signal that they have found HIV instead. Since it is accepted that 10% of AIDS-diagnosed patients carry HTLV-I and that the normal human genome contains sequences related to HTLV-I and HTLV-II, this type of cross-reaction can be anticipated.

• Normal human cells contain hundreds or thousands of retrovirus-like sequences, that is, small stretches of DNA that match a small part of the proposed genome of HIV or other retroviruses. And, since PCR often amplifies just a small part of the entire genome of whatever it's looking for, how do you know that what it finds isn't a normal cellular gene sequence that just happens to match part of what's proposed for HIV?

• Further evidence that PCR is nonspecific is that positive PCRs can be obtained from cells without nucleic acids. So if there's no nucleic acid, there's no DNA or RNA, and if there's no DNA or RNA, there's certainly no HIV.

• The chemicals used in labs in the preparation of tissue cultures (called buffers and reagents) may give positive PCR signals for HIV.[18]

PCR DETECTS ONLY A SMALL FRAGMENT OF AN ENTIRE VIRUS

PCR detects at best single genes and most often, only bits of genes. If PCR finds two or three genetic fragments out of a possible dozen complete genes, this is not proof that all the genes (the entire genome) are present. Part of a gene does not equal a complete virus particle.

HIV experts admit that the majority of proposed HIV genomes are incomplete; they could never orchestrate the synthesis of a virus particle.

Turner explains: "Even if all genomes were complete, having the plans doesn't mean you've built the house. You can carry a whole retroviral genome around inside your cells all your life without ever making a virus particle." These two problems make it even more uncertain what the significance of a positive PCR is.

THE FINDING OF "HIV RNA" ON PCR DOES NOT SIGNIFY THE PRESENCE OF HIV

These days, one keeps hearing the phrase "HIV RNA PCR." What's the difference between that and regular old DNA PCR? Regular PCR looks for the DNA version of what is often accepted to be the HIV genome; RNA PCR looks for the RNA version, that is, free virus that has not infected a cell.

With the new notion that HIV was busily replicating by the billions, it was now thought necessary to find how much free virus there might be at any given time. Free virus would contain only RNA, so if the PCR finds a lot of "HIV RNA," it is believed billions of copies of free virus are swarming around the patient's tissues. In other words, if you find RNA, you've found HIV as well. Since it's believed HIV contains two strands of RNA, the suggested formula is: Two RNAs = one virus.

In actuality, things are not this simple. In 1993, during the "HIV is hiding in the lymph nodes" phase of the viral load theory, Piatak and colleagues, including Shaw, admitted that in order to determine the quantity of HIV particles, one must have prior evidence that the RNA actually belongs to an HIV particle.[5] No such evidence was presented. No relationship has yet been established between the amount of RNA and the amount of particles that may or may not be present. And no one has established whether the RNA comes from a virus particle or from somewhere else. Without virus isolation, how do you know the origin of the nucleic acid (RNA)?

CELL-FREE VIRUS IS NOT INFECTIOUS VIRUS

Even if Ho were right about billions of cell-free HIVs being present in the bloodstream, free virus is by definition not infectious virus; it's irrelevant as a pathogen. For HIV to infect a cell, its envelope protein, gp120, must bind to the CD4 receptor site on the cell's surface. However, as far back as 1983, Gallo pointed out that "the viral envelope which is required for infectivity is very fragile. It tends to come off when the virus buds from infected cells, thus rendering the particles incapable of infecting new cells." Because of this, Gallo said "cell-to-cell contact may be required" for retroviral infection. Since gp120 is "crucial to HIV's ability to infect new cells," and since gp120 is not found in the cell-free particles, even if huge amounts of free HIV are present in the blood, they would be non-infectious.[17]

PCR IS NOT STANDARDISED OR REPRODUCIBLE

In a recent paper, Teo and Shaunak commented on in situ PCR: "Despite considerable effort, the technique is still technically difficult and has not yet proved to be reliable or reproducible."[19]

In a study which compared PCR results to antibody test results, PCR was found not to be reproducible and "False-positive and false-negative results were observed in all laboratories (concordance with antibody tests ranged from 40% to 100%)."[20]

PCR IS SUSCEPTIBLE TO CROSS-CONTAMINATION

Minute quantities of nucleic acids from prior specimens can easily contaminate the specimen currently being tested, giving a false-positive result.[21] Even microscopic bits of skin or hair from the lab technician can cause this problem. Many sources of cross-contamination exist, and it can occur "at any step in the procedure, from the point of collection of samples through to the final amplification..."[22]

Other causes of false-positives are enumerated by Teo and Shaunak: "We have now identified a number of factors which can contribute to the poor amplification of the target DNA and to the generation of false-positive signals. These factors include the effects of fixation, reagent abstraction, DNA degradation, DNA end-labelling and product diffusion.... We believe considerable caution should be exercised in the interpretation of results generated using PCR in situ."[19]

FALSE-POSITIVES FREQUENTLY OCCUR WITH PCR

• A proficiency study to rate HIV PCR's performance on detecting cell-free DNA showed "a disturbingly high rate of nonspecific positivity" using the commonly employed primers (SK38/39, for the gag or p24 gene). In fact, similar rates of positivity were found for both antibody-negative and antibody-positive specimens (18% versus 26%)![23]

• Out of 30 uninfected children, 6 had "occasional" positive PCR

results.[24]

• PCR performed on uninfected infants under one year of age showed 9/113 (9 out of 113), 15/143, 13/137, 7/87, and 1/63 infants to have positive PCR tests.[25]

• Among 117 uninfected children born to HIV-infected mothers, six (5%) had a false-positive PCR on cord blood.[26]

• In a PCR proficiency study, 54% of the laboratories involved had problems with false-positive results; 9.3% of the total uninfected specimens were reported as positive.[22]

• One out of 69 antibody-negative, non-seroconverters was PCR positive.[27]

• A high-risk individual was initially PCR positive but negative on repeat PCR testing of the same specimen by two different laboratories.[27]

• The World Health Organisation's PCR working group demonstrated high levels of false-positive results obtained during "blind" HIV PCR studies.[22]

• Sheppard et al. stated in their study: "This trial demonstrated that false-positive results, even with rigorous testing algorithms, occur with sufficient frequency among uninfected individuals to remain a serious problem."[28]

• Out of 327 health care workers exposed by needlestick to HIV, 4 had one or more positive PCR results and 7 had indeterminate results. Later samples for all 11 were negative and none seroconverted or developed p24 antigenemia, leading to the conclusion that "false-positive results occur even under the most stringent test conditions."[29]

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CONCLUSION

Essential to Dr. Ho's theory is the idea that HIV mutates so rapidly that within days or weeks it has become resistant to whatever "antiviral" drug the patient is taking. In order to prevent this, it is recommended that the patient take three-drug "combos" which theoretically hit HIV from all angles simultaneously, thus reducing the chance that a resistant strain will survive. Meanwhile, one must continuously monitor the "viral load" with tests that cost 200 bucks a pop. Emphasis is placed on early intervention, that is, dose patients with multi-drugs the minute they seroconvert (assuming that anyone would know when this event took place to begin with) and keep them on these drugs for the rest of their lives.

Even though no one has shown them to be accurate, viral load assays are being vigorously promoted as state-of-the-art necessities for PWAs, and it's not hard to figure out why. In the *Washington Post* (2-06-96), David Brown inadvertently revealed the reason: "Aggressive HIV treatment will probably be even more expensive than in the past. Measuring viral load will cost about $200 per test, and the new generation of HIV medicines will probably be at least as expensive as the ones they replace."

***U. S. News and World Report* (2-12-96) was more specific, estimating the yearly cost of a protease inhibitor at around $6,000, and the cost of triple-drug combinations at up to $12,000 to $18,000. Combos of three or four drugs are now prescribed, where one (AZT) used to suffice. As more and more drugs are considered necessary to "treat" people, many of whom have nothing wrong with them, it is obvious what a cash cow this is going to be for the pharmaceutical industry.**

The viral load theory has created a new worry to produce unbearable stress in the lives of desperate people. It is now said that a person has only one shot at the new "anti-viral" drugs, chiefly the protease inhibitors. If you don't take them at exactly the right time, in exactly the right combinations or amounts, or if you foolishly take only one drug at a time, or lower your dose because the current dose is making you sick, your virus will become resistant and the drugs will never work on you again. And you can't just quit the drugs either, for the same reason, even if they are making you deathly ill.

Every article on the subject so far has a different expert guess about how this whole program is supposed to work: no one knows if you can get cured or merely hold the line; no one knows the long-term prognosis for those who take this triple-toxic triple-combo. (Protease inhibitors have produced extreme adverse reactions in many people, so it shouldn't be hard to figure it out). Anyone foolish enough to sign up will become a test animal for people who don't know what they're doing.

When will we stop allowing ourselves to be used as guinea pigs for whatever crack-brained scheme comes down the pike? When will we put a lock on our wallets and refuse to pay for the privilege of being poisoned? And when will we quit supporting the most degraded human beings in existence – those who profit from the suffering of others?

With acknowledgements to:
Paul Philpott, former research assistant in immunology and current editor of Reappraising AIDS;
and Todd Miller, Ph.D. in biochemistry and molecular biology, of the University of Miami.
A similar version of this piece first appeared in the HEAL/New York Bulletin, *Oct. 1996*

VIVE LES ANIMAUX!

The three articles on animal experimentation in the last Continuum made fascinating reading. Peter Tatchell and Michael Baumgartner spoke the truth: animal experiments are medically invalid in human disease investigation, since there are innumerable unpredictable physiological, immunological and psychological differences between animals and humans. To believe that a mouse, rat or even a chimp is a reliable biological replica of a human is to do precisely what Alex Russell rightly condemns: to indulge in the grossest forms of anthropomorphism.

Animals do NOT naturally contract most human diseases (measles, smallpox, polio, diphtheria, typhus, bubonic plague, yellow fever, leprosy, cholera, multiple sclerosis, Parkinson's disease, haemophilia, sickle cell anaemia, etc., etc.). This means that experimenters wishing to investigate human diseases in animals are forced to create an artificial construct of those diseases – something very different from the real thing, the spontaneously occurring human maladies.

Furthermore, animals frequently respond differently to chemicals/foods than we do. Thalidomide causes neurological damage in humans, but it has been shown that mice are 60 times less susceptible than humans, rats 100 times less sensitive, dogs 200 times and hamsters 700 times less sensitive to Thalidomide damage than humans! Rabbits can survive (relative to body weight) nearly 30 times the amount of strychnine that could kill a human, and dogs and cats can survive 100 mg of the poison, scopolamine, whereas just 5 mg will kill a man/woman. Yet cats can be fatally poisoned by lemon juice – some rabbits too! Vitamin C is essential in our diets (to ward off deadly scurvy), but cats, dogs, rats, mice and hamsters require no dietary vitamin C at all.

Last year a vivisector boasted on TV about a new drug for heart disease which had passed the animal tests and was promising to save many human lives. This year the clinical trials of that drug have been stopped, since the "life-saving" drug seems to be KILLING some of the patients.

As animal experimenter, Dr Frederick Coulston, has stated regarding extrapolating animal data to humans: "... this is ALL GUESS ... and we shouldn't put too much faith in it" (emphasis added). Another (ex)-vivisector, Prof Pietro Croce, insists: "... it is hard to find anything in biomedical research that is, and always was, more deceptive and misleading than vivisection."

As a researcher and author of two books on animal experimentation, I wholeheartedly endorse both Peter's and Michael's rejection of blood sacrifices – vivisection – which should be consigned to the 19th century where it truly belongs.

Dr Tony Page
Kennington, London

Sources (amongst others):
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The Lancet (numerous issues)

SWINDLE SWINGERS

I have been delighted in reading all these interesting articles by authors with different backgrounds, but having at least one thing in common: the ability to use their commonsense.

You are doing a very important job in England to help the world get rid of what I called as early as December 1983, "the widest scientific swindle of this century". With what you are currently doing I am sure that Montagnier and Gallo (and overall the ideas they are spreading) will soon have to face some "hard times".

I particularly appreciated the article which rejected the idea of the existence of what is called the "Human Immunodeficiency Virus" (HIV). Even this name for this "virus" is a scam, because before giving that name to the "virus", Montagnier, Gallo, Chermann... had to bring evidence that this "zombie-virus" could really cause what is called "Human Immunodeficiency".

When I started fighting the "LAV=HTLV3"/AIDS theory in 1983, I imagined that it would not have taken a long time for both Montagnier and Gallo to be convicted of scientific fraud. Thirteen years after, Montagnier, Chermann, Gallo... are still insulting the human (and also simian) intelligence. Nevertheless, I have now the strong impression that the year 1997 will bring the end of this "HIV/AIDS" bad tale. I have another surprising story about the genesis of the "AIDS-phenomenon", but it will come later.

Your organisation is offering money to those who are able to prove that the so-called HIV really exists and has been isolated. How can we explain that the "HIV experts" have not yet showed up to grab this money? So far, these "HIV experts" have resisted the idea of proving that HIV can be transmitted through items like American dollars, British pounds, French francs, German marks, Haitian gourdes... since those items are every day meeting multiple partners.

Professors Luc Montagnier and Jean-Claude Chermann will probably come soon to see you. I am imagining that they have asked some famous French tailors to design for them special pants with extra large pockets to put in the money you are offering. Please don't give them the money BEFORE they really bring the proof that they really have discovered and isolated the "HI virusse". They have already taken a lot of money for nothing and worse, in selling death, lies, desolation, social and racial hatred all over the world.

Henri-Claude Saint-Fleur
True Research Unit to Throw-away HIV (TRUTH), Miami

***Continuum* welcomes your letters – write to the Editor at the usual address**

LIVE, LIVE, LIVE!

I am sitting here with Sadie (my Yorkie) and we are watching the rain and hail as it pounds against the windows. Even though it's cold we are finally settled and getting ready for the Holiday Season. For myself this preparation begins with Thanksgiving, another turkey dinner to cook. I enjoy a great day in the kitchen. I get to do all my Delia Smith recipes.

Then in the next week I get the house ready for Christmas, which to me is the most fun. Yes Christmas comes but once a year, but I wish it came twice as I love the decorating of the house. I hope your Christmas is as much fun as mine is going to be.

To think next year I will have been in this lovely place they call England for five years. How time flies when your having fun! I am seriously glad that I have to stay. Where else can you have a royal family that makes you feel they are just next door. If you could see the letters that I have from them alone... All who saw the Ruby Wax Special on the Duchess of York must believe Sarah really does still love Andrew – who wouldn't? He's so good-looking.

With the Holidays upon us we tend to do more and go to many more parties, and we tend to run ourselves down. Ortis has a new product out called Super Royal Jelly caps I have been taking for a year. I know that if I start to feel tired and have a lot to do, I can take two of these at about four in the afternoon and I have the energy of ten people. So if you want to order these Ortis' number is 0181-398 9888 and ask for Maggie and tell her Goldie told you to call and you will get excellent service. If you order three things you get a 25% discount.

You know you can write to *Continuum* with comments or questions that you would like me to answer – I'm always here for you, be it on health, love, or just Life itself – feel free. I want you to have the best to LIVE LIVE LIVE with.

MERRY CHRISTMAS AND HAPPY NEW YEAR

With love, *Goldie Glitters*

REAPPRAISING AIDS

is a monthly publication from The Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis. Their mission statement reads as follows:

The Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis came into existence as a result of our efforts to get the following four-sentence letter published in a number of prominent scientific journals. All have refused to do so.

"It is widely believed by the general public that a retrovirus called HIV causes the group of diseases called AIDS. Many biomedical scientists now question this hypothesis. We propose that a thorough reappraisal of the existing evidence for and against this hypothesis be conducted by a suitable independent group. We further propose that critical epidemiological studies be devised and undertaken."

The publication is available by subscription ($25 p.a. USA, $35 p.a. elsewhere) from:

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Researcher

wishes to interview any Continuum readers

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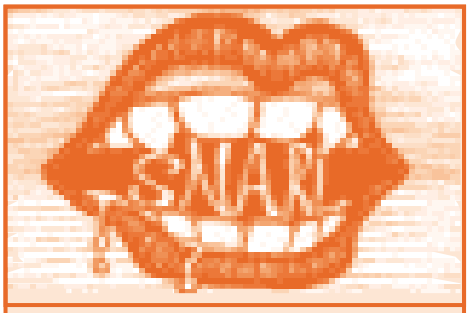

ONE WORLD ONE HYPE?

Loathe though we all are to return to the *brouhaha* which surrounded the recent Vancouver AIDS Conference, some of the media coverage which was current at the time cannot pass without comment. ITV's *News at Ten* in its infinite wisdom decided to feature daily special reports reflecting the theme of this year's World AIDS Day "One World, One Hope", promoting the theory that there are supposed to be AIDS epidemics in various parts of the world. Surprisingly, these reports – done in the usual hushed "millions of deaths", "doom'n'gloom", "nightmare scenario" tones actually unwittingly exposed the lies which tell the truth about the "pandemic" theory.

The emergence of Multi-Drug Resistant Tuberculosis (MDR-TB) in areas such as the Indian sub-continent, South East Asia and sub-Saharan Africa is reported as a recent phenomenon, and linked neatly to the "HIV" infection theory. Yet the fact that large numbers of people become infected with TB in Third World countries is a historical fact, with new strains being reported at regular intervals for centuries. Millions die annually from a whole variety of immunosuppressive illnesses, none of which have a sole "viral" cause, nor are they anything new.

The ITN reports admitted that in the Third World no real attempt is being made to test people for "HIV" due to lack of resources, *and the inaccuracy of testing methods.* However, as it is assumed that "HIV infection" must be the cause of these spreading TB cases, the WHO is once more pumping money into local "HIV" health missions (with their "jobs or the boys" culture – making doctors and other "experts" wealthy while their patients starve) instead of relying upon medical evidence.

Since when has TB="HIV"="AIDS"? And why has no real research been done into malnutrition-related immune deficiencies in these regions? As has been shown in Haiti, Uganda and other previously targeted "risk areas", the "AIDS epidemic" has not always happened in the ways predicted. Whole populations suffering from poor diet, lack of hygiene and common tropical diseases have been in turn terrified and hospitalised by UN-sponsored "HIV=AIDS=MONEY=DRUGS" campaigns, backed by millions of dollars of foreign aid which could have been equally well spent on agricultural (i.e. nutritional) improvement of their lot.

We do indeed owe a huge debt of compassion to people who are starving and consequently more likely to fall ill or die as a consequence of their desperate living standards, but as always it seems that dubious diagnoses and enthusiasm for perpetuating widespread "AIDS paranoia" prevails.

by MAVIS CRUET
the (Welsh) Fairy

Lust for Life

Margaret Turner describes how her thinking has changed on HIV/AIDS issues and her commitment to life found direct expression

The first thing I want to do in this article is justify my contribution to this page that has, so far, been written exclusively by people who have received an HIV+ diagnosis. I have not. I am a middle-aged, bisexual woman who hates having to categorise her sexuality and who has had her life changed dramatically by the existence of HIV diagnoses in the lives of people around me and, ultimately, in my own.

When I first came across the issues in 1985, I was a housing manager at Manchester City Council, well known for welcoming gay men and lesbians onto my list. I received many referrals from Manchester Gay Centre who, at the time, ran the AIDS helpline, and it was from there that I first learned that something real was happening. My reputation must have made me appear safe in a world which, at the time, condemned people with an HIV+ diagnosis to a life of isolation and fear.

I began to be approached by the Gay Centre and individuals with the diagnosis for safe rehousing. All believed they would die in the near future and so did I. The world was very different then. I can remember going out of my way to drink a cup of tea in someone's house to demonstrate that I didn't believe it could be caught from sharing crockery. This sounds incredibly patronising but it wasn't meant that way. I knew something was not right and I wanted to know more.

I embraced the mainstream wholeheartedly, trained as an HIV trainer and ran courses for lesbians about HIV and AIDS – although I believed this was not an issue for them. Nevertheless, on I went, took a counselling job with a local GP and had referred to me a number of clients with the diagnosis. One of these men was to become a close friend.

His name was Kevin. I loved him deeply, still do, eight months after his death from what I believe was an avoidable series of illnesses brought on by self-abuse, self-hatred and a lack of true love in his life. The people he cared for most didn't care for him as deeply and he could never come to terms with what he believed was his perversion. He was feisty all right, he didn't apologise for himself in any way. But a big hug from the right person at the right time would have meant a lot to him. Gay men and lesbians have to find an inordinate amount of self-esteem to keep going in the face of wicked homophobia and that's what Kevin was doing. And, when I watched him day after long day taking incredibly toxic medication, even when it interfered with his appetite making it impossible for him to receive real nutrition, I wondered how much the medical profession really valued these people in what it had termed 'high risk groups' or did they think we were expendable in the name of research. A euphemism for profiteering at a time when the AIDS wards became like the trenches of the Somme.

I spent two years with Kevin, helpless in the face of the self-fulfilling prophecy that was his diagnosis. Probably the worst thing was to see him decide to ignore the advice he received through reading Continuum magazine. He was intelligent, a former social worker who understood all the ramifications of everything he was doing. I could only offer him an alternative to the E/poppers/Special Brew/dance-till-you-drop lifestyle he'd decided was what he wanted. He chose not to do ordinary life. And I respect his decision and the right he had to make it. And therein lies the lesson in all of this for me. There is of course much more to what happened to Kevin but this article is about me and what it meant to my life.

Shortly after I met Kevin, the man who was a son to me, John, told me he had been given the same diagnosis. This is hard to write because I have a long way to go before I have dealt with the loss of this beautiful, beloved person from my life, but it was John who brought me to meet Jody Wells and the thinking of the people who work at Continuum.

Huw and I met in Morocco, on a never to be forgotten holiday with my son-once-removed. We became good friends and through his influence, dedicated research and exactness of language, I took a new look at HIV and AIDS.

Why do some people not die? Why do others die fast? Why was this not the biggest issue of all for researchers? Surely in the finding of the life factor there would be an end to all these deaths – and the imminences. I left the GP's practice after trying unsuccessfully to talk through some of the issues and get some support from other counsellors there. Also, I no longer believed that what I was doing was helpful. I came to the conclusion that self-interest lay behind what we tried to do out of what we liked to believe was a desire to help. But no helping is totally altruistic! There's always a pay-off for the helper. This position was confirmed by my work this year for the Village Charity.

I saw vested interests, careerism, bandwagons jumped on and offensive, histrionic displays of theatricals in the name of memory for those lost to HIV. I was open-mouthed and offended at the morbid display of punishment of partying gay men.

The candlelight vigil, in memorial of all those people who have died, was an orgy of self-indulgent histrionics by an obviously frustrated drama producer who had decided to use the opportunity to stage what he imagined would be an emotional tribute to 'those who have gone before us.' (My words)

The event opened (late because the straight star was drunk) with a group of hooded, black-robed figures carrying flaming torches, walking slowly across the stage to the dirge from Carmina Burana. They then flung off their cloaks and became partying gay men, stripped to the waist, dancing frantically to that early eighties anthem 'Can You Feel It' only to be struck down by a torrent from above of red AIDS ribbons. They fell to the floor in a simulation of sudden death. A morality tale or what?

I stayed no longer and have not hesitated to make my feelings known to anyone in Manchester who would listen. I sold Continuum to Clone Zone, sat at the stall all weekend and defended to the hilt our alternative stance.

I am no longer the popular woman I was, invited to all the parties, the events at the Town Hall, the receptions in the trendy cafes on Canal Street. But I have my integrity. And the memory of those two men who loved me before they died and all the others who love me now. And I have my integrity intact.

Yet I can only conclude this is a symptom of the society in which we live, a complex, sometimes caring, other times, careless world where powerlessness is felt by the majority allowing the unscrupulous few to be in charge.

Meanwhile, I miss John and Kevin and hope I never have to go through that again. I do not believe I will.

Could your ***Lust For Life*** be an inspiration to others?
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