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Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
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August Chron Files 1993 [3]

2018-0756-F
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RESTRICTION CODES

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THE WHITE HOUSE

WASHINGTON

August 2, 1993

Pao C. Pien, Ph.D.
The Promenade Towers
Unit 204 S.
5225 Pooks Hill Road
Bethesda, Maryland 20814

Dear Dr. Pien:

Thank you for writing, and for your interest in more effective methods of preventing transmission of HIV.

The Agency responsible for reviewing and approving any new barrier device is the Food and Drug Administration (FDA), and I suggest that you contact the FDA when you are ready to proceed with your product. The address is:

Office of AIDS Coordination
Food and Drug Adminstration
Parklawn Building, Room 12-A-40
5600 Fishers Lane
Rockville, Maryland 20857

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc:
Office of AIDS Coordination, FDA

THE WHITE HOUSE

WASHINGTON

August 2, 1993

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Food and Drug Adminstration
Parklawn Building, Room 12-A-40
5600 Fishers Lane
Rockville, Maryland 20857

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc:
Office of AIDS Coordination, FDA

Prepared by: APO: KMGebbie: gw: 7/28/93: 690-5471: b:\pien

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

Dear Mrs Hooper -

Thank you for writing, to ~~share your views on the~~ Rams

Dear Dr Pien -

Thank you for writing and for your interest in more effective ~~methods~~ methods of preventing ~~transmission of~~ transmission of HIV.

The agency responsible for reviewing & approving any new barrier device is the Food & Drug Administration, & I suggest that you contact ~~them~~ _____ at that agency when you ~~have~~ are ready to ~~proceed~~ with your product.

~~Best~~ sincerely

END ϕ

The Promenade Towers
Unit 204 S.
5225 Pooks Hill Road
Bethesda, MD 20814
July 2, 1993

Mrs. Kristine M. Gebbie
The White House Office of AIDS
Policy Coordinator
1600 Penn. Avenue N.W.
Washington, D.C. 20500

Dear Mrs. Gebbie:

I want to congratulate you for you new position as AIDS Policy Coordinator. To combat AIDS epidemic is the most demanding and difficult task at the present time. According to the recent news from the Ninth International Conference On AIDS at Berlin, Germany, the cure and vaccination would be decade away. At the present time a $2.5 billion a year prevention effort can only hope to cut in half the number of new AIDS infections expected to occur by the turn of the century. Faced with this reality, you need all possible public and private supports.

With the cure and vaccination decade away, the AIDS policy now must intensify the prevention efforts. The current preventive effort is to education people the danger of the HIV virus and its transmission through sexual contacts. To protect themselves, people should either practice obstinacy or "safe sex" by using condoms. Unfortunately, there are two important facts which thwart our effort. The first fact is that the sex drive is a basic elemental human force. The second fact is that latex condoms substantially reduce the satisfaction of sexual intercourse. Because of these two facts, people continue to have sex without protection.

We can not change the fist fact, but we can change the second fact by providing people with a better device as disclosed in a patent application a copy of which is enclosed herewith. The new device is a universal condom which could be used by a man or a woman. It addresses many of the faults of the current male and female condoms. It is better than the traditional male condom because it is loose fitting, allowing direct rubbing on the penis. Thus, sensation is not reduced. It is better than the existing female condom for several reasons. First, the device is easier to insert since it does not need a large applicator. Second, the device does not have a large ring that hangs down outside the female. Thus, it would be more comfortable to wear. Third, the device incorporates a plug that could easily contain contraceptive jelly or any other germicides.

Because the new device does not diminish sexual sensation--indeed, in some instances it may increase sexual

sensation--it should be widely accepted. In addition, because the new device is essentially a large-diameter male condom, it could be easily manufactured with existing technology at a low cost. Would you please examine the new device carefully and promote it if you agree it is far better than existing male and female condoms. It could be one of the most cost effective weapon to combat the spread of HIV virus. If you need more information, I can be reached on (31)564-0725. Thank you very much for your valuable time.

Very truly yours,

Pao C. Pien

Pao C. Pien, Ph.D.

Be it known that I, Pao Chi Pien, a citizen of the United States of America, residing in Marco Island, Florida, have invented certain new and useful improvements in UNIVERSAL CONTRACEPTIVE AND PROPHYLACTIC DEVICE of which the following is a specification.

~~Confidential~~

Proprietary information not to be released without written permission of Pao C. Pien

DETERMINED TO BE AN
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INITIALS: JGP DATE: 7/23/19

2018-0756-F

BACKGROUND OF THE INVENTION

Various types of contraceptive and prophylactic devices have been developed in the prior art for the purpose of preventing the exchange of body fluids between partners during sexual intercourse. Because of the AIDS epidemic, the use of such devices to provide so-called "safe sex" has become of supreme importance to the public, and many efforts have been made to provide improved forms of protection.

Male condoms are the most common form of device to prevent conception as well as the sexual transmission of disease. However, many men are reluctant to use male condoms because of reduced sexual sensation. Female condoms have also been developed so that women can protect themselves and ensure that they are not at risk during sexual intercourse. In addition, universal contraceptive and prophylactic devices have been designed for use either by a male or female. Even though male and female condoms are readily available at the present time, the spread of the HIV virus has not been significantly slowed by the use of such condoms due to the fact that they have not proved to be satisfactory to the general public because of certain shortcomings thereof. A drastically improved device is now required which will be readily accepted by the public in order to make efforts at arresting the spread of the HIV virus successful.

Since the practice of "safe sex" is literally a matter of life and death for everyone, people should not depend on their sex partner to take necessary precautions, but rather should have the ability to personally ensure that they are properly protected. It is accordingly highly desirable to provide a universal device which

can be used by either men or women and which will be sufficiently attractive to use so that there will be no objection to its use by either sex partner.

The present invention is designed to enhance rather than to diminish sexual gratification, and therefore should receive quick acceptance by the general public. The use of the invention device thereby provides the only cost effective means to effectively stop the spread of HIV virus at the present time.

SUMMARY OF THE INVENTION

The present invention is a universal contraceptive and prophylactic device which can be used by either a man or a woman with equal facility. A condom support means is provided to which a condom means is secured. The condom support means includes means for securing the support means in place on a person's body in the form of holes formed in the support means and straps extending through the holes, the straps being suitably connected to a person's body.

The condom means comprises an elongate tubular sheath formed of thin, flexible fluid impermeable material, the condom means having a closed end and an open end. The open end of the condom means includes a rim which is disposed within a groove formed in a central opening in the condom support means. The closed end of the condom means includes a portion of inwardly tapered configuration which forms a reservoir at the closed end of the condom means.

The condom means includes a main portion of a given diameter which is sized to fit loosely about an erect penis, and the condom means has a reduced diameter at the open end adjacent the rim thereof. The condom support means is annular in configuration and

has an outside diameter large enough to cover the vagina opening and an inside diameter large enough to allow an erect penis to slide therethrough.

Plug means formed of soft, elastic material capable of absorbing body fluid is disposed within the sheath at the closed end thereof. This plug means is a body of revolution having a central hole formed therethrough. The plug means has a tapered configuration complementary to the tapered closed end of the sheath so as to fit snugly within the tapered closed end.

When the invention is used as a female condom, the sheath is inserted into the vagina and the plug means exerts pressure against the vagina wall to retain the closed end of the sheath in place, the open end of the sheath being secured to the condom support means which is secured in place on the woman. The plug means also serves to absorb or sponge up the body fluid from an ejaculation and thus prevents it from leaking out of the sheath, thereby providing a unique means for preventing the spread of body fluid from the man to the woman.

When the invention is used as a male condom, the condom support means and the sheath are fitted loosely over the erect penis and the condom support means is secured to the man's body in a suitable manner.

In addition, the plug means may be removed from the condom means for use either by a man or a woman under certain circumstances as will be explained hereinafter.

BRIEF DESCRIPTION OF THE DRAWINGS

Fig. 1 is a longitudinal section through the invention device;

Fig. 2 is a top view of the device shown in Fig. 1;

Fig. 3 is an enlarged section taken along line 3-3 of Fig. 2; and

Fig. 4 is a view similar to Fig. 1 with the plug means removed.

DESCRIPTION OF THE PREFERRED EMBODIMENT

Referring now to the drawings wherein like reference characters designate corresponding parts throughout the several views, the invention incorporating the plug means is shown in Figs. 1-3. A condom support means is indicated generally by reference numeral 10 and comprises an annular member formed of a soft yet durable substance such as soft rubber. A pair of diametrically opposite holes 12 are formed through member 10 for receiving straps 14 shown broken away in Fig. 1 for securing the condom support means in position on a person's body. These straps may be of a suitable material such as NYLON which is flexible and strong and which provides a pleasant feeling to the skin. The opposite ends of the straps may be provided with conventional attachment means such as VELCRO for connecting the straps around the thighs, or if desired, the ends of the straps may be taped to the skin. In any event, the means for securing the straps in place should be capable of being attached and detached relative to one another with little effort and with a minimum of discomfort to the skin.

Member 10 has a hole 20 formed therein which has a diameter slightly greater than an erect penis which can slide freely therethrough. An inwardly facing groove 22 is formed in the wall defining the hole and is adapted to receive the rim at the open end of an associated condom means to support the condom means.

The condom means is indicated generally by reference numeral 26 comprises an elongate tubular sheath formed of thin, flexible fluid

impermeable material such as latex. The condom means includes a main portion 28 having an inner diameter adapted to fit loosely about a male penis. The main portion joins with a reduced diameter portion 30 adjacent a relatively rigid rim 32 provided at the open end 34 of the condom means. The rim is pressed into groove 22 of member 10 for supporting the condom means. This arrangement preferably enables the condom means to be detached from member 10 so that a new condom means may be attached to member 10 after the previous condom means has been used and discarded. However, the condom means may be permanently secured to member 10 if the cost of discarding member 10 after each use is acceptable.

Main portion 28 of the condom means includes a tapered portion 40 which terminates in the closed end 42 of the condom means. A reservoir 44 is provided at the closed end for receiving ejaculate. A plug means 50 shown partly in section is disposed within the condom means and is formed of soft elastic material which is capable of absorbing body fluid. The plug means may for example be formed of the same material as that used to form artificial sponges or a similar suitable material. The plug means is a body of revolution having a central hole 52 extending therethrough which provides a passage through which ejaculate may pass into reservoir 44.

It will be noted that the external surface of the plug means has a tapered configuration complementary to the tapered portion 40 of the condom means and fits snugly therewithin and in engagement therewith. The plug means may be removed from within the condom means when so desired as hereinafter described.

When the device shown in Fig. 1-3 is used as a male condom, sheath 26 and member 10 slide loosely onto the erect penis, and

member 10 is secured to the man's body by straps 14. When the penis is inserted into the vagina, the plug means presses the sheath against the vagina wall to keep the closed end of the sheath in place inside the vagina. The sheath exerts a pressure on the vagina wall to create friction between the sheath and the wall which is slightly greater than the friction between the sheath and the penis so that the inner closed end of the sheath remains stationary until the condom means is pulled outwardly by straps 14.

It is not only unavoidable, but actually desirable that there is some slack in the straps securing member 10 to the man's body. When there is such slack, plug means 50 at the closed end of the sheath does not move outward with the penis until the slack is taken up. This delay of plug means motion creates a gap between the plug means and the tip of the penis as well as between the member 10 and the base of the penis. In the following inward stroke of the penis, the sheath remains stationary until the gap between the plug means and the tip of the penis is closed. The sheath then moves inwardly with the penis and acts like a male condom. During the beginning of either an inward or an outward stroke of the penis, the sheath will not move and acts like a female condom until the plug means is pushed inwardly by the thrust of the penis or pulled outwardly by the straps.

Accordingly, the invention device functions as a female condom and a male condom on successive strokes of the penis. The proportions of the duration of these two functions can be adjusted by varying the amount of slack in the straps.

The invention device when used as a male condom also has additional advantages. The sheath of the device is loosely fitted

around an erect penis without any unpleasant tight feeling such as that caused by the use of a conventional male condom which is tightly rolled onto an erect penis and relies on the tight fit to hold it in place and prevent the escape of body fluids from the condom.

The device can assist a man in delaying his orgasm so as to achieve a simultaneous climax with his partner. At first, the device can be secured to the man's body with a minimum amount of slack in the straps. The plug means shields the sensitive penis tip to reduce the sexual sensation for delaying orgasm. Then, at a later opportune moment, the device may be released from the man's body and pushed by the penis into the vagina to become a female condom which excites the man and woman together to obtain a simultaneous climax.

When the invention device is used as a female condom, the closed end of the sheath is pushed into the vagina by pushing the plug means with a finger, and the plug means is then pushed all the way in by an erect penis. The plug means presses the sheath against the vagina wall to keep the closed end of the sheath in place inside the vagina. The condom support means is then secured to the woman's body by the straps.

The invention device has certain advantages over existing female condoms. It can be inserted into the vagina by a finger and then by an erect penis whereas prior art female condoms must be inserted with a large applicator. Furthermore, the invention device may be worn as comfortably and inconspicuously as a tampon and can be put in place beforehand whenever desired. It is far more convenient to use than existing female condoms.

The plug means of the invention is more reliable in keeping the inner end of the condom means in place than a loosely placed inner ring as used in existing female condoms so that it can be put in place and comfortably worn for long periods of time. The plug means also absorbs body fluids from ejaculation and prevents it from leaking out of the condom means, whereas body fluids can leak from prior female condoms.

The open end of the condom means is secured to the condom support means which is in turn secured to the woman's body. This is a significant improvement over a female condom wherein the outer open end dangles freely outside the vagina and can interfere with the woman's normal movements, thus preventing the condom means from being inserted in place beforehand.

Additionally, the annular condom support means formed of soft rubber or the like is so dimensioned that when a man's body presses against the annular member, it is squeezed outwardly so that it may gently touch the clitoris to provide a pleasant sensation to the woman.

The plug means may also be manually removed so that the device can be used as shown in Fig. 4. When the device shown in Fig. 4 is used as a female condom, there is a desirable rubbing action between the sheath and the vagina wall instead of between the sheath and the penis alone. Hence, both partners can share the sexual sensations. When the device shown in Fig. 4 is used as a male condom, the rubbing, sliding motion is also distributed between the inside and outside surfaces of the sheath. Since the plug means can be easily squeezed into or pulled out of the closed end of the sheath, the invention can be readily converted from the configuration shown in

Fig. 1 to that shown in Fig. 4.

Because of the unique concept and construction of the invention, the thickness of the tubular sheath has very little influence on the sexual sensitivity and can be increased to obtain greater safety so that the failure rate can be drastically reduced. The sheath of the present invention should cost only slightly more than that of a conventional male condom since the dimensions of the invention sheath are only slightly greater.

The invention has been described with reference to a preferred embodiment. Obviously, various modifications, alterations and other embodiments will occur to others upon reading and understanding this specification. It is our intention to include all such modifications, alterations and alternate embodiments insofar as they come within the scope of the appended claims or the equivalent thereof.

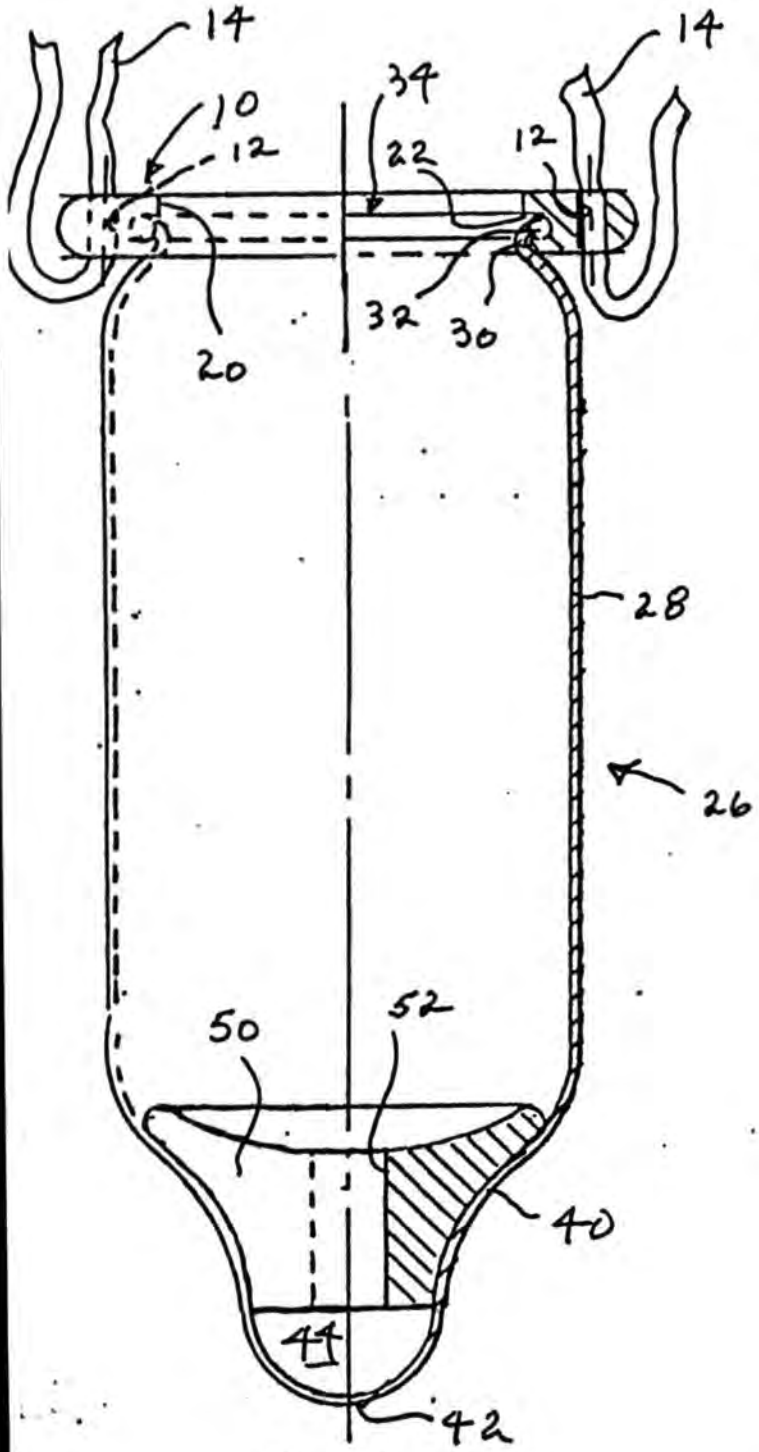


Fig. 1

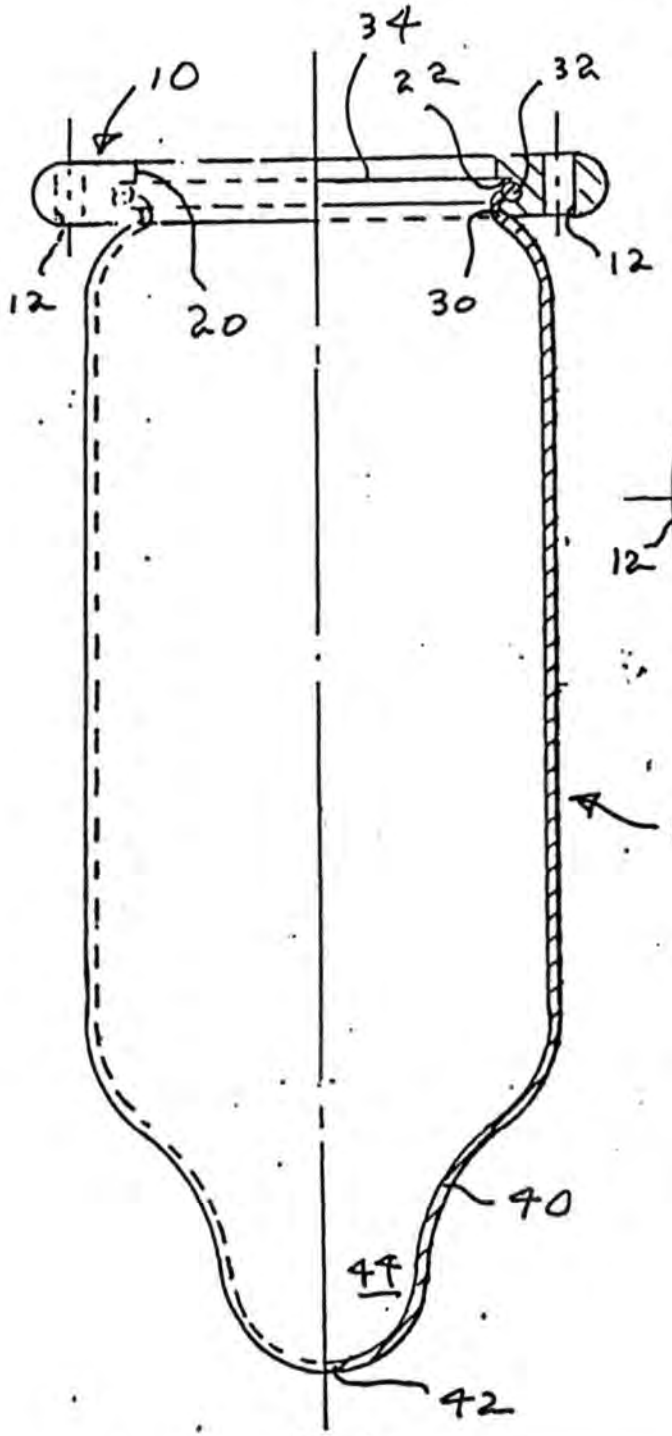


Fig. 4

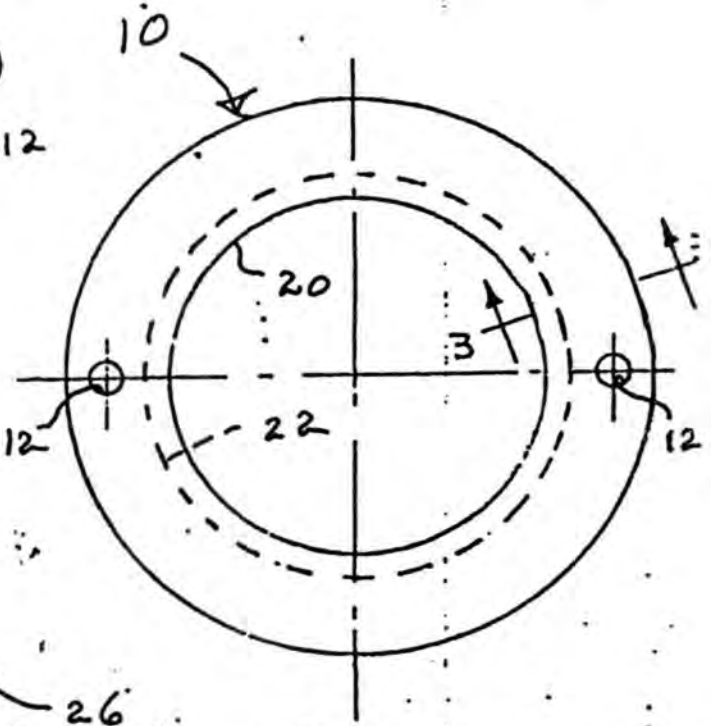


Fig. 2

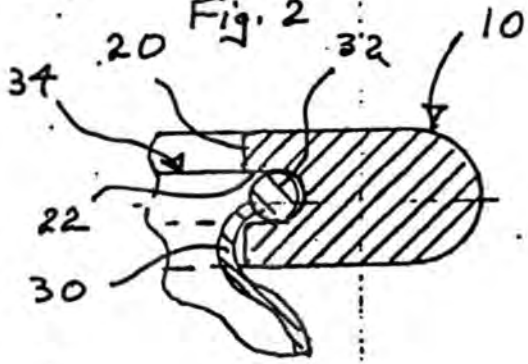
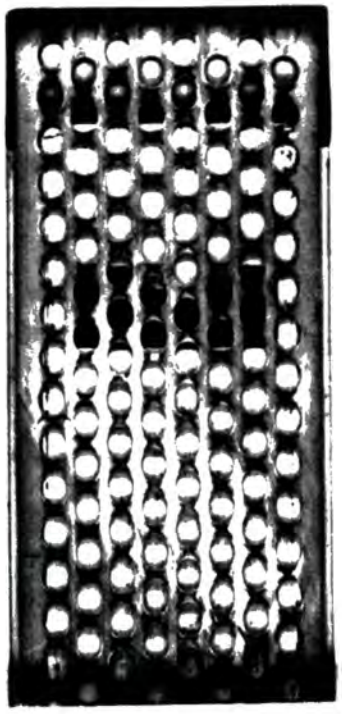
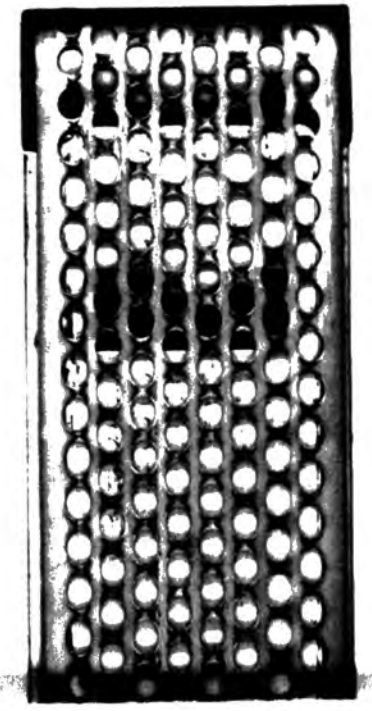


Fig. 3

Pao Chi Pien
5225 Pooks Hill Road
Unit 204 South
Bethesda, MD 20814

Mrs. Kristine M. Gebbie
The White Office Of AIDS Policy
Coordinator
1600 Penn. Avenue N.W.
Washington, D.C. 20500





Pao Chi Pien
5225 Pooks Hill Road
Unit 204 South
Bethesda, MD 20814

Mrs. Kristine M. Gebbie
The White Office Of AIDS Policy
Coordinator
1600 Penn. Avenue N.W.
Washington, D.C. 20500

THE WHITE HOUSE

WASHINGTON

August 2, 1993

Patricia G. Strauch, Ph.D.
Senior Vice President and Managing Director
DRI/McGraw-Hill
The McGraw-Hill Building
1200 G Street, NW Suite 1000
Washington, D.C. 20005-3802

Dear Dr. Strauch:

Thank you for your kind words of congratulations and for the information about your ability to assess the economic costs of the AIDS crisis in terms of future output. Knowing the direct and indirect costs of medical care and lost productivity is an important factor in emphasizing the devastating effects of this disease not only in the United States but globally.

I would be pleased to meet with you to learn a little more about your proposal. I believe, however, you should meet with the staff at the Agency for Health Care Policy and Research, the agency within the Public Health Service that develops and uses data similar to that which you are capable of producing. I am forwarding your letter and proposal to the AIDS Coordinator there. Best wishes in your efforts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc: AIDS Coordinator, AHCPR

CC sent to
Don Schneider
on 8/5/93

THE WHITE HOUSE

WASHINGTON

August 2, 1993

Patricia G. Strauch, Ph.D.
Senior Vice President and Managing Director
DRI/McGraw-Hill
The McGraw-Hill Building
1200 G Street, NW Suite 1000
Washington, D.C. 20005-3802

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Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc: AIDS Coordinator, AHCPR

Prepared by: APO: JMessore:8/5/93:202-690-5560:b:\strauch.200

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

DRI/McGraw-Hill

Patricia G. Strauch, Ph.D.
Senior Vice President and
Managing Director

July 27,1993

Kristine Gebbie, RN
Director, National AIDS Program Office
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Gebbie:

Congratulations on your appointment from President Clinton.

DRI/McGraw-Hill (DRI), a world leader in economic analysis and impact studies, has developed a number of quantitative approaches to assess the economic costs of the AIDS crisis in terms of its effect on future output. In addition, we believe that the framework developed for estimating costs can be used to measure the impact of key parameters that in turn may be influenced by future research breakthroughs, specified policy or funding actions in the areas of education and prevention.

Thus far, DRI has completed some preliminary analysis that examines the economic costs of the AIDS epidemic on a world-wide basis. In this effort, we have conducted research on four important factors that are integrated into DRI's world economic modeling system to estimate future losses in real GDP arising from the disease. Our previous analyses included:

- Epidemiological factors--the annual number of HIV infections and AIDS cases. The estimates vary from a low of 30 million to an upper limit of 110 million HIV infections by the year 2000.
- Demographic assumptions--the rate at which the labor force is reduced in a particular country.
- Direct costs--the direct medical costs of treatment.
- Indirect costs--the reduction in output resulting from death, productivity declines after the onset of the disease, and reduced productivity from caregivers who would otherwise be employed. Differing assumptions were applied between developing countries and developed countries.

The McGraw-Hill Building
1200 G Street, N.W. – Suite 1000
Washington, D.C. 20005-3802
Telephone: (202) 383-2000
Fax: (202) 383-2005

Estimates from each of these factors was then incorporated into DRI's trade-linked model of the world economy. This incorporated the influence of domestic and international multipliers.

The reduction in world output was examined relative to a baseline that assumed the number of AIDS cases is fixed at 1992 levels. Reductions in real GDP are examined under optimistic and pessimistic epidemiological assumptions.

Enclosed is a proposal to develop a more detailed analysis of the economic costs of the AIDS epidemic in the United States. Other issues that we would investigate include a number of refinements that DRI can incorporate in its study. For example:

- First, DRI will work with HHS to make use of more sophisticated epidemiological estimates for individual countries. This will include the development of time profiles of the incidence of the disease toward steady state levels on a country by country basis.
- Second, more research will be conducted to estimate the indirect costs of AIDS, and these will be presented on a country by country basis.
- Third, additional scenarios will be developed to see how sensitive the estimating framework is to changes in funding for education and prevention. These can be implemented on a world-wide basis, or for selected countries. In this way, there may be ways of determining where increased funding will have the greatest effect in terms of reduced economic costs and overall levels of AIDS cases.
- Finally, the economic costs attributable to domestic and international multipliers can be isolated from the first round effects that emanate from the four factors described above.

My colleagues and I would appreciate the opportunity to discuss this matter with you. Greg Farrell of my staff will call you to schedule a meeting. In the interim, please do not hesitate to contact me at (202) 383-3621.

Sincerely,

Patricia G. Strauch
Senior Vice President
Enclosure

DRI/McGraw-Hill

Kristine Gebbie, RN
Director, National AIDS Program Office
200 Independence Avenue, SW
Washington, DC 20201

The McGraw-Hill Building
1200 G Street, N.W.
Suite 1000
Washington, D.C. 20005-3802

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NAPO Document Control Slip

NAPO Number : 7046 PHS Number : OS Number : Document Type : White House Letter

Document Date: 8/10/93 Refer'd Date : 8/10/93 Int Due Date : 8/10/93 Ext Due Date : 8/10/93
NAPO Xref : PHS Xref : OS Xref : Keyer ID : KWilliam
Purge Date : 8/10/95 Disposition : DESTROY Final Date : 8/10/93 Document Loc : MAIN-03D08

********** Correspondent Information **********

From : KRISTINE GEBBIE Title : DIRECTOR Organization : ONAPC
Address : City : Washington State : DC Zip : 20500
On Behalf Of : To : PATRICIA STRAUCH

********** Subject or Title **********

Senior Vice President and Managing Director - DRI/McGraw-Hill - The McGraw-Hill Building - 1200 G Street, NW Suite 1000 - Washington, D.C. 20005-3802

********** Keywords **********

GEBBIE

********** Special Instructions **********

********** Assignment/Action History **********

Process Type : Kristine Gebbie Correspondence

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Kristine M. Gebbie	_____	DIRS	CLOS	8/10/93	8/10/93	

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Related WordPerfect Filenames: _____ _____ _____

Comments FROM assignees:

Aug 5

THE WHITE HOUSE

Dear Allen

I enjoyed the chance to visit with you in San Francisco last week. My best wishes in your continuing efforts. I look forward to future opportunities to collaborate -

Clinton

KAISER PERMANENTE

Allen Harris, R.N., C.
Research Nurse
HIV Research Unit

Kaiser Foundation Medical Center
2590 Geary Boulevard
San Francisco, California 94115

(415) 202-3481
Fax (415) 202-3483

Main
#03008

NAPO Document Control Slip

NAPO Number : 7057 PHS Number : OS Number : Document Type : White House Letter

Document Date: 8/11/93 Refer'd Date : 8/11/93 Int Due Date : 8/11/93 Ext Due Date : 8/11/93
NAPO Xref : PHS Xref : OS Xref : Keyer ID : KWilliam
Purge Date : 8/11/95 Disposition : DESTROY Final Date : 8/11/93 Document Loc : MAIN-03D08

********** Correspondent Information **********

From : KRISTINE GEBBIE Title : DIRECTOR Organization : ONAPC
Address : City : Washington State : DC Zip : 20500
On Behalf Of : To : ALLEN HARRIS

********** Subject or Title **********

Kaiser Foundation Medical Center - 2590 Geary Boulevard - San Francisco, California 94115

********** Keywords **********

GEBBIE

********** Special Instructions **********

********** Assignment/Action History **********

Process Type : Kristine Gebbie Correspondence

Assignee	Initials	Action	Status	Due Date	Completed	Comments TO assignee
Kristine M. Gebbie	_____	DIRS	CLOS	8/11/93	8/11/93	

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Related WordPerfect Filenames: _____ _____ _____

Comments FROM assignees:

Main
#03D08

NAPO Document Control Slip

NAPO Number : 7050 PHS Number : OS Number : Document Type : White House Letter

Document Date: 8/11/93 Refer'd Date : 8/11/93 Int Due Date : 8/11/93 Ext Due Date : 8/11/93
NAPO Xref : PHS Xref : OS Xref : Keyer ID : KWilliam
Purge Date : 8/11/95 Disposition : DESTROY Final Date : 8/11/93 Document Loc : MAIN-03D08

********** Correspondent Information **********

From : KRISTINE GEBBIE Title : DIRECTOR Organization : ONAPC
Address : City : Washington State : DC Zip : 20500
On Behalf Of : To : JANET SHIKLES

********** Subject or Title **********

Assistant Comptroller General for Human Resources Programs - U.S. General Accounting Office - NGB - 441 G Street, N.W. - Washington, D.C. 20548

********** Keywords **********

GEBBIE

********** Special Instructions **********

********** Assignment/Action History **********

Process Type : Kristine Gebbie Correspondence

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Kristine M. Gebbie	_____	DIRS	CLOS	8/11/93	8/11/93	

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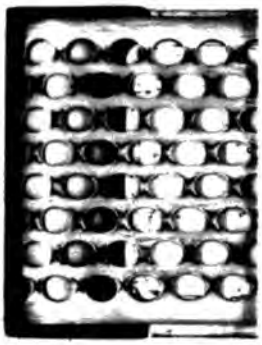
Related WordPerfect Filenames: _____ _____ _____

Comments FROM assignees:

Aug 2

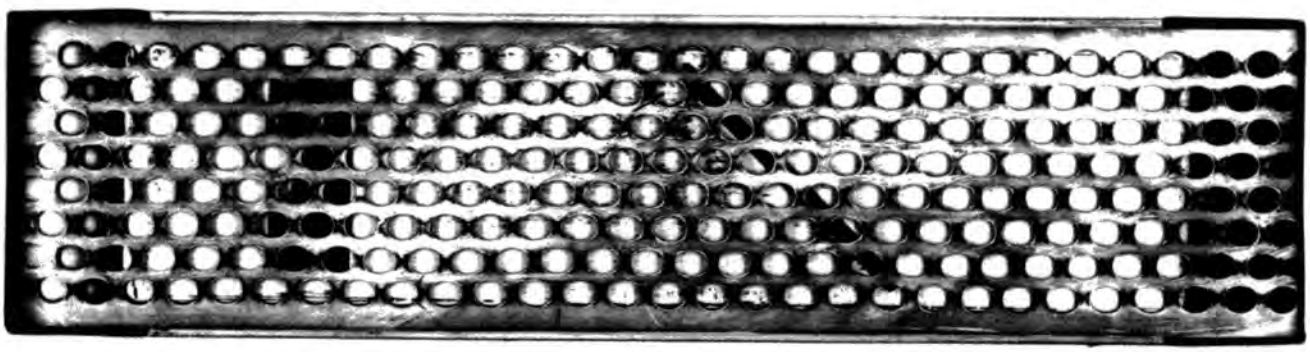
THE WHITE HOUSE



Dear Janet —

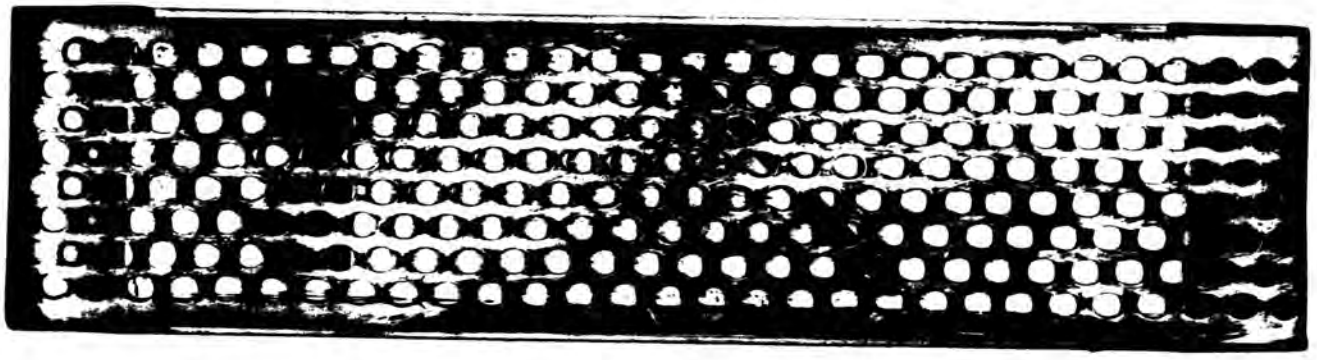
Congratulations on your appointment as Assistant Comptroller General for Human Resource Programs. Though I'm no longer able to serve on the Health Advisory Committee, I'm sure our paths will cross. All the best in your new duties —

Kathleen Cleaver



THE WHITE HOUSE
WASHINGTON

Ms. Janet L. Shikles
Assistant Comptroller General
for Human Resources Programs
U.S. General Accounting Office
NGB
441 G Street, N.W.
Washington, D.C. 20548



Aug 3

THE WHITE HOUSE

Dear Peg

Slightly delayed congratulations on the birth of your daughter - I hope you're having a great time of exploration & enjoying each other! I'll miss seeing you on the IOM HIV/substance Abuse etc. committee, but know our paths will cross other times - all the best

Kristine Gebbie

Chron File

CIRCLE OF CARE

THE STEWART B. McKINNEY FOUNDATION

P.O. Box 338
Fairfield, CT 06430
Tel.: (203) 255-7965
Fax: (203) 254-3337

Lucie McKinney, Chairman

August 3, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
Executive office of the President
Washington, D.C. 20500

VIA: FAX (202) 690-1096

Dear Ms. Gebbie,

We wish to extend an invitation to you to be our keynote speaker at a Regional Conference at Sacred Heart University in Fairfield, Connecticut on Saturday, October 16, 1993, sponsored in collaboration with Sacred Heart University, Fairfield, Connecticut and St. Joseph's College, Hartford, Connecticut. In attendance will be health care providers, educators, students, faculty and interested community advocates. From conferences held over the past 4 years we anticipate somewhere between 350 and 500 participants.

We would invite you to address in a broad context the history of the aspects of AIDS; i.e. what persons with HIV disease have been confronted with socially and economically; by insurance limitations, lack of community services; medical services and counter this discussion with what your future plans might look like for a national agenda on AIDS.

I hope to hear from you soon in the affirmative. Thank you for your consideration.

Very truly yours,

Lucie McKinney

Lucie McKinney
Chairman

FOUNDATION HISTORY

The Stewart B. McKinney Foundation was established in May 1987 by Lucie C. McKinney, widow of Stewart B. McKinney, a nine-term congressman from Connecticut. Mrs. McKinney's overall goal was simple and straightforward —to carry on her husband's legacy of caring for the disadvantaged among us. The McKinney Homeless Act, which Congressman McKinney co-authored and instituted is one example of his compassion and vision. To follow Stewart's commitment to "the quality of life," Mrs. McKinney's priority became housing; specifically the establishment of residences for homeless people with AIDS (P.W.A.s).

The Foundation's primary role is to fund existing service organizations who are establishing residential programs for homeless P.W.A.s. The Foundation, in collaboration with St. Luke's Community Services, has opened a residence for P.W.A.s in Stamford and Fairfield, and in collaboration with the Whitman-Walker Clinic in Washington D.C., the Stewart B. McKinney Family Home was dedicated in that city.

Grants have been given to fund residential programs for IV drug users with HIV disease and alliances have been made with other AIDS organizations across Connecticut (Connecticut AIDS Residential Coalition).

CIRCLE OF CARE

In addition to residential programs, contributions have been made to other support services such as: the Greater Bridgeport AIDS Project, Greenwich Health Department for the HIV Testing and Counseling Office and All Saints AIDS Services in California.

The Foundation has established an emergency fund in memory of a P.W.A. The fund provides immediate monies for such items as medication, rent/mortgage, physicians' services, transportation, food and wishes. The fund supplies needed dollars on a one-time basis. It is our hope that it will increase in size, allowing us to extend assistance for longer periods of time.

The AIDS Education Consortium was funded by the Foundation in 1990. It is a concerted effort of educational institutions throughout New England formed to foster greater AIDS awareness and education on each institution's campus. And recognizing the need for trained professional health care providers fully versed on HIV disease, the McKinney Scholarship Program was established. Its goal: to establish quality and consistency in heath care provided to P.W.A.s.

The Stewart B. McKinney Foundation recognizes the devastating effect on a family when a family member or loved one tests positive for HIV virus. In cooperation with St. Luke's Episcopal Church in Darien, the Foundation has established a family support group to assist the loved ones of P.W.A.s in coping with their own emotional crisis. It has been our experience, learned from other such groups, that many of the people stay through the entire illness for further assistance in the grieving process. Although it might appear a paradox, often those in grief can be very supportive to those who are trying to cope with a loved one's illness. The Foundation provides two facilitators for this group which meets on the first and third Tuesdays of every month in Darien. If you are aware of anyone who might benefit by this group, please contact the Foundation at 255-7965.

CIRCLE THE STEWART B. McKINNEY FOUNDATION OF CARE

THE STEWART B. MCKINNEY FOUNDATION

FROM: Gary Smith - Stewart B. McKinney Foundation

RE: Requesting you to speak to gathering of 300 to 500 Educators, Nurses, and Medical Professionals on Oct. 16 in Connecticut.

This event is being held at Sacred Heart University.

His number is 203-255-7965

I advised him to fax in request and send letter of invitation in the mail,

Talk to Ros about this.

203-254-3337
FAX

[27] From: Robert Ameen 8/2/93 10:52AM (667 bytes: 14 ln)
To: Retina Holmes
Subject: phone call
---------- Message Contents ----------

Gary Smith, the Programming Director from the Stuart B. McKinney Foundation, an AIDS organization in Conneticut, called to request Kristine's appearance at an HIV conference.

Topic: Address issues a person with HIV faces everyday

Tentative Date: Oct 16 (This is during Conn. AIDS awareness month)

He would like Kristine to be a speaker at this conference of about 500 people.

Phone: (203) 255-7965

10-2
M-Th
8-12 Fri.

FAX TRANSMITTAL
(In Progress)

DATE: 9-20-93

TO: WARREN BUCKINGHAM

Fax Number 202 632-1096

FROM: BABU GEORGE

Sacred Heart University
5151 Park Ave.
Fairfield, CT 06432-1000
Telephone Number: (203)-371-7793
Fax Number: (203)-371-7888

Pages (including cover) 3

Comments: MR. BUCKINGHAM: ENCLOSED IS THE ROUGH DRAFT OF THE ANNOUNCEMENT ABOUT THE AIDS CONFERENCE. THANK YOU VERY MUCH FOR COMING TO SHU. YOU ARE SCHEDULED TO SPEAK AT 12:45 - 1:30 P.M. I HOPE THIS IS O.K.

Registration form:

AIDS IN CONNECTICUT:
In the laboratory, in the community, in the classroom.

Please print or type

NAME_____
If you are a teacher or administrator, please give the following information.
School _____ District _____
S.S.# _____
Grade _____ Subject _____
All participants fill out the bottom.
Address _____

City, State _____
ZIP Code _____

Telephone: Home _____
Work _____

Admission Charge: FREE

CEU 0.5

Detach and mail your registration to:

Babu George, Ph.D
Sacred Heart University
5151 Park Avenue
Fairfield, CT 06432-1000

Any questions, please call. Ask for Barbara Chop
(203) 365-7627

CONNECTICUT UNITED FOR RESEARCH EXCELLENCE, INC.
Stewart B. McKinney Foundation
and
SACRED HEART UNIVERSITY

PRESENT:

An outstanding education forum for area teachers and other interested parties.

AIDS IN CONNECTICUT:
In the laboratory, in the community, in the classroom.

Saturday, October 16, 1993
Sacred Heart University
Schine Auditorium 9:00am - 3:30pm
(Doors will open at 8:30 a.m. for registration and coffee)

This workshop, offered free of charge to Conecticut K-12 teachers, and other interested parties such as administrators, health professionals, and students, offers a unique opportunity to hear and to question a panel of top Connecticut AIDS researchers, scientists and medical professionals.

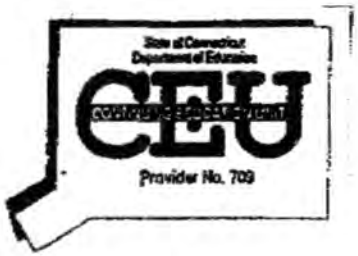
A major highlight of the conference will be keynote address by Mr. William Buckingham, Special Assistant to President Clinton's National AIDS Coordinator. Mr. Buckingham, whose track record includes nearly a decade of HIV/AIDS work and health and social service policy development, is also a consultant to the White House Task Force on Health Care Reform.

AIDS IN CONNECTICUT:
In the laboratory, in the community, in the classroom

Saturday, October 16, 1993

9:00 am:	Welcome and Opening remarks Dr. Anthony J. Cernera, President Sacred Heart University Overview of the day & introduc tions Debra K. Pasquale, Executive Director of CURE
9:15:	Overview of AIDS in Connecticut Co-morbidity: Risk of contracting & spreading AIDS-related diseases Andrea Hubbard, Ph.D., University of Connecticut, Storrs
9:45	Simulation of how AIDS spreads through a community (involves participating teachers). Babu George Sacred Heart University Ronald Perkins Greenwich High School
10:15	Children's understanding of AIDS David Schonfeld, M.D. Yale School of Medicine
10:30 - 10:45	BREAK
10:45 - 11:00	Toward an AIDS Vaccine Larry Silbart, Ph.D. University of Connecticut, Storrs
11:30	Living with AIDS: Advances in treatment and related health issues (co-morbidities) Julian Adams, Ph.D. Boehringer Ingelheim Pharmaceuti cals, Inc.
11:50	Panel Discussion
12:00	LUNCH
12:45	Warren Buckingham (Keynote speaker, Special Assistant to President Clinton's national AIDS coordinator Introduced by Mrs. Lucy McKinney

1:30	Prevention and transmission of HIV Zane Saul, M.D., Infectious Disease Specialist, Fairfield/Bridgeport
2:00	Break
2:10	Working with children with AIDS: A nursing perspective Sostena Romano, RN, Yale-New Haven Hospital Pediatric Aids Clinic
2:40	Overview of the role of school in dealing with AIDS Sandy Shipkowitz, RN, Pediatric AIDS Coordinator, Bridgeport Hospital/Bridgeport Public Schools
3:10 - 3:30	Panel Discussion



PROGRAM ABSTRACT

Overview of AIDS in Connecticut

How is it spreading and where, to which populations, how prevalent in youth under 18?

How does the disease spread through the body? Compare with normal physiology. Physical and physiological manifestations? "Timeline" describing stages of the disease, especially in children.

Simulation of how AIDS spreads through a community.

Participate in a chemical demonstration which simulates the spread of AIDS.

Children's understanding of AIDS

How much do young children know about AIDS? What are some of the common misconceptions?

What is the role of the school in addressing AIDS?

How should educators and parts talk to young children about AIDS?

Toward an AIDS vaccine

What general approaches are researchers taking toward finding an AIDS vaccine -- e.g. post-disease and preventive vaccines?

Discussion of the different types of possible prevenmive vaccines: systemic and mucosal.

What is the "State of the Art" in AIDS vaccines? What are the chances of seeing a viable vaccine in the future (any guess how many years in the future?)?

Living with AIDS: Advances in treatment and related health issues (co-morbidities)

First 10 minutes: Given the fact that there is no one effective treatment inhibiting the progress of AIDS itself, what else can be done for AIDS sufferers? What are some of the opportunistic diseases connected with AIDS. What drugs or treatments (anti-virals, etc?) are available or being developed to treat these diseases?

Discussion how one drug (Nevirapine or equal). How it was discovered, developed, uses, aims for future development.

Prevention and Transmission of HIV

How is HIV transmitted? How is it not transmited (common fears and misconceptions)? What are the most effective ways to prevent AIDS.

AIDS in the context of other sexually transmitted diseases.

What universal precautions are needed to protect teachers and children from infection with HIV and other more infectious diseases?

Working with children with AIDS: A Nursing perspective

What are social challenges HIV-positive children and their families face? What may be some of the physical needs of the child as the illness progresses? What are some of the medical treatments for children with AIDS? What counseling is available? What do teachers need to know about working with children with AIDS? What counseling is available? What do teachers need to know about working with children with AIDS and other serious diseases?

Overview of the role of school in dealing with AIDS

What role does confidentiality play in dealing with AIDS in schools? What are the implications for th classroom learning environment with a child with a serious illness like AIDS? How long can a child function "normally" in a classroom? Involvment of special education professionals? How do health services and schools work together both to prevent and treat AIDS in young people?

DIRECTIONS TO SACRED HEART UNIVERSITY

From Connecticut Turnpike (I-95)
Exit 27A (North or South). Continue straight ahead on combined Routes 8 and 25 to fork. Bear left onto Route 25 to Exit 7 (Merritt Parkway South). Take ramp turn left onto Park Avenue and proceed 1 block to Sacred Heart University.

From Merritt Parkway
Exit 47 (North or South). At end of ramp turn left onto Park Avenue and proceed 1 block to Sacred Heart University.

Parking is available at the corner of Jefferson/Old Town Rd. & Park Ave. Entrance is on Jefferson Street.The Schine Auditorium is in the base of the library.

PROGRAM SPONSORS

CONNECTICUT UNITED FOR RESEARCH EXCELLENCE, INC.

Connecticut United for Research Excellence (CURE) is a diverse not-for- profit coalition of corporations and institutions dedicated to improving human and animal health, safety and well-being. Its membership includes many of the state's -- and the country's top health-related institutions, including pharmaceutical research facilities, hospitals, universities, professional societies and voluntary health groups.

SCIENCE & MATHEMATICS AREA RESOURCE TEACHER CENTER (SMART Center)

The Center provides workshops for area teachers (K-12) in all areas of sciences and mathematics. Combined with Project SMARTNET (see below) we have provided workshops for over 3000 teachers in 1992. All activities are free for teachers. SMART Center also operates a materials lending library. Funding for SMART Center activities comes from the *Dwight D. Eisenhower Mathematics & Science Education Act Title II Grant* and support from local industries and individual contributions.

PROJECT SMARTNET

Is a National Science Foundation funded project between Sacred Heart University and Fairfield Public Schools for teacher enhancement activities for over twenty school districts. Project SMARTNET provides workshops in science and mathematics for teachers and administrators (K-12). It also operates an instrumentation on loan program for area High School chemistry teachers. Project SMARTNET also arranges lectures on variety of topics that are of interest to teachers and the general public.

STEWART B. McKINNEY FOUNDATION

The foundation was formed by the nine term congressman's family after his death from an AIDS related illness. The foundation mission statement clearly establishes its primary goals; to establish and support housing HIV - AIDS infected persons and provide assistance and guidance for AIDS education programs.

CIRCLE OF CARE

THE STEWART B. McKINNEY FOUNDATION

P.O. Box 338
Fairfield, CT 06430
Tel.: (203) 255-7965
Fax: (203) 254-3337

Lucie McKinney, Chairman

FACSIMILE COVER SHEET

DATE: 10.13.93

TO: MR. Warren Buckingham

FROM: Gary Smith

TOTAL PAGES INCLUDING COVER SHEET:

REMARKS: Buck - I've arranged for your transportation for Oct 16th.

They will pick you up at 9:00 A.m. at your hotel and again at 1:30 PM to return to N.Y. L.G.A. for your flight.

The Company when use is;
Regency Limousine
Wilton's Ct
1-800-243-5606
(203) 762-7780

If for any reason you need to change any of arrangments call me at H(203) 259-4205 OR O) 255-7965

P.S. Enjoy the "Queen of Mean's" Palace !! Beware of falling Plaster.....

THE WHITE HOUSE

WASHINGTON

August 4, 1993

Judy Auerbach, Ph.D.
~~Institute~~ of Medicine
Division of Biobehavioral Sciences
and Mental Disorders
2101 Constitution Avenue
Washington, D.C. 20418

Dear Judy:

This letter is slow coming because I am reluctant to leave the Committee! This is, however, my formal resignation from the HIV/Substance Abuse/Mental Health Research Committee. I remain excited about the work of the Committee. If there is anything I can do for you or the Committee from my new position, please let me know.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 2, 1993

Mr. A. Auerbach
Aravaipa Associates Inc.
Design and Manufacturing
P.O. Box 256
Oracle, Arizona 85623

Dear Mr. Auerbach:

Thank you for writing. I agree that condoms will continue to be a major part of our efforts to stop the spread of HIV infection.

Both the National Institutes of Health and the Centers for Disease Control and Prevention are conducting research on improved barrier methods. You many wish to contact them, as well as continue your efforts with manufacturers.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 7/28/93: 690-5471: b:\auerback

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

August 4, 1993

Judy Auerbach, Ph.D.
Institute of Medicine
Division of Biobehavioral Sciences
and Mental Disorders
2101 Constitution Avenue
Washington, D.C. 20418

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Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by:APO:KMGebbie:BR:8/5/93:632-1090:Auerbach.ltr

Mail
#03008

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NAPO Number : 7047 PHS Number : OS Number : Document Type : White House Letter

Document Date: 8/10/93 Refer'd Date : 8/10/93 Int Due Date : 8/10/93 Ext Due Date : 8/10/93
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Purge Date : 8/10/95 Disposition : DESTROY Final Date : 8/10/93 Document Loc : MAIN-03D08

********** Correspondent Information **********

From : KRISTINE GEBBIE Title : DIRECTOR Organization : ONAPC
Address : City : Washington State : DC Zip : 20500
On Behalf Of : To : JUDY AUERBACH

********** Subject or Title **********

Division of Biobehavioral Sciences and Mental Disorders - 2101 Constitution Avenue - Washington, D.C. 20418

********** Keywords **********

GEBBIE

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Comments FROM assignees:

THE WHITE HOUSE

WASHINGTON

August 4, 1993

Mr. Richard H. Larsen
6 Oyster Shell Lane
Hilton Head Island, South Carolina 29926

Dear Mr. Larsen:

Thank you for writing. You identify a key part of the national response to AIDS: supporting behavior change which reduces spread of the virus. I will be making this a part of my efforts. I appreciate hearing from you.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 2, 1993

Arthur J. Ammann, M.D.
Chair, Health Advisory Committee, PAF
Director, The Ariel Project
81 Digital Drive
Novato, California 94949

Dear Dr. Ammann:

I am so glad we had a chance to meet, although briefly. As you probably know, since then I have had the opportunity to spend some time with Elizabeth Glaser and Susan DeLaurentis as well.

The points you raise in your editorial are excellent ones, and I look forward to working with you. If you will be back in D.C. in the near future, please call so we can arrange some time together. The Pediatrics AIDS Foundation is an important part of our national effort, and you are a key component!

Your personal experience with health insurance add fuel to the fire regarding need for universal coverage. I hope you have shared that information with others, including Dr. Lee.

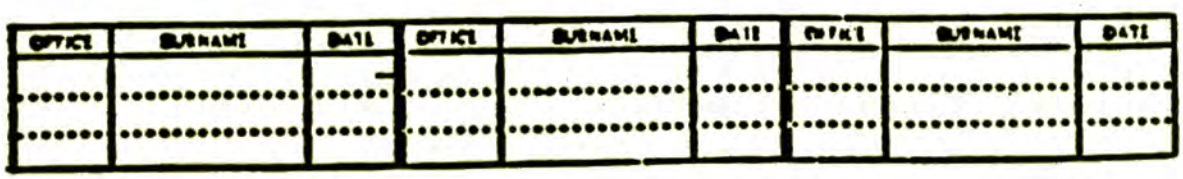
I hope to see you soon.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 7/28/93: 690-5471: b:\ammann

FILE COPY



Lawrence Thompson
Deputy Commissioner
Social Security Administration

~~Dir.~~

Dear Mr Larsen

Thank you for writing. You identify a key part of the national response to AIDS: supporting behavior change which reduces spread of the virus. I will be making this a part of my efforts.

I appreciate hearing from you.

Sincerely

R I C H A R D H. L A R S E N
6 OYSTER SHELL LANE
HILTON HEAD IS . SC 29926
(803) 681-3234

July 28, 1993

Ms.Kristine Gebbe
AIDS Policy Coordinator
The White House
Washington, DC

Dear Ms.Gebbe:

Congratulations on your recent appointment. It is an important responsibility.

Certainly your background, as portrayed in a recent Atlantic Constitution article, is ideal for the job.

In addition to the research for a cure, isn't time for responsible people as yourself to call for behavioral change to be part of a powerful two-pronged attack on this hideous disease. On the packs of cigarettes the government calls attention to the health threat to smokers. Isn't it time the government does something similar in the area of AIDS where the spread of the disease is, in the main, a behavioral problem?

I hope you will make this kind of "call" a part of your program.

Sincerely yours,

Richard H. Larsen

Main= 03D08

NAPO Document Control Slip

NAPO Number : 7045 PHS Number : OS Number : Document Type : White House Letter

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********** Correspondent Information **********

From : KRISTINE GEBBIE Title : DIRECTOR Organization : ONAPC
Address : City : Washington State : DC Zip : 20500
On Behalf Of : To : RICHARD LARSEN

********** Subject or Title **********

6 Oyster Shell Lane - Hilton Head Island, South Carolina 29926

********** Keywords **********

GEBBIE

********** Special Instructions **********

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Related WordPerfect Filenames: _____ _____ _____

Comments FROM assignees:

THE WHITE HOUSE

WASHINGTON

August 4, 1993

Mr. Jonathan Haber
185 Quarry Road
Warwick, Massachussetts 01378

Dear Mr. Haber:

Thank you for taking the time to write. You are correct that HIV infection is a dreadful thing and that difficult dissussions are needed to craft an effective national approach. While I support widespread testing as a part of our effort, I do not think a mandatory testing program is appropriate. We must, however, continue consideration of any appropriate actions.

I appreciate your interest.

Sincerely,

Kristine Gebbie

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 4, 1993

Mr. Jonathan Haber
185 Quarry Road
Warwick, Massachussetts 01378

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I appreciate your interest.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 7/28/93: 690-5471: b:\haber

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

185 Quarry Road
Warwick, MA 01378

Tel:(508)544-7862
Tel:(508)249-4696
Fax:(508)249-2134

July 30, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
200 Independence Avenue S.W. (Rm# 729 H)
Washington, D.C. 20201

Fax:(202)690-7054

Dear Ms. Gebbie:

Education is presently our most effective means to prevent the spread of AIDS. However, this epidemic is growing and an effective new policy is required to prevent needless suffering. My proposed idea, if implemented, would alter the course of this horrible disease.

Have you ever felt or wondered what it would be like to be HIV positive?

The most effective means to promote education and responsibility is to be tested for the virus. Waiting for the results makes you wonder. (I know from personal experience.) Was the act of unprotected sex really worth it?

Many in our society prefer to live in denial and spread the disease, rather than to know the frightening truth. This exists especially in the high risk groups of sexually active and intravenous drug users. This ignorance also legally protects a person to act irresponsibly.

Mandatory testing of this virus makes more sense than the madatory immunizations required of school children. This would create an environment of personal and legal responsibility of one's actions. Our civil liberties will be protected by annonymous disclosure of test results and counseling. I understand the difficulty of enacting this radical program. However, by educating and showing the results of such a program, showing how the suffering of a new born child might be prevented.., then, in due course, a referendum vote could be used to enact a new AIDS test policy.

People are ready for changes. This was President Clinton's agenda and why he was elected. There is urgency in stopping the spread of such suffering; every day is significant. I hope you will give grave consideration to this idea. If I may be of any assistance, please don't hesitate to contact me.

Best Regards.

Sincerely,

Jonathan Haber

Jonathan Haber

185 Quarry Road
Warwick, MA 01378

Tel:(508)544-7862
Tel:(508)249-4696
Fax:(508)249-2134

August 2, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
200 Independence Avenue S.W. (Rm# 729 H)
Washington, D.C. 20201

Fax:(202)690-7054

Dear Ms. Gebbie:

I am resending the attached letter because of the incorrect spelling of mandatory in my letter of July 30, 1993.

I am confident that my proposal would have a tremendous impact and could possibly reverse the trend of the AID's epidemic.

Please replace the July letter with the hard copy being sent to you today via priority mail. I am hoping this letter may be forwarded by you to people such as Ms. Hillary Rodham-Clinton and others working on health and human policies.

The concept requires debate in order to be implemented effectively. A widespread mandatory AID's test should require a referendum public vote. However, the role of Government could serve all by promoting policies, which could end the AID's epidemic.

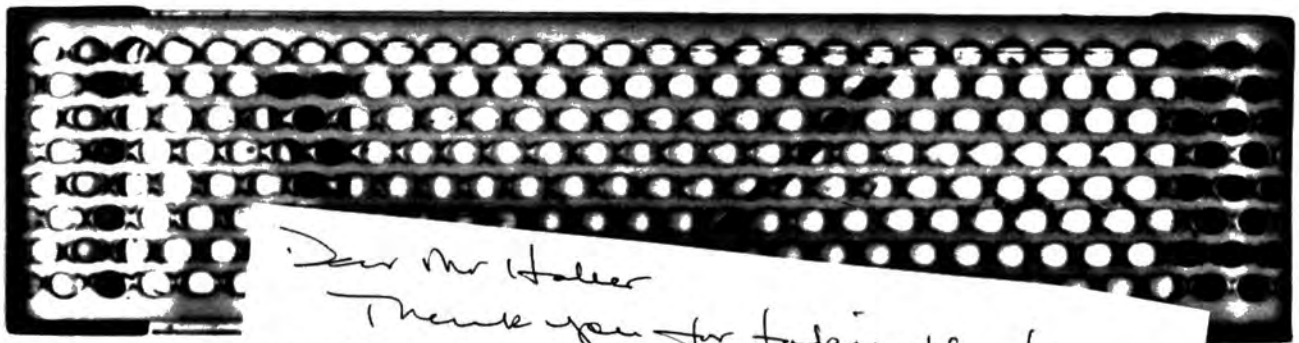
I appreciate your reading and considering these ideas.

Regards.

Sincerely,

Jonathan Haber

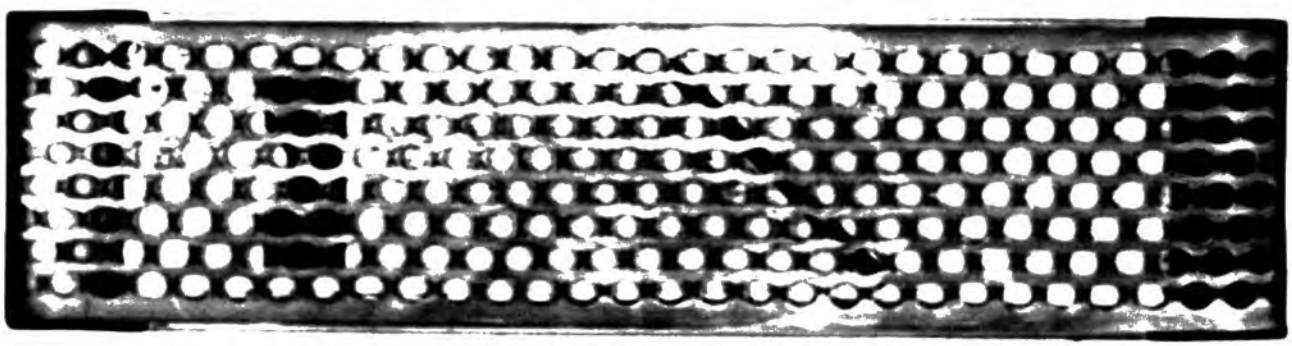
pg/aid



Dear Mr Haller

Thank you for taking the time to write, you are correct that HIV infection is a dreadful thing and that difficult decisions are needed to draft an effective National response to the AIDS problem. While I support widespread testing as a part of our effort, I do not think a mandatory testing program is appropriate. We must however continue consideration of appropriate actions. I appreciate your interest.

Sincerely,



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NAPO Xref : PHS Xref : OS Xref : Keyer ID : KWilliam
Purge Date : 8/10/95 Disposition : DESTROY Final Date : 8/10/93 Document Loc : MAIN-03D08

********** Correspondent Information **********

From : KRISTINE GEBBIE Title : DIRECTOR Organization : ONAPC
Address : City : Washington State : DC Zip : 20500
On Behalf Of : To : JONTHAN HABER

********** Subject or Title **********

185 Quarry Road - Warwick, Massachussetts 01378

********** Keywords **********

GEBBIE

********** Special Instructions **********

********** Assignment/Action History **********

Process Type : Kristine Gebbie Correspondence

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Kristine M. Gebbie	_____	DIRS	CLOS	8/10/93	8/10/93	

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Related WordPerfect Filenames: _____ _____ _____

Comments FROM assignees:

THE WHITE HOUSE

WASHINGTON

August 4, 1993

Angela Barron McBride, Ph.D., RN, FAAN
Distinguished Professor and University Dean
1111 Middle Drive
Indianapolis, Indiana 46202-5107

Dear Dr. McBride:

Thank you for writing, and for the good wishes. I look forward to an opportunity to talk this over in the near future.

I have taken a look at the materials from Mr. Meister, and will be responding to him directly. Thank you for serving as intermediary.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

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National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 7/28/93: 690-5471: b:\mcbride

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

Dear Angela—

Thank you for writing, and for the good wishes. I look forward to an opportunity to talk things over in the near future.

I have taken a look at the materials from Mr Meister, and will be ~~writing~~ responding to him directly. Thank you for serving as intermediary.

Sincerely—

- .. appreciation for agreeing to deliver the keynote address at NACHO's annual conference on Thursday in Chicago.

- Your PIN Number for the Sky Pager is 5041792. I left a message on the pager today, please let me know if you received it.

Buck wants to speak with you regarding a possible demonstration by ACT-UP against you tomorrow. If you do not reach him in the office tonight, please phone him at home at (202) 364-7357.

A meeting has been scheduled for you to meet with Mr. Kevin Thurm, Chief of Staff and Ms. Patsy Fleming on Thursday, July 22 9:00 a.m. to 10:00 a.m. The meeting will be held in the Chief of Staff's office and they would like to discuss with you, how the Department can be of assistance to you in your position.

I have also scheduled a meeting with you and Ms. Torie Osborn, Executive Director of National Gay & Lesbian Task Force for Friday, August 6, 10:00 a.m. to 11:00 a.m. Since that is the week in which you move into your new office, would you like me to reschedule and not schedule any meetings for that week?

Retina

INDIANA UNIVERSITY

SCHOOL OF NURSING

July 6, 1993

Kristine Gebbie, MN, RN, FAAN
606 Lilly Road, NE
Apartment 723
Olympia, WA 98506

Dear Kris:

First of all, I want to congratulate you on being named AIDS Czarina. Not only did President Clinton make an excellent choice, but you have been very impressive in all the interviews that I have heard where they tried to trip you into saying something problematic. I am a C-SPAN junky, and I so appreciate being able to see you doing so well when I tune on that station.

A college classmate of my husband's, Karl Meister, is President of Carrington Laboratories (PO Box 569500, Dallas, TX, 75356-9500). When he saw you, a nurse, named to your position, he asked if I knew you and would be willing to bring the drug that they are developing to your attention. I am passing the materials that he sent me on to you in case you are interested.

I wish you the very best in your important work.

With admiration,

Angela Barron McBride, PhD, RN, FAAN
Distinguished Professor and University Dean

OFFICE OF THE DEAN

1111 Middle Drive
Indianapolis, Indiana
46202-5107

317-274-1486
Fax: 317-274-2996

Located on the campus of
Indiana University
Purdue University
Indianapolis

ABM/jc

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THE WHITE HOUSE

WASHINGTON

August 4, 1993

Mr. Karl Meister
President
Carrington Laboratories
P.O. Box 569500
Dallas, Texas 75356-9500

Dear Mr. Meister:

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National AIDS Policy Coordinator

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National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 7/28/93: 690-5471: b:\meister

FILE COPY

Karl Meister
President
Carrington laboratories
PO Box 569500
Dallas Tex. ~~569500~~
75356-9500

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Sincerely

July 12, 1993

Hi Ms. Gebbie:

Sorry I missed your call today. I am faxing you the following documents:

- A draft note composed by Art to Patsy Fleming for your signature. Please let me or Art know if it is ok to finalize.
- Information requested for a calling card is attached with instructions on how to use it and the PIN Number for the card.
- A copy of a fax received from Larry Gostin with a letter attached to Dr. Lee for clearance and he is asking if you want your name added to this letter. The response was due today but Ms. Pynter in Mr. Barnes' office said that tomorrow would be fine.
- Buck wanted you to have a copy of the attached article from the Washington Blade.
- A letter from Ms. Donaldson of the California Nurses Association.
- A letter of app

ACEMANNAN - A BIOLOGIC RESPONSE MODIFIER

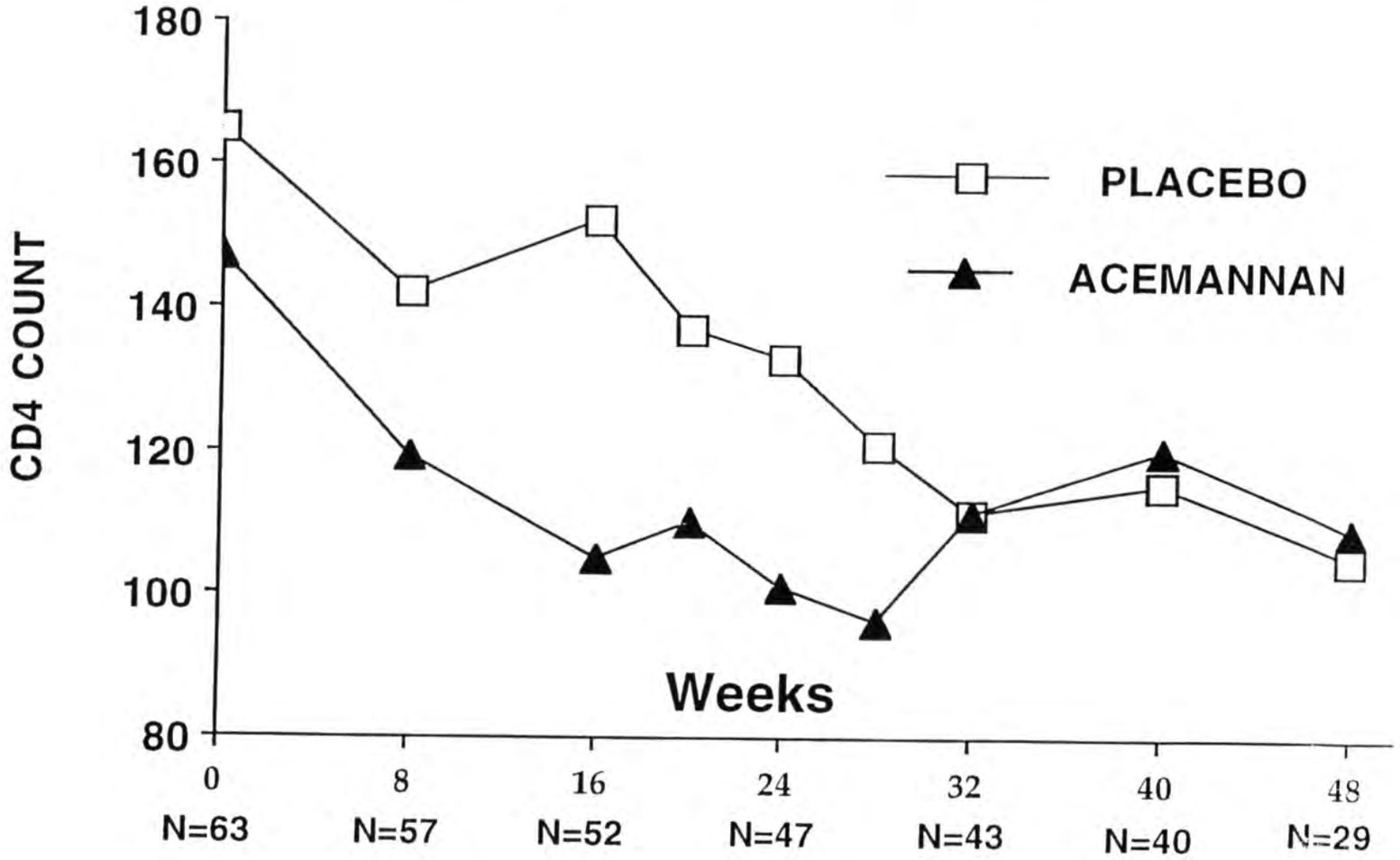
Acemannan is a naturally occurring, complex polysaccharide consisting of long-chain, beta-linked mannan polymers interspersed with acetyl groups. Carrington scientists have shown that acemannan is extremely stable and exhibits a long half-life. Acemannan can be formulated as an oral medication as well as an injectable or a topical product. No significant side effects have been noted using therapeutic doses in an extensive series of preclinical and clinical tests in animals and humans. Acemannan, thus, is a very safe compound.

Acemannan has immunomodulating and antiviral mechanisms of action which have been extensively studied; data continues to be gathered and evaluated from *in vitro*, animal and human studies. Macrophage stimulation by acemannan with subsequent cytokine release and enhancement of anti-tumor activity have been established. Recent *in vitro* studies using human blood mononuclear cells demonstrated the release of IL-1β, IL-2, TNFα, IFNγ and GM-CSF after incubation with acemannan. Thus, acemannan has the potential to modulate the body's immune response in diseases such as cancer, AIDS and inflammatory bowel disease. Acemannan is believed to possess a direct antiviral effect as well, by altering the virus' glycoprotein, thus inhibiting its ability to assemble and to infect other cells.

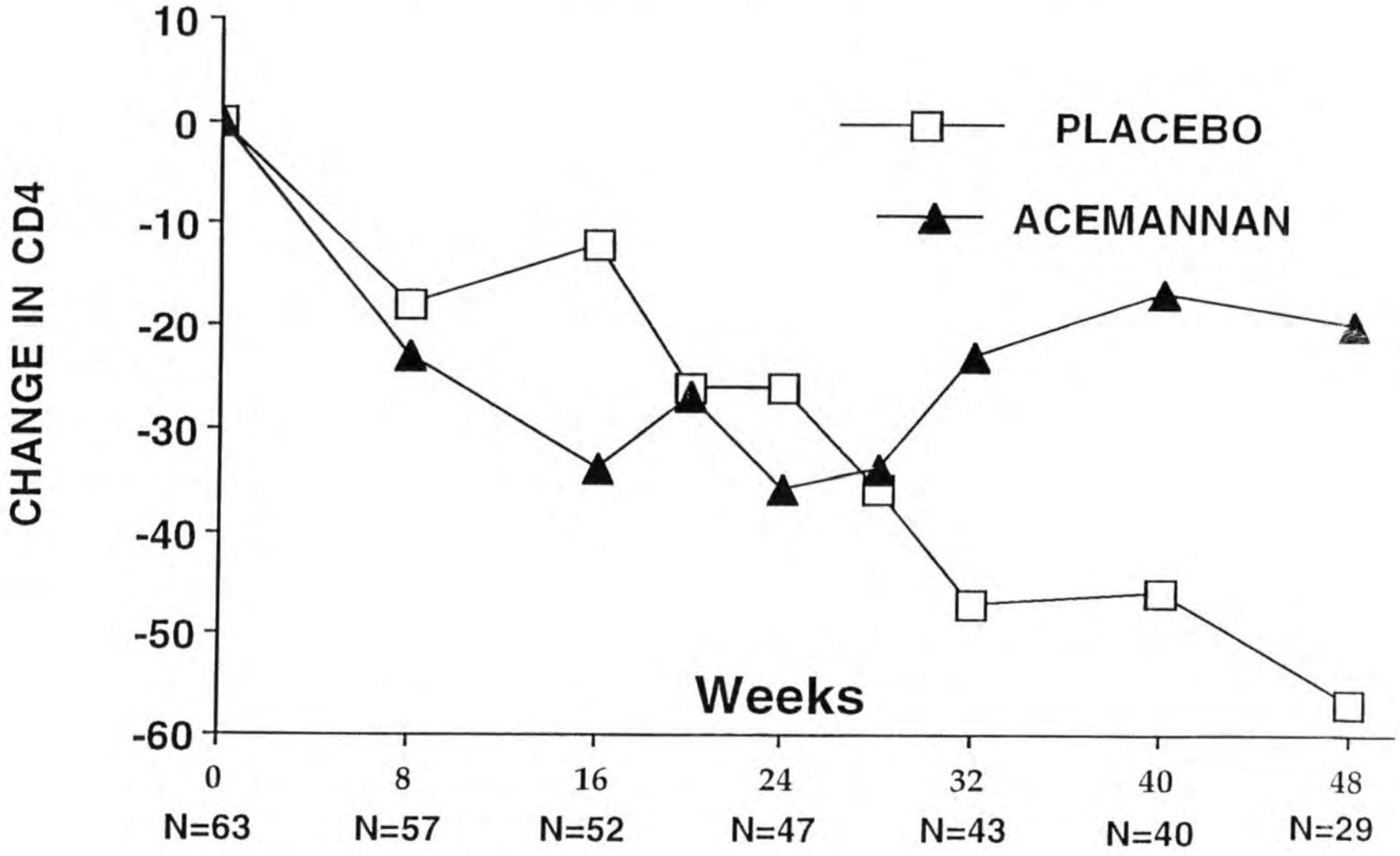
AIDS Oral. In early 1991, the HIV Trials Network of the Canadian Government's Health Protection Branch and Carrington initiated a clinical trial of oral acemannan capsules in patients with advanced HIV disease who were experiencing a diminished response to their long-term AZT treatment. The trial protocol called for the treatment of 60 patients in two groups, one receiving AZT plus acemannan, the other AZT plus a placebo, under double-blind conditions. Treatment of each patient was scheduled to continue for 48 weeks. This trial has recently been successfully completed. The results confirmed the Company's expectation of a bi-phasic pattern of CD4 cell response in the acemannan-treated group; early decreases, believed to result from natural killer cell stimulation, were offset by a statistically significant stabilization of CD4 cell counts between weeks 16 and 48 in the acemannan group. Carrington believes these positive findings to be very promising. The trial also confirmed that acemannan is a safe medication. Study patients will now be followed to assess longer-term outcomes.

AIDS Injectable. The acemannan injectable IND was filed with FDA on July 15, 1992, and Carrington received permission to initiate human trials according to the Phase I protocol that was submitted with the IND. The trial is now completed. A powerful biologic effect was observed in the higher dose groups; cytokine levels will be examined as they relate to the observed clinical effects. The Company is extremely encouraged by these preliminary results and expects to move to a Phase I/II multi-dose study in AIDS patients in 1993. The Company plans to pursue a fast-track, accelerated-approval regulatory strategy for the AIDS injectable indication.

ABSOLUTE CD4 COUNT OVER TIME



CHANGE IN ABSOLUTE CD4 OVER TIME



INTENTION-TO-TREAT ANALYSIS

ANNUALIZED RATE OF CHANGE OF CD4 COUNT BY TREATMENT GROUP BASED ON LINEAR SLOPE OF CD4 OVER TIME

	Rate of Change		
	Mean	Std Dev	p value
Placebo	-77.5	135	.87
Acemannan	-70.6	187	

INTENTION-TO-TREAT ANALYSIS

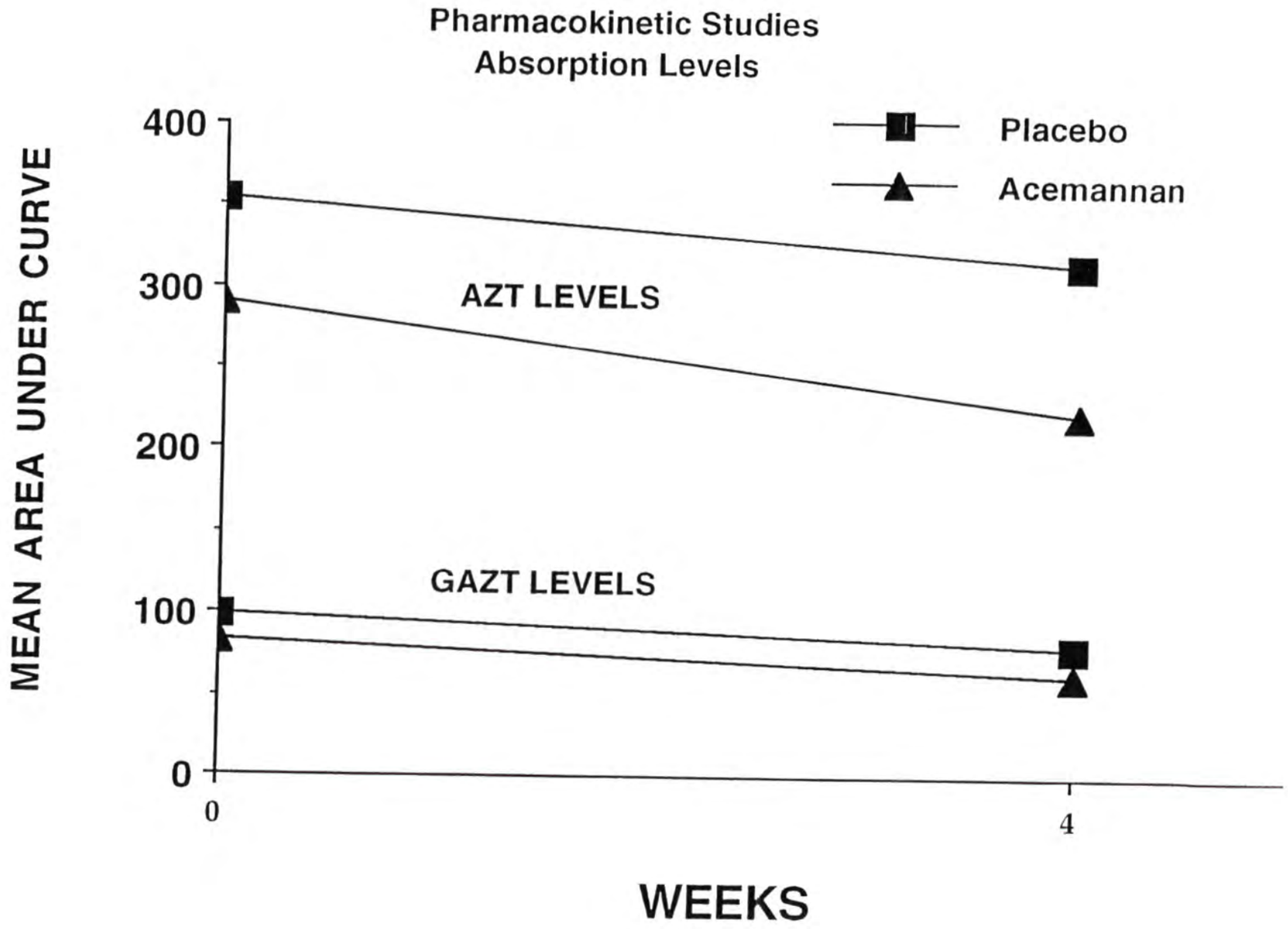
CONFIDENCE INTERVALS FOR CHANGES IN CD4 COUNTS

	Placebo		Acemannan	
Week	Mean Change	95% CI	Mean Change	95% CI
12	-40	(-61,-19)	-30	(-50,-8)
24	-21	(-50, 8)	-33	(-54,-10)
36	-63	(-93,-33)	-34	(-59,-9)
48	-67	(-96,-37)	-31	(-45,-17)

EFFICACY ANALYSIS

ANNUALIZED RATE OF CHANGE OF CD4 COUNTS (RESTRICTED TO PATIENTS ON AZT+ACEMANNAN)

Time Period	Treatment	Rate of Change N	Mean	Median	t test p value	nonparametric p value
0-16 Weeks	Placebo	25	-74	-121	.17	.45
	Acemannan	19	-132	-120		
16-48 Weeks	Placebo	25	-17	-61	.62	.11
	Acemannan	19	8	0		


Pharmacokinetic Studies
Absorption Levels
Placebo
Acemannan
AZT LEVELS
GAZT LEVELS
MEAN AREA UNDER CURVE
400
300
200
100
0
0
4
WEEKS

OPPORTUNISTIC INFECTIONS

	Placebo	Acemannan
AIDS-Defining		
PCP	2	3
MAI	0	1
CMV	0	1
Esophageal Candidiasis	2	0
Atypical mycobacterium	0	1
Lymphoma	1	0
Subtotal	5	6
Non AIDS-Defining		
Salmonella	0	1
Candida	4	3
Herpes Zoster	2	2
Herpes Simplex Virus	1	1
Oral Hairy Leukoplakia	0	2
Molluscum contagiosum	1	0
Cryptosporidiosis	0	1
Subtotal	8	10
Total	13	16

SUMMARY OF RESULTS

1. NO DIFFERENCE BETWEEN GROUPS ON CHANGE IN CD4 BASED ON:

   (a) LINEAR SLOPE OF CD4 OVER TIME

   (b) NORMALIZED AREA UNDER THE CURVE

   (c) CHANGE FROM INITIAL TO POST 40 WEEKS VALUES ON THERAPY

2. NO INCREASE IN CD4 COUNT AT ANY TIME AFTER START OF TREATMENT

3. MODERATE (NON-SIGNIFICANT) TREND IN LINEAR SLOPE IN FAVOUR OF ACEMANNAN BASED ON A PRIORI COMPARISON OF PATIENTS ON THERAPY FROM 16 TO 48 WEEKS.

4. NO DIFFERENCE BETWEEN GROUPS ON CHANGE IN P-24 ANTIGEN.

5. NO DIFFERENCE BETWEEN GROUPS IN TOXICITY AS DOCUMENTED BY SERIOUS ADVERSE EVENTS, SYMPTOMS OR LABORATORY OUTCOMES.

Conclusions

- Acemannan, as used in this protocol, has no significant effect on CD4 counts or P24 antigen. However, the possibility of a stabilization of CD4 counts after 16 weeks of therapy cannot be excluded by our data.

- The safety profile of oral Acemannan is confirmed by our data.

A18

A Comparison of Routes of Administration on the Efficacy of Acemannan in Feline Immunodeficiency Virus-Infected Cats

KM Yates, MC Kemp, Y Ni, J Raboud, CR Ford and IR Tizard

ABSTRACT

OBJECTIVE:
To compare survival and laboratory parameters among feline immunodeficiency virus (FIV) infected symptomatic cats when acemannan (ACM) was administered intravenously, subcutaneously or orally.

METHODS:
49 cats that tested positive for FIV by two serologic tests and classified as FIV disease stages 3,4 or 5 were enrolled. 23 cats were lymphopenic at enrollment. Cats were randomly assigned to one of three groups and received ACM by either weekly intravenous or subcutaneous injections for 12 weeks, or daily oral ACM for 12 weeks. Laboratory parameters were evaluated at weeks 0, 6 and 12.

RESULTS:
No significant differences among the three groups were seen in hematological and blood chemistry parameters. Therefore, groups were combined for further analyses. Significant improvement was seen in lymphocyte ($p<0.001$) and absolute neutrophil ($p<0.008$) counts, indicative of improved immune function. Median survival time was 58 weeks for all cats. Survival time did not differ among treatment groups. No significant adverse events occurred as a result of treatment with ACM.

DISCUSSION:
ACM has been shown to alter glycosylation of viral glycoproteins, including those of FIV. In addition, ACM has been shown to suppress the cytopathic effects of HIV-1. Binding of ACM to monocytes has been shown to induce the production of IL-1, IL-6 and TNF-α. The observed effects on lymphocyte and neutrophil counts along with the increased survival suggest ACM may have similar therapeutic effects in HIV-1-infected patients.

CONCLUSIONS:
Survival in ACM-treated FIV-infected cats has exceeded historical data reported in the literature for untreated animals. This may have relevance in treatment of HIV disease with ACM.

INTRODUCTION

FELINE IMMUNODEFICIENCY VIRUS DISEASE

Feline immunodeficiency virus (FIV) is a lentivirus as is human immunodeficiency virus (HIV) and shares morphological, biochemical and enzymatic similarities to HIV, the etiologic agent of AIDS. FIV was first isolated in 1986 (Pedersen et al., 1987). Like HIV, FIV shows a high degree of tropism for CD4+ T-cells and, as a result, induces a slowly progressive immunodeficiency syndrome in domestic cats analogous to that seen with HIV.

Currently no cure exists for FIV-infected cats. Treatment is supportive to try to prevent secondary infections which eventually result in death. Survival data is limited for the general population of FIV-infected cats due to the extended course of the disease and its relatively recent discovery. However, it has been reported that Stage 5 cats (AIDS-like) have a survival of approximately 1-6 months and Stage 4 cats (ARC-like) months to 1 year (Ishida and Tomoda, 1990). In one study of 11 naturally infected cats which were asymptomatic and observed for 2 years, four cats (36%) showed progression of disease of which two developed AIDS-like disease and died within 1 year (Ishida et al., 1992).

MECHANISM OF ACTION OF ACEMANNAN

Acemannan (ACM) is a polydispersed β-(1,4)-acetylated mannan having a mannose monomer-to-acetyl group ratio of approximately 1:1 (Fig. 1). ACM is unique in that it has immunomodulatory and antiviral properties. It has been shown to induce a variety of human cytokines including IFN-γ, IL-2, GM-CSF, TNF-α, IL-1β and IL-6 (Marshall et al., 1993). In addition, ACM directly stimulates NK activity in a manner similar to INF-γ and IL-2 (Marshall and Druck, 1993) and enhances cytotoxic T-cell activity (Womble and Helderman, 1992).

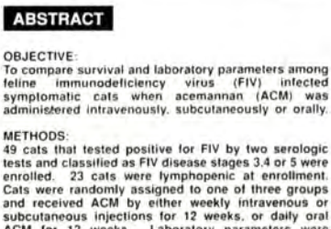
1

STRUCTURAL FORMULA OF ACEMANNAN

The antiviral effects appear to be due to ACM-induced changes in the glycosylation of viral coded glycoproteins. The cytopathic effect of HIV-1 and FIV on CD4+ cells *in vitro* is mediated by cell fusion with syncytia arising among cells that express viral envelope glycoproteins and those that express the CD4 receptor. The glycoprotein precursors of HIV-1 (gp160) and FIV (gp145) are endoproteolytically processed to yield an attachment protein and a fusogenic transmembrane (TM) protein, gp120 and gp41 for HIV-1 and gp95 and gp34 for FIV. *In vitro*, ACM has been shown to dramatically reduce HIV-1 induced syncytium formation (Kahlon et al., 1991) (Fig. 2). In addition, ACM treatment of NDV-infected cells inhibited syncytium formation and caused at least a 1,000-fold titer reduction (Fig. 3).

2

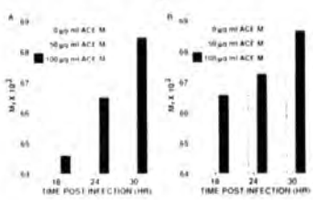
3



ACEMANNAN CONCENTRATION (µg/ml)

In vitro, the maximum inhibitory effect of ACM, with respect to HIV-1, was observed in CEM-SS cells infected with the RF_{II} strain, in which the 50% inhibitory effect of ACM (IC_{50} = 45 µg/ml) was similar to that of castanospermine (CAS) (IC_{50} = 28 µg/ml), an inhibitor of α-glucosidase I. Deoxymannojirimycin (DMN) and swainsonine (SWS), inhibitors of mannosidase I and II, tested in parallel to CAS and ACM, exhibited no IC values. These results suggested ACM acts as an inhibitor of α-glucosidase I. In support of this mechanism of action ACM treatment altered the processing of NDV glycoproteins causing time and concentration dependent shifts in the electrophoretic mobilities of the HN (Fig. 4A) and F_0 (Fig. 4B) glycoproteins. The reduction in the processing of the F_0 glycoprotein is consistent with the observed decrease in virus-induced syncytium formation.

4



METHODS

CLINICAL POPULATION

Naturally-infected cats exhibiting clinical signs of FIV infection were presented by their owners to three veterinary clinics in Texas. All were ELISA-positive and immunofluorescent antibody-(IFA) positive for FIV.

Upon entering the study, cats were randomly assigned to one of three treatment groups. Group 1 received 2 mg/kg ACM intravenous (IV) once weekly. Group 2 received 2 mg/kg ACM subcutaneously (SQ) once weekly. Group 3 received 100 mg ACM orally (PO) daily. The study population consisted of 49 cats. Groups 1 and 2 (IV and SQ groups) consisted of 17 animals each; Group 3 (PO group) consisted of 15 animals. Injectable acemannnan was reconstituted prior to use with sterile saline to 1 mg/ml. PO ACM was provided in 100-mg capsules, the contents of which were mixed with food.

Cats were allowed to receive concomitant supportive therapy, i.e., antibiotics, vitamins, fluid therapy. Study duration was 12 weeks, but cats were permitted to continue on therapy if the owners so elected. Cats treated post-study received acemannnan by monthly injection (2mg/kg; Groups 1 and 2) or daily PO administration (100 mg; Group 3).

All cats were staged at initiation of treatment (Table 1).

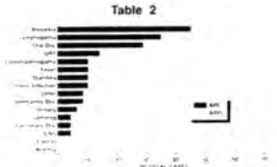
Table 1

ENTRY CRITERIA

Group	Stage 3	Stage 4	Stage 5	Total
1	0 (0)	14 (28.6%)	3 (6.1%)	17
2	1 (2%)	15 (30.6%)	1 (2%)	17
3	0 (0)	12 (24.5%)	3 (6.1%)	15
Totals	1 (2%)	41 (83.7%)	7 (14.2%)	49 (100%)

Ages of animals ranged from 1.5 to 17 years with a median age of 7 years. The most frequent clinical findings upon study entry were anorexia/weight loss, lymphopenia and oral mucosal pathology (Table 2).

Table 2



Frequency histogram of primary clinical signs of FIV-infected cats upon study entry. The cases are divided into those animals presenting with AIDS-Related Complex (ARC) and those with frank AIDS

Treated cats underwent extensive clinical examination at screening, week 6 and week 12. Clinical indices included general condition and appetite, weight change, body temperature and presence of sepsis and lymphadenopathy. Body weight at entry was used to determine subsequent body weight change.

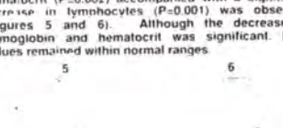
Hematology and complete blood chemistry were performed prior to entry, at week 6 and at week 12. Necropsies were performed on all animals that died, and subsequent histopathological exams were performed on submitted tissues.

RESULTS

CLINICAL

Since statistical analyses of clinical scores, hematology and chemistry using Friedman's test showed no differences in efficacy among the three groups at weeks 0, 6 and 12, and a random distribution of disease and demographics existed among the three groups, the groups were combined to evaluate changes over time (Yates et al., 1992). A trend toward increase in body weight as well as reductions in fever and lymphadenopathy was observed. A significant reduction in sepsis was seen. A significant decrease in neutrophils ($P=0.007$), hemoglobin ($P=0.008$) and hematocrit ($P=0.002$) accompanied with a significant increase in lymphocytes ($P=0.001$) was observed (Figures 5 and 6). Although the decrease in hemoglobin and hematocrit was significant, both values remained within normal ranges.

5

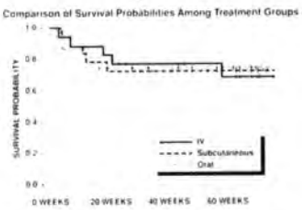


6

Survival

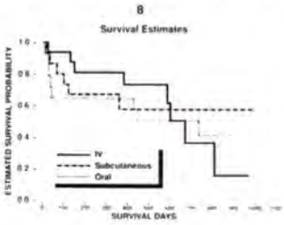
Of the 49 cats which entered the study nine died during the 12-week treatment and four others died during post maintenance follow-up. Of the 13 cats that died, nine were Stage 5 (AIDS-like). The resulting estimated probability of survival once all cats completed the 12 week course of treatment is shown below. The ability to follow animals past the 12-week study period facilitated long term survival analysis (Figure 7). No significant difference existed among the three treatment groups. Probability of survival of cats in each of the three groups (0.75) is substantially higher than that reported in the literature for untreated cats.

7



Cats were followed as long as possible through contact with referring veterinarians. Five of the 36 surviving cats continue to receive treatment with four receiving daily oral administration and one monthly IV injections. Updated probability of survival is illustrated in Figure 8. No statistically significant difference existed in survival probability among groups receiving ACM by different routes. Median survival was 681 days for cats that received IV ACM and 748 days for cats that received oral ACM. Median survival could not be computed for cats that received SQ injections due to the number of censored observations (animals still living at last follow-up or animals lost to follow-up).

8



DISCUSSION

The primary finding in FIV is a decrease in lymphocyte counts over time, with increasing frequency of secondary infections ultimately leading to death. The increase in total lymphocytes, normalization of neutrophil and white blood cell counts and reduction in sepsis seen in ACM-treated cats suggests an improvement in general immune mechanisms for handling disease. This improvement could result from, at least in part, decreased viral activity as well as increased macrophage activation and enhanced NK cell and or cytotoxic T-cell activity.

The fact that many Stage 3, 4 and 5 cats are surviving without continuous therapy is quite remarkable. The increased median survival of cats receiving oral ACM compared to cats receiving IV dosing probably reflects the increased number of cats on continuous therapy and the frequency and number of administered doses. The extended survival for acemannan treated FIV-infected cats is much higher (reported survival for Stage 4 and 5 untreated cats is 6 months to 1 year) than what would be expected from survival data that is reported in the literature for untreated cats.

CONCLUSIONS

1. No evidence of acemannan toxicity was noted in this study.
2. Route of administration did not significantly affect the degree of improvement or survival, although weekly IV administration showed a trend toward improved efficacy.
3. Survival rate estimates for acemannan-treated FIV-infected cats were significantly higher than those reported in the literature for untreated cats.

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B29

CD4 AND CD8 LYMPHOCYTE LEVELS IN ACEMANNAN (ACM) - TREATED HIV-1 LONG-TERM SURVIVORS

H.R. McDANIEL*, L.J. ROSENBERG**, B.H. McANALLEY**

*DALLAS-FT. WORTH MEDICAL CENTER, GRAND PRAIRIE, TEXAS
**CARRINGTON LABORATORIES RESEARCH DIVISION, DALLAS, TEXAS, USA

ABSTRACT

A 6th year analysis was done on 5 survivors of a 1986 open-label clinical pilot to evaluate the potential efficacy of oral ACM in the treatment of symptomatic HIV-1+ patients (pts). Pre- and post-therapy CD4 and CD8 levels were as follows:

AVE. n=5	CD-4/ mm³	CD-8/ mm³
1986 Pre-Therapy (n=15)	337	359
1992 Annual Eval. (n=5)	346	1395
1993 Annual Eval. (n=4)	310	1057

In addition to existing medication, pts consumed each day a beverage (Caraloe™) which contained an average of 800 mg ACM. CD4 and CD8 levels and clinical status of these pts and clinical deterioration of 10 deceased study pts closely paralleled their compliance for the daily intake of ACM. Deceased pts lived 18-24 months after voluntarily ceasing the ACM intake. The survival of these 5 pts may be due to the expansion of cytotoxic CD8 lymphocyte population through complex leukocyte interactions essential for host defense. Previously it was reported that ACM activates human cytotoxic CD8 cells in vitro in a dose-dependent manner. In addition, ACM induces human peripheral blood mononuclear cells to produce IL-1, IL-6 and TNF-α on a dose-related basis. The induction of cytokine synthesis and expansion of the CD8 population with maintenance of CD4 levels may provide a rational basis for long-term survival of these HIV-1+ pts.

BACKGROUND

1984-85
Six symptomatic patients, meeting the C.D.C. definition of AIDS, reported clinical improvement by oral intake of Caraloe™, an aloe vera - derived beverage of plant extract processed specifically to preserve its physiological activity.

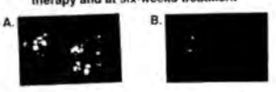
1985-86
Acemannan (ACM), a β-(1,4)-linked acetylated mannan, a labile polysaccharide was isolated from Caraloe™.

An F.D.A. exploratory pilot protocol was conducted at Dallas-Ft. Worth Medical Center. Fourteen symtomatic HIV-1 patients were treated under this IND. They demonstrated:

1. Global clinical scoring progressively improved (P = 0.01).
2. Opportunistic infections improved or were eliminated.
3. HIV-1 virus could be propagated following co-culture of patient leukocytes with susceptible target lymphocytes. Six weeks into treatment the virus could not be cultured. (See photos, Plate 1).
4. Fatigue, fever, chills, sweats and weight loss were abated.
5. A dose threshold of 500-800 mg/day ACM was required to induce the above ameliorative effects.

(Clinical Research, 35(3):483A, 1987)

PLATE 1
Lymphocyte Co-cultures taken prior to ACM therapy and at six-weeks treatment



Pre-treatment Leukocyte Cultures
White blood cells from symptomatic AIDS patients were co-cultured with donor cells and immunostained with an HIV-1 antibody. Leukocytes that contain viral antigen are yellow by U.V. microscopy.

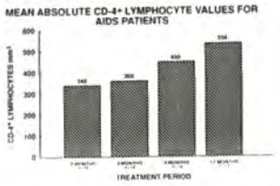
Cultures Taken After 6 Weeks ACM
No HIV-1 antigen was detected or rare lymphocytes were found that showed a ragged stain pattern typical of infected cells that had been attacked by activated cytotoxic lymphocytes in that cell membranes exhibited perforin damage.

1986-87
Confirmatory clinical pilot study of 15 patients. Each subject received an average of 500 mg/day oral ACM as Caraloe™. The study exhibited the following findings:

1. Global clinical scoring progressively improved and symptoms were alleviated (P=0.01).
2. P-24 core antigen levels were lowered or became non-detectable.
3. Anemia, leukopenia, thrombocytopenia and abnormal enzyme levels improved or normalized and patients gained weight.
4. Skin-test anergy (DCH) was restored.
5. CD-4 lymphocyte levels increased progressively in responsive patients.

(Who 1st Int. Conf. Global Impact of AIDS, London, England, 1987)

MEAN ABSOLUTE CD-4+ LYMPHOCYTE VALUES FOR AIDS PATIENTS



1986
Predictive pilot study with 26 symptomatic HIV-1 patients. Analysis of the first 29 treated patients suggested that some individuals responded well to ACM and others did not. A hypothesis was tested in this study.

Patients would show progressive clinical improvement if:

1. Pre-treatment CD-4 level was >150/mm³
2. P-24 core antigen was <300 pg/dl

Criteria for a good response were:

A. Rising CD-4 levels
B. Reduction in P-24 core antigen levels
C. Improvement of global clinical scoring

Results:

1. Predicted to improve prior to therapy	16
Improved as predicted	13
Met 2 of 3 criteria	3
2. Predicted to deteriorate pre-therapy	10
Deteriorated as predicted	7
Improved 2 of 3 criteria	1
Improved 3 of 3 criteria	2

(IV Int. Conf. AIDS, Stockholm, Sweden, June 1988)

1989-93 - ACEMANNAN FDA PHASE I TOXICITY PROTOCOLS
These studies demonstrated that there was virtually no organ toxicity in oral and injectable multiple species testing including human studies.

1. Subchronic oral administration in the rat and dog. (Fogleman, et al., Vet. and Human Tox. - April 1992)
2. Toxicological evaluation of injectable acemannan in the mouse, rat and dog. (Fogleman, et al., Vet. and Human Tox. - April 1992)
3. Graduated dose human oral toxicity study. (Pharmaco #9002, F.D.A. IND no. 29,886, 1989)
4. Graduated dose injectable human toxicity study. (UTHSCH-Marshall, #9003, F.D.A. IND no. 35,431, 1993)

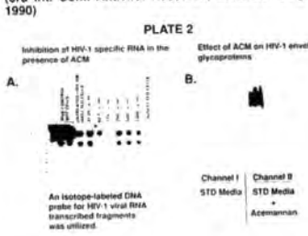
Pilot studies in multiple AIDS, Ulcerative Colitis and Crohn's Disease patients treated with ACM exhibited: Normalization of Anemia, Thrombocytopenia, Leukemia and Liver Enzymes, while improving or eliminating clinical symptoms of the disease.

MULTIPLE MECHANISMS OF ACTION

1989 - BLOCKS VIRAL mRNA TRANSCRIPTION
ACM was shown to block mRNA transcription from viral DNA integrated in an HIV-1 infected T-lymphocyte cell line. (See plate 2A)
(Int. Sym. Antiviral Therapy, Sardina, Italy, 1989)

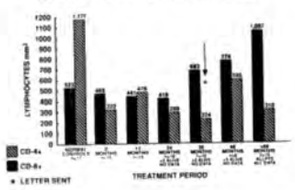
1990 - ALTERS VIRAL ENVELOPE GLYCOPROTEIN SYNTHESIS
ACM induced viral envelope glycoprotein dyssynthesis in HIV-1, Newcastle disease virus and Paramyxovirus rendering the agents potentially non-infectious. (See plate 2B)
(3rd Int. Conf. Antiviral Research, Brussels, Belgium, 1990)

PLATE 2



1990 - ELEVATES CYTOTOXIC CD8 LEVELS
Oral ACM 800-1000 mg/day taken for over 4 years was reported to slow the drop of CD4 and increase the CD8 cells (which include cytotoxic CD8+ lymphocytes). It was noted that the cytotoxic CD8 antiviral lymphocytes are in this cell pool. Global clinical scoring and P-24 core antigen levels improved. Analysis of this patient group is extended to 1993 in the following graph. (6th Int. Conf. AIDS, Abst. 1007, June 1990)

CD-4+ AND CD-8+ LYMPHOCYTE COUNTS FOR STUDY II AIDS PATIENTS TREATED WITH ACEMANNAN



FLOW CYTOMETRIC DATA SHOWING LARGE MONOCYTE INDUCTION BY ACM IN PERIPHERAL BLOOD

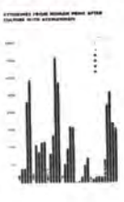
Flow cytometric two-parameter displays of lysed whole blood from a pre-treatment and HIV+ patient who received ACM over 36 months. (A.) Pre-ACM control displaying typical light scatter and fluorescent profiles following staining with CD45 and CD14 antibodies. CD14+ monocytes are colored green. (B.) HIV+ blood sample from a patient on ACM in excess of 3 years. Note the new cell population of larger CD14+ monocytic cells (yellow) in addition to normal monocytes. The increased forward light scatter (FSC) is indicative of the cell size.

(6th Int. Conf. AIDS, Abst. 1007, June 1990)

A. PRE-TREATMENT: B. 36 MONTHS ACM THERAPY:

1992 - INDUCES ANTIVIRAL CYTOKINE SYNTHESIS
ACM demonstrated a dose response for induction of cytokine production. Potential antiviral effects are included in this group to cytokines (TNF, IL-1, IL-2, IL-6, INF-Gamma). The levels produced were significantly enhanced. Cytokines stimulate immune response and activate the cellular audit system for discrimination against non-genomic nucleic acid dictated synthesis.

(Marshall G., et al. Amer. Acad. Aller. Immuno., 1992)



EXPERIMENTAL QUESTION OBJECTIVE

WILL ORAL ACEMANNAN IMPROVE THE IMMUNE STATUS AND EXTEND QUALITY OF LIFE FOR AIDS PATIENTS?

STUDY SCOPE:
HIV-1 patients in the 1986 pilot study were offered gratis oral ACM as Caraloe™ and an annual evaluation. Continuation and degrees of patient compliance were intermittent and ranged widely. Despite external pressures on these patients due to the unproven nature of this treatment regimen, patients have chosen to remain on this protocol.

METHODS:

1. Test material Caraloe™ (avg. 800 mg ACM/L) was provided or shipped to participants.
2. An annual CD4, CD8 absolute lymphocyte levels, CBC, SMAC, history and physical exam was performed.
3. Compliance for Caraloe™ intake was evaluated.

RESULTS:
Overview of 1986 study II patient survivals

SURVIVING PATIENTS

PATIENT I.D.	ENTRY DATE	GLOBAL SCORES	ENTRY 1993	COMPLIANCE %
JH	12-19-85	5	2	>90
ED	8-5-86	8	2	I - N >75
PD	9-11-86	5-5	0	I - N >75
DL	3-1-87	7	2	I - N >50

I – Intermittent
N – None

DECEASED PATIENTS

PATIENT I.D.	ENTRY DATE	DEATH DATE	MONTHS SURVIVING	REASON FOR DEATH	COMPLIANCE %
BS	12-26-85	6-6-88	42	Depressed Caused an Rx	0 > '87
DD	2-24-86	12-12-87	18	Suicide: Drug Overdose	<50
DW	6-7-87		3	Suicide: Drug Overdose	Unknown
BD	5-17-87	11-30-87	6	PCP presumptive	Poor
MB	1-5-86	9-27-90	50	Hemoptysis	0 > '87
MM	1-30-86	3-30-93	87	Intensive Caloreux Poor Rx	< 20 > '87
AH	9-15-88	8-20-91	59	PCP Pneumonia	0 > '88
GM	12-11-86	1-10-90	48	Depressed Caused an Rx	
RJ	1-27-86	7-15-91	53	Cerebral Pneumonia	0 > '91
MA	4-1-87	3-24-91	51	CMV Retinopathy Tracheal Inf.	> 90
BR	6-15-87	7-26-91	51	Dementia, Pneumonia	Poor

SURVIVAL SUMMARY IN MONTHS

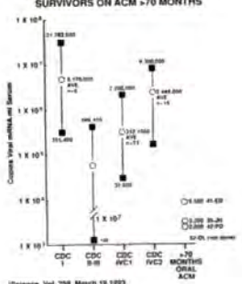
MINIMUM - 3 MAXIMUM - 87 AVERAGE - 51.5

PROFILES OF LONG-TERM SURVIVORS

PATIENT I.D.	CD4	CD8	HGB	WBC	PLATELETS	SMAC	ACTIVITY
#35 JH	360	1,140	13.6	3,900	191,000	NSA**	100% Employed
#41 ED	60*	990	14.5	3,700	100,000	NSA	100% Employed
#42 PD	486	1,030	14.8	5,100	232,000	NSA	100% Employed
#52 DL	370	900	14.1	4,600	171,000	NSA	Part-time Job

* Went on AZT 1990 ** No Significant Diagnostic Abnormality

COMPARISON OF 66 CDC-STAGED HIV-1 PATIENT'S SERUM VIRAL mRNA* WITH SURVIVORS ON ACM >70 MONTHS



*Science, Vol. 258, March 19,1993

CONCLUSIONS

1. In compliant patients: ACM stabilizes CD4 lymphocyte counts, increases CD8 counts and induces a relatively low viral mRNA level over an extended treatment period.
2. Long-term survivors acquired a high circulating monocyte/macrophage population in peripheral blood.
3. Long-term survivors had weight loss and anergy for skin test antigens restored.
4. Energy, symptoms and incidence of AIDS associated opportunistic infections were improved.
5. ACM has demonstrated a very low oral and injectable toxicity profile in multiple animal and human FDA criterion protocol studies.
6. ACM has systemic adjuvant activity and may enhance antibody production when used with HIV-1 vaccines.
7. ACM has the potential of being relatively low in cost compared to other past and proposed therapeutic agents.
8. ACM improved quality of life, employability, immune status and general health.

A RANDOMIZED PLACEBO-CONTROLLED TRIAL OF ORAL ACEMANNAN AS AN ADJUNCTIVE TO ANTI-RETROVIRAL THERAPY IN ADVANCED HIV DISEASE.

Joel Singer, J Gill, R Arseneau, B McLean, J Raboud, J Ruedy, and JSG Montaner.
Canadian HIV Trials Network. CANADA.

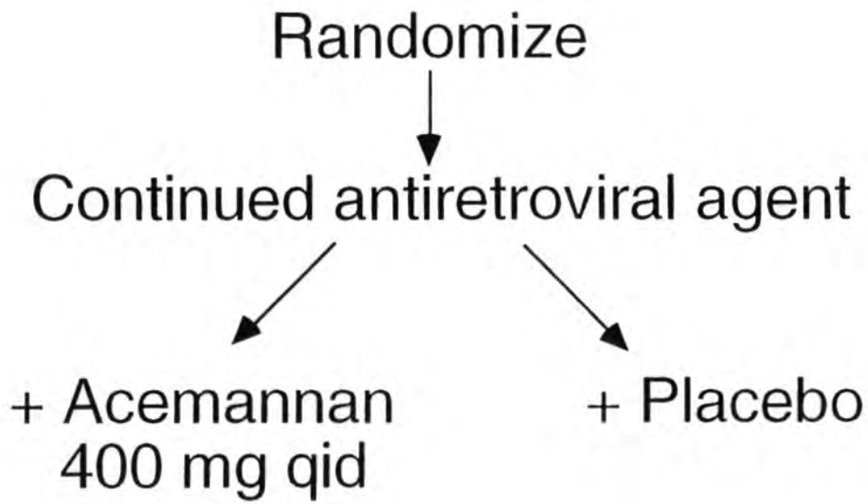
Objective: To assess safety and CD4 count effect of acemannan as adjunctive to antiretroviral therapy (AZT or ddI).
Methods: This was a randomized, double blind, placebo controlled trial of acemannan (400 mg PO QID). Eligible patients had CD4 counts of 50 to 300/mm3 (x2) within 1 month of entry and had received ≥ 6 months of antiretrovirals, at a stable dose for the month prior to entry. CD4 counts were done every 4 weeks for 48 weeks. P24 atg was measured at entry and every 12 weeks thereafter. Quantitative viral cultures were similarly done in a subset of patients. AZT pharmacokinetics were assessed at baseline, 4 and 24 weeks.
Results: Sixty-two patients were randomized; they were all males; mean age was 39; mean baseline CD4's were 165/mm3 and 144/mm3 in the placebo and acemannan groups, respectively; 90% were on AZT at entry (30% were later switched to ddI). 10 patients on each arm discontinued study therapy prematurely, none due to serious adverse reactions. 7 patients in the acemannan and 5 in the placebo group, respectively, developed AIDS-defining illnesses. There was no difference between groups in CD4's at 48 weeks. Among AZT treated patients, median rate of CD4 change (ΔCD4) over the initial 16 weeks was -121 and -120 cells/year in the acemannan and placebo group, respectively (p=.45); ΔCD4 from week 16 to 48 was 0 and -65 cells/year in the acemannan and placebo groups (p=.04), respectively. There was no statistical difference between groups with regard to adverse events, p24 atg, quantitative virology or pharmacokinetics.
Conclusions: Our results demonstrate that, at the dose tested, acemannan is well tolerated and has no pharmacokinetic interaction with AZT. Although the rate of decline of helper cell count from 16 to 48 weeks favoured the acemannan group, there was no difference between groups in helper cell count at 48 weeks. Acemannan showed no significant effect on p24 atg and quantitative virology.

Background

Acemannan, a complex carbohydrate:

- stimulates interleukin-1 (IL-1) and enhances T cell function.
- reduces the amount of detectable HIV-1-specific RNA in vitro.
- is effective in the treatment of cats with feline leukemia virus.
- had no toxicity in normal, healthy males when given orally in high doses
- showed possible beneficial effects on CD4 counts in a pilot study with HIV/AIDS patients

Design:



TREATMENT AND FOLLOWUP FOR 48 WEEKS
CD4 counts every 4 weeks
P24 antigen every 12 weeks

Objective

- To determine the effect of adjunctive therapy with Acemannan on CD4 counts.
- To explore the potential effect of Acemannan on other commonly used surrogate markers such as P24 antigen.

Baseline Characteristics

	Placebo (N=33)	Acemannan (N=30)
Age *	39	41
Gender (Male %)	100%	100%
Homosexual Men (%)	94%	90%
AIDS (%)	27%	17%
Prior AZT/ddI (mo.)*	16	16
CD4/mm^3 *	165	147
Karnofsky *	88	87

*Mean

SUMMARY OF ANTIRETROVIRAL TREATMENT

	Number of Patients	
	Placebo	Acemannan
Patient on ddI at enrolment	1	5
Patient switched to ddI during study	9	8
Patient on AZT throughout	23	17
Total	33	30

Premature Discontinuation of Treatment

	Placebo (N=33)	Acemannan (N=30)
Self-withdrawal	10	9
Intercurrent Illness	1	2
Adverse Event	0	2
Total	11	13
Timing of Discontinuation		
<16 Weeks	5	6
>16 Weeks	6	7

THE WHITE HOUSE

WASHINGTON

August 5, 1993

Mr. Charles A. Mazur
321 Shippan Avenue
Stamford, Connecticut 06902

Dear Mr. Mazur:

Congressman Shays has forwarded your recent correspondence to me.

You have certainly done a lot of study about HIV infection and AIDS. You have identified major issues, and are aware of many of the current efforts to combat this disease.

Continued input from concerned citizens is important to my work. I appreciate hearing from you, and wish you well.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc:
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Prepared by:APO:KMGebbie:BR:8/5/93:632-1090:Mazur.ltr

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CONGRESS OF THE UNITED STATE

July 27, 1993

Ms. Kristine Gebbie
White House AIDS Coordinator
738H Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Ms. Gebbie:

RE: Charles A. Mazur
321 Shippan Avenue
Stamford, Connecticut 06902

Enclosed is correspondence from a resident of my district, Mr. Mazur. My constituent has contacted my office concerning his desire to have your office review the information he has compiled related to AIDS.

I understand from Mr. Mazur that he has already forward of copy of this material to First Lady Hilary Clinton.

Your time and attention to Mr. Mazur's correspondence is greatly appreciated.

Sincerely,

Christopher Shays
Member of Congress

CS:kh

Enclosure

Congressman
Christopher Shays
Fourth District Connecticut

Offices
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Bridgeport, CT 06604
579-5870

Government Center
888 Washington Boulevard
Stamford, CT 06901
357-8277

City Hall
125 East Avenue
Norwalk, CT 06851
866-6469

1034 Longworth Building
Washington, DC 20515-0704
202/225-5541

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Washington, DC 20515-0704
202/225-5541

EX LIBRIS et TABULIS

Composed: July 4th 1993
FREEDOM DAY
Final Copy Date - July 7th

TO: Christopher Shays,
Congressman from Connecticut,
"The Constitution State"
Motto - "Qui transtulit, sustinet."

RE: Presentation and Introduction of this letter (or copy) to:
1. Mrs. Hilary Clinton, Presiding First Lady;
2. Attention copy to President Bill Clinton;
3. Attention copy to Christine Biddey; (and)
4. Attention copy to Surgeon General,

under the protections of: National Catholic Patroness, Mary Immaculate; Patroness Queen of Poland, The Blackened Madonna of Czesto-chowa; Virgin of Lourdes; Lady of Fatima, and Lady of Guadalupe, Litanies personified.

Mrs. Clinton, friends, fellow citizens and enemies:

Lend me your ears (and eyes). I come to bury the "Caesars or Czars," not to praise them. I come to exhume the past and expose it to the present for future's sake against those who are responsible for what I have been subjected to, seen and heard.

In these present matters of mine, and now

yours, I am sanely and soberly serious and candid, not "terror-ist," like "them" -- for this country was founded upon certain principles, principals and a Constitution with rights and privileges guaranteed and secured.

I present you with both timely and untimely matters, having done the same with Governor Lowell Weicker of Connecticut through Mr. R. D'Addario, his advisor, this past June, U.S. postage prepaid.

In certain matters, each "man" must be and remain "on island" unto himself, first; Or loose his independence and individuality, respect and esteem. Upon uniting with his own "kinds," they can now grow together in a common bond and consensus becoming a community, city, state, nation or league! "E pluribus unum." I rather prefer -- "Meipse sum inter pluribus atque permaneo." For no pledged allegiance is of any worth unless it is consciously and honestly carried through.

Kindly read, review, reference, discuss, etc. the enclosed/appended papers of my own free doings -- research, findings, facts and conclusions. They are all based on documentary evidences and proofs. They are non-contestable nor controvertible with me, personally and individually.

They are, however, contestible, debatable and

detestible with "those persons" who are of both high and low ranks in a "conspiracy, complicity and collusion," as well as a "probable monopoly racketeering" "under color and guise of law", profiteering at the expense of you, me, and most of our citizens, even the aliens, legal and illegal, but especially now Medicaid programs and their patients.

I am now a medicaid covered person. I refuse to subject my "self" body or soul, to any so-called licensed, professional "expert" or "quack" who fits the preceding paragraph exposition and description. I am now also a handicap, welfare recipient, struggling to maintain myself in the face of all of this and more. Must I now "turncoat" and take any and all advantages due to this? Permit me to introduce first hand experiences as example.

A physician, recently, "only echoing" his "superiors/supervisors," wanted me to re-commence prescriptive BACTRIM/4 times weekly, TID 500 mg (?), as well as, A.Z.T., without first determining:

1. Pre status of my total health in a comparison of present to past.
2. Discussing this with me first, before even suggesting such toxin intake.
3. Ordering and waiting for test results of a more current nature.
4. Asking for my "Informed Opinion and Consent," rather than "ordering" me, etc.

NOTE WELL: I can and will produce and present all pertinent and relevant data and documents to support and prove my "contentions and allegations some of which are herewith appended. I, first of all, wish these my presents to be received as acceptible and considered thoughtfully. Secondly, I would appreciate some honest reaction and response. Finally, I hereby and herewith grant you permission right to access my medical records at St. Joseph's Medical Center, its Family Clinic, its laboratory, etc. (in Stamford, CT) as well as, Stamford Health Department, HIV Antibody Testing Procedures and Results, c/o Mrs. Pam-Wright, R.N., Counselor.

Also, before approaching you, Madame, I have presented these matters to other persons and have received most favorable reaction and response, in the matters of:

I - "AIDS" -- the "epidemic/disease" (?)
II - The "causative" agent of "AIDS" -- HIV-1,2,3,4 OR HTLV-I,II,III,IV OR LAV, etc.
III - "AIDS" as the "listed cause of death," i.e., primary and direct like cancer, heart disease(s), aneurism, etc.
IV - AZT as a (the) drug/chemotherapy treatment either mono- or conjunctive.
V - Costs, especially for AZT per annum per Burroughs Wellcome, Co. estimate -- $8,000-$10,000 per patient; plus other therapies, "medications," "care," "facilities," etc.
VI - Media "terror-ism," panic, chaos, pandemonium coverage of "epidemic" proportions, under guise and pretense of "sim-

-ply reporting "NEWS." "

VII - Government (and "other Organizations") policies, priorities and spending (fund raising) under our past incompetent, un- and mis-informed "really not such know-it-alls" as we were led to believe and accept.

VIII - Present policies, priorities and spending of a "new" administration, which appears to be "refreshing" and "hopeful" in spite of its "inheritance," Mr. President and his Leading Lady.

IX - Effective controls over and "deregulations" of Pharmaceuticals "monopolies" amounting to "gross" exhorbitant billions for one drug alone, (e.g. AZT = RETROVIR) toxic and ineffective as an antiretroviral in humans (as the "probable cause" of thousands of deaths to date).

X - ETC., and more.

I am now even more demanding that D- You and others of kind unite under all of our "just" banners, mottoes and slogans. The truth shall set us free again to regain integrity and honor, world-wide. Otherwise, I shall withdraw, cease and desist if I so choose, and remain my own island.

I have put aside annonimity and confidentiality before you. I stand and demand the truth, the whole truth and nothing but the truth, so help me G-d, Allah, etc.

I am interested in my own economy, welfare,

and security, first. Then, my city, state and nation can follow. I will not sacrifice to or for anyone else at any price unless and until I can fairly and equitably determine need and exigency, under favorable conditions with requisites. (eg. Haiti, Japan, Korea, Russia, etc.)

How about you, my Fair Lady, Mr. President, et al, leading this United States back to our fore?

Please do not even think it of me that I know or understand it all. For so much has been withheld, occluded, obfuscated and mismanaged in these and other matters. No matter! I will continue in pursuit to "exhume" whatever for the sake of the living and in fond memories of the dead.

I also propose, with these presentments, National Policies" changes and revisions for peace, harmony and "security," based on my ideologies, that:

I- The citizenry - taxpayers shall reap the full benefits for which they have sown (been taxed and burdened), by and with our own resources, first. Does not "charity begin at home, first, before it can be shared and spread?

II- Any other person/nation/country in destitute or desperate need of relief shall be justly and equitably heard with all due con-

sideration with fair response. It is better to give than to receive; better yet, to share.

III- Any citizen who, after just and equitable hearing, finding and conclusion on charges of high crimes to disturb the national peace, harmony and security, shall be banished in exile to any other "island" of his own choosing "kind." We will not pay, any longer, for their support in our bloated prisons and "country clubs." The same shall apply to any alien, like it or not -- deportation with full recision of status with rights.

IV- And more, if necessary and demanded. Enough is enough! Toleration is not a solution. Forgive and forget is moot.

Remember and FAIL not that I am a constituent of Stamford, Connecticut State and the United States. You would not be representing me and my interests without votes. We shall survive as an undivided nation with liberty and justice for those who deserve and merit it, only, into a long and prosperous (maybe not profitable) future for ourselves and our followers from and of the dust of this earth.

Respectfully and sincerely submitted,

Karol (Charles) C. A. Mazur
c/o F. J. Mazur
321 Shippan Ave.
Stamford, CT 06902
(OR)

Ms. Barbara Sheridan, M.S.W.
at St. Joseph Med. Center
(203) 353-2294

cc: FILE (Original Retained
B. Sheridan
P. Wright
Sr. Daniel Marie, CEO - SJMC
F. J. Mazur
Gov. Weicker / R. D'Addario
McKinney House of Stamford
et al.

P.S. - Hand written, revised, amended for emphasis. Please excuse any over-sights. Dr. J. Tilden once wrote -- "No greater fool exists than the fool who fools himself." An old Chinese adage translates -- "Better to keep the foot in the mouth than to take it out and remove all doubt." Once said and written -- "The road to hell is paved with good intentions." & revise to -- "Any road to any hell is paved with "good" intentions ruh amiss; and, bad intentions purposefully perpetrated."

In the Almighty we place trust; in His fallible human creation we reserve rights.

So mote it be.

Study questions early use of AZT

Los Angeles Times

BERLIN — For Evan Wilder and thousands of others infected with the virus that causes AIDS, the introduction of the drug AZT six years ago was a godsend, a miraculous compound that, the U.S. government said, might extend their lives if they took it quickly, before they showed any signs of the disease.

"When AZT was made available, I went on it right away," says Wilder, a 33-year-old New York City waiter who is attending the Ninth International Conference on AIDS here. At the time, Wilder had no symptoms of AIDS; his taking of AZT reflected the so-called "early intervention theory" that the government had adopted.

Yesterday, that theory came under attack when a Paris scientist presented details of the longest and largest study ever of AZT in people who have no symptoms of AIDS. The results: Those who took the drug right after becoming infected lived no longer than those who waited until symptoms set in.

The Concorde Study, so named because it was conducted in France, Britain and Ireland, has stirred great controversy here. Its findings, which contradict several earlier American studies and suggest U.S. policy about prescribing AZT may need to be revised, raise fundamental questions about when, and how, people with human immunodeficiency virus, or HIV, should be treated.

The results, presented in preliminary form two months ago, have frightened patients and befuddled doctors trying to make decisions about how to care for them. The study has also generated criticism from those who disagree with it.

"This study has generated so much emotion, so much questioning," Dr. Joep Lange, director of clinical research for the World Health Organization's Global Programme AIDS. "This is not something that is easy to work with for practicing physicians."

Nor is it easy for patients.

"It's hard, as a patient, to read these things in the papers," said Duane Dugger, a San Francisco man who has been infected for more than a decade and is also attending the conference. Although he went off AZT some time ago, Dugger says: "With HIV, a big part of the therapy is the willingness to live, and the trust in the medical research that is going on. And then, you wake up and read all these things are in doubt."

AZT is one of three currently approved "anti-retroviral" drugs that attempt to prevent HIV from replicating inside the nucleus of cells. The two other so-called "nucleoside analogs" are ddI and ddC; researchers are now studying how these drugs work in combination with one another, as well as in combination with other experimental therapies.

Current U.S. guidelines recommend that a patient receive AZT when his or her CD4 cells — the immune system cells that are the main target of AIDS — drop below 500 per cubic millimeter of blood. Later this month, the National Institutes of Health will convene a symposium to address whether the policy should be changed in light of Concorde.

The Concorde results also challenge another basic assumption about AIDS research: that CD4 counts are an accurate way to measure whether drugs are effective. Scientists have long regarded CD4 cells as a good "surrogate marker;" declining counts signaled an immune system in decline, and therefore a drug that did no good.

AIDS ~ A Corrective Update.

To: The Advocate (Stamford) and all other media & the public

(note: Underlining and/or capitalization is by the writer for emphasis)

When is the media going to stop promoting lies by printing them under the guise of simply reporting "news" to the public?

On Wednesday June 9, 1993 in an article ~ "Study Questions Early Use of AZT" in the Stamford Advocate ~ the opening paragraph reads:

Los Angeles Times

BERLIN — For Evan Wilder and thousands of others infected with the virus that causes AIDS, the introduction of the drug AZT six years ago was a godsend, a miraculous compound that, the U.S. government said, might extend their lives if they took it quickly, before they showed any signs of the disease.

First of all, AIDS is not, can not, nor should not be called a DISEASE! ~ like tuberculosis, cancer, diabetes, osteoporosis, arteriosclerotic heart, HIV, leukemia, leukocytopenia, lymphocytopenia, etc. "AIDS" is a result/effect ~ not the cause ~ of immune system suppression/breakdown.

The "S" in the acronym stands for SYNDROME, not "disease". Anyone having a subnormal count of white cor-

puscles (cells) ~ fewer than 5,000 per cubic millimeter ~ has leukocytopenia and/or lymphocytopenia (now called AIDS). These are diseases that are indicative of Immune Deficiency Syndrome (IDS) and breakdown.

Acute, ACTIVE HIV infection causes Human Immuno-suppressing Disease (HID) which further breaks down an already suppressed immune system leaving it, and the body, open and defenseless to secondary and opportunistic diseases (Kaposi's sarcoma (KS), Pneumocystis Carinii Pneumonia (PCP), as well as neurological dysfunction, etc.

Acquired Immune Deficiency Syndrome IS NOT caused by HIV, (HTLV) ~ human T-Cell lymphotrophic virus, (LAV) ~ lymphadenopathy associated virus, (ARC) ~ aids related complex.

The word "ACQUIRED", in AIDS does mean ~ "get, come down with, receive" ~ from both externally generated [exogenous] and internally generated [endogenous] sources. Simply put AIDS can result from outside-the-body sources, as well as autogenous, self-induced. HIV cannot survive long outside of the body fluids; nor can it survive an attack of a healthy, unsuppressed immune system. We only get "sick" when we go into a progressive toxemia. And when this toxemia is not eliminated and relieved by the body and its systems, the immune

system begins to self-destruct. Eliminating these accumulated and stored up toxins eliminates the "sickness".

Now, look again at the opening paragraph. How many "thousands of others," who were immuno-deficient patients took AZT and died anyway? How many of them were immuno-suppressed/deficient prior to being "infected" with HIV? Did they die as a result of AZT being ineffective and toxic? Were their doctors properly and professionally counseling, warning, and testing them clinically in regards to AZT - a drug-chemotherapy? Read for yourself, especially note last 3 paras.

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Is AZT [azidothymidine, a.k.a., zidovudine; brand name ~ RETROVIR] made by **BURROUGHS WELLCOME COMPANY**, who estimated that the annual treatment costs would be $8,000.00 to $10,000.00 per patient,

- is this DRUG an effective antiretroviral therapy/treatment against HIV in humans?
- is this drug safe?
- is this drug "a godsend"?
- is this drug "a miraculous compound"?
- does this drug prolong/extend lives per U.S. government claim?

YOU DECIDE!

- The frequency and severity of adverse events associated with the use of AZT in adults are greater in patients with more advanced HIV infection at the time of initiation of therapy.
- Severe headaches, nausea, insomnia and myalgia have been reported at a significantly greater rate in AZT recipients.
- Other reported adverse events caused reactions in the body as a whole, plus some specifics in cardiovascular, gastrointestinal, musculoskeletal, nervous, respiratory, skin, special senses, and urogenital systems of the body.

- Therapy with AZT may cause hematologic (blood) toxicity including granulocytopenia and severe anemia requiring transfusions.

- Patients may also continue to develop opportunistic infections and other complications.

- Whether AZT is an effective inhibitor of HIV in man has not been established.

- Current methods used to (test) establish virologic responses to AZT therapy may be relatively insensitive in detecting changes in the quantities of actively replicating HIV or reactivation of these viruses.

- The development of resistance to AZT has not been adequately studied and the frequency of ~~AZT resistant~~ AZT resistant isolates existing in the general population is unknown.

- The quantitative relationships between IN VITRO (test-tube) susceptibility of HIV to AZT and the clinical response to AZT therapy has not been established.

- Studies of the development of resistance to AZT are incomplete and the frequency and degree of changes in IN VITRO

sensitivity of virus isolates from HIV infected patients with differing severity of immune compromise are unknown.

- AZT is cytotoxic.

- AZT is toxic to bone marrow, in humans.

- In one test of AZT therapy for adults with HIV infection, but showing no symptoms of HIV disease (or AIDS), virtually all patients, for whom data were available, experienced a decline in CD_4 cell counts from 500 to less than 200 per cubic millimeter, before developing an AIDS-defining opportunistic infection.
  This study was terminated early because of a statistically significant difference in progression from asymptomatic to advanced symptomatic disease between the AZT and the placebo groups.

- It is not known whether early treatment prolongs lives.

- Patients who receive too much (high) dosage, more often develop the toxicities of anemia, granulocytopenia and bone marrow.

- Long term effects of AZT are unknown.

WOULD YOU TAKE THIS DRUG?

Death, when it comes, is blamed upon AIDS, which is false. AIDS is an effect not a cause. AIDS did not cause death. AIDS is the "syndrome/condition" the body finds itself in when it (the body) has destroyed its own ~~body~~ immune system by endogenous toxemia or has been destroyed by exogenous toxemia due to chemicals and or drugs; whether they are legal or illegal makes no difference, the result is the same.

In a letter to the editor of "INSIGHT" magazine (Aug. 1986) written by Dr. Stephen S. Chiazza, who was Chairman of the New York Committee of Concerned Physicians, said:

> "AIDS is becoming big business, involving billions of dollars in potential profits for the biomedical industry..."
>
> "Due to the limited and extremely difficult manner in which it is transmitted, AIDS is fundamentally a disease of behavior. With proper health policies at all levels, sound education of All Americans and appropriate individual responsibility, AIDS, is essentially 100% preventable."

I add and conclude: The Syndrome (AIDS) and HIV infection and "disease" are preventable and reversible with proper care.

detoxing the body, using biological, not-pharmaceutically toxic, medicine as the natural method(s) of treating illness and disease rather than isolated symptoms of the disease.

Researched and submitted,
C.A. Mazur 6-13-93

cc. Stanford Health Dept.
c/o Pam Wright, AIDS Counselor

St. Joseph's Medical Center
c/o Barbara Sheridan, M.S.W.

Various other organizations and people involved with helping diagnosed patients.

P.S.~ AIDS is big business. It involves billions of dollars in potential profits for the biomedical industry [et al.] Have we already reached ~~that~~ irrevocable time? Do we "need" AIDS and cannot do without because it is too "essential" to the earnings of too many companies? How many tax dollars are still propagating this?

CYTOTOXICS Drugs that kill or damage cells. Cytotoxics are used as ANTINEOPLASTICS (drugs used to treat cancer) and also as IMMUNOSUPPRESSIVES. They are taken as tablets or given by injection, and several cytotoxics with different types of action may be used in combination. Possible side-effects: nausea, vomiting, loss of hair. Because cytotoxic drug action can affect healthy as well as cancerous cells, these medications may also have more dangerous side-effects. For example, they can damage bone marrow and affect the production of blood cells, causing anemia, increased susceptibility to infection, and hemorrhage. Therefore, frequent blood counts are recommended for anyone who is having such treatment.

Drugs and their effects

A drug can be defined as any non-nutritional chemical substance that can be absorbed into the body. The word "drug" is commonly used to mean either a medicine or something taken (usually voluntarily) to produce a temporary (usually pleasurable) effect. Sometimes, the two categories overlap. Morphine may be prescribed as a medical treatment for relief of pain. Self-administered by an otherwise healthy person, it gives a temporary sense of well-being. Some drugs, including morphine, are strongly addictive and harmful. Such apparently innocent substances as tea and coffee may be addictive (more accurately the caffeine that they provide is addictive) and also capable of harming some people.

All non-medical use of drugs carries an element of risk in pregnant women and should be avoided if possible for the health of mother and child.

Type of drug	What it does	Outward signs of use	Some long
Amphetamines, often called "pep pills," uppers, or diet pills.	Speeds up physical and mental processes, produces extreme energy and unusual excitement.	Weight loss, dilated pupils, insomnia, diarrhea, tremoling.	Paranoia and Possible deat
Barbiturates, often called downers.	Produces extreme lethargy and drowsiness.	Blurred and confused speech, lack of coordination and balance.	Disruption of pattern; dang ion; possible d dose, especia with alcohol. (jection site.
Cannabis, including marijuana and hashish, often called pot, grass and hash.	Relaxes the mind and body, heightens perception, and causes mood swings.	Red eyes, dilated pupils, lack of physical coordination, lethargy, sometimes obvious nausea.	Long-term phy clude brain, he reproductive s Decreased mo
Cocaine, often called coke or snow.	Stimulates nervous system and produces heightened sensations and sometimes hallucinations.	Dilated pupils, tremoling, apparent intoxication, agitation.	Ulceration of n drug is "sniffec itching, which open sores, dar heart and lungs
Opiates, including opium, morphine, heroin and methadone as well as synthetic painkillers.	Relieves physical and mental pain, and produces temporary euphoria.	Weight loss, lethargy, mood swings, sweating, slurred speech, sore eyes.	Loss of appetite nutrition; extrer to infection; abs in women; poss overdose.
Psychedelic drugs, including lysergic acid (LSD) and mescaline, as well as "designer drugs," such as MDMA, chemically fabricated for purposes of abuse.	Unpredictable. Usually produces hallucinations, which may be pleasant or frightening.	Dilated pupils, sweating, trembling, sometimes fever and chills.	Possible irrespo although apparer tive, a single druc may cause long-t cal upset.
Volatile substances such as inhaled fumes of glue, cleaning fluids, etc.	Produces hallucinations, giddiness, temporary euphoria, and sometimes unconsciousness.	Obvious confusion, dilated pupils, flushed face.	Risk of brain, liver age; possible sud halation.

Immunodeficiency

An immunodeficiency is a decrease in your body's immune defenses. There are two general types of immunodeficiency. In one, there is an inadequate production of antibodies (substances that protect your body from infectious diseases), in response to a previous infection or an immunization. This may affect only one type of antibody, or several at once. Because of this immunodeficiency, your resistance to some kinds of infection, especially bacterial, is decreased.

The second type of immunodeficiency results from disorders of, or decreased numbers of, the various kinds of lymphocytes. These are white blood cells from the bone marrow and the lymph glands. In this form of the disorder, the ability of the lymphocytes in your bloodstream to gather around and kill invading organisms is decreased. As a result, your resistance to infections caused by fungi, certain viruses, and the organisms that cause tuberculosis is impaired. It is possible to have both general types of immunodeficiency at the same time.

There are many types of inherited defects of the immune system. If you are born with one of these you are susceptible to certain types of infections. Many diseases also impair the functioning of the immune system. These diseases include the leukemias (see p.433), the lymphomas (see previous page, and Hodgkin's disease, see previous article), cancer in general, diabetes mellitus (see p.529) and uremia. Finally, some drugs that are used to treat many disorders, especially steroids, and cytotoxic (anticancer) drugs, and also radiation therapy, can significantly affect your immune system.

What is the treatment?

If you have an inherited deficiency of antibody production, injections of antibodies collected from other persons may be helpful. This treatment must be repeated every few weeks. If you have certain types of inherited deficiencies of lymphocytes, transplantation of tissue from the thymus, a small gland in the neck, offers some hope. This still highly experimental treatment is based on the thymus gland's influence on certain lymphocytes. Another possible treatment is long-term antibiotic therapy. For most people with an immunodeficiency, however, there is no specific treatment, and you must be careful to avoid infection and be sure to get immediate treatment if you do become ill.

INTERNATIONAL DICTIONARY of MEDICINE & BIOLOGY
3 VOLS.
1986

syndrome V S. disease

syndrome [Gk *syndromē* (from SYN- + Gk *dromos* a running, course, from *dramein*, 2nd aorist inf. of *trechein* to run) a running together, concourse of people] The aggregate of signs and symptoms considered to constitute the characteristics of a morbid entity: used especially when the cause of the condition is unknown. Also called *symptom complex*. • The term *syndrome* is variously used in medicine. It is sometimes argued that its scientific use should be restricted to describe only those conditions whose causes are either unknown or diverse, but this principle is widely contravened. Nevertheless, *syndrome* is more commonly applied than *disease* to any postulated morbid entity whose characteristics are not well established. However, many conditions to which *syndrome* was originally applied because of this consideration have now been systematically studied and their characteristics established, yet because the original term is still familiar to many, *syndrome* often continues in widespread use in defiance of the injunction that a distinction between *disease* and *syndrome* be made. Terms known by various designations are listed in this dictionary under the form that predominates in actual usage. For particular syndromes not found under *syndrome*, see also under DISEASE.

disease [Middle English *disese* sickness, discomfort, from Old French *desaise* (from *des-* DIS-[1] + *aise* ease, from L *adjacens* lying close) discomfort] A condition which alters or interferes with the normal state of an organism and is usually characterized by the abnormal functioning of one or more of the host's systems, parts, or organs. It may be due to an unknown cause or may result from an inherent metabolic or structural deficiency, including congenital and hereditary defects and degenerative processes, or from such factors as stress, noxious stimuli, toxic agents, injury, or infection. A given disease is often manifested by a characteristic set of signs and symptoms, although a host organism can be asymptomatic while having microscopic, serologic, or immunologic evidence of disease. • *Disease* is usually distinguished from *injury*, the disruption of an organism's integrity, especially by an external agent, and often from *syndrome*, a complex of symptoms descriptive of a disorder, especially a particular combination of phenotypic manifestations. See also note at SYNDROME. For particular disease entities not found under *disease*, see also under SYNDROME.

acquired Developed and manifested after birth; not congenital.

acquired immune deficiency syndrome An immunodeficiency occurring epidemically worldwide which in the United States principally affects young, previously healthy homosexual men and, less frequently, parenteral drug abusers, recipients of blood products (such as hemophiliacs), prisoners, prostitutes, some Haitian immigrants, and close contacts of affected patients, particularly sexual partners or children. The condition renders patients susceptible to multiple opportunistic infections with pathogens such as *Pneumocystis carinii*, herpes simplex virus, cytomegalovirus, typical and atypical mycobacteria, various fungi, *Toxoplasma gondii*, and cryptosporidia; to a virulent form of Kaposi sarcoma; to a diffuse, undifferentiated non-Hodgkins lymphoma; and to central nervous system deterioration. Prodromal states (sometimes called the lymphadenopathy syndrome, AIDS-related complex, or pre-AIDS) have been reported, lasting many months and often characterized by chronic fever, diarrhea, weight loss, and lymphadenopathy. Affected patients have profoundly depleted levels of helper T lymphocytes and reduced ratios of helper to suppressor T lymphocytes. The condition has a high mortality, because even if the initial infections or tumors are treated successfully, the underlying immunodeficiency remains and is not reversible. Its etiological agent is a retrovirus, called human T cell leukemia/lymphoma virus-3 (HTLV-3) which infects and causes premature lysis of T cells of the T_4 subset, and may cause functional defects in B lymphocytes, natural killer cells, and cytotoxic T cells. The virus is transmitted by intimate contact or blood transfusion and is present in bodily fluids (semen, blood cells, plasma, saliva, and probably mother's milk) of infected persons. It may be capable of remaining latent in the body for long periods. The syndrome was first recognized in the United States in 1979 but appears to have existed earlier in parts of equatorial Africa. Also called *acquired cellular immunodeficiency syndrome*, *gay immunodeficiency syndrome* (outmoded), *gay immunocompromise syndrome* (outmoded). Abbreviation: AIDS.

VIRION
(aka. VIRUS)
POISON — TOXIN

DNA VIRUS (AKA. VIRIDAE)

RNA VIRUS (AKA RETROVIR

RETROVIRUS

virus

virus [L (akin to Sanskrit *visha* poison and Gk *ios* poison, esp. of serpents), a slimy or poisonous liquid, poison, venom] **1** Any of a number of small, obligatory intracellular parasites with a single type of nucleic acid, either DNA or RNA, and no cell wall. The nucleic acid is enclosed in a structure called a capsid, which is composed of repeating protein subunits called capsomeres, with or without a lipid envelope. The complete infectious virus particle, called a virion, lacks ribosomes or any means of generating adenosine triphosphate and consequently must rely on the metabolism of the cell it infects. Viruses are morphologically heterogeneous, occurring as spherical, filamentous, polyhedral, or pleomorphic particles. They are classified by the host infected (animal, plant, or protist), the type of nucleic acid, the symmetry of the capsid, and the presence or absence of an envelope. **2** Any contagium or infective agent, especially one that is not identifiable as a bacterium or other full-fledged organism. An outmoded usage. See also FILTRABLE VIRUS.

virus III of rabbits A DNA-containing virus belonging to the Herpetoviridae family which infects rabbits but not man.

2060 virus An early designation for rhinovirus type 1A, one of the first common cold viruses to be discovered.

viroid [*vir(us)* + -OID] An infectious agent consisting solely of nucleic acid without any capsid structure or virus particles. The prototype viroid, or pathogenic RNA, is potato spindle tuber viroid. Its molecular weight is about 130 000. Viroids usually reside in the nucleus of an infected cell, where they function as abnormal regulatory molecules, although they do not code for specific proteins. Viroid replication apparently involves reliance on the host cell's enzyme system. A helper virus is not required. About a dozen different viroids have been identified since 1971, each of which causes a particular disease of a higher plant. Compare PRION.

virulent Characterized by a relatively high degree of virulence.

virulence The pathogenicity or disease-producing capacity of any infectious agent.

virucide [*viru(s)* + -CIDE] A material that inactivates a virus on direct contact. Also called *viricide.*

simian virus Any of the viruses isolated from monkeys and serially numbered, though they belong to many different families. Abbreviation: SV

simian virus 40 An oncogenic polyomavirus originally discovered in apparently normal cultures of monkey kidney cells. It is frequently used as a model for studies in molecular biology. Also called *simian vacuolating virus, SV40 virus, vacuolating virus.* Abbreviation: SV40

serum hepatitis virus An outmoded term for HEPATITIS B VIRUS.

DNE

Retroviridae [RETRO- + *vir(us)* + -IDAE] A family of pleomorphic, membrane-bound, single-stranded RNA viruses which possess a virion-associated, RNA-dependent DNA polymerase. The virion-associated enzyme synthesizes DNA from an RNA template, which is the reverse of the usual, DNA-to-RNA, transcription. The family contains such viruses as the murine leukosis viruses, the Rous sarcoma virus, visna virus, and the foamy viruses.

retrovirus A virus belonging to the Retroviridae family.

human lymphotrophic retroviruses Any of three viruses belonging to the oncovirus subgroup of the family Retroviridae. See under HUMAN T CELL LEUKEMIA/LYMPHOMA VIRUS. Abbreviation: HTLV

oncovirus [ONCO-[1] + VIRUS] Any of various tumor-producing viruses of the Retroviridae family. They are grouped into three genera or types. Type B includes mouse mammary tumor viruses. Type C viruses produce leukemias and sarcomas in various birds, mammals, and reptiles. Type D viruses produce tumors in primates. Also called *oncornavirus.*

-oncus [New L (from Gk *onkos* mass, bulk)] A combining form meaning a tumor, mass.

oncoma [ONCO-[1] + -OMA] NEOPLASM.

oncology [ONCO-[1] + -LOGY] The study of tumors.

oncotropic Having an affinity for neoplastic cells.

clinical oncology The study of tumors in human patients, particularly in relation to therapy.

experimental oncology The study of tumors by laboratory experiments, particularly in laboratory animals.

oncolysis [ONCO-[1] + LYSIS] Destruction of tumors or tumor cells.

oncolytic [ONCO-[1] + LYTIC] Able to destroy tumors or tumor cells.

virocyte ATYPICAL LYMPHOCYTE.

parasite [L *parasitus* (from Gk *parasitos* one who lives at another's table, a parasite, from PARA- + Gk *sitos* grain, wheat, food) a guest, parasite] **1** An animal, plant, or microbe that lives within or on another organism, the host, and depends upon it for energy or sustenance. **2** The less complete or smaller of conjoined twins, which is dependent on the larger or more normal member (the autosite).

intracellular parasite Any parasitic organism that can grow or sustain itself, usually with multiplication, within a host eukaryotic cell. Examples are chlamydiae, rickettsiae, tubercle bacilli, leishmaniae, toxoplasmas, even some multicellular parasites such as certain larval filarial worms developing in their insect vector. Also called *cytozoic parasite.*

obligate parasite A parasite that cannot live independently of its host. Also called *onligatory parasite.* Compare FACULTATIVE PARASITE.

pathogenic parasite A parasite that causes disease in the host.

"ANALYSIS of → AIDS (acquired immune deficiency syndrome)

by paras.#

1. AIDS is an acronym that sprang from and was known formerly as: gay immunocompromise syndrome, gay immunodeficiency syndrome, acquired cellular immunodeficiency syndrome, Aids related complex (ARC), Aids related virus (ARV), etc. ad-nauseam.

— AIDS is not, therefore, a disease but a syndrome, complexed and compromised.

— A person with AIDS is not necessarily infected with HTLV-III, -II, or -I, and, therefore, could test antibody-negative.

1 AIDS, or acquired immune deficiency syndrome, is a disease in which some of the body's white blood cells (lymphocytes) are destroyed and, consequently, the body's natural defense system is impaired. A person with AIDS has a lowered resistance to certain infections and diseases.

2 AIDS is caused by a virus known as the human T cell lymphotropic virus III (HTLV III), and was first recognized in 1981 in the United States. Research has since shown, however, that cases of AIDS have been occurring here since 1979, and that the disease seems to have been present in parts of Africa and possibly the Caribbean for much longer. By 1987, approximately 25,000 Americans had been diagnosed as having AIDS, and several thousand cases had also been reported in Europe, Australia, and Asia.

3 The AIDS virus destroys one type of lymphocyte, known as the T4, or helper cell. A person who is infected by the AIDS virus is susceptible to certain infections and cancers that helper cells normally protect against. These include lung infections, such as pneumonia caused by *Pneumocystis carinii* (see p.365); infections that result in swollen lymph glands, fever, and often encephalitis; and various forms of cancer, most commonly a rare type of skin cancer known as Kaposi's sarcoma.

4 A person infected with the AIDS virus may never develop any symptoms and may simply carry the virus for his or her lifetime. A carrier of the virus may, however, develop one of the AIDS-associated diseases, which result in swollen lymph glands and a high temperature. At this early stage of the disease the body's level of immunity remains normal. If the condition develops further, the helper cells are destroyed and the person has low immunity to a wide range of potentially more serious diseases.

5 AIDS is primarily a sexually transmitted disease, and it is more prevalent in homosexual than in heterosexual communities. It may be spread by both conventional and anal sex. It is also possible for the AIDS virus to be transmitted to a woman during artificial insemination, if the semen introduced into her is infected, and to the unborn child during pregnancy.

6 However, AIDS is not always acquired sexually. As with some other viruses, notably hepatitis B (see p.494), the disease can be transmitted via the blood. Therefore, it is possible for a person infected with the disease to spread it by means of a razor, syringe or any other such item that has come in contact with his or her blood.

7 The HTLV III virus may be transmitted by means of blood transfusions using blood given by donors infected with the virus. People at special risk in the early history of AIDS included hemophiliacs (who need regular transfusions of blood products), and patients undergoing surgery that entailed transfusions of large volumes of blood. But by the end of 1985, most Western countries had introduced screening tests to discover whether the blood of prospective donors contained the HTLV III virus, and this screening resulted in a substantial reduction in the risk to a patient of acquiring the disease by transfusion.

8 AIDS is not spread by ordinary social contact such as sharing the same house, working alongside, nursing, or kissing a carrier of the disease.

9 *What are the symptoms?*

Anyone who becomes infected with the HTLV III virus may remain in apparent normal health for several years. If a carrier of the virus develops AIDS, symptoms include fever, weight loss, swollen glands, weakness, headaches, drowsiness, confusion and chest, skin or mouth infections.

10 *What are the risks?*

In spite of treatment with antibiotic and antiviral drugs, patients with AIDS have so far followed a pattern of repeated infections, progressive loss of weight, general weakness and eventual death.

11 *What should be done?*

If you think that you may be infected with the AIDS virus, a blood test can be carried out by your physician to determine whether or not you are infected. Within a few weeks of infection your body develops antibodies to the virus and these are detectable in the blood. The condition in which a person who has AIDS antibodies in the blood is said to be antibody positive. However, before deciding to have a blood test, you should get advice from a counselor, since a positive test result may have profound psychological effects.

12 *What is the treatment?*

Pneumonia and other infections characteristic of AIDS respond to treatment with antibiotic and antiviral drugs. Treatments that may correct the underlying defect in the lymphocytes are currently under investigation, but their value can only be assessed after their long-term use. Research is continuing into the development of vaccines and antiviral drugs to combat AIDS but no breakthrough has yet been made.

— any person who is immunodeficient or immunosuppressed (lowered resistance) is susceptible to infections caused by body "Acquisition" of: ① DNA Virus, or/and ② RNA Virus (retrovirus-HIV[1,2,3]) ③ a bacterium, ④ a parasite (viral + non-viral) or a fungus. These may be complexed and/or compromised in any Immune Deficiency Syndrome, (IDS) of the human types.

2. AIDS is not caused SINGULARLY (solely) by HTLV-III (refer back to "notes on HTLV-I, II, + III. AIDS is the result of the body's system(S) being compromised (poisoned) resulting in a complex of infection(s)/disease(s) resulting in any Deficiency Syndrome, as well as Identifiable Deficiency Diseases such as: anemia's, leukemias, lymphomas, mineral and vitamin, etc.

— This paragraph states: "and was first recognized in 1981 in the U.S." ~ The International Dictionary of Medicine + Biology states: "identified in 1984 as THE probable agent (etiological) of AIDS." (see - notes + article on HTLV-III)

Also note, "A similar virus (LAV) has been isolated from persons with AIDS in France and is probably (?) identical to (U.S.A's) HTLV-3." — A SIMILAR cannot be IDENTICAL at the same time.

— IDS, in Africa, resulted from MALNUTRITION (Vitamin + mineral deficiencies) due to starvation resulting from famine, which then resulted in Immune Suppression (complexing the auto-I.S. by drug/chemical therapies for the treatment of other infections/diseases, combined with compromising the already difficient/suppressed I.S.) result in a "syndrome" UNILATERALLY called AIDS without showing exposure/infection/anti-body tests results to any specific HIV, either I, II, or III. (Ref to notes on this).

ANALYSIS of AIDS (cont'd.)

para 2
"the Caribbean" ~ i.e, Haitian. Persistant and long term use of drug therapies in Haiti amounted to LEGAL DRUG ABUSE, not only for infections/diseases, but also for birth control which suppressed I.S.'s, compromised by other resulting infections/diseases, and in some cases, complexed by illegal drug abuse resulting in further suppression as well as nutritional deficiencies and highly unsanitary living conditions, particularly in large urban population areas, resulting in AIDS. BUT, how many of these people were exposed/infected/tested for antibody presence? How many were diagnosed with "AIDS" and further put on more drug therapies with - ① Bactrim ② Zovirax ③ Interferon AND/OR AZT, etc.?

All of the above, and more, points to an accumulation of severe toxemias resulting in a "syndrome" of severe systemic sepsis, which the American Medical Association in conjunction with Centers for Disease Control (AMA + CDC, et al.) now are calling AIDS a disease, while making the "culprit" HIV! ~ calling it the AIDS-VIRUS! Totally preposterous, haughtily presumptuous, and damagingly prejudicial.

etc., etc. BS → PhD. → M.D. etc.

para 3 - The "AID VIRUS" (unknown, non-specified) is not the only "cause" of T-DC$_4$ cells. What about the T-CD$_8$'s?
- "normally" should read "naturally"
-

ANALYSIS of AIDS (cont'd)

- An uninfected person (HIV-positive) is IV no "more" "susceptible" than any other who is even "HIV-Neg" having abnormal CBC & DIFF + Flow Cytometry (ABS).
- Kaposi's Sarcome is prevalent in some parts of Africa.

para 4. - "may simply carry" = encapsulated for reactivation (due to? caused by?) I.S. deficiency/disease/infection/reactivation/suppression, etc.
- A non-carrier could develop the same "AIDS-"ass"ociated diseases."

para 5. - "AIDS" is NOT a "sexually" transmitted "disease."
- "Communities" like what? Large urban or small rural. ARE N.Y., Miami, S.F., etc. "homosexual communites?" are N.Y.S., FLA., CALIF., CONN., etc. "homosexual STATES?" etc.
- IF, SEMEN introduction (even artificially) into M or F is "transmissible" I want a test of my ① semen, ③ Sputum ② Urine, etc. for the presence of HTLV-I, II, III !!! No more Anti-Body froma "jack-offs."

para. 6 - Quet look at Sent. #1.
- Now look at #2 - Admits "Hepatitis B" can also be transmitted by the blood." How about by semen, saliva, etc. ??

para. 7 - "may (?) be (not IS) transmitted by blood."

para 8 - IF, HIV is found in sputum AS CLAIMED FRENCH (DEEP THROAT) kissing ought to be a transmission !!

SORRY:

ENOUGH IS ENOUGH - Don't you think so? I have left this absurdity go on too long without continuing to speak.

human T cell leukemia/lymphoma virus-1 A virus belonging to the oncovirus subgroup of the family Retroviridae, closely associated with human T cell malignancies. It is an enveloped virus 80–110 nm in diameter which contains a 9-kilobase RNA genome, reverse transcriptase, and no oncogene. The virus apparently requires intimate person-to-person contact for transmission and is highly lymphotrophic, infecting primarily T lymphocytes of the T_4 subset and also, in some persons, transforming B cells. Endemic in some regions of Africa, the Caribbean basin countries, southern Japan, and the southeastern United States, the virus causes T cell leukemias and lymphomas which can be rapidly fatal and which are often manifested by lesions of the skin and bones. Abbreviation: HTLV-1

human T cell leukemia/lymphoma virus-2 A virus belonging to the oncovirus subgroup of the family Retroviridae, possibly associated with leukemic reticuloendotheliosis. Like other lymphotropic retroviruses (particularly HTLV-1 and HTLV-3), it is an enveloped virus 80–110 nm in diameter which contains an RNA genome, reverse transcriptase, and no oncogene. Little is known about this virus other than its basic structural features. Abbreviation: HTLV-2

human T cell leukemia/lymphoma virus-3 A virus belonging to the oncovirus subgroup of the family Retroviridae, identified in 1984 as the probable etiologic agent of acquired immune deficiency syndrome (AIDS). Related to and sharing features with human T cell leukemia/lymphoma viruses 1 and 2 (HTLV-1 and HTLV-2, also called human lymphotrophic retroviruses), HTVL-3 is an enveloped virus 80–110 nm in diameter with a characteristic bar-shaped tubular core containing a dimeric, 10-kilobase RNA genome and reverse transcriptase. HTLV-3 is highly lymphotrophic, infecting the T_4 subset of T cells, and strongly cytopathic, causing premature death of the infected T_4 cells. The virus or its precursor may have originated in Africa. HTLV-3 has spread rapidly throughout the world since the late 1970s. The virus is transmitted from person to person via intimate contact and blood transfusions, and is present in the bodily fluids (semen, blood cells, blood plasma, saliva, and possibly mother's milk) of infected persons. The exact mechanism of transmission by intimate contact is not known. It is not known what determines which individuals are susceptible to infection and expression of disease. A similar virus (lymphadenopathy-associated virus, or LAV) has been isolated from persons with AIDS in France and is probably identical to HTLV-3. Abbreviation: HTLV-3

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lymphocyte [LYMPHO- + -CYTE] A leukocyte of blood, bone marrow, and lymphatic tissue that characteristically has a round nucleus with well-condensed chromatin, no identifiable nucleolus, and usually agranular cytoplasm that stains pale blue with Romanowsky dyes. A narrow lighter halo, or perinuclear clear zone, may surround the nucleus, and a few azurophilic granules may be seen in the cytoplasm. Lymphocytes play a major role in both cellular and humoral immunity, and thus several different functional and morphologic types must be recognized, i.e. the small, large, B-, and T-lymphocytes, with further morphologic distinctions being made among the B-lymphocytes. These distinctions are important in the classification of lymphocytic malignancies. Also called *lymphoid leukocyte, lymphoid corpuscle, lymphoid cell, lymph cell.*

atypical lymphocyte A large lymphocyte which by Romanowsky stain has abundant basophilic cytoplasm that often exhibits distinct paler cytoplasmic zones and an oval nucleus resembling that of a monocyte. Atypical lymphocytes, when numerous in blood, are characteristic of infectious mononucleosis, cytomegalovirus infection, viral hepatitis, and other viral infections. Also called *Downey cell, variant lymphocyte, virocyte.*

B lymphocyte One of the two major classes of lymphocytes having important immune regulatory functions. In birds, B lymphocytes pass through the bursa of Fabricius during their development. In mammals, the fetal liver is believed to be the equivalent of the bursa of Fabricius. B lymphocytes carry certain characteristic surface markers such as membrane-bound immunoglobulin. They recognize antigen independent of MHC molecules. When stimulated by antigens, they enlarge, develop very basophilic cytoplasm (from increase in RNA), and transform into plasma cells that secrete antibody. Also called *B cell, thymus-independent lymphocyte.* Compare T LYMPHOCYTE.

Notes:

I Suppresses T lymph cells and inhibits conversion of B lymphocytes into plasma.
- Normal ratio of these in the blood are 2/3 T-helper cells to 1/3 T-suppressor cells (a.k.a. Suppressor inducers) approx.
- Lesion Manifestation of the skin = Kaposi's Sarcoma (KS)

II Leukemic reticuloendotheliosis

III T-lymphocytes are either Suppressor or helper cells
- Compare:

RVI ⟷ RVII ⟷ RV III

1. all 3 are in ONCOVIRAL Subgroup
2. all are of Retroviridae
3. all are interrelated closely and associated with human T-cell malignancies.
4. I + III are highly lymphotropic; II is both lympho- + leukotropic.
5. III - is strongly lymphocytopathic; neither I or II are cytopathic.
6. I contains a 9 Kilobase RNA genome; III - a 10 Kilo genome II - measurement not listed.

(cont'd).

Notes (cont'd) - underlining + some caps. for emphasis.

7. All are enveloped, RNA viruses 80-110 mm in diameter, containing reverse transcriptase.
8. I + II contain no oncogene; III admits oncogene.
9. I + III APPARENTLY require "intimate person to person contact for transmission.
10. III is pandemic (not endemic nor epidemic).
    I is endemic (not pandemic nor epidemic).
11. I CAUSES T-Cell leukemias and lymphomas, manifested by lesions of the skin. [hematosarcoma]
    KS is a sarcoma manifested by tumors/lesions such as leukemias.
12. Even though "the exact mechanism of transmission of HTLV-III is not known, nor is it 'known' what determines which individuals are susceptible to infection and to expression of 'disease,'" the preceding "definitive" statement - "the virus is transmitted from person to person via intimate contact and blood transfusions, and is present in the bodily fluids (semen, blood cells, blood plasma, saliva, and possibly mother's milk) OF INFECTED PERSONS" IS contradictory, contravening, and INSANE as well as INANE!

IF, therefore, HTLV-III is present in these systems, WHY are "they" testing for ANTIBODY presence, rather than VIRUS presence?

- The presence of HTLV-III, incorrectly called HIV (human immunodeficiency VIRUS, note the singular although there are 3 HI viruses), anti-

Notes (cont'd.)

bodies is not a diagnosis of AIDS.
IF antibody presence is not AIDS then there cannot be an "AIDS VIRUS." NOR can AIDS mean HIV infection/disease.

- HIV Antibody (Abbott-EIA Assay) Test with a positive result is consistent with prior exposure to HIV. The significance is UNKNOWN. A negative result does not exclude the possibility of exposure to OR infection with HIV.
- Western Blot Confirmatory Assay (performed by Mayo [Clinic] Medical Laboratory, Rochester, Minnesota) BY ITS OWN Title is contradicted by this statement:
  "Positive Western Blot Test strongly suggests (where's the CONFIRMATION?!) antibodies (presence) to HIV!
- From a Medical, INFORMED Consent to AIDS-Virus (HIV) antibody Test FORM.

> 1. Before anyone can give you the AIDS-VIRUS (HIV) Antibody Test, you must give your consent.

Copies follow as pp. IV, V + VI

[redacted]

STAMFORD, CONNECTICUT

VI

INFORMED CONSENT TO AIDS-VIRUS (HIV)* ANTIBODY TEST
***(Human Immunodeficiency Virus)**

Before anyone can give you the Aids-Virus (HIV) Antibody Test, you must give your consent. This form explains the and how the test results can be used. It should help you decide whether you want to take the test. Please read it carefully. Yuor doctor should go over this information with you. If you have any questions, ask them. Please read a this information, before you make up your mind. **If you agree to be tested, you must sign the back of this form.**

1. What is the Aids-Virus (HIV) Antibody Test?

It is a blood test. It shows if you have antibodies to the Aids Virus. Aids Virus antibodies are a sign that the Aids Vir has entered your body. A sample of your blood will be taken from your arm with a needle and tested in the laborator the first test shows that you have antibodies, a different test will be done on the same sample to make sure the first t was correct.

2. What does it mean if the test is negative?

A negative test means that you're probably not infected with the Aids Virus. But it takes the body time to produce the AIDS-VIRUS Antibodies. It may just be too soon for the antibodies to be found in the test. If you recently had sexua relations or shared needles with someone who may be infected, you may want to be tested again in 3-6 months. Ple talk to your doctor about this.

3. What does it mean if the test is positive?

A positive test result means you are infected with the Aids Virus. It doesn't mean you have have Aids or that you'll become sick with the Aids Virus in the future. But many people who have the virus have become sick over time. It a means you can give the virus to other people. People who are infected can pass the virus during sex or by sharing needles during drug use. A pregnant woman who is infected can pass the virus to her baby during pregnancy.

4. How will the test help me?

If the test is negative:

- Your doctor will tell you how to keep from getting the Aids Virus in the future.

If the test is positive:

Your doctor can take better care of you by knowing your test result.

- You can learn about ways to stay healthy and new medicines that may help.
- You can learn how to avoid passing the AIDS Virus to others.
- If you are pregnant, your doctor can give you and your baby special care and advice.

5. Do I have to take the test?

No! Taking the test is up to you. If you don't want the test, you can still get medical care. But sometime it may be ha for your doctor to give you the best and latest care.

If you want to take the test, you don't have to let anyone know your test results. You don't even have to tell anyone you've taken the test. There are places where you can take the test and not give your name. You can find a testing near you by calling the [redacted] Health Department [redacted]. This type of anonymous testing is not possible at [redacted] Medical Center.

6. What will happen when the Laboratory has tested my blood?

The laboratory will report the results of your blood test to your doctor. He or she will explain these results to you, discuss changes in your behavior for your future health and the health of others around you. This is called Post Test Counseling.

7. Do I have to tell anyone my test results?

If you take the test, your results are private. Under Connecticut law, AIDS-Virus (HIV) test results are confidential an may only be given:

- To you or a person authorized by law who agreed to the test for you.
- To anyone you give written consent to get the test result.
- To a Healthcare Facility such as a hospital, blood bank or laboratory who is giving health care to yc your child.
- To a Healthcare provider such as a doctor or nurse who is giving healthcare to you or your child.
- To a committee or organization that reviews records in a health facility to monitor the care provided that facility
- To insurance companies or government programs such as Medicaid if needed to pay for services y receive or for other types of claims such as a disability claim.
- To a person who gets a court order that gives them the right to your test result.
- To a state institution such as a correctional facility or state mental hospital, where employees may have the information in special cases.
- To a healthcare worker who is accidently exposed to your blood.
- To a medical examiner.
- To a Public Health Officer where permitted by law.

All of these people are also required by state law to keep your results private. You can ask your doctor or Healthcar provider if your AIDS-Virus (HIV) Test result has been released to anyone

IV

8. Should I tell anyone I've taken the test?

You should be careful about telling people that you have been tested. If you feel you have been treated unfairly because of the results of your test you may contact the Connecticut Commission of Human Rights and Opportunities at (203) 566-3550 (Hartford). This state agency is responsible for protecting your rights.

If your test result is positive, your sex and needle-sharing partners need to know. This is true for the past and present partners. If you won't tell your partners yourself, they may be told the test results from your doctor. If this should happen, your name will not be used.

9. How can I get more information about the test and my rights?

If you have more questions about the test or your rights, please call the Connecticut Department of Health Services at (203) 566-1157 or ask your doctor.

I have read all of this form, or it has been read to me and I have discussed it with my doctor. I have been told about the nature of HIV, AIDS, HIV-related illness and have been told about how the virus may be passed from one person to another.

I agree to take the AIDS-Virus (HIV) Antibody Test.

Name of Patient (Please print)	Signature of Patient or Person Authorized to Consent for the Above Named Patient	Date

If someone other than the person to be tested has signed, state the name and address of person signing and relationship to person being tested. Explain below why the person to be tested did not sign.

I have provided to the person who signed this form an explanation of the nature of HIV, AIDS and HIV-related illness, information about transmission of Aids (HIV) Virus due to accidental exposure of blood. I have discussed and answered any questions about the information covered in this form.

Name of Physician (Please print)	Signature of Physician	Date

THIS CONSENT FORM IS TO BE KEPT IN THE MEDICAL RECORD. DO NOT SEND THIS FORM TO THE LABORATORY!

HIV TESTING MUST BE ORDERED USING THE HIV-1 ANTIBODY LABORATORY REQUEST FORM

[redacted] MEDICAL CENTER
STAMFORD, CONNECTICUT

VI

HIV-1 ANTIBODY LABORATORY REQUEST FORM

PART 1 - PATIENT INFORMATION

PATIENT NAME:		BIRTHDATE:	SEX: ☐ M ☐
ADDRESS:			
CITY:		STATE:	ZIP CODE:
PATIENT STATUS: ☐ OUTPATIENT ☐ INPATIENT	ROOM NUMBER:	MEDICAL RECORD UNIT NUMBER:	ADMISSION NUMBER:

PART 2 - PHYSICIAN INFORMATION

NAME OF ORDERING PHYSICIAN:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:

Conecticut Public Act No. 89-246 "An act concerning AIDS-Related testing and medical information and confidentiality" requires that a physician ordering an HIV test must certify that informed consent has been received from a patient prior to testing or that testing without consent is being ordered pursuant to one of the exceptions of the act. Whenever practical written consent should be obtained. Oral informed consent is permitted and must be properly documented in the patient's medical record.

THE FOLLOWING INFORMATION IS REQUIRED AND MUST BE ANSWERED

☐ This HIV Test is being performed **with the informed consent** of the above named patient pursuant to Connecticut Public Act No. 89-246.
The signed "informed consent to AIDS-Virus (HIV) antibody test" form has been placed in the patient's medical record.

☐ This HIV Test is being performed **without the informed consent** of the above named patient pursuant to Subsection E of Section 2 of the Connecticut Public Act No. 89-246.

ONE OF THE FOLLOWING EXCEPTIONS TO INFORMED CONSENT APPLY:

☐ 1. Patient unable to grant or withhold consent and no other individual is available who is authorized to consent to health care for the individual. HIV Test results needed for diagnostic purposes to provide appropriate urgent care.

☐ 2. Blood, Organ or body part donation to be used in medical research, therapy or for transplantation to individuals.

☐ 3. Deceased person. HIV test being conducted to determine cause or circumstances of death or for epidemiological purposes.

☐ 4. **FOR OCCUPATIONAL EXPOSURE COMMITTEE USE ONLY:** Significant exposure of a health care provider or other person in the course of occupational duties

SIGNATURE OF ORDERING PHYSICIAN

DATE OF REQUEST

THIS SPECIAL REQUEST FORM IS TO BE USED FOR ALL ROUTINE HIV TESTING NO OTHER LABORATORY REQUEST FORM WILL BE ACCEPTED

FORM NO 671-68 5/92

"My people are destroyed for lack of knowledge."
HOSEA 4:6

"Our people are being destroyed for lack of truthful knowledge and a basic apathy generated by misinformation, financial conspiracy and cover-up."
C.A. Mazur 6-13-93
Author-in-hand

AIDS is not a (nor even THE) DISEASE, it is a SYNDROME of compromises and complexities added to an already suppressed/deficient immune system. Therefore, if anything, AIDS is a result not a cause.

There is, therefore, no such thing as an AIDS VIRUS, (as claimed by "them") which is, or can be, the SINGULAR/OMNIPOTENT cause of Acquired Immune Deficiency Syndrome. Or it has been already established and proven medically that there are other IDS's not caused by the supposed "HIV-AIDS VIRUS." E.G. Iron Deficiency Anemia, Vitamin and Mineral Deficiencies, Blood Cell Deficiencies/Diseases, Deficiencies caused by infections of BACTERIA, FUNGI, DNA VIRUSES, DRUG OVER-USE (whether legal-medically prescribed or illegal-non-prescriptive, etc, etc. which all suppress immune systems as well as other bodily systems such as blood, lymph, respiratory, urogenital, gastrointestinal, etc, etc.

"AIDS," therefore, if not a disease, cannot nor should not be called "epidemic." The disease we generically (unilaterally) call "CANCER" ~ of which there are many types ~ far exceeds the cases + deaths than "AIDS" as a causative (direct) of death for the last 13+ years. YET, no-one calls CANCER an EPIDEMIC, not even on a word-wide (pandemic) or localized (endemic) scale/proportion.

At best this "syndrome" is the result of abusive life styles, as well as and in conjunction with, malnutrition, mal-sanitation, other primary and secondary infections, etc. compromised and complexed on an already suppressed/deficient system (or systems).

FOR, IF, your I.S. is being compromised and complexed, it is totally open for further "STRANGE" infections (diseases) like: HIV, KS (Kaposi's Sarcoma), PCP (Pneumocystic Carinii Pneumonia), Pneumo-+Strepto-coccal Pneumoniae, Candida Albicans (Oral Thrush), ALL abnormal blood diseases (called "epotic"), ETC., ETC.

THEREFORE, AIDS is the RESULT of, not CAUSE of a non-functioning, "sick/diseased" immune system. FOR, logically, a RESULT cannot also be its own cause.

A healthy, non-suppressed/deficient system is naturally able and capable of fighting off infection/disease almost 95% of the time. E.G.~ A person with ABS (Anti-Body Screen) Test results that are higher than the minimum, will either destroy, even HLTV 1, 2, or 3, or "encapsulate" it rendering it "inactive." BUT, let your I.S.

or cause it to become dangerously suppressed/deficient, And you not only open it back up (susceptible) to infection/disease BUT you're also open it up for re-infection (REACTIVATION) of any encapsulated morbid entity.

E.G. A hospital "Tran" such ABS (a.k.a-Flow Cytometry) test on me, while I was unconscious.

— BLOOD COLLECTED 2/27

		RANGE
LYMPH ABS	580 L (low)	(660–4600)/cumm
T-LYPH ABS	174 L (Total)	(594–2201)cumm
B-LYMPH ABS	197	(109–532)cumm
T-HELPER ABS	116 L	(300–1500)cumm
T-SUPPRESSOR ABS	157 L	(282–999)/cumm
ACTIVE T ABS	36.0	(30–500)cumm
N KILLER CELL ABS (NATURAL)	180	(70–600)cumm

INTERPRETATION – DIAGNOSES (NOTE)

The above was the result of:

1. DEFICIENCIES and SUPPRESSIONS (System-wide)
2. RESPIRATORY FAILURE due to septic poisoning (Sepsis) and pneumonia caused by STREPTOCOCCI in lungs and especially blood.
3. Candida Albicans in lungs, throat and mouth.
4. Re-activated Herpes Simplex Virus
5. Lymphopenia
6. COPD – Chronic Obstructive Pulmonary Obstruction(s).
7. ET. AL.

— This test, alone, points to Acquired-IDS. WITHOUT the necessity of either ~~abbott~~ EIA ASSAY or Western Blot CONFIRMATORY (?). This test is ab-

solutely indicative, consistent and conclusive of Immune Suppression or DEFICIENCY, in some way.

- The CBC w/ differential revealed that:
  1. On 2/26 to 3/01 my white cell count fell into normal range until drugs were pumped I.V. – 3/01 – 15.14 (range – 4.5 – 10.0); 3/04 – 16.59; 3/06 – 17.93; 3/09 – 23.68; 3/15 – 7.6; released 3/17; 4/02 – 8.34 (no Flow Cytometry – ABS was done at that time)
- Final Diagnosis upon reexam Immunosuppressed NOT AIDS for AIDS cannot nor should not be a or the diagnosis because – here is a list of drugs (none of which I was taking prior to Hosp. Admission, and no other drug ingestion of any note except: ① subminimal caffeine, and ② probably high nicotene, ③ moderate alcohol

I am, at time present 6/23, awaiting results of CBC w diff. and Flow Cytometry which I had the audacity to order the M.D. to order collection of blood for on 6/21. WE SHALL SEE AND COMPARE. (ATTACHED – Copy DRUGS – DOSAGE – COST)

C. A. Mazur

P.S. More to come and be revealed by my own hand. Stuff "Anonymity + Confidentiality" – this opportunity to get to "the truth, the whole truth, and nothing but the truth," for a CHANGE, is of my own free will, LIKE IT OR NOT.

NAME	Dosage	Hospital Cost/charge
Aminophylline	IV 500 mg.	23.77
Bactrim	IV 80 mg	2655.36
Deltasone	20 mg tab (Prednisone) Steroids	22.14
Diazepam	IV 10 mg. (Valium IV)	123.00
Dopamine	400 mg. Inj.	24.15
Heparin	10,000 U. Inj. (Sodium)	386.88
Hexavitamin	1 Tab	34.16
Norcuron	10 mg Inj. (neuro-musc. for intubation)	11,026.09
Nystatin	100,000 unit ORAL	28.44
Pfizerpen	100,000 units IV (Penic & Potas anti-bact intra musc-neuro)	6883.62
Polymox	500 mg Cap. (amoxicillin)	40.18
Theo-dur	300 mg Tab	69.02
Ventolin	90 mg Inhal aero	99.64
Haldol	5 mg IV (anti-psychotic instead of Lithium)	350.02
Humulin	100 U IV (Diabetes)	24.98
Zovirax	200 mg Cap	267.67

Bactrim DS QD Tab 2.68@	29.48
Heparin Flush	14.52
Maalox 30 ml. QD	17.58
KCL 20 MEQ IV	288.17
Solu-Medrol 40 mg IV	484.50
Rimactane 300 mg Cap	49.28
Thiamy/Versed/Zinacef/Tylen./Zovirint. Tagam.	133028

Regretfully I have not yet double checked BUT I will

Blood disorders

Introduction

Your blood has two basic parts: blood cells, which are also called blood corpuscles; and plasma, the fluid in which the blood cells are suspended. The disorders of the blood that are discussed in this section are principally concerned with the blood cells.

Most of the blood cells in your body are red blood cells. Their main function is to carry oxygen from the lungs to all parts of the body. Red blood cells contain a protein called hemoglobin, which combines with oxygen in the lungs and releases it to the tissues as the blood circulates through your body. The red blood cells also carry the waste product carbon dioxide from the tissues to the lungs so that it can be exhaled.

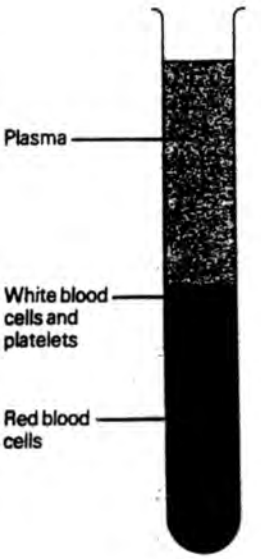
Your body also contains white blood cells, which protect the body from infection. There are several different kinds of white blood cells. Most of them are neutrophils, which attack and engulf bacteria. Another kind, the lymphocyte, recognizes foreign cells, infectious agents, and other foreign substances and participates in the body's immune reaction against them. There are other varieties of white blood cells, but these two are the most numerous.

A third type of blood cell is the platelet. Platelets gather wherever a blood vessel is injured, to plug the hole. This is the first stage in the blood clotting process. Chemical substances in the plasma then assist in forming a clot that seals the wound.

Most blood cells are produced in the bone marrow. However, lymphocytes are made in the spleen or in the lymph glands, which are found in the neck, armpits, groin and many other parts of the body. The spleen and lymph glands, together with the channels and ducts connecting them, are called the lymphatic system. When red blood cells and platelets become old or defective they are filtered out of the bloodstream and broken down by the spleen, and also by the liver and lymph glands.

Disorders of the blood are grouped as follows: lack of hemoglobin, which causes anemia; disorders in clotting, which cause bleeding and bruising; cancerous changes in the white cells, which cause leukemia; disorders in the production of blood cells in the bone marrow; and disorders that affect the lymphatic system.

Basic parts of the blood
Blood can easily be separated into its different parts like cream from milk. Red blood cells are heavier than white blood cells and platelets, which are heavier than the plasma.

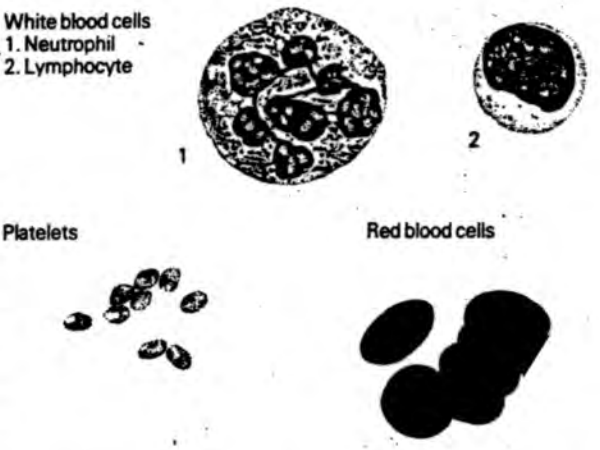


Plasma
Plasma is a yellowish fluid that contains salts, antibodies, and blood-clotting factors.

White blood cells
White blood cells protect the body against infection by destroying bacteria and producing antibodies.

Platelets
Platelets help plug damaged blood vessel walls and form the first stage of a blood clot.

Red blood cells
Red blood cells account for almost half of your blood, and contain a protein, hemoglobin, that carries oxygen throughout the body.



Anemia

The main component of red blood cells is the protein hemoglobin, which combines with oxygen in the lungs and carries it throughout your body, and releases it to those tissues that require it. Anemia is defined as a decrease in either hemoglobin or the number of red blood cells to below the normal level.

Iron is an essential ingredient in hemoglobin. If you do not have enough iron in your body, you cannot make enough hemoglobin. This form of anemia is called iron-deficiency anemia. A severe shortage of vitamin B_{12} in your body also affects the production of red blood cells. This is called B_{12} deficiency anemia. Lack of folic acid in your body has the same effect, and this is called folic acid deficiency. In hemolytic anemia the red blood cells are destroyed more quickly than they normally would be and the number of red blood cells in your body may fall well below normal. Inherited defects of the blood such as sickle-cell anemia cause your body to produce abnormal hemoglobin.

The characteristic symptoms of anemia include paleness, fatigue, weakness, fainting, breathlessness, and palpitations. Palpitations, or an increased awareness of your heartbeat, can occur when your heart tries to compensate for the anemia by pumping blood faster than is normal.

prolonged period of time. An adequate intake of vitamins and minerals is assured if you eat a well-balanced diet (see p.26) with an adequate calorie level.

Although serious vitamin and mineral deficiencies are uncommon in the well-fed Western world, some people may not be getting enough of these nutrients to fully meet their needs. The tables on pp.505–7 summarize up-to-date facts and theories about the most important known vitamins and minerals, their sources and their functions.

Who lacks vitamins and minerals?

In the developed countries, unmistakable vitamin deficiency diseases such as scurvy or pellagra are rare. The occurrence of mineral deficiencies is hard to determine since, for most minerals, clear-cut deficiency diseases have not been identified. However, iron-deficiency anemia (see p.426; for children, see p.697) is one of the most common deficiency diseases in the world.

When vitamin and mineral deficiencies do occur, they are not likely to be severe, since they are usually caused by not getting enough of these nutrients rather than by a complete lack in the diet.

Mild deficiencies are most common among children, teenage girls, pregnant women and the elderly. People of any age who eat an abundance of highly processed foods and few fruits and vegetables, or who often go on crash diets to lose weight may also develop deficiencies. People with marginal diets may not show symptoms of deficiencies, but they will have few reserve stores of vitamins and minerals to help them withstand the stresses of serious illness or injury.

Children are most likely to be deficient in iron and vitamin A, which are needed for growth. Low intakes of vitamin C are also common. Concern about weight often prevents teenage girls from eating enough to get the proper amounts of many nutrients, particularly calcium and iron.

Most women of childbearing age obtain enough iron from food. Greater-than-average blood loss during menstruation increases the need for iron. Pregnancy further increases this need. For this reason, many healthy women may need iron supplements at some point during their lives. Folic acid deficiency (see p.427) may also occur during pregnancy. The requirements for iron and folic acid as well as other nutrients are higher during pregnancy and breast-feeding.

The elderly may not be able to absorb needed amounts of calcium and iron because of physical changes that occur with aging. Many elderly people live alone on fixed incomes, which may decrease their desire or ability to eat properly.

"Street people," or the "homeless," may demonstrate the classical symptoms of malnutrition. Alcoholism, which many street people suffer from, seems to exaggerate the effects of low vitamin and mineral intakes. Alcoholics often have deficiencies of vitamin B_6 (pyridoxine), vitamin B_1 (thiamin), folic acid (folacin) and magnesium.

In extremely rare cases, people who may not be in deprived circumstances and follow a reasonably varied diet may suffer from a vitamin deficiency because of a metabolic abnormality. For instance, some individuals have anemia because their bodies cannot absorb vitamin B_{12} (see p.427). In addition, some women who use oral contraceptives may show signs of a vitamin B_6 deficiency, but there is some question of whether this is a true deficiency.

You may develop a vitamin or mineral deficiency after surgery on the intestinal tract. If you develop a severe intestinal disorder such as Crohn's disease (see p.481), you may become predisposed to deficiencies because your body cannot absorb needed vitamins and minerals.

Should you eat differently?

The chance of having a deficiency of a vitamin or mineral depends on two factors. First, how available that vitamin or mineral is in your diet, and second, how effectively your body can store it. If you eat the proper amounts of nourishing foods, you should be able to assure an adequate vitamin and mineral intake. The guidelines below describe food groups and the amounts you need of each group every day.

Foods can be divided into four groups on the basis of similarities in composition and nutrient content: (1) milk and its products, two or more servings per day; (2) meats, fish, poultry, dried beans and other protein-rich foods, two or more servings; (3) vegetables and fruits, four or more servings, with emphasis on good sources of vitamins C and A; (4) breads and cereals, whole grain or enriched, four or more servings. The minimum number of recommended servings will provide about 1300 calories and from 80 to 120 per cent of the nutrients needed. Active people of normal weight can have more and larger servings of these foods (plus other foods such as fats, oils and sugars) in order to meet the need for more calories.

Vitamin C, important in the healing of wounds and enhancing iron absorption, has

Nutritional cardiomyopathy

Like any muscle, the heart muscle can be damaged by a vitamin or mineral deficiency or by poisoning. The most important form of such nutritional cardiomyopathy in Western societies is found among alcoholics (see Alcohol abuse, p.309). Heart specialists attribute the damage either directly to the alcohol or to the lack of vitamin B_1 that may be characteristic of the alcoholic's diet. In non-alcoholics, nutritional cardiomyopathy can also occur because of vitamin B_1 deficiency. It can also be caused by a lack of potassium in the bloodstream. This is a potentially serious deficiency that occasionally develops in people

tent diarrhea or who are under long-term treatment with diuretic drugs.

The symptoms of nutritional cardiomyopathy vary greatly. You may simply have palpitations, which is increased awareness of your heartbeat, and swollen hands and feet. Since the damage can cause disorders such as atrial fibrillation (see p.396) or even heart failure (see p.388), you also may have the symptoms of those ailments.

Treatment will probably consist of an attempt to correct the dietary deficiency. How this is done depends on the circumstances, but if your problem is alcoholism, only total

Aplastic anemia

If you have aplastic anemia, your bone marrow's production of blood cells decreases. This causes a reduction in the total number of cells in your bloodstream. This may occur gradually or suddenly. In most cases the cause of the problem cannot be identified. Sometimes the cause can be tentatively traced to exposure to a toxic substance such as benzene, a drug taken for another disorder, or radiation. Most anticancer drugs produce similar changes in the bone marrow, but the condition usually improves when the drug is discontinued for awhile.

What are the symptoms?

There are three main groups of sympton The decrease in production of red blood ce causes the symptoms of anemia (see p.42

The decrease in production of granulocyte type of white blood cell, makes you mo susceptible to infection. Finally, the decre in platelet production (see Thrombocy penia, p.432) leads to spontaneous bruisi red dots on the skin, and bleeding from t nose, mouth and other sites.

Iron-deficiency anemia

Iron is an essential component of hemoglobin, the protein in red blood cells. Insufficient iron in your body causes an inadequate production of hemoglobin, and therefore leads to iron-deficiency anemia.

Normally, extra iron is stored in your body and then used to produce hemoglobin in newly developed red blood cells. Most of this iron is recovered as old red blood cells are destroyed. The small amount of iron lost from the body is replaced by iron absorbed from your diet. Some people, for a variety of reasons, have little or no iron stored in their bodies. If you are one of these people, you can stay healthy if you balance the iron you lose with iron absorbed from your diet. If you lose more iron than you are able to absorb, you may become anemic.

There are three general causes for a lack of iron reserves. The first is that there may not be enough iron in your diet to replace the amount that is lost each day. This problem occurs mainly in young children (see Iron deficiency anemia in children, p.697) and in people who, for one of several reasons, are living on restricted diets.

The second major reason for iron deficiency is that the digestive system is unable to absorb iron, even though there may be enough of the right forms of it in the diet. This occurs most often because part of the stomach has been removed surgically (see Stomach ulcer, p.473, and Cancer of the stomach, p.474).

The third reason for iron deficiency is th the iron reserves may become deplete through excessive loss of blood. This is tl most common cause. If the blood loss caused by a temporary problem, reserves iron will rebuild in time. Many women ha heavy menstrual periods, which can gradual deplete their iron reserves. In other case blood loss may occur in the intestinal trac This type of blood loss, in sufficient quantit can produce bloody or black stools. But, if is limited in quantity, there may be no sign the bleeding. Some of the common causes intestinal blood loss are gastritis (see p.472 stomach ulcer (see p.473), duodenal ulcer (s p.476), cancer of the stomach (see p.474 cancer of the large intestine (see p.489), an hemorrhoids (see p.491).

What are the symptoms?

Symptoms are those characteristic of mo forms of anemia. You may be weak, pal tired, faint and/or breathless. You may als have palpitations, or an increased awarene of your heartbeat that occurs when your hea tries to compensate for the anemia by pump ing blood faster than is normal.

Anemia of chronic disease

This type of anemia frequently complicates other diseases. Disorders that often bring on this type of anemia include rheumatoid arthritis (see p.563), hepatitis (see p.494) and tuberculosis (see p.574). It can also occur in anyone who has an acute infection such as pneumonia (see p.365).

The symptoms of anemia of chronic dis ease are the same as those for other forms o anemia, combined with the symptoms of th underlying disease. It cannot be treated, ex cept by transfusions, but it should improv when the disease that produces it improves i response to treatment.

Multiple myeloma

The plasma cells are among the less common types of white blood cell in the bone marrow. They produce antibodies that help to destroy bacteria, viruses and other infectious agents and foreign cells. In addition, they also produce antibodies in response to vaccination or immunization.

Normally, plasma cells make up only a small percentage of the cells in the marrow, but in multiple myeloma one plasma cell undergoes a malignant, or life-threatening, change and begins to multiply excessively. This has three serious effects. First, it disrupts the production of red blood cells, platelets and granulocytes (a type of white blood cell) in the marrow, which leads to anemia (see p.426), thrombocytopenia (see p.432) and a reduction of granulocytes in the blood. Second, the excess plasma cells cause destruction of bone. Third, the remaining normal plasma cells produce fewer antibodies and this reduces resistance to infection.

What are the symptoms?

Usually the first symptoms of myeloma are the symptoms associated with anemia (see Iron deficiency anemia, p.426). Increased susceptibility to infection may also appear early. The most characteristic symptom of the disease is pain in your bones, particularly in the vertebrae, or backbones.

What are the risks?

Myeloma is a rare disease, occurring in less than 4 of every 100,000 people in the United States. Myeloma affects mainly people over 50 and it is somewhat more common in men than it is in women.

Myeloma cannot be cured, but if you have the disease, treatment can give you several years of fairly normal life. Recurrent infection is a common problem with this disease, and it can be quite serious. There is a risk of chronic kidney failure (see p.522), and bleeding is another common problem.

What should be done?

If you are over 50 and you have developed bone pain, especially in your back, you should see a physician. If you have multiple myeloma, laboratory analysis of blood and urine samples and X-rays of the skeleton will usually detect it.

What is the treatment?

In the early stages of multiple myeloma, if there are no complications, the usual treatment that is currently used is an anticancer drug. The amount of the medication that is given must be carefully controlled, because too much of the drug can damage too many of the other cells in the bone marrow, and too little of it will not be able to halt the progress of the disease. Blood samples are taken during treatment to find an effective, safe dosage. Often steroids are also prescribed.

This treatment controls the disease in many but not all cases. Because your resistance to infection remains low during this treatment, antibiotics may be prescribed if you have any symptoms of an infection. Troublesome bone pain can usually be relieved by radiation therapy.

If you respond to treatment at first, and then have a relapse, your physician may try different drugs. With modern drug treatment patients with myeloma may be restored to normal health for long periods.

Vitamin and mineral deficiency

Your body needs food for energy and for creating and repairing tissues. It also needs a variety of complex compounds that, like the spark plugs in a car, provide neither fuel nor structural material but are essential for smooth running. Vitamins are such compounds. Although your body can manufacture limited amounts of some vitamins, notably vitamin D and niacin, most of these compounds are obtained in the foods you eat.

Minerals are also vital for good health. Like vitamins, minerals also ensure that the body will function properly. Your body needs small but regular supplies of minerals. These include sodium and potassium (although dietary deficiencies of these elements are virtually unknown), calcium, phosphorus and magnesium. In addition, you require much smaller quantities of minerals known as trace elements: these include iron, iodine, zinc, copper, chromium and selenium. The table on p.505 shows the essential minerals your body needs and outlines their specific functions for the maintenance of good health.

The precise functions of some vitamins and minerals are not yet fully understood, but they are all known to be involved in basic metabolic activities. For example, vitamin D plays a role in controlling the absorption of calcium, which is needed for strong bones and for the functioning of nerves and muscles. Iron is important in delivering oxygen to body tissues to provide energy and in protecting against infection. As a result, a lack of any one vitamin or mineral can lead to many disorders. If the deficiency is severe or prolonged, the resulting disease may be disabling or even fatal.

Vitamin deficiency is uncommon in this country, and when it occurs it is usually due to prolonged faulty eating habits, alcoholism, gastrointestinal disorders or long-term neglect. Vitamin deficiency diseases that were once quite common here now seldom occur because many foods are fortified with vitamins, and nourishing foods are available year-round. Mineral deficiency is most likely to occur if a person follows a diet extremely restricted in calories or in kinds of foods. The sale of vitamin and mineral supplements is overpromoted, since foods can meet needs best and most economically. Moreover, excessive amounts of certain nutrients such as vitamins A and D can be toxic if taken over a

Leukemia

Leukemia is a cancer of white blood cells. Normally the number of white blood cells that are produced equals the number that die off as part of the natural process of cell turnover in the body. This keeps the total number of white blood cells constant. In leukemia, white blood cells often multiply at an increased rate. It is also significant that the cancerous cells tend to live longer than normal white blood cells. Thus the number of abnormal cells increases, either gradually or rapidly, and this causes an over-accumulation of leukemic cells throughout the body. These cells often interfere with the functions of various organs. And, because the leukemic cells are abnormal, they do not cope effectively with infectious agents such as bacteria that the normal white blood cells help to eliminate from the body.

There are two main types of leukemia, which affect different types of white blood cells. Lymphocytic leukemia is a malignancy of lymphocytes (see p.439) and/or the cells from which they originate. Myelogenous (or granulocytic) leukemia is a cancer of the cells from which granulocytes originate. Both of these leukemias may be acute or chronic. Acute lymphocytic leukemia mainly affects children; it is discussed elsewhere (see Leukemia in children, p.698).

leukocyte [LEUKO- + -CYTE] Any of several nucleated cells that occur in blood or tissue fluid, exclusive of erythrocytes and erythrocyte precursors. Major classes of leukocytes are lymphocytes, monocytes, neutrophils, eosinophils, and basophils. Also called *white cell, white blood cell, white corpuscle, white blood corpuscle, amebocyte* (rarely used), *amoebocyte* (rarely used).

Chronic lymphocytic leukemia

The disease begins when one or more lymphocytes, a type of white blood cell, become malignant, or life-threatening. Instead of maturing and dying in the normal way, the leukemic cells multiply and produce more of their kind. These also produce leukemic cells, and so on. After some time, perhaps several years, the leukemic cells gradually crowd out normal white blood cells in the lymph glands, and reduce the ability of the remaining healthy cells to fight infections. The leukemic cells also overflow from the lymph glands into the bloodstream, and from there into the spleen, the liver, the bone marrow and other parts of the body. As the number of leukemic cells in the marrow rises, they interfere increasingly with the ability of the marrow to produce other blood cells. This leads to a number of problems, including anemia, susceptibility to infections, and bleeding.

What are the symptoms?

The disease often produces no symptoms for a while and is most often discovered by a blood test done for another purpose. In some cases, the first signs of the illness are enlarged lymph glands in the neck, armpits, or groin, or a feeling of fullness in the upper left portion of the abdomen, due to an enlarged spleen. In other cases of the disease, the first symptoms may be those that are caused by anemia (see p.426) or infection. In some cases, general ill health, loss of appetite and weight, fever, and sweating at night are the first indications of the disease.

Acute myelogenous leukemia

This disease, which is also called acute granulocytic leukemia, is caused by a malignant, or life-threatening, change in cells that produce granulocytes, one of the types of white blood cells made in the bone marrow. The resulting leukemic granulocytes multiply and survive longer than normal cells. As their numbers increase, the leukemic cells invade the bone marrow. This invasion disrupts the production of normal granulocytes, red blood cells and platelets.

Then, the leukemic granulocytes begin to enter the bloodstream, and their numbers increase fairly rapidly. Next they invade organs and tissues, particularly the spleen and liver. These organs become enlarged.

What are the symptoms?

The common early symptoms of acute myelogenous leukemia are fatigue, infections (especially of the mouth and throat), fever, lip and mouth ulcers, and a tendency to bruise and bleed. You may also have the usual symptoms of anemia (see Iron-deficiency anemia, p.426).

The disease often occurs suddenly, with the symptoms becoming pronounced over one or two weeks. But, sometimes, the symptoms appear gradually over two or three months. An elderly person may have what is called smoldering leukemia, in which the onset of the disease is very gradual. In such cases, treatment is usually postponed.

Chronic granulocytic leukemia

Chronic granulocytic leukemia begins in th same way as acute myelogenous leukemi (see p.433). A malignant, or life-threatenin change occurs in bone marrow cells that pr duce granulocytes, a type of white blood cel As a result, the number of granulocytes i your blood rises excessively, often to betwee 20 and 40 times the normal level. When th disease is not treated, the multiplication o granulocytes may limit the production of re blood cells, so you may also become anemic In addition, the accumulation of leukemi cells may cause enlargement of both you spleen and your liver.

What are the symptoms?

If you have chronic granulocytic leukemia, you feel generally ill, have little appetite, and lose weight. You may have a fever and sweat at night. In addition, your enlarged spleen may cause a sense of fullness in the left upper portion of the abdomen. You may also have symptoms of anemia (see p.426).

Agranulocytosis

The white blood cells known as neutrop act as the body's first defense against in tions. Normally the neutrophils are produ in the bone marrow and are released into bloodstream. In agranulocytosis, most o of the neutrophils are destroyed, and the a severe reduction in the number of n rophils that are circulating in the blood. result of this reduction in circulating n rophils is decreased resistance to infectio

The disease is often caused by a drug you are taking for some other disorder. It also be caused by a viral infection or by antibody, or normally protective biochem in your blood, that you develop against y own white blood cells. The disease may be first sign of leukemia (see p.433) or apl anemia (see previous article).

What are the symptoms?

The characteristic symptom of the disea susceptibility to infection. This is especi true in the mouth and throat, where ul often occur. Sometimes, if you have ranulocytosis, infections such as pneum (see p.365) progress unusually rapidly and extremely severe, or even fatal.

Pneumonia

(*pneumonitis*)

Pneumonia, also called pneumonitis, is not a specific disease. It is a general term for several kinds of inflammation of the lungs. Pneumonia is usually caused by a bacterial or viral infection, but it can also be caused by chemical damage to the lungs from inhaling a poisonous gas. The pneumonia, or lung inflammation, can be anything from a mild complication of an upper respiratory tract infection to a life-threatening illness.

The symptoms, the treatment, the impact, and the outcome of pneumonia depend on the cause, the general health of the person concerned, and on other factors, such as the effectiveness of drug treatments. Viral pneumonia, for instance, does not respond to treatment with antibiotics. See the accompanying table for a comparison of the causes and likely results of some of the most common types of pneumonia.

The variability of pneumonia has led to many popular and medical descriptive terms. If you are told that you have "double" pneumonia, it means that both your lungs are affected. If your attack is due to bacteria-like microbes called *Mycoplasma*, you may be said to have "atypical" pneumonia. "Bronchopneumonia" is patchy inflammation of one or both lungs, and "lobar" pneumonia affects the entire area of one or more lobes of the lung. When your physician determines what kind of pneumonia you have, you can ask for a description of that type.

What are the symptoms?

No single symptom is characteristic of all types of pneumonia. You should consider the possibility of pneumonia, however, if you already have a respiratory illness with symptoms such as a cough and fever, and you become short of breath while at rest and for no apparent reason. Additional symptoms to watch for besides coughing and a temperature are chills; sweating; chest pains; cyanosis, or a bluish tinge to the skin; blood in the phlegm; and, occasionally, mental confusion or delirium. The larger the lung area that is affected, the more severe the symptoms you experience will be.

How quickly the symptoms begin and which symptoms are most prominent varies with the cause of the infection. An especially virulent strain of the influenza virus can cause a pneumonia that can kill a feeble person within 24 hours. In a healthy young adult, pneumonia resulting from a mild respiratory infection might cause symptoms that are no worse than those of an ordinary cold.

What are the risks?

In the United States, about 15 people out of 1,000 have pneumonia each year. The disorder is often the final complication of some other debilitating disorder, and this is why many people who get pneumonia die. Anyone whose resistance is already low is very susceptible to pneumonia, so for people who are dying of heart failure, cancer, stroke or chronic bronchitis, the actual cause of death is often pneumonia. In anyone who is semiconscious or paralyzed, infection of the lungs is extremely likely. This is because under such conditions the normal coughing reflex that keeps the lungs clear of mucus and stagnant fluid is reduced, or even absent.

You are also more likely than other people to get pneumonia if you are very young (under 2) or very old (over 75), if you have a chronic chest disease such as asthma or some other chronic illness that reduces your body's resistance to infections, or if you are a heavy smoker or drinker.

Pneumonia is a common cause of illness in people whose natural defense mechanisms have been reduced in efficiency. Such people include: 1) those who have had an organ transplant and have been given immunosuppressive drugs to prevent rejection of the transplant (see Transplants, p.408); 2) people who are suffering from leukemia, Hodgkin's disease or some other form of cancer and who are being treated with steroids or cytotoxic drugs, because these medications suppress the body's immune system; 3) people with certain chronic diseases (such as rheumatoid arthritis) who are taking steroids or similar drugs; and 4) people suffering from AIDS (acquired immune deficiency syndrome), whose natural defenses have been impaired by the disease itself.

In all these cases, pneumonia may be caused by organisms (such as the cytomegalovirus or *Pneumocystis carinii*) that are not usually a threat to people in normal health. These "opportunistic" infections often have a slow, insidious onset so that at first the affected person may simply feel off-color, lacking in energy, and may possibly have a slight fever and a dry cough. Later, the more usual symptoms of pneumonia develop – shortness of breath, chest pain and fever, for example. The diagnosis of these new types of pneumonia depends on laboratory tests, including a transbronchial lung biopsy, in which a specimen of lung tissue is removed by means of a bronchoscope.

Because pneumonia varies so much, no generalizations can be made about its outcome. In old, weak, or debilitated people, the main risk is death. Any type of pneumonia may lead to pleurisy (see next article), or empyema (see p.370). The most dangerous type of pneumonia is caused by viruses such as an influenza virus, because they do not respond to antibiotics. As a result, the mortality rate for viral pneumonia is higher than that for bacterial pneumonias (pneumococcal pneumonia, for example), which can be equally virulent but can be treated with antibiotic drugs. With increasing age or chronic illness, the chances of surviving even a mild case of pneumonia are reduced more and more with time.

A healthy young person should recover completely from pneumonia within two to three weeks. Even in cases of viral pneumonia, the chances of serious complications are minimal, since antibiotics can prevent secondary bacterial infection.

Following recovery, you may still feel very tired for a long time after the infection is gone. A heavy cigarette smoker, or someone who is vulnerable in some other way, may take several months to recover from the illness or may even die.

COMMON KINDS OF PNEUMONIA

Cause	Onset of symptoms	Temperature	Other possible symptoms
Pneumococcus bacterium	Abrupt (within hours of infection)	Up to 104°F (40°C) or above	Chills, chest pain, blueness and, late cough with bloodstained sputum
Influenza virus	Abrupt (within hours of infection)	104°F (40°C) or above	Severe cough, bloodstained sputum blueness, dry cough
Cytomegalovirus	Gradual (over several days)	About 101°F (38.3°C)	Dry cough, lethargy
Other viruses	4 to 5 days after infection	About 101°F (38.3°C)	Dry cough
Mycoplasma (bacterium-like)	3 to 4 days after infection	About 101°F (38.3°C)	Dry troublesome cough, headache
Legionnaire's disease bacterium	2 to 10 days after infection	Up to 104°F (40°C) or above	Nausea, vomiting, chills, muscle ach headache, bloodstained sputum, che pain
Pneumocystis carinii (a protozoan)	Abrupt, or gradual (over several weeks)	About 104°F (40°C)	Rapid breathing, cough, shortness o breath

AMA-EMG

Anxiety

AMA-EMG

For most people, anxiety is a temporary reaction to stress. It becomes an illness only when it persists, and prevents one from leading a normal life. Some anxiety states are caused by severe stress, but in anxiety-prone people only slight stress, or none at all, may be involved. People who have "free-floating" anxiety live in a constant state of apparently causeless anxiety.

If you have an attack of anxiety, you will probably feel apprehensive and tense, and be unable to concentrate, to think clearly, or to sleep well. You may have frightening dreams and occasional symptoms of fear such as a pounding heart, sweating palms, trembling, or diarrhea. Some people in a state of anxiety find it hard to breathe, as if their lungs are under constant pressure. And they may become convinced that they have heart or stomach trouble when in fact they are physically healthy (see Hypochrondriasis, p.306). A man may have trouble maintaining an erection or may have premature ejaculation (see p.628). In so-called "anxiety attacks," which can occur apparently without cause at any time, the physical symptoms of fear intensify alarmingly.

What are the risks?

Anxiety is a very common form of psychological disorder. It is slightly more common in women than men, and adolescents and the elderly are especially susceptible. If severe anxiety is not treated, you may sink into psychotic depression (see p.301).

What should be done?

If your anxiety is caused by a specific stress, try to remove it. For example, consider changing jobs if your current work makes you anxious. If there is no way to deal with the stress, or if severe anxiety persists, consult your physician, who will examine you to determine whether your symptoms may be due to a physical condition such as an overactive thyroid gland (see Hyperthyroidism, p.536) or a vascular disorder of the brain (see p.269). If no physical cause for your symptoms is found, you may be referred to a specialist. The first time you have an anxiety attack, you may think you are having a heart attack. To be on the safe side, call your physician. If he or she is not available, call an ambulance to take you to a hospital.

What is the treatment?

Self-help: Various methods of relaxation can lessen the severity of symptoms. Whenever you feel tense and troubled, try doing relaxation exercises or some physical activity such as swimming, jogging, or brisk walking.

Professional help: Your physician may suggest exercises to relax tense muscles. In addition, or alternatively, your doctor may prescribe an anti-anxiety drug or recommend psychotherapy. Severe cases may also require a period of hospitalization.

What are the long-term prospects?

If your disorder is due to a stress that can be dealt with, you have a good chance of permanent cure. But if you are anxiety-prone or have free-floating anxiety, recurrent attacks are likely. You may be able to avoid them, or at least minimize symptoms, by continuing to do relaxation exercises even when you are not actively anxious. Ask your doctor if there is a drug that you can take as soon as you feel that an attack is beginning.

The Race for an AIDS Vaccine

By Steve Wittkoff

In 1980, Franklin Volvovitz, a doctoral student in immunology with a penchant for reading *The Wall Street Journal*, leaves the research world of academia to start up a biotechnology company in central Connecticut.

A few years later, Gary Blick, a young doctor just graduated from the University of Miami School of Medicine, leaves the humidity of Florida to seek pastoral New England surroundings for a family practice.

Today, Volvovitz has become a controversial figure on the very cutting edge of AIDS research, and Gary Blick has 130 HIV-positive patients in Greenwich with everything riding on a therapeutic AIDS vaccine developed by Volvovitz and his Meriden company, MicroGeneSys.

MicroGeneSys has been in the spotlight since June 1987, when VaxSyn, its trade name for the vaccine, became the first AIDS vaccine approved for human clinical trials by the Food and Drug Administration. Trials began in September 1987, in collaboration with the U.S. Army, to test VaxSyn as a preventative vaccine in uninfected gay men.

Not long afterward, Lt. Col. Robert Redfield of the Walter Reed Army Institute of Research became interested in the therapeutic possibilities of the vaccine and approached Volvovitz. Redfield theorized that the same immune response used to protect uninfected people against HIV infection might also help people who were already infected.

So, in April 1989, Redfield and the Walter Reed Army Medical Center began vaccine therapy trials using VaxSyn in asymptomatic HIV-infected individuals.

"There was widespread prejudice against this theory," says Volvovitz. "Experts said you cannot inject vaccine in those already infected, that you would hurt the person. They created all sorts of doomsday scenarios. But we had established safety, antibody response and improved immune responses in the uninfected."

Meanwhile, Gary Blick was facing a growing caseload of patients with HIV and AIDS. "I never intended to make a specialty out of caring for people with HIV," he says, "but a patient said to me, 'You have to do something for people with AIDS. There's nothing for them around here.' I never imagined that there would be such a great need here—not in Greenwich."

FRANKLIN VOLVOVITZ, *ABOVE*, PRODUCES AN AIDS VACCINE IN HIS MERIDEN LAB; DR. GARY BLICK, *BELOW*, ADMINISTERS IT TO HIS PATIENTS IN GREENWICH. SO FAR, THE RESULTS HAVE BEEN IMPRESSIVE.

Blick rose to the challenge. He approached the disease as though it were a chronic, but treatable and manageable illness, stressing a preventative approach that emphasizes nutrition, vitamin therapy and regular cardiovascular exercise for keeping the immune system strong, along with stress management and support groups.

"I'm very grateful to Gary," says Jim, a 37-year-old patient. "He instills hope in his patients and empowers them to be part of their own healing process."

Word of Blick's practice spread among the HIV support community and his HIV caseload grew rapidly.

In 1990, Volvovitz was approached by Phil Zwickler, editor of the People With AIDS Coalition's *Newsline*. Zwickler pleaded the case for more VaxSyn trials, and put Volvovitz in touch with Blick. That phone call led to the first community-based trial of VaxSyn in October 1990. "It was a natural choice to make," says Volvovitz. "Blick already had all the technology in place to run clinical trials."

Those first trials at Blick's office, conducted on 30 patients, were the first time VaxSyn was tested on people with more advanced HIV infection. With the decline of CD4 T-cell counts being the accepted gauge of HIV progression, participants in the Walter Reed trials had been selected only if they had 400 or more T-cells. Blick's volunteers had between 0 and 500 T-cells. (Healthy, uninfected adults can have anywhere between 800 and 1200.) The results have been impressive.

One participant, Peter, who'd had a T-cell count of only 10 before going on VaxSyn, was up to 800 T-cells a year-and-a-half later. "My immune system is stable and normal," he says today. "I haven't been sick one day with any HIV-related problem."

Then, in June 1991, encouraging early results from the Redfield studies at Walter Reed, published in *The New England Journal of Medicine*, made headlines. Blick began expanded Phase II trials of VaxSyn, adding 100 new patients to a second study.

But by October, Blick found himself suspended from practicing at Greenwich Hospital. The hospital had charged Blick with failing to provide quality care to his hospitalized patients.

Blick claimed the charges were a case of not-in-my-backyard discrimination, with Greenwich Hospital trying to protect the affluent community's reputation as the idyllic white-steepled suburb insulated from the reality and urban horror of AIDS. Blick's AIDS practice had expanded beyond a handful of well-to-do white men to include those from other socioeconomic populations also affected by the disease.

With the financial support of a well-organized group of private sympathizers, Blick mounted a full-scale discrimination suit against Greenwich Hospital.

Despite the toll all this took, he continued VaxSyn trials, with encouraging results.

► 117

◄ 67 Jim, who's been HIV-positive since 1986, stopped taking AZT—the most common treatment for HIV/AIDS, though its effectiveness is limited—altogether a year ago and has seen a strong improvement in his blood profile. "If you'd told me six years ago that I'd still be around . . . putting money away for retirement," he says, "I would have told you that you were crazy. I've just gradually switched over to believing I'm like anyone else. I'm going to live a normal, healthy life.

"I no longer live my life like this is going to be my last summer, my last Christmas—the maudlin stuff we used to go through five years ago," he says.

Lorraine, a 31-year-old photographer, comes all the way from California every three months for vaccinations. Her cell counts remain stable and she's had no symptoms of opportunistic infections since going on VaxSyn. "I'm very optimistic," she says. "I've started going back to school. I want to be a teacher."

While MicroGeneSys provides VaxSyn free of charge, patients in Blick's trials must pay for the bloodwork necessary after each vaccination. With vaccinations every month for the first six months and blood work costing over $500 for each vaccination, participating in the trials is an expensive proposition. After the first six months, the vaccinations are required only every three months.

In July 1992, results from Redfield's trials, Blick's trials and three other therapeutic VaxSyn studies were presented at the VIII International Conference on AIDS in Amsterdam. Heightened antibody response to HIV in most of the trial participants was reported, including those in Blick's trial who had between 200 and 500 T-cells, though results for those with fewer than 200 were not as promising.

Still, Volvovitz, Blick and Redfield were excited. In his report to the conference, Volvovitz said the data "clearly suggests the feasibility of controlling disease in HIV-infected individuals with VaxSyn," and "that genetically engineered vaccines may stimulate the immune system of HIV-infected people to halt, if not defeat, HIV."

At that point, Volvovitz came up with an unorthodox strategy to win further government financial support for the VaxSyn tests: Rather than wait patiently for the National Institutes of Health (NIH) to dole out research funds, he employed a prominent Washington, D.C. lobbyist to gain a $20 million congressional appropriation for Phase III efficacy trials of VaxSyn as part of the Army's AIDS research budget.

The move caused an uproar, with NIH Director Bernadine Healy saying "lobbyist-directed research" set "a very dangerous precedent for the entire biomedical research enterprise."

While the $20 million did get appropriated, it was with the provision that the NIH review the appropriation. NIH determined that the money should be used for trials of several manufacturers' vaccines and not just for MicroGeneSys'. Many feel this is justified because the multiple strains of HIV and the ability of the virus to mutate itself may require several vaccines or a "cocktail" vaccine (made up of a range of molecules cloned from the AIDS virus).

Volvovitz thinks NIH wants to find the perfect vaccine before one is approved by the FDA. "But it may take a year or more just to develop the infrastructure for these trials," he says. "By that time we'd already have an answer. Penicillin wasn't perfect when it was first approved."

NIH's decision to divide the $20 million among several manufacturers may also be due to pressure from the pharmaceutical companies. "It's a very competitive field. The market potential is hundreds of millions of dollars, with the first company to get FDA approval winning the lion's share of that market," says Steve Delco, president of DSR Inc., a biotechnology market-research company in Fairfield.

It has yet to be determined how a preventative AIDS vaccine might be administered. Would the vaccine be given only to populations at risk or would it be administered as a nationwide childhood vaccine, like those for polio or smallpox? There are tremendous liability factors involved in introducing a new childhood vaccine, not to mention the moral questions raised by administering a vaccine for a disease that is often sexually transmitted.

For now, the primary focus is on developing a vaccine that will help those already infected with HIV. Were it not for Volvovitz's impatience and his unorthodox lobbying effort, it is questionable whether any vaccines would now be going into the expensive final stage of efficacy trials needed for FDA approval. "We'd be even further behind than we already are now," says Volvovitz.

In the meantime, seeking to avoid a costly and potentially embarrassing discrimination suit in the face of a planned $116 million expansion, Greenwich Hospital has reinstated Gary Blick. And Blick has a waiting list of volunteers eager to participate in Phase III VaxSyn trials. Encouraged by other trial participants' results, they see VaxSyn as a way to turn their HIV from a death sentence to something they can live with.

As Jim says, "I really feel more like a diabetic . . . I've made adjustments in several areas, but otherwise I lead a pretty normal, happy life." ■

AIDS VACCINE

Vaccine for AIDS

Salk's project draws doubt

By Sheryl Stolberg
Los Angeles Times

BERLIN — Releasing long-awaited test results, polio vaccine pioneer Jonas Salk announced yesterday that his experimental AIDS vaccine appears to boost the immune systems of people infected with the human immunodeficiency virus. But his work met with immediate skepticism from other scientists gathered here at the Ninth International Conference on AIDS.

"I'm less than enthusiastic," said David Ho of the Aaron Diamond AIDS Research Institute in New York. Said Robin Weiss, the renowned British virologist, of the presentation by Salk's collaborators: "It was a dog-and-pony show."

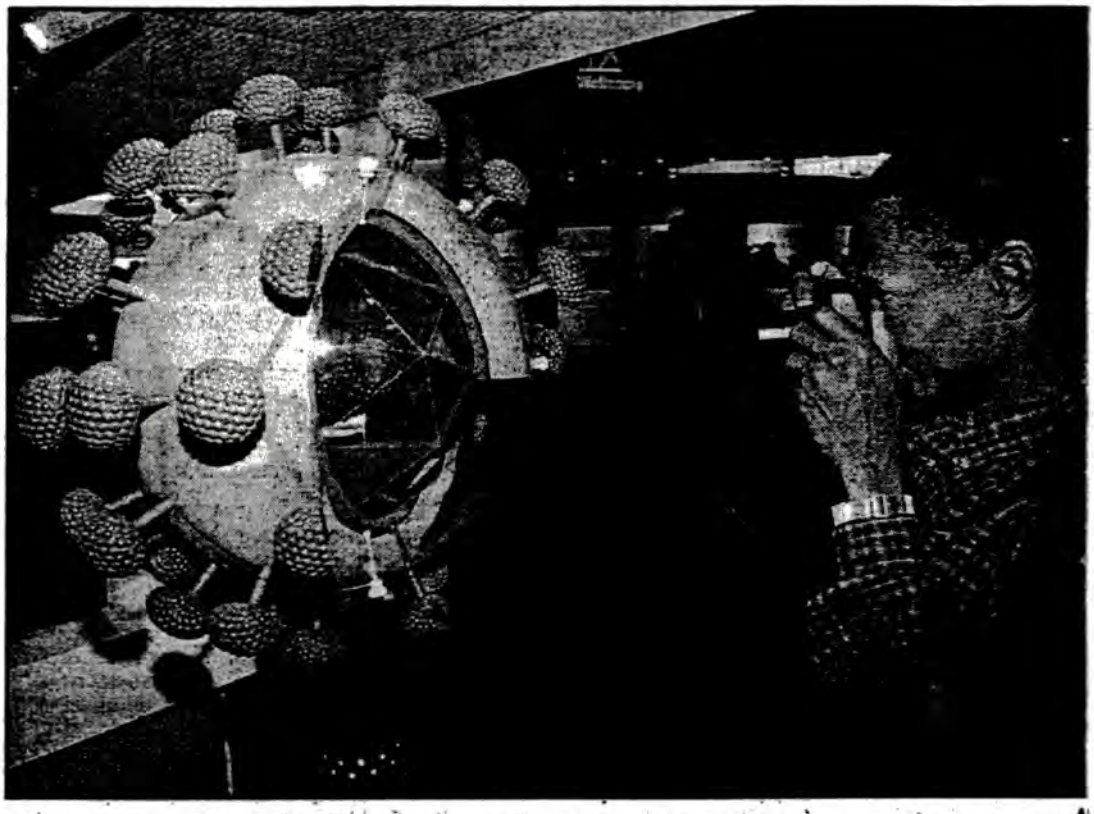
And in a sense, it was.

Yesterday in Berlin was a media jamboree that only Salk, with his love-hate relationship with the limelight, could attract. As cameras rolled and reporters scribbled during a news conference that was linked by satellite to the United States, the 78-year-old scientist simply smiled and shrugged off the attacks.

"We've been explorers," he said. "We're like Columbus going to India and finding America and saying, 'That's not where I was headed,' and then he still didn't know that there was St. Louis and San Francisco."

He acknowledged that the results of his double-blind, placebo-controlled study — a tightly guarded secret until yesterday — were far from conclusive.

Still, Salk and his commercial partners — Carlsbad, Calif.-based Immune Response Corp. and Rhone-Poulenc Rorer, the French pharmaceutical giant — said that their findings were encouraging enough to warrant a large-scale clinical trial, conducted over a long period, that would demonstrate whether the vaccine truly helps people live longer.



A visitor to the AIDS conference yesterday takes a photo of a model of the AIDS virus at an information stand in Berlin's Congress Center. The man, from Burundi, did not give his name.

Unlike traditional vaccines, the so-called Salk Immunogen is a "therapeutic vaccine," designed to improve immune response in infected people rather than prevent infection.

Several preventive vaccines are also being tested in humans; in a plenary address at the conference Wednesday, AIDS expert Dani P. Bolognesi of Duke University said two of those vaccines look promising and could proceed to large-scale clinical trials next year.

While most experimental AIDS vaccines rely on modern genetic engineering techniques, Salk is using an old-fashioned approach that employs a killed form of the AIDS virus — the same approach that worked for him nearly 40 years ago with polio.

His critics have said that is far too blunt an instrument for such a sophisticated invader as HIV. But Salk, no stranger to criticism, has pushed ahead.

The vaccine was tested in three separate clinical trials over a six-year period. The first, conducted at a Los Angeles County University of Southern California Hospital under the direction of noted AIDS researcher Dr. Alexandra Levine, involved 23 homosexual men and concluded the vaccine was safe. The second, at the University of Pennsylvania, was designed to determine the correct dose.

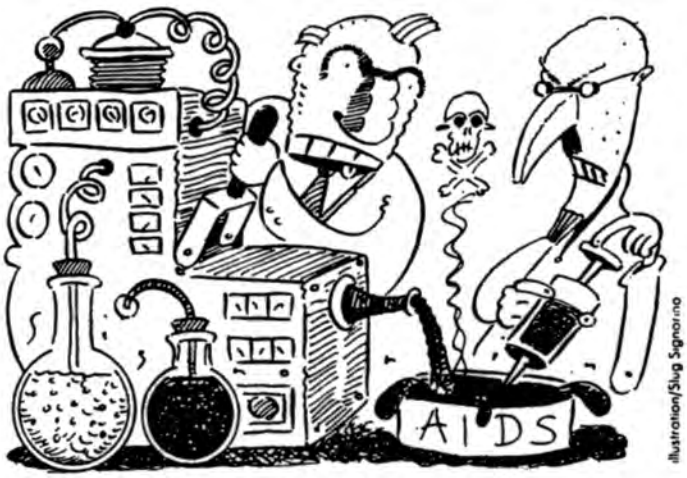
The largest, most recent and most significant trial was a one-year study in which the vaccine was compared to placebo in 103 HIV-infected volunteers, none of whom showed symptoms of AIDS at the outset. The study's timetable was too short for researchers to measure their success in terms of health; the asymptomatic patients were unlikely to become ill within a year. Instead, the scientists examined "surrogate markers" — biological changes — including levels of HIV in the blood detected through an extremely sensitive test called polymerase chain reaction, or PCR.

According to Levine, the hematologist who presented th sults, the tests showed three st cally significant changes in those took the vaccine vs. those wh not:

Vaccinated patients devel more antibodies to a core prote HIV. They also showed stable l of "viral burden" — the amou virus in the blood — while unva ated patients showed an incr And their CD4 cells — the imr system cells that are the main ta of HIV — demonstrated impr function.

But several prominent resear who attended yesterday's talk not convinced. In instant ana delivered in the corridors of the ference center after Levine gav talk, they complained that the r showed only trends, rather tha tailed data for individual pati and questioned the precision o PCR tests used by Salk's group.

THE STRAIGHT DOPE



illustration/Slug Signorino

There are two main alternative AIDS theories

The enclosed ad describes something called The Strecker Memorandum, *a video that purports to show that AIDS is a man-made disease. This sounds like the usual AIDS-conspiracy mumbo jumbo, but it's so well documented it's made me wonder. Can you get to the bottom of it?*

—Edna Welthorpe

Cecil is reluctant to spend too much time on this, because it seems so obviously nuts, but I've gotten a few letters about it and hey, we live to serve. There are two main alternative AIDS theories, as we might call them: the Strecker AIDS theory and the Duesberg risk-group theory. The Strecker theory, which is the wilder of the two, is the work of Roberto Strecker, an L.A. gastroenterologist. He claims that "AIDS was a disease that was requested, manufactured and deployed and does exactly what it was intended to do," i.e., it's a germ weapon.

Strecker says scientists cooked up AIDS around 1972 from something called "bovine visna virus." He guesses that smallpox vaccine made from the lesions of BVV-infected cattle was injected into humans in Africa, where it transmuted into AIDS. One item of evidence in support of Strecker's theory is a quote from the July 1, 1969, *Congressional Record* in which a physician mentions a government-sponsored research project that would create a "synthetic biological agent...for which no natural immunity would have been acquired."

Strecker's work has been expanded on by a host of others. Among the claims (I rely here mainly on a 1990 story in *Essence*): (1) It was invented by the CIA or (2) the Russians. (3) It was manufactured at the U.S. Army Biological Research Center in Fort Detrick, Maryland. (4) It has something to do with Agent Orange. (5) It was invented to kill black people; gays were a pilot test. (Crack cocaine was also created to destroy blacks.)

Mainstream AIDS scientists say Strecker's a kook. From a microbiological standpoint, HIV bears little resemblance to bovine visna virus; it bears a lot of resemblance to simian immunodeficiency virus (SIV), from which HIV is widely thought to have naturally evolved. There may have been some proto-AIDS cases substantially predating 1972. And frankly, inventing a fatal disease that singles out minorities, gays, and drug abusers would require the CIA/Russians/U.S. Army to be a lot smarter a lot earlier in the day than there is any evidence of them ever being.

The Duesberg risk-group theory isn't quite as bizarre. Peter Duesberg, a respected (until now) virologist at UC Berkeley, says human immunodeficiency virus (HIV) doesn't cause AIDS, as is otherwise almost universally believed. Instead, AIDS is caused by a general weakening of the immune system due to drug abuse, disease, parasites, malnutrition (in Africa), etc. Evidence: U.S. AIDS patients don't get the same opportunistic diseases that African AIDS patients do; predictions of a sharp upswing in heterosexual U.S. AIDS cases have not come true; the HIV virus isn't especially virulent and is suppressed by the immune system, etc.

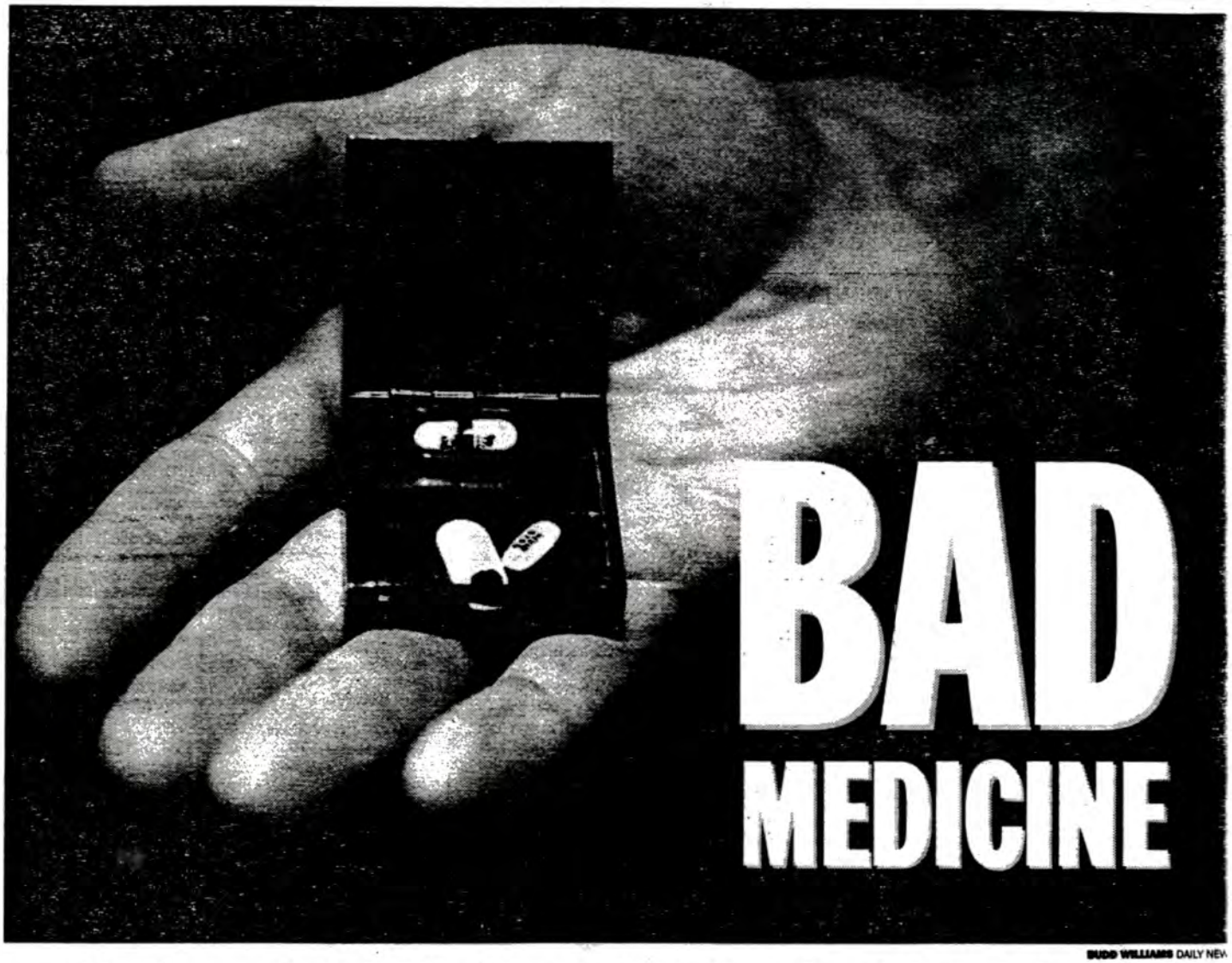
Duesberg's ideas, like Strecker's, are dismissed by mainstream AIDS researchers. The main counter-argument is that people without HIV don't get AIDS (although a couple apparent exceptions have turned up), while most of those with HIV do get it. Also, drug abuse, parasites, malnutrition, and so on have been around for a long time, but nobody got AIDS until HIV showed up.

Still, Duesberg isn't a paranoid conspiracy theorist like those in the Strecker crowd. A few scientists think he may be on to something; more than a hundred have joined the Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis. There have been efforts to portray the guy as a latter-day Galileo, scorned but maybe right. Cecil, Lord knows, isn't about to dismiss a fellow contrarian out of hand. But I wouldn't bet the mortgage money on him either.

CECIL ADAMS

DAILY NEWS

$1.00 NEW YORK'S HOMETOWN NEWSPAPER Sunday, June 13,



BUDD WILLIAMS DAILY NEV

Black market AZT, often tainted and outdated, is sold to unsuspecting AIDS patients through illegal pill mills and seemingly legitimate pharmacies.

PAGE 5

By BRIAN KATES
Daily News Staff Writer

NEWS • Sunday, June 13, 1993

THE ANTI-AIDS DRUG AZT and other vital medicines — watered-down or tainted — are being sold at full price to unsuspecting patients through a thriving New York-based black market.

Authorities say that the medicine — bought cheap from Medicaid patients or stolen from samples intended for doctors — may be outdated and change hands a half-dozen times with no regard for proper storage or sanitation as it passes from street-level dealers to repackagers to sophisticated black marketeers.

By the time AIDS patients buy AZT — from seemingly legitimate pharmacies as far away as Puerto Rico — expiration dates have been altered and packages refitted with forged labels and counterfeit instructions so they have no clue they are not receiving safe, effective medicine.

"What they did to me was attempted murder," said Eric Pesantez, an AIDS patient who is suing an upper West Side pharmacy the FBI busted for selling black market AZT.

In some cases, "drugs in capsules have been replaced with talcum powder or other substances, a circumstance that can be proved only by laboratory analysis," said FBI Special Agent Jaclyn Zappacosta.

In raids on black market pill mills in the Bronx, state investigators reported finding "plastic bags containing thousands of loose prescription drugs" — including AZT — "in closets, in suitcases and stuffed in dresser drawers."

While much of this AZT is sold in the metropolitan area, "a significant percentage of it, no one can say for sure how much, is smuggled across state lines," said Special Agent William Esposito, former chief of the FBI's white-collar crime division.

QUICK TURNAROUND TIME

Some of it, state Medicaid fraud investigators report, comes into the city through black market pipelines in New Jersey, Connecticut, Massachusetts and Maine.

"Amazingly, it took less than three days for a bottle of AZT dispensed in Maine to make its way onto the black market in the Bronx," said state special prosecutor Edward Kuriansky.

"It is truly outrageous that pharmacists would take advantage of people with AIDS, people who are so sick and vulnerable, in this way," said David Eng, a Gay Men's

The economics of the AZT black market are simple. Without paying a dime, a Medicaid patient gets medicine that costs the taxpayer $200 and sells it on the street at 10 cents on the dollar.

The AZT is then sold again, mixed with pills from dozens of other Medicaid patients, to a "non-con man," street jargon for a dealer in noncontrolled prescription drugs.

The dealer, mixing it with medicine bought from other patients, sells it to a repackager. It is bottled with forged labels and bogus instruction inserts and sold to a black marketeer, who peddles it to a pharmacist for about 65% of its value. The druggist sells it at full value.

Everyone profits — except the taxpayer and the AIDS patient, who believes the medicine to be safe and effective.

In raids last June, federal agents arrested 100 people in 17 cities — 69 of them in the metropolitan area — for peddling black market AZT and other prescription drugs. The operation was the largest of its kind.

But "hundreds, perhaps thousands, of cases (federal authorities) already know about are not being investigated, let alone prosecuted," said Rep. Charles Schumer (D-N.Y.), chairman of the House subcommittee on crime.

And, Schumer added, the feds are so "ill-equipped, undermanned and overwhelmed" by the problem that "it's like we've sent Barney Fife out to meet the Terminator."

The AZT black market begins pill by pill with people like Nilda Santana, a Bronx Medicaid patient whose AZT prescription label was found in a federal raid at a Washington Heights pill mill.

Santana obtained the bottle of Retrovir — the AZT brand name — at the New Pharmacy on Third Ave. in the Bronx, said an investigative source.

The capsules were sold to a neighborhood non-con man — starting them on an illicit odyssey to Puerto Rico. On the island, with the fourth largest per capita incidence of AIDS in the country, the capsules "might well carry a $600 to $700 price tag," said Kuriansky.

"These drugs, man, they jump around in price like the stock market," said Randy A., a Harlem street hustler who spoke to The News on the condition his full name not be used. "Sometimes one drug is high, other times it's something else that's the hot thing. But AZT always gets a good run."

The street hustler who bought the AZT likely sold it to Geronimo Espinal, who, until he was arrested last summer, was among the neighborhood's top non-con men, federal agents said. Espinal's apartment on Hennessey Place is near the pharmacy.

Espinal was one of dozens of dealers from the South Bronx, Bedford-Stuyvesant and Harlem who showed up regularly at Joseph's Beauty Supply, a shabby storefront at Broadway and 159th St. in Manhattan, to sell plastic bags filled with AZT and other drugs hustled off the street.

When federal agents raided Joseph's, they found checks to Espinal from Jose Vargas, the owner of the shop, who is awaiting sentencing on federal charges.

ELABORATE OPERATION

The AZT would have been worth about $65 to Espinal, who sold drugs there in lots of $2,000 or more, federal sources said.

Susan Brune, an assistant U.S. Attorney who has prosecuted more than a dozen black marketeers, including Espinal and Vargas, described Joseph's as "an operation that bought, repackaged and sold diverted prescription drugs ... with a particular emphasis on Retrovir."

AZT FROM PAGE 5

An FBI operative posing a black marketeer paid cents each for 5,000 loos AZT capsules in plastic ba and reported seeing 1,0 AZT bottles on a table in th store's second-floor offic where a man and woma were hastily resealing an putting forged labels o them.

There were as many a 100,000 forged Retrovir l bels in the store, according t an FBI agent who requeste anonymity.

AZT was only one of th drugs channeled through J seph's. The place also dea in black market Tagamet (u cer medicine), Zantac (fo gastric problems), Nupoge (for a blood disorder), Pr ventil (for broncho-spasm and other pricey prescriptio pharmaceuticals.

But black market AZT wa what Joseph's Beauty Supp was all about.

When Vargas bought J seph's in November 1990, th owner — convicted blac marketeer Roberto Martine — set the price at two shi ments of AZT, according t federal court papers.

There is no record of how big those shipments were But consider this: In 1987 when Martinez, a Cuban exile who attended Long Islanc City High, bought the stor from fugitive black marke teer Niero Mora, he was a $70,000-a-year businessman according to court papers.

In the first year he operat ed it, Martinez admitted ir court testimony, his incom jumped to about $300,000. B 1990, he was making $500,00 a year.

The business continued t prosper after Vargas bough it.

By last summer, court pa pers reveal, he was getting a much as $40,000 a week fo the AZT and other prescrip tion drugs he sent to Mart nez, who moved to Miami i 1989 and was smuggling blac market medicine to San Juan

Bad medicine for an AIDS sufferer

By BRIAN KATES
Daily News Staff Writer

AIDS PATIENT ERIC PESANTEZ was getting sicker, and neither he nor his doctor could understand why.

Then last summer, when he went to his pharmacy to refill his prescription for AZT — the life-prolonging anti-AIDS drug — there were "FBI agents all over the place," he said.

Apthorp Pharmacy, which had operated for more than 20 years at 78th St. and Broadway, had been busted for selling adulterated drugs.

It was among 33 drugstores in the metropolitan area raided that day as part of a vast black market in prescription drugs.

"Suddenly, things began to make sense," Pesantez said.

A graphic designer, Pesantez, 29, was diagnosed as HIV-positive in June 1990. In August 1990 his T4 — or white blood cell — count was a relatively healthy 465. But in April 1992 — five months after he started filling his AZT prescription at Apthorp — it dropped to 295, indicating a major and mysterious decline in his condition.

"I was concerned," said his physician, Dr. Barry Rosenthal. "But it seemed prudent to wait until his next blood test before getting unduly alarmed."

On June 30, after the next test, Pesantez' T4 cell count had dropped to 243. That was the day he saw the FBI agents at Apthorp.

"I freaked out," Pesantez said. "I was going to die because of their greed."

Pesantez has sued Apthorp and the druggists there who sold him AZT, Steven Goldfarb and Kenneth Cohen, as well as the black marketeers convicted of supplying the store — Martin Bobb, Donald Solof and the kingpin, Stanley Jacobson.

The suit charges them with "failing to dispense unexpired, properly labeled, fully potent" drugs.

After switching to another pharmacy, Pesantez' cell count began rising and is hovering at 318 — an improvement, but far from what it had been when he began patronizing Apthorp.

No one knows how many people were harmed.

DRUGS BY EXPRESS MAIL

When Martinez received the shipments — he was so brazen he often had Vargas send drugs directly to his home by express mail — he would send them to Nelson Narciso Reyes Villar, a confederate in Puerto Rico, according to federal prosecutors in San Juan.

If the medicine had not already been doctored with bogus labels and safety seals, Villar would do the job, storing hundreds of thousands of misbranded and adulterated drugs in his house on Arturo Arches Dias St. in Carolina, Puerto Rican law enforcement officials said.

Villar, serving a federal sentence in Puerto Rico, sold the drugs through a photocopied flyer he distributed to pharmacies all over the island.

Perhaps Nilda Santana's AZT wound up on a shelf at Farmacia Prako on Las Flores St. in Catano, P.R., one of the pharmacies authorities say Villar sold drugs to.

Or maybe it found its way into the vast stockpile of Aurora Arguelles Archilla, who, federal prosecutors in San Juan charge, paid Martinez and other New York City black marketeers more than $1.1 million in 1991 and '92 and greased Villar's palm with nearly $640,000.

Using her legitimate prescription drug wholesaler's license, Archilla distributed outdated and adulterated drugs to pharmacies in Puerto Rico and shipped untold quantities back to Miami, federal authorities said.

The Martinez ring has been broken; Espinal, Vargas and Martinez have all been convicted or pleaded guilty. But the Medicaid patients who sell their drugs on the street remain virtually beyond the reach of the law.

"It would be naive to believe that we have put an end to all this," said prosecutor Brune. "We have made a beginning, but clearly there is a long way to go."

KINGPIN SENTENCED

Several Manhattan Federal Court judges have been thinking about this for nearly a year, but have meted out punishment to only one — Steven Goldfarb.

Goldfarb, whom Assistant U.S. Attorney Susan Brune put "at the very top" of the corrupt druggists who dealt with Jacobson, pleaded guilty to charges that could have put him behind bars for five years and hit him with $225,000 in fines.

But Judge Kevin Duffy gave him six months in prison and six months home arrest. The fine was $40,000. And in two years Goldfarb can apply for the restoration of his pharmacist's license.

Over five years, Apthorp pharmacists paid at least $940,000 to Jacobson, who has confessed that for eight years he peddled medicine he knew could be outdated, disguised with forged labels and bogus safety seals, stolen from hospitals or meant for Medicaid patients.

The pharmacists have admitted selling this medicine — knowing the potential harm — to heart patients, women with breast cancer, people with severe infections or ulcers or agonizing pain — even to people with AIDS.

Jacobson's inventory of black market pills was so large that he rented a small warehouse on Route 109 in Farmingdale, L.I., to store it and needed a computer to keep track of it.

He sold the medicine to at least 10 pharmacies in middle-class neighborhoods of Long Island, Manhattan, Brooklyn and Queens at prices vastly lower than they could expect to pay through legitimate channels.

CHORTLING SCAMSTER

In one phone call — bugged by the FBI — Jacobson noted that medicine he was peddling had come from Medicaid patients in Harlem. "Your tax dollars are paying for this," he chortled.

Some of Jacobson's drugs had been stolen from Jamaica Hospital. Some were provided by a corrupt pharmacist at Nassau County Medical Center.

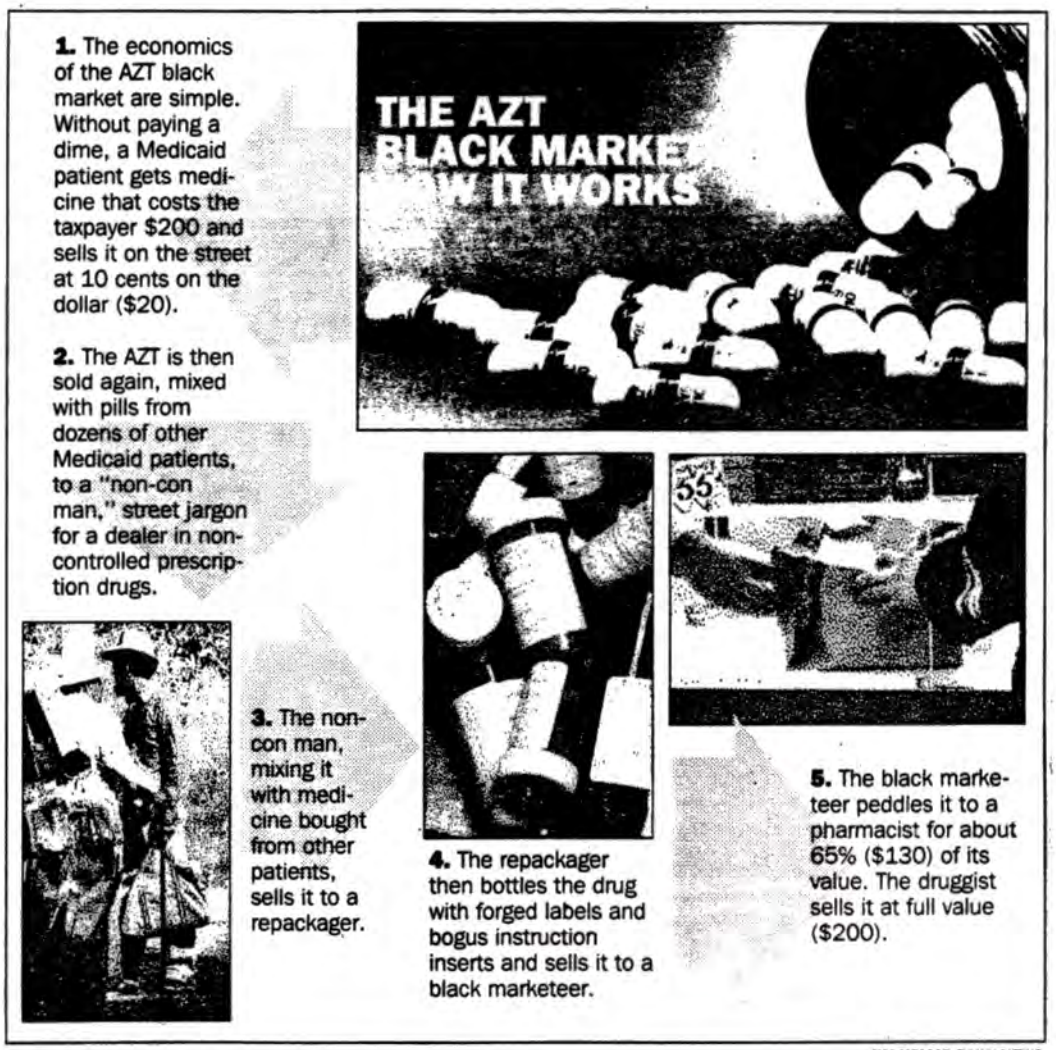
For Jacobson, the black market was a family affair.

His wife, Nora; his son Alan, and Alan's father-in-law, Lawrence Galina, also have pleaded guilty to charges stemming from the sale of black market medicine.

In one of the phone calls the FBI tapped, Jacobson and his son discussed the business, and Alan said: "You're such a great father because you want your son to make money."

Stanley Jacobson faces five years in prison on one count and 10 years on another and the forfeiture of $410,360. His wife faces 10 years and a $250,000 fine. Alan Jacobson is undergoing court-ordered psychiatric testing.

Apthorp is doing business under new management.



JIM WILLIS DAILY NEWS

AIDS news dispiriting

By DOLORES KING
Boston Globe

BERLIN — In ceremonies marked by protest and disagreement, the Ninth International Conference on AIDS closed here after a week of few major scientific advances and the release of more grim worldwide statistics about the disease.

AIDS activists chanted, "No more talking. We want a cure" during French Health Minister Philippe Douste-Blazy's speech, and public health officials, scientists, women and indigenous people called for more to be done about the epidemic that is estimated to have infected 14 million people.

"Clearly, the AIDS pandemic is an emergency, but society is responding as though it is not," said Lars Kallings, a Stockholm scientist who helped plan the conference that ended Friday. "The news is, the epidemic is still on the rise."

While the science goes slowly, public health officials and scientists called for more efforts in prevention.

Yamil H. Kouri, a Harvard researcher, said, "We need to change our priorities. We need to emphasize prevention, and we need to allocate the resources for it."

The World Health Organization has estimated that an investment of up to $2.5 billion a year could mount effective AIDS prevention programs that could cut in half the number of estimated new infections in the developing world by the end of this century.

FOUNDED IN 1801 BY ALEXANDER HAMILTON

NEW YORK POST

SPORTS EXTRA

NEW YORK'S $30B AIDS TIMEBOMB

. . . and that's just for starters

Full details on the disease's staggering financial toll: Pages 4, 5 and 15

NEW YORK'S $30

NEW YORK POST, MONDAY, JUNE 14, 1993

AIDS NIGHTMARE

Shattered dreams & broken hearts

By ROCCO PARASCANDOLA

It was their dream come true.

For 13 years, Stephen Bernstein and Daniel Cass ran Modern Food, a successful catering business that served the high and mighty — from Robert Redford to Henry Kissinger to Barbara Walters to Polly Bergen and her famous Oscar-night parties.

Their success enabled them to chase a second dream — opening a restaurant near Woodstock in upstate New York.

But a short time later, Cass, Bernstein's companion as well as partner, became ill. He died of AIDS in May 1989 at the age of 39.

"I tried to keep the restaurant going, but it got to be overwhelming," said Bernstein, 52. "My mind was always on Daniel.

"My heart was broken. I couldn't go on. I kept the restaurant open for the entire summer. Then I closed it after Labor Day weekend."

And when he did, eight full-time workers and several part-time employees lost their jobs. Another dozen or so in the city also became unemployed when Bernstein decided to shut down Modern Foods.

"A lot of people were out of work," said Bernstein, who now works in an East 57th Street art gallery. "And it took them quite a while before they found work."

Danny Cass' death illustrates how the AIDS virus can have a profound impact on people beyond immediate family and loved ones.

The ripple effect can be far reaching.

Tax dollars were lost from the people who worked for Cass — at the restaurant and in his catering business.

The restaurant building, which now stands shuttered, has failed to generate real-estate taxes for the past four years.

Considering the number of people who have succumbed to AIDS or contracted the HIV virus, the loss in dollars and cents can be devastating.

"It strikes people in the 25-to-44 age range," said Paul Farnham, a visiting health economist at the federal Centers for Disease Control.

"These people are dying very young. They would probably have worked another 30 years or so."

That's 30 years of lost income and productivity, 30 years of lost tax revenue, and 30 years in which a person could have

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DREAMS *from Page 4*

provided services or made decisions that affect many.

Indirect financial losses, the kind demonstrated in Danny Cass' case, make up a staggering 84 percent of the monetary toll taken by AIDS, Farnham said.

"The proportion is very high, and I think that's an important thing for people to understand," said Farham.

Richard Jasper, 40, was the successful owner of a management-consulting company until he was forced to liquidate his business when he learned he had contracted HIV.

"First, I tried to borrow from family and friends," Jasper recalled. "But your pride hits bottom . . . very quickly."

As Jasper scaled down his business, he found jobs for his six employees.

He then moved out of a fashionable rented Chelsea townhouse into a much smaller studio apartment in Midtown.

"It was a shock to me — the expense of AIDS," Jasper said. "I traveled all over the world, summers in the Hamptons, the whole bit.

"Now I live day-to-day. I went from eating at the Russian Tea Room to boiling rice and beans."

As Jasper sits in his empty apartment, he realizes the scope of the AIDS crisis.

"It didn't just affect me," he said. "It was people working with me. There was my family, my friends, my clients.

"It became difficult to get business. I'd walk in and there were people who just said, 'I don't think so.' "

"These people are dying very young. They would probably have worked another 30 years or so."

PAUL FARNHAM, CENTERS FOR DISEASE CONTROL

AIDS "is the No. 1 killer of both men and women age 25 to 44 in New York City."

DR. DAVID ROGERS, HEAD OF THE STATE AIDS ADVISORY COUNCI

Disease taking disastrous toll on city's economy

By ROCCO PARASCANDOLA

The cost of caring for New Yorkers inflicted with AIDS and the HIV virus that causes AIDS will reach at least $30 billion over the next 10 years, according to the city's leading medical authorities.

And that's only the beginning. With an estimated 235,000 HIV-positive city residents, the AIDS price tag — borne by individuals, insurers and local, state and federal governments — could easily climb to $50 billion and beyond.

But the true cost of AIDS goes far beyond health care.

AIDS patients and health experts agree that the deadly disease has dramatic indirect costs that most people do not even recognize.

For example, the $30 billion to $50 billion price tag does not include the new HIV cases that will arise in the coming years.

Nor does it factor in lost workplace productivity and the tens of billions of dollars in taxes contributed by these members of society — among them many of the city's most talented and influential people.

"It's a monstrous epidemic," Dr. David Rogers, professor of medicine at New York Hospital-Cornell Medical Center and head of the state AIDS Advisory Council, told The Post.

"It's already killed more young people than our last three wars combined," said Rogers. "We chose to ignore it for so long because it started in the gay population and drug population.

"But now it's moving relentlessly to our teen-agers — and it's the No. 1 killer of both men and women age 25 to 44 in New York City."

Ronald Johnson, city coordinator for AIDS policy, says those who think AIDS doesn't affect them are mistaken.

"Many people still distance themselves from the epidemic, particularly if they don't have someone in the family who has AIDS," he said. "But it's a lot closer than most people think."

A closer look at the extraordinary impact of AIDS bears out Johnson's observation.

> ***"Many people still distance themselves from the epidemic."***
>
> RONALD JOHNSON, CITY COORDINATOR FOR AIDS POLICY

Beyond the $30 billion health bill, there are these other non-retrievable losses:

- An estimated $150 billion in income that AIDS and HIV patients would have earned in their lifetime had they not taken ill.
- At least $1 billion in taxes they would pay each year to the city, state and federal governments if they remained in the work force. (The city's AIDS budget is about $420 million for fiscal year 1994.)
- The billions of dollars in productivity losses to local companies each year.
- The incalculable lifetime costs for a new and growing class of AIDS victims — orphans who are the healthy offspring of mothers or fathers who have died of the disease.
- The drain on the city's public-assistance programs — unemployment, welfare, food stamps, disability and foster care, among others.
- The proposed $59 million needed this year alone for rent assistance and other housing costs for thousands of afflicted New Yorkers.
- The cost of drug and alcohol rehabilitation for despairing AIDS patients — and their sons, daughters and other relatives whom

See **AIDS** *on Page 15*

NEW YORK'S $30B AIDS NIGHTMARE

AIDS *from Page 4*

experts say often cannot cope with seeing their loved ones suffer.

- An estimated $1.2 billion paid out by insurance companies annually for AIDS-related death benefits and health claims.

And none of these stark statistics contains the immeasurable emotional cost of broken dreams.

"There is definitely a domino effect," said David Eng of the Gay Men's Health Crisis.

"It doesn't just affect one person. I think some people realize it — but most people do not."

But it's difficult to ignore the hard numbers.

Nationwide, 289,320 people are known to have contracted AIDS, of which 182,275 have died since the disease was identified.

According to the latest statistics, 50,724 of those affected are New Yorkers, 33,743 of whom have died, including 647 infants.

Even more frightening is the number of those who are HIV-positive.

Health authorities estimate that 1 million people nationwide have the virus — 125,000 to 235,000 of them in the city alone.

"My personal belief is it's closer to 235,000 — if not higher," said Johnson, citing the high numbers in the city's high-risk groups.

On average, the lifetime health-care costs for each AIDS patient is $102,000.

At the outset of the disease, it costs about $10,000 in medical care for those with HIV. But the the price skyrockets to $38,300 a year when the victim develops full-blown AIDS.

And authorities say the expense is even greater in New York because of the region's higher medical costs.

But with the rising cost of health care — and an often-slow reimbursement process by insurance companies — social-service programs provide barely enough for patients to get by, much less live with dignity.

"I have never seen anyone go through the course of the disease without impoverishing themselves," said Ruth Finkelstein, GMHC's director of policy. "And it's wrong that being sick can be financially ruinous."

To compensate, many AIDS patients — when they've borrowed all they can from family and friends — turn to a growing number of companies that will buy their life-insurance policies at a discount.

The ill get much-needed cash and the companies are paid the full amount when the patient dies.

In 1991, the latest year for which statistics are available, life insurers paid out $756.5 million in AIDS-related death benefits, up from $648 million the year before.

Despite anticipated increases in such payouts, most life-insurance companies cut their losses by refusing to insure those with HIV.

Premiums have increased each of the last three years by about 20 percent for Empire Blue Cross/Blue Shield and about 15 percent among health-maintenance organizations.

But AIDS is "not a significant factor" in the rising cost of health insurance, said John Calagna, a spokesman for the state Department of Insurance. He cited increased costs for hospital care, doctors' fees and medicine as the main factors.

Larry Mayewski, a senior vice president for A.M. Best, an insurance rating firm based in New Jersey, said AIDS has "been a manageable issue for the insurance industry. It's been up to 3 percent of our claims, at most."

Authorities say some companies, to avoid accusations of discrimination, have altogether stopped insuring certain groups — such as non-profit organizations, many of which are AIDS advocacy or support groups.

The toll on the workplace, however, is likely to worsen because the average AIDS victim has his working life curtailed by an average of 30 years.

According to government statistics, the average resident of the New York metropolitan area earns $35,074 a year.

The average income of an AIDS victim in New York city, however, is estimated to be sligthly lower because 46 percent of AIDS patients are intravenous-drug users who are less likely to work steadily — if at all. (The other two leading categories are homosexual or bisexual males, 33 percent, and women who have sex with infected men, 5 percent.)

At an average salary of only $25,000 a year, the lost income for all city AIDS victims, if they were to work another 20 years, would be $142 billion.

In tax revenue, that would translate into at least $35 billion.

And those figures account for only the current number of AIDS and HIV cases.

A new definition of the illness — in which people with various symptoms will for the first time be classified as having AIDS — is expected to increase the number of those with AIDS by about 15,000 this year — more than double the 6,000 to 7,000 cases that were added to the list in each of the last few years.

"We have seen nothing like the misery that's going to hit us," Rogers warned ominously. "It's going to get much worse before it gets better."

Promiscuous teen-agers may spark VD surge — experts

By ROCCO PARASCANDOLA

An increasing number of teens are having sex — and authorities are fearful that a sharp rise in sexually transmitted diseases (STD) will follow.

Judith Wasserheit, a top venereal-disease expert with the federal Centers for Disease Control, observed that "we now see the initiation of intercourse in the 15, 16 and younger [age] range."

"We are initiating intercourse early, we are postponing marriage, and we are divorcing more frequently and more people have many more different sex partners," she said.

In 1990, the number of syphilis cases reached a 40-year high nationwide, said Wasserheit, director of the CDC division of sexually transmitted diseases.

Especially hard hit were men and women between 20 to 24 — the groups with the highest rate of the disease, a bacterial infection spread by vaginal, anal or oral sex, officials said.

In 1990, syphilis — which can cause brain damage if not treated with pencillin — reached a 25-year high in the city.

There were 16,047 cases — up significantly from 6,465 six years earlier.

The number of cases dropped to 15,828 in 1991 and to 12,524 last year — a dip tied to safer sex practices and a drop in trading drugs for sex.

But Dennis Murphy, manager of the sexually-transmitted-disease program at the state Health Deparment, is cautious about predicting a trend.

"Our concern is we may now have a plateau at a higher level," he says, "and then the numbers of VD cases may go up again."

From 1984 to 1992, however, there was a substantial drop in cases of gonorrhea — a bacterial infection of the penis, cervix, rectum or throat that can normally be cured by antibiotics — from 69,998 to 21,709, the lowest total in more than 20 years, according to the city Health Department.

Still, authorites are worried about the possible effects of declines in funding.

The city's proposed $11 million VD budget is only slightly less than two years ago, officials said.

And the state's VD budget has actually risen from $1.5 million to $5.5 million.

But federal funding for AIDS prevention — which authorities say would also prevent increases in the number of STD cases — has dropped sharply from $159 million in 1991 to $143.7 last year to $129 million this year.

Dr. Nicholas Rango, director of the state Health Department AIDS institute, called the decline "devastating."

"It will be directly responsible for the infection, sickness and death of thousands of Americans, particularly youths," he said.

Alternative medicine

In recent years, the growth of "alternative medicine," or those treatments generally not considered to be "orthodox," has accelerated. Such treatments appeal to many people, particularly some who are deeply dissatisfied with modern medicine, its cost and its emphasis on the scientific rather than the "spiritual" approach to treatment.

The following are a few examples of alternative medicine that are available in the United States today. They are by no means the only ones, but they are among the best known. The list and descriptions are intended purely as a source of information, not as an endorsement.

Holistic health care

This approach to health care attempts to focus on the person. This is not really radical, since health workers traditionally have a person's total welfare as a top priority. Also, all trained health professionals are fully aware that physical conditions do not exist in isolation. However, the tendency toward medical specialization also has increased as the amount of medical knowledge has expanded. It is not surprising, therefore, that there is renewed emphasis on the "whole patient." Holistic health care is an attempt to combine scientific treatment of medical problems with treatment of psychological and spiritual problems.

Herbalism

In herbalism, plants are used in treatment, including prevention (rosemary as an insect repellant), cures (garlic as a germ killer) and relief of pain and discomfort (aloe vera for arthritis pain).

Centuries ago, herbs were the only available medications for many poorly understood diseases. Today, however, the modern pharmacy stocks many examples of purified herbs in the form of pills, pastes or liquids as well as medications synthesized in order to treat specific diseases.

In herbalism, the number of plants that are used medically is diverse and further complicated by the differing effects of barks, leaves, stalks, roots, flowers and seeds.

Chiropractic

Chiropractic does not use drugs or surgery, nor is it intended to treat diseases as such. Instead, it attempts to maintain the structural and functional integrity of the nervous system. According to the theory of chiropractic, this is accomplished by massage and manipulation of the spine, joints, and soft tissues.

Acupuncture

Chinese medicine considers a cycle of energy called "chi" (pronounced "chee") to be essential to health. This cycle of energy is thought to flow through the human body in meridians, or channels, each day.

Acupuncturists deal with 12 to 14 of these meridians and some 500 to 1000 points along them. After a diagnosis of an imbalance of the energy flow, an acupuncturist may use the insertion of thin needles (acupuncture), the heating of points with burning mugwort (moxibustion) or finger point pressure (Shiatsu or acupressure) to treat a patient, most often for pain. Theoretically, this treatment works by adjusting the energy flow along the meridians.

Naturopathy

Naturopathy attempts to use natural forces to maintain health and treat disease. Typical remedies include sunbathing, diet regimens, steam bathing, exercise and manipulations. High vegetable consumption is encouraged as is abstinence from salt and stimulants.

Spiritual healing

The term spiritual healing refers to the restoration of physical, mental, emotional or spiritual health by prayer and other religious practices. Through the ages, most of the recognized religions have practiced some forms of spiritual healing. Some other semi-spiritual groups that do healing border on the magical or occult. Be very cautious if a healer asks you to suspend your own religious values or relinquish large amounts of money or property to participate in a form of therapy.

Homeopathy

Homeopathy is a form of medical practice in which the practitioner administers remedies that cause reactions in a person that are similar to symptoms of illness. The philosophy is in marked contrast to conventional modern medical practice, which makes use of medications to counteract the symptoms of disease. An example of homeopathy is treating diarrhea by giving the patient a very small dose of a laxative.

N.Y. DAILY NEWS 7/6/93

Docs give AIDS patients bad news about AZT Rx

Drug's help is short-term

By ANNETTE FUENTES
Daily News Staff Writer

When AIDS activist David Barr went to the International Conference on AIDS in Berlin last month, scientists confirmed research that he had suspected to be true: AZT, the main drug treatment for AIDS, has only a short-term benefit in slowing the AIDS virus, and even combined with another drug, ddC, it does no better.

For HIV-positive people with no AIDS symptoms, early AZT use is the wrong medical strategy. If AZT gives only a short boost, perhaps it is better to wait until the immune system really needs it, when AIDS symptoms are acute.

"It's depressing news," said Barr.

Barr, who is assistant director of policy at Gay Men's Health Crisis, is HIV-positive but has not developed AIDS. He had been on AZT since he tested positive four years ago. For the last two years, he had been in combination drug therapy. But no more.

"I stopped taking drugs about three to four weeks ago," Barr said. "I discussed it with my doctor, and he agreed that because I'm stable, the best thing is to stop and monitor myself."

Report makes many unhappy

The mood of AIDS researchers, activists and people with the virus is grim indeed since the Berlin conference. The Concorde study on AZT was only one piece of the bad news about drug research that was presented there. More than a decade into the epidemic, and data showed that other promising methods to stop replication of the AIDS virus were not effective, Barr said.

"We had hoped that these drugs would open a window," he said. "They do, but not very wide."

The bad news from Berlin hovers over people with AIDS who had put their faith in AZT, said playwright and AIDS activist Larry Kramer.

"Everybody is very depressed. People who have blindly believed in the effectiveness of anti-virals have had their pacifiers taken away," he said.

Never believed in AZT

Kramer said he never believed in AZT and that false hope in the drug delayed research into other AIDS treatments and cures. Now, he said, AIDS advocacy organizations must fund research that the U.S. government has refused to do.

AZT is in a class of drugs called nucleoside analogs, which includes ddI and ddC. They work to create a blood/brain barrier that keeps infections out, according to Dr. Marvyn Silverman, president of the American Foundation for AIDS Research. Although AZT's effects are limited, he said it does help people with AIDS dementia and other acute symptoms. But he agreed that the Berlin conference did deal a psychological blow.

"People were putting hope into anything and everything that works," Silverman said. "I still think there is a chance of treating AIDS as a chronic disease, like diabetes. We have to redouble our efforts ... to find drugs that attack the virus.... But nothing can ever be fast enough for someone who is suffering."

Silverman insisted that researchers do not have to go back to square one. But there is a general consensus that scientists must rethink basic assumptions about how the AIDS virus destroys the immune system and whether new drugs should be tested on people without symptoms.

"Some people have said, 'Not so many people are dying, why are we doing all this research?'" he said. "But ... we can't nickle-and-dime this."

Research is important

Research is critical and must go hand-in-hand with AIDS education and prevention efforts. It shouldn't be an either/or choice, according to Don DesJarlais, a social psychologist at Narcotic & Drug Research in Manhattan.

"Progress in retarding the progression of HIV infection is in small steps," DesJarlais said, "and a vaccine is quite a ways away. The optimistic research comes from behavioral studies that show people do change their behavior when programs are in place."

DesJarlais, who is also a member of the National Commission on AIDS, is concerned that people may revert to unsafe behavior.

"People who are moderately depressed can make each other more so," he said. "We can do counseling to counter that, but there is a strong reality component."

"One would have hoped that 13 years into the epidemic, we'd be better at treating the virus than we are," said DesJarlais. "But medicine is terrible at treating viral infections. The common cold is the best example."

U.S. urged to promote development of vaccines

WASHINGTON — The federal government should establish a National Vaccine Authority, a new agency that would encourage the private, public and academic sectors to cooperate in developing and producing new and improved vaccines — for children both here and in developing countries, the Institute of Medicine recommended yesterday.

Such an organization, which the institute estimated would cost between $30 million and $75 million to launch, would form a partnership with the private sector to set priorities for vaccine development and support research and clinical trials. Ultimately, it would license vaccines to public or commercial manufacturers in the United States or a foreign manufacturer or government to produce, the report said.

The Institute of Medicine, part of the prestigious National Academy of Sciences, is a private organization that provides health policy advice to the federal government and other decision-makers.

The report is likely to be taken seriously by the Clinton administration, which has made universal childhood immunization the cornerstone of its commitment to children's health.

Coalition touts campaign to blast health care plan

WASHINGTON — An ad-hoc coalition of conservative organizations yesterday announced a campaign to denounce the Clinton administration's health-care-overhaul plan and to build support for an alternative: medical savings accounts.

"We don't want a government-managed system that will lead to rationing," Donald Devine, former director of the Office of Personnel Management and chairman of the American Conservative Union, said at a news conference.

The savings-account idea, favored by some conservative Republicans in Congress, would abolish the employer-based system in which most employees' insurance costs are paid directly by their employer.

New help in AIDS?

Study: Thalidomide sedative slows HIV

By MIA NIELSEN
Special to The News

Thalidomide, the notorious sedative that caused thousands of birth defects in the 1950s and 1960s, could make a comeback in the fight against AIDS, researchers said yesterday.

Reporting in the Proceedings of the National Academy of Sciences, scientists said the drug shows promise in controlling the growth of HIV, the deadly virus that causes AIDS.

"We are very optimistic about the potential clinical usefulness of the drug," said Dr. Gilla Kaplan, head of the team of researchers from Rockefeller University and New York Hospital-Cornell Medical Center.

"If it works the way we predict, it would definitely delay progression of HIV infection and the onset of symptoms."

Further study

But Kaplan acknowledged that the findings are not yet conclusive and warrant further study, and other experts urged caution.

Dr. Jeffrey Laurence of the New York Hospital-Cornell Medical Center said he has little expectation for the drug. "The idea is not new," he said, noting that several drugs have been shown to control the virus.

But Dr. Mervyn Silverman, president of the American Foundation for AIDS Research, said the study raises "an exciting possibility" for people for whom pregnancy would not be a factor.

No legs

Thalidomide is best remembered for causing deformities in babies born to mothers who took the sedative to ease morning sickness more than 20 years ago.

Many of the babies were born without arms or legs. The drug was removed from the market in 1962 and was never approved in the United States.

By the time its German manufacturer acknowledged its tests had been faulty, children in more than 48 countries had been affected — chiefly Britain, Germany and Japan.

Subsequently, the drug has been used to treat leprosy patients for severe skin reactions and experimentally to combat a major complication of bone marrow transplant.

Yesterday's report said new studies have shown that thalidomide can ease some symptoms of AIDS and can inhibit the action of an immune system protein called tumor necrosis factor-alpha, or TNF-alpha, believed to trigger HIV production.

In one study, the drug was tested on infected blood drawn from 17 AIDS patients at Bellevue Hospital and New York Hospital; researchers found it slowed the production of the virus.

In another study, thalidomide eased such severe AIDS symptoms as skin lesions, fever and weignt loss in patients who took the drug.

— With News Wire Services

CDC: AIDS is No. 2 killer

ATLANTA — AIDS has surpassed heart disease and cancer to become the second leading killer of young men in the United States, a government agency said yesterday.

The federal Centers for Disease Control and Prevention also said AIDS has become the leading cause of death among young Cuban and Puerto Rican men in the U.S. and for the first time has become a leading killer of a group of women — those ages 25 to 44 of Puerto Rican descent.

Injuries, such as car wrecks, are the leading cause of death in men age 25 to 44.

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