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Series/Staff Member: Patsy Fleming
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OA/ID Number: 10183
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Folder Title:
[Patsy Fleming Correspondence February 1997] [1]

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COLLECTION:

Clinton Presidential Records
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Patsy Fleming (National AIDS Strategy)
OA/Box Number: 10183

FOLDER TITLE:

[Patsy Fleming Correspondence February 1997] [1]

2018-0755-F
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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Februari

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3576

Date Rcvd: 02-11-97

From: Arthur J. Ammann, M.D.
AmTAR Ltr Sent to the President.

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ✓

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97

n:\corresli



AmFAR

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NEW YORK, NY 10017-3204
TEL (212) 682-7440
FAX (212) 682-9812

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In Memoriam
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Mrs. Albert D. Lasker
Peter Scott, Esq.

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Fax (202) 331-6606

February 11, 1997

The Honorable William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

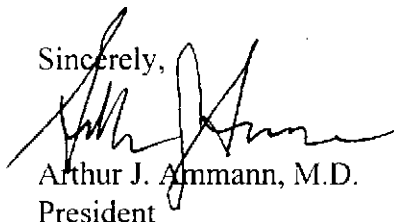
Dear President Clinton:

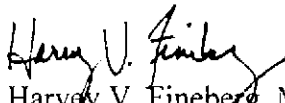
The American Foundation for AIDS Research (AmFAR) is writing to you regarding the upcoming Department of Health and Human Services report to Congress on needle exchange programs.

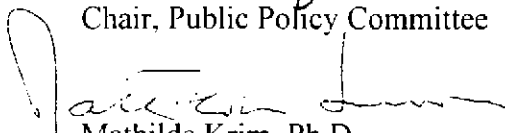
AmFAR has long been a major funder of needle exchange research, including the study recently published in *The Lancet*, one of the world's most respected medical journals. The study showed significantly lower rates of HIV infection among injection drug users who participated in needle exchange programs.

The ethical imperative to provide sterile injection equipment to intravenous drug users is strongly supported by the nation's foremost bioethicists, whose consensus statement is attached for your consideration.

Sincerely,


Arthur J. Ammann, M.D.
President


Harvey V. Fineberg, M.D., Ph.D.
Chair, Public Policy Committee


Mathilde Krim, Ph.D.
Founding Co-Chair and Chairman of the Board

cc: Vice-President Albert Gore, Jr.
Secretary of Health and Human Services Donna E. Shalala
Assistant to the President for Domestic Policy Bruce Reed
Office of Management and Budget Director Franklin Raines
National AIDS Policy Director Patsy Fleming

ON THE ETHICS OF DENYING INJECTION DRUG USERS ACCESS TO STERILE INJECTION EQUIPMENT

There are an estimated 1.5 million injection drug users (IDUs) in the United States. For more than a decade it has been clear that the sharing of injection equipment by such individuals can result in the transmission of HIV infection. Such infection can, in turn, be transmitted to sexual partners and infants born to infected mothers. As AIDS prevention efforts have taken hold in the gay community, slowing down the rate of new infections, injection drug users have emerged as the most critical element in the course of the AIDS epidemic in the United States. More than one third of all new cases of AIDS are among injection drug users, their sexual partners or their offspring. Fifty percent of incident cases of HIV infection are among those groups.

Although drug abuse treatment has a critical role to play in altering the course of this evolving public health tragedy, only about 15 percent of IDUs are in treatment on any given day. Limited treatment slots have resulted in lengthy waiting lists in many cities. Some drug users are not yet ready to forego drug use.

When the dangers of HIV among drug injectors became apparent early in the epidemic, IDUs were thought by many to be totally refractory to public health messages. After all, did they not imperil their health daily by injecting drugs? Yet this view was belied as early as 1984, when drug dealers began to capitalize on fears about AIDS by repackaging used needles and syringes and selling them as sterile.

At about this time, the idea of providing drug users with sterile injection equipment emerged in Europe as a method for reducing the risk of HIV infection in drug users. The idea was simple, yet controversial. Would drug users seek out needle exchange programs even if they were not yet ready to stop using drugs? If so, would the rate of HIV transmission be reduced? Would establishing needle exchange programs send a "mixed message," undermining efforts to reduce drug use? Would it pose other hazards in the form of contaminated needles left in parks or playgrounds?

What was open to question a decade ago is no longer a matter of responsible debate. Study after study has shown that needle exchange programs can reduce the rate of HIV transmission. While studies in different locales have reported varying degrees of success, none has demonstrated that the existence of needle exchange increases the risk to the public health. Given the data, as documented by the National Commission on AIDS (1991), the General Accounting Office (1993), the National Academy of Sciences (1995), and the Congressional Office of Technology Assessment (1995), we find the continued refusal by the federal government to permit the use of federal funds for needle exchange profoundly troubling from the perspective of medical ethics.

Among the principles of medical ethics that are pertinent to this issue, as well as to other public health challenges are:

Beneficence. Beneficence requires that we act on behalf of the interests and welfare of others. Potential risks must be weighed against potential benefits and actions with the most favorable risk-to-benefit ratio adopted.

and

Justice. Justice requires that the benefit and burdens of particular actions be distributed fairly. It also prohibits invidious discrimination.

These principles inform our conclusion that the failure to fund needle exchange efforts, with the predictable loss of life that can be traced to HIV infections that might have been averted, is ethically unacceptable.

When the risks and benefits of needle exchange are weighed against each other it becomes clear that the principle of beneficence is violated by the continued ban on federal funding. Given the scarcity of effective treatment and the cost of denying access to sterile injection equipment, the current federal policy represents a violation of the principle of justice. All public health decisions take place under varying degrees of uncertainty. The issue of needle exchange is no different. Thus, public health officials must make determinations that involve distributing the burdens of uncertainty. To continue the ban on federal funding of needle exchange represents a violation of the principle of justice because the entire burden, one with life-threatening consequences, falls on drug users, their sexual partners and their offspring.

Providing sterile injection equipment to drug users does not represent an endorsement of drug use. It is not a substitute for the treatment that seeks to address addiction. Public health measures often seek to reduce harm, even when there is dispute about the behaviors that are linked to an increased risk of morbidity and mortality. Condoms are provided to sexually active adolescents, not because it is believed that early sexual behavior is desirable, but because in the face of such behavior it is crucial to reduce the risk of pregnancy and sexually transmitted disease. It is with disbelief that one reads that at an earlier moment in American history the Army sought to express its disapproval of sexual activities by soldiers by denying them access to condoms. Sexual activity did not decrease, but the costs in venereal disease were staggering. Thus, providing sterile injection equipment falls squarely within the tradition of public health, and a failure to extend the benefits of that tradition to injection drug users comes at the cost of great suffering and loss of life.

This central concern makes the incessant call for more research before lifting the federal ban ethically troublesome. There was a moment when the evidence was either unavailable or equivocal, when the call for more research before action might have been supportable. But that moment has long since past. A refusal to lift the federal ban on needle exchange funding

constitutes a policy decision with life-threatening consequences. More research is crucial; there are indeed many questions that require further analysis. But such research cannot ethically serve to justify inaction at this moment. The laudable goal of improving our understanding of HIV transmission among drug users cannot be allowed to serve as a pretext to block a strategy of intervention that has proven effective and that has not resulted in the dire public health side effects feared a decade ago.

There are moments when ethical dilemmas pose nearly intractable problems for policy and decision makers, where any course of action comes at a price that appears morally troubling. This is not such an instance. Tens of thousands of drug users are at risk for HIV infection. Although needle exchange will not eliminate that risk, it can reduce it dramatically.

We believe that a failure to lift the federal ban on funding of needle exchange programs represents a policy that will consign thousands of men, women and children to early deaths. By every principle of medical ethics this situation calls out for a change.

**SIGNATURES TO STATEMENT
ON THE ETHICS OF DENYING INJECTION DRUG USERS
ACCESS TO STERILE INJECTION EQUIPMENT**

George J. Annas, J.D., M.P.H.
Edward R. Utley Professor and Chair
Health Law Department
Director, Law, Medicine & Ethics Program
Schools of Medicine and Public Health
Boston University

John D. Arras, Ph.D.
Porterfield Professor of Biomedical Ethics
Department of Philosophy
University of Virginia

Ronald Bayer, Ph.D.
Professor
School of Public Health
Columbia University

Dan W. Brock, Ph.D.
University Professor of Philosophy &
Biomedical Ethics
Director, Center for Biomedical Ethics
Department of Philosophy
Brown University

Arthur L. Caplan, Ph.D.
Trustee Professor
Director, Institute for the Medical
Humanities
University of Texas Medical Branch

Norman Daniels, Ph.D.
Goldthwaite Professor
Professor of Biomedical Ethics/Community
Medicine
Department of Philosophy
Tufts University

Nancy Neveloff Dubler, LL.B.
Director, Division of Bioethics
Department of Epidemiology & Social
Medicine
Montefiore Medical Center

Norman Frost, M.D., M.P.H.
Director, Program in Medical Ethics
School of Medicine
University of Wisconsin

Larry Gostin, J.D.
Professor
Georgetown University Law Center
and John Hopkins School of Hygiene
and Public Health

Bruce Jennings, M.A.
Executive Director
The Hastings Center

Albert R. Jonsen
Professor and Chair
Medical History and Ethics
University of Washington, Seattle

Patricia A. King, J.D.
Professor
Georgetown University Law Center

Carol Levine, M.A.
Executive Director
The Orphan Project

Ruth Macklin, Ph.D.
Professor of Bioethics
Department of Epidemiology
& Social Medicine
Albert Einstein College of Medicine

**SIGNATURES TO STATEMENT ON THE ETHICS
OF DENYING INJECTION DRUG USERS
ACCESS TO STERILE INJECTION EQUIPMENT**

Page 2

Steven H. Miles, M.D.
Associate Professor of Medicine
Center for Biomedical Ethics
University of Minnesota

Jonathan Moreno, Ph.D.
Professor, Director
Division of Humanities in Medicine
SUNY Health Science Center, Brooklyn

Timothy F. Murphy, Ph.D.
Associate Professor, Philosophy in
Biomedical Sciences
Department of Medical Education
University of Illinois, Chicago

William Ruddick, Ph.D.
Professor, Philosophy and Medicine
Program
New York University

Jeff Stryker
Center for AIDS Prevention Studies
University of California, San Francisco

Jeremy Sugarman, M.D.
Division of General Internal Medicine
Duke University Medical Center

Daniel Wikler, Ph.D.
Professor, Program in Medical Ethics
School of Medicine
University of Wisconsin

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Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3587

Date Rcvd: 02-20-97

From: Diane Arenth & Wendy Hoetler
Staten Island AIDS Task Force, Inc.

Staff Action:

Reviewed By Jeff: _____ Reviewed By: ^{EG} Patsy

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

Decline

To Support Staff: _____

Date of Response: 2-25-97

n:\corresli

Staten Island AIDS Task Force, Inc
42 Richmond Terrace
Staten Island, N.Y. 10301
(718) 981-3366

Staten Island HIV CARE Network
42 Richmond Terrace, 2nd Floor
Staten Island, N.Y. 10301
(718) 448-8789

February 14, 1997

Office of AIDS Policy
750 17th Street N.W., Suite 600
Washington, D.C. 20503

Dear Sir: *W. Mason*

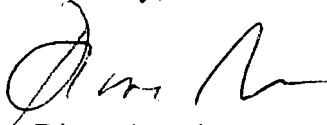
We would like to invite you to attend the "AIDS Alert: What is Happening on Staten Island" breakfast that we are hosting Friday, March 14, 1997, from 8:00 - 10:30 a.m. at the Colonnade Diner, 2001 Hylan Blvd., Staten Island, NY.

As part of the HIV CARE Network's mission of planning for the delivery of HIV/AIDS services on Staten Island we have completed a local needs assessment, compiled and analyzed epidemiological data on the picture of the epidemic here as well as on the trends and changes in the populations infected, and written an HIV/AIDS Service Delivery Plan for Staten Island based on this material.

This is the most comprehensive analysis and description of the AIDS epidemic on Staten Island. It both describes the existing service delivery system and identifies critical community needs in this area. We want to share this important and compelling information with our elected officials and community leaders. We would also like you to hear the testimony of several people living with HIV/AIDS on Staten Island regarding their own experience and perception of the needs here.

Please join us for this breakfast. We would appreciate an **RSVP by Friday, February 28th** to Wendy Hoefler at (718) 448-8789. Thank you very much. We look forward to seeing you on March 14th.

Sincerely,



Diane Arneth
Executive Director
Staten Island AIDS Task Force



Wendy Hoefler
Coordinator
Staten Island HIV CARE Network

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3573

Date Rcvd: 02-07-97

From: John Birmingham

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ☒

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97

25 Kensington Avenue, No. 304
Jersey City, New Jersey 07304
February 1, 1997

Patricia S. Fleming
National AIDS Policy Director
Office of National AIDS Policy
725 Sixteenth Street, N.W., Suite 600
Washington, D.C. 20503

Dear Ms. Fleming:

Hope this letter finds you well, happy and working productively for the President on AIDS prevention and treatment efforts.

Thank you for sending me so promptly the 1997 National AIDS Strategy and its appendices. You and your staff deserve tremendous credit for the effort that undoubtedly went into seeing those important documents from their inception through to publication.

You may recall that recently I sent my résumé to the President with an offer to serve him on AIDS public policy issues. Judge Richard S. Arnold suggested I write to you and Mr. Nash as well. On January 8th I did so. Enclosed is my updated résumé.

Best wishes for a vigorous start to the next four years.

Sincerely,


John Birmingham

Enclosure (updated résumé)

cc: Mr. Bob J. Nash (with updated résumé)
Assistant to the President and
Director of Presidential Personnel
Old Executive Office Building
1600 Pennsylvania Avenue, N.W., Room 153
Washington, D.C. 20502

Mr. Richard Socarides (with updated résumé)
In care of OASAM
U.S. Department of Labor
200 Constitution Avenue, N.W., Room 52203
Washington, D.C. 20210

JOHN BIRMINGHAM
25 Kensington Avenue, No. 304
Jersey City, New Jersey 07304

2/1/97

(201) 451-0228
jbirming@pegasus.rutgers.edu

EDUCATION

Rutgers, The State University of New Jersey. University College, Newark, NJ, 1995-96.

All degree requirements complete, B.A., sociology. Graduate 5/22/97.

Dean's list, three semesters. Grade point average: 3.763/4.0.

University of Massachusetts, Boston, MA, 1986-87, '82-85, '77, part-time. Major: sociology.

GPA: Approx. 2.0/4.0. Earned grades of "A" in nearly all completed courses.

Howard University, College of Pharmacy and Pharmacal Sciences, Washington, DC, 1974-75. Major: pharmacy. Dean's list, two semesters. GPA: 4.0/4.0.

George Washington University, Washington, DC, 1972-74, part-time.

Major: mathematics. GPA: 3.75/4.0. Offered board of trustees scholarship.

Joint Carpentry Apprenticeship Committee, Upper Marlboro, MD, 1972-75, part-time.

Catholic University of America, Washington, DC, 1967-68. Major: psychology.

GPA: 0.563/4.0. Dismissed, poor scholarship.

EMPLOYMENT

Kavanagh Maloney & Osnato, New York, NY

(Senior) Legal assistant - litigation, Oct. 1996 - present. Support complex civil litigation (legal and accounting malpractice). Digest, organize and track documents. Shepardize, check style of citations and verify quotations in memoranda and briefs. Retrieve cases and articles from libraries, West Premise CD-ROM libraries, WestMate, WestLaw, Lexis-Nexis.

Fox and Fox, Partners, Livingston, NJ. Legal secretary, part-time, Nov. 1995 - Sept. '96.

New York University School of Law, Institute of Judicial Administration

Program coordinator, Sept. 1992 - Nov. '94. Administrator of 600-member not-for-profit organization. Assisted all officers and finance committee. Sent personal invitations from executive director each year to Nation's 1,350 appellate judges and responded to inquiries. Coordinated two summer Appellate Judges Seminars, Advanced Series and New Appellate Judges Series. Organized meetings of board of directors and breakfast meetings of members. Helped with occasional continuing professional education seminars and research conferences. Coordinated work of four to six part-time program assistants.

JOHN BIRMINGHAM

EMPLOYMENT, continued

New York University School of Law

Administrative secretary, Nov. 1989 - May '94. Served several professors, including dean. Assembled hand-outs for courses and seminars on employment discrimination, civil procedure, labor and employment law, role of prosecutor, labor law theory, theory of regulatory state, current constitutional issues and current issues in bankruptcy. Administered faculty workshops, '89-92. Aided annual workshop on bankruptcy and business reorganization, '90-94.

Law Office of Edward M. Altman, Cambridge, MA

Legal assistant, Aug. 1987 - Aug. '88; May '86 - Feb. '87. Supported representation of people with drug problems. Drafted pre-sentencing memoranda. Helped persons with cocaine and alcohol problems get into, and stay in, rehabilitation programs. Supported representation of plaintiffs in discrimination cases. Helped negotiate re-admission into drug and alcohol rehabilitation program of youngster discharged on suspicion of testing positive for AIDS and hepatitis B. Helped prepare memoranda of law and appellate briefs. Monitored implementation of City of Boston Human Rights Ordinance and court decisions.

Law Office of David L. Kelston, now with Friedman & Atherton, Boston, MA

Legal secretary, legal assistant, March - July 1987. Served three active lawyers on single trial, Murphy v. Int'l Society of Krishna Consciousness, representing minority religion.

Channing Laboratories, Brigham & Women's Hospital, Boston, MA

Secretary, Sept. 1986 - Feb. '87. Helped prepare medical research grant proposals.

New York University School of Law, Clinical Law Center

Legal secretary, July 1985 - April '86. Served three professors, including director. Assisted committee administering 18-B Assigned Counsel Panel (First Department) supervising private attorneys representing indigent people in criminal and family courts in Manhattan and the Bronx. Ensured that applications for membership and complaints concerning representation were in order for committee meetings. Helped prepare briefs in criminal and death penalty appeals. *Member*, United Staff Association, Local 3882, A.F.T.

Silverglate, Gertner, Baker, Fine & Good, now Silverglate & Good, Boston, MA

Secretary, 1983 - April '85. Served partner and two associates. Supported complex criminal (political corruption, espionage) and civil litigation (defense of minority religions). Helped prepare pleadings, trial documents and appellate briefs. With legal assistants, prepared and proofread appendices to motions and memoranda. Monitored media coverage of cases. Read public statement for radio broadcast. Under lifetime protective order, designated by U.S. Department of Justice as custodian of national defense documents.

JOHN BIRMINGHAM

EMPLOYMENT, continued

Various heavy construction contractors, Allston, Brighton and Cambridge, MA
Carpenter, 1980-83. Member, carpenters union. Candidate, trustee, Local 40, June '83.

Mount Auburn Hospital, Cambridge, MA. Emergency room secretary, part-time, c. 1980.
Assisted with unruly patients under the influence of drugs and alcohol.

Altman & Lapon, Cambridge, MA

Legal assistant, 1975-80. Served both partners. Supported representation of El Concilio Hispanico de Cambridge, Inc., social service agency for Spanish-speaking citizens. Helped persons with heroin, cocaine and alcohol problems get into rehabilitation programs. Supported representation of individuals before Immigration and Naturalization Service and Social Security Administration. Upgraded military discharges. Supported liquor licensing of establishments in Massachusetts. Under supervision, worked on briefs submitted to six appellate courts. Monitored executive orders and policy advisories affecting pending cases.

Various heavy construction contractors, Washington, DC and Northern VA

Apprentice carpenter, 1972-75. Member, carpenters union, Local 132; member, political action committee. Laid out several thousand feet of WMATA subway track pads, '74.

Altman & Garfinkle, Cambridge, MA

Legal assistant, 1969-71. Served partner and associate. Supported defense of persons charged under Military Selective Service Act and Uniform Code of Military Justice. Helped persons with heroin, cocaine, LSD and alcohol problems get into rehabilitation programs.

George Washington University Hospital, Pharmacy Department, Washington, DC

Messenger, acting aide, 1971-72. Worked with officials of U.S. Food and Drug Administration. Learned about assessment of safety and efficacy of experimental drugs and mechanisms (like "compassionate use") for making them available to seriously ill persons.

Brookings Institution, Foreign Policy Division, Washington, DC

Secretary, 1971. Served senior U.S. military officers and civilian researchers studying public policy on strategic nuclear weapons, Trident nuclear submarine, B-1 bomber, NATO troop levels in Europe and General Agreement on Trade and Tariffs (GATT).

City of Boston, Department of Health and Hospitals

Division of Maternal and Infant Health, Day Care Consultation and Licensing Unit

Senior clerk-typist, 1970-71. Assisted director. Maintained files, answered inquiries, reviewed applications and scheduled sanitary and building inspections. *Member, AFSCME.*

JOHN BIRMINGHAM

EMPLOYMENT, continued

Western Union Telegraph Co., Washington, DC

Automatic teletype operator, 1970. Spent eight hours each late-night shift sending casualty messages from U.S. armed services to families of service members killed, maimed or wounded on duty in Republic of Viet Nam. **Member**, United Telegraph Workers Union.

Western Union Telegraph Co., Boston, MA

Automatic operator, 1969-70. **Member**, United Telegraph Workers Union.

East Boston Camps, Inc., East Boston, MA

Unit director, summer 1968. Designed experimental program for teenage boys from economically depressed inner city. Prepared brochure, recruited campers. **Counselor**, summers '67, '66. Crafts director, lifeguard, assisted waterfront director.

East Boston Social Centers, Inc.

Woodwork instructor, 1966-68. Organized after-school crafts program for preteen boys.

COMMUNITY SERVICE

Iris L. Long, Ph.D., Jackson Heights, NY

Assistant to pharmaceutical chemist working in public interest. Help prepare reports to government agencies, testimony before legislative bodies and presentations to scientific conferences on AIDS and tuberculosis, *1988-94; Aug. '96 - present.* With ACT UP and others, helped restore two TB medications, streptomycin and para-amino salicylate, to availability. Helped expedite FDA approval of Reality female condom. With Dr. Long and Juan A. Leger, co-wrote poster presentations on women's enrollment in Federal clinical trials and TB patient activism for World AIDS Conferences. **Volunteer work: 4,000 hours.**

ACT UP/Golden Gate, San Francisco, CA

Assistant to treatment activist Bill Thorne, *1995 - present.* Projects include expanding access to HIV-1 viral-load diagnostic tests, making available treatment for wasting syndrome.

ACT UP/New York, NY

Member, general meeting, 1988-90. Took part in many demonstrations seeking action from National Institutes of Health, Food and Drug Administration, City of New York Health Department and pharmaceutical manufacturers to cut medication prices; simplify, rationalize and speed medication development, testing and approval; broaden access to treatments for all people living with AIDS; and make sterile injection equipment available to drug users. Demonstrated in favor of clean needle-exchange programs in New York City and Jersey City. Vehemently opposed disruption of religious services, '89.

JOHN BIRMINGHAM

COMMUNITY SERVICE, continued

ACT UP Working Groups, with Iris L. Long, Ph.D.

Tuberculosis, 1990-94; Women's Issues, '90-92; Pediatric Issues, '90-92.

AIDS Treatment Registry, Inc., now AIDS Treatment Data Network, New York, NY

Volunteer, April 1989 - Nov. '90. Assisted executive director of not-for-profit organization providing consumer health information in English, Spanish and Haitian Creole on access to experimental medications in clinical trials, via compassionate use and via parallel track. Proofread all publications. Helped draft grant proposals. Convinced U.S. Postal Service to allow use of acronym "ATR" in return address on bulk mail to protect addressee privacy. Urged recruitment of board members and hiring of staff representative of all New Yorkers. Advocated scrupulous adherence to honest and informative standards in reporting funds raised and resources used. With Iris L. Long, Ph.D., assisted advocates for people living with breast cancer, childhood cancer, hemophilia, lupus, tuberculosis and Alzheimer's disease. **Volunteer work: 2,000 hours.**

Civil Liberties Union of Massachusetts, Boston, MA

Member, Public Education Committee, 1985; Medical-Legal Committee, '87. With Robert Tucker, proposed language for AIDS policy statement explaining why males who are sexually active with males do not constitute an insular minority and calling for repeal of laws requiring prescriptions to buy sterile needles and syringes.

University of Massachusetts, Boston, MA

With Bill Thorne, Robert K. Jarvis and others, *initiated* and **coordinated** AIDS and hepatitis B outreach and education project at **Lesbian and Gay Center**, '87, '83-85. Posted information about AIDS and hepatitis B in every classroom and kiosk on campus for two-year period, '83-85. Prepared articles for publication in New England's largest-circulation Lesbian and gay weekly newspaper and student-run weekly. With permission, photocopied brochures and made them available in gay bars, baths, movie theater, roller-skating rink and dance clubs at own and Robert K. Jarvis' expense. With Bill Thorne and others, visited gay establishments in downtown Boston weekly for two years, negotiating distribution of brochures and free condoms, '83-85. Personally counseled and distributed brochures to youngsters at highest risk, including sex workers and drug users.* **Volunteer work: 3,500 hours.**

*In the mid-1980's, the Reagan Administration blocked the use of Centers for Disease Control money for education targeted at preventing the spread of HIV infection among males sexually active with males and people who use illicit injectable drugs. Even today, public officials are reluctant to deal with the explicit issues of "safer" sexual practices, use of condoms and distribution of sterile injection equipment. **Result: 400,000 dead in 1997.**

JOHN BIRMINGHAM

COMMUNITY SERVICE, continued

Howard University, College of Pharmacy and Pharmacal Sciences, Washington, DC

Elected first-year class secretary, **1974-75**. With fellow officers, negotiated with dean for better-equipped classrooms and laboratories, extra-help hours in zoology, chemistry and physics and coordination of remedial English and math programs with pharmacy curriculum.

Washington Free Clinic, Inc., Washington, DC

Worker, 1970-71. Helped dozens of persons with heroin, cocaine and alcohol problems get into rehabilitation programs, including clinical trial of experimental heroin detoxification medication. Procured educational materials and laboratory services from Federal government, helped maintain records, cleaned laboratory and swept floors. Each week, 100 youngsters sought contraceptives, treatment of sexually transmitted diseases or help with drug problems. **Volunteer work: 500 hours.**

Boston Draft Resistance Group, Cambridge, MA

Volunteer, full-time, 1968-69. As member of network of students, academics and lawyers, advised youngsters of alternatives military service. Counseled more than 200 persons without indictment. Coordinated exchanges of memoranda of law, appellate briefs and court decisions among fellow draft counselors, members of Harvard Law School Committee for Legal Research on the Draft, counselors for Legal In-Service Project and service organizations for conscientious objectors. **Volunteer work: 2,500 hours.**

Catholic University, Washington, DC

Publicist for War and Peace Lecture Series co-sponsored by departments of religion and of psychiatry and psychology, **1967-68.** **Advocate** for Poor People's Campaign sponsored by Southern Christian Leadership Conference, '68. Political advisor, '67-68, campaign strategist, '67, Paul Buckley, first-year class president.

Boston College High School, Dorchester, MA

Graduate, concentration in classical Greek and Latin, **1967.** **Editor-in-chief**, Eaglet, student newspaper, '66-67. **Art editor**, Eaglet, '65-66. **Associate editor**, Renaissance, yearbook, '65-66. **Member**, Sodality, '63-66. Awarded silver medal in religion *ex aequo*, '64. **Letter awardee**, championship cross-country team, '63.

Cambridge Council, Boy Scouts of America, Cambridge, MA

Junior assistant scoutmaster, 1963-66, Troop 77 sponsored by Alpha Phi Omega service group at Massachusetts Institute of Technology. Elected to Order of the Arrow service group, '64. Eagle scout, three palms, '64-63. Received Pope Pius XII Award, '64, Ad Altare Dei medal, '63.

JOHN BIRMINGHAM

SELECTED WRITINGS

Letter explaining what you can do about AIDS and how to decide which AIDS service and advocacy organizations are worth your support, Boston Magazine, *Feb. 1997* (forthcoming).

Your superb story on AIDS had misleading misprint, letter on availability of medications to treat AIDS and its illnesses at no or low cost, New York Amsterdam News, *11/16/96*.

Civil rights and the election, letter defending civil liberty to marry, analyzing Clinton record on civil rights and urging political action, Bay Area Reporter, San Francisco, *9/12/96*.

Demolition deadly, letter explaining injury and death, particularly among young and inexperienced workers, on demolition and construction sites, New York Press, *6/22/94*.

No cuts, letter (2,500 words) explaining ACT UP's vehement opposition to privatization of New York City's Division of AIDS Services and advocating increased capital spending by Bureau of Tuberculosis Control, New York Native, *5/16/94*.

Howard's end, letter defending Howard University against charge of anti-Semitism, commending its support of free speech and academic freedom, New York Newsday, *5/12/94*.

AIDS remains an understatement, letter defending free speech right of ACT UP member Luke Sissyfag who spoke aloud at religious service attended by President Clinton, explaining AIDS advocacy and defending AIDS research budget, Washington Square News, *4/13/94*.

Act Up, diverse, nonpartisan, fights both AIDS and bigotry, letter defending ACT UP against charge that it is dangerous hate group seeking unfair entitlements for homosexuals, and explaining its make-up, functions and accomplishments, New York Times, *3/22/94*.

A diatribe of intolerance, letter, among several, ascribing anxiety about homosexuality to reasoned and articulate religious teaching, and pointing out damage to our common life done by discrimination against Lesbians, gays and bisexuals, Wall Street Journal, *3/3/94*.

Is New York City serious about increasing tuberculosis treatment completion? presentation with Iris L. Long, Ph.D. and Todd Weisse of ACT UP/New York Tuberculosis Working Group (8 pages) describing dangerous conditions in City out-patient chest clinics and lampooning naive enthusiasm for imprisonment of non-compliant patients, Community Working Session on Tuberculosis, Beth Israel Medical Center, New York, NY, *3/11/93*.

Proposed CLUM Policy on AIDS, memorandum drafted with Robert Tucker for Medical-Legal Committee, Civil Liberties Union of Massachusetts. Rejected notion of "insular minorities" and stressed need for including specifics on AIDS education, *4/7/87*.

JOHN BIRMINGHAM

SELECTED WRITINGS, continued

Illegal harassment and discrimination against Lesbians and gays at the University of Massachusetts at Boston, open letter (with enclosures, 15 pages) advocating policy of nondiscrimination to protect Lesbian, gay and bisexual persons. Personally delivered or mailed to elected officials, university chancellors, counsel, trustees, interested faculty, fellow students and civil rights lawyers, 3/11/87.

Homophobia and UMB, letter defining term, citing evidence and explaining destructive and injurious effects of fear and hatred of homosexuals on campus, Mass Media, 4/23/85.

Obtaining information on sexually transmitted diseases, letter criticizing lack of health information at University Health Service. Advocated stepped-up efforts to educate students, faculty and staff members about AIDS and hepatitis B. Mass Media, 4/9/85.

AIDS and UMB students, letter citing evidence and charging discrimination against gay and apparently gay students by employees of University Health Service, Mass Media, 3/5/85.

Foreword to the "Catholic complaint": A brief history of anti-Catholic bigotry in Massachusetts. With Fred Longenecker, **Fictional complaint**. Demonstrated unfairness and futility of civil court scrutiny of beliefs and proselytizing practices of adherents of religious organizations. Appendix, status memorandum, vol. II, Church of Scientology of Boston, Inc. v. Flynn, (Mass. Sup. Ct.) No. 40906 and five consolidated cases, 1984.

Who unlocked Gerry's door? front page feature, drafted with Bill Thorne, Robert K. Jarvis and others, on media coverage of Congressman Gerry Studds' coming out, 8/18/83. Gave chronology of gay liberation movement. Emphasized roles of ordinary people. Tommy's Connection was New England's largest-circulation Lesbian and gay weekly, readily available to young Lesbian, gay and bisexual persons free of charge at bars, restaurants and clubs.

Reducing your risk of getting A.I.D.S., front page feature, drafted with Bill Thorne, Robert K. Jarvis and others. Published prior to discovery of HIV. Listed ten ways to reduce risk, in plain and explicit language. Tommy's Connection, 8/11/83. Just 26 months after first report of AIDS from Centers for Disease Control, this feature compiled information for those who read at 8th-grade level.* Life-preserving advice thus reached a readership estimated at 30,000, including college and university opinion leaders throughout New England and Long Island, NY.

*In October 1985, 26 months later, the CDC issued a "definitive" statement on AIDS transmission less accurate and less useful to those at risk than this feature.

JOHN BIRMINGHAM

SELECTED WRITINGS, continued

Sexually speaking . . . the new vaccine, front-page feature, drafted with Bill Thorne, Robert K. Jarvis and others in consultation with the Massachusetts Department of Public Health. HeptaVax/MSD was the first vaccine for hepatitis B, a sexually transmissible disease epidemic both among young males who have sex with males and among people who share or use dirty needles. Explained disease transmission and prevention. Offered further information by mail and telephone through Lesbian and Gay Center of University of Massachusetts at Boston. Cited and publicized, at no charge, other sources of information on topics of concern to gay adolescents and adults. Tommy's Connection, 8/4/83.

Hepatitis B and UMass, letter drafted with Bill Thorne and Robert K. Jarvis explaining seriousness of hepatitis B. Publicized availability of low-cost screening and vaccination through University Health Service. As requested, accompanied by re-publication of official announcement, Mass Media, 7/12/83. Later, with Bill Thorne, negotiated with executive director of health services to reduce screening and vaccination fees.

You have the right to know, note drafted in consultation with fellow class officers explaining the Family Educational Rights and Privacy Act of 1974, Black Apothecary, Howard University College of Pharmacy and Pharmacal Sciences, 12/16/74.

Drafting 19-year-olds, letter analyzing rationale for reversing order of call for military conscription, drafting teenagers first, calling for public discussion, New York Times, 9/17/69. **Nixon and the draft**, letter on drafting teenagers first, Boston Globe, 9/12/69.

Praise to draft refusers, letter on government response to Roman Catholic position on conscientious objection, Pilot, weekly newspaper, Archdiocese of Boston, 11/30/68.

Urges more anti-war news, letter questioning large amount of space devoted to military news notes, Cambridge Chronicle and Cambridge Sun, 11/21/68.

Mature decision revisited, letter, with Paul Buckley, defending Dr. King against charges of inciting violence, subversion and criminal activity. Student council had refused to support the Southern Christian Leadership Conference's Poor People's Campaign. Tower, 5/3/68.

Furth urges active opposition to war effort, suggests establishment of peace curricula, interview with chair of department of psychiatry and psychology discussing war and peace lecture series, urging students to lead discussion of morality of war, Tower, 3/29/68.

Furth scores war compliance, stresses necessity for thought, interview about faculty opposition to war in Viet Nam, university responsibility to advance peace, Tower, 3/22/68.

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	[Personally Identifiable Information] [partial] (1 page)	02/01/1997	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office
Patsy Fleming (National AIDS Strategy)
OA/Box Number: 10183

FOLDER TITLE:

[Patsy Fleming Correspondence February 1997] [1]

2018-0755-F

rs3184

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

JOHN BIRMINGHAM

SELECTED ORAL PRESENTATIONS

Interviewed with ACT UP/Golden Gate members Bill Thorne and Rob Sabados on medical use of marijuana to treat often-fatal AIDS wasting syndrome and counteract chemotherapy nausea, anxiety, depression and physical pain, *1/3/97*, WITS-FM, San Francisco.

Organized theater evenings at Angels in America during seminars for appellate judges. Recruited and *introduced* fellow ACT UP member, playwright Tony Kushner, as luncheon speaker, *7/13/94*. Recruited and *introduced* George C. Wolfe, director of New York Shakespeare Festival, as speaker, *6/29/94*.

Made oral statement on behalf of Iris L. Long, Ph.D. and ACT UP/New York before New York City Council General Welfare Committee oversight hearing on City's Division of AIDS Services. Emphasized that history argues against privatization of City AIDS services, *4/12/94*. Reported hearing in No cuts, letter to New York Native, *5/16/94*. Mailed copies to all 50 Council Members and all public officials named.

Made oral statement with Carl Sigmon of ACT UP/New Jersey before New Jersey Community Advisory Committee for AIDS Plan Development about needs for prevention and treatment outreach and education, *11/13/90*. Emphasized dangers facing teenagers and prisoners. Explained alternative Roman Catholic philosophical and theological justification for condom use. Pointed out that the Second Vatican Council recognized primacy of conscience in making personal decisions on moral issues.

Interviewed with other members of ACT UP/New York by reporters for the New York Times, New York Newsday, Star-Ledger (Newark), Jersey Journal (Jersey City), Noticias del Mundo and El Diario/La Prensa (both New York City) on need for clean needle-exchange AIDS outreach and education, harm reduction and need for drug treatment on demand *1989-90*. Emphasized that drug treatment programs often exclude pregnant women.

Discussed conscientious objection and the draft with John Carr, Massachusetts director of Selective Service, at Boston College colloquium on religion and the law, *Fall 1969*. *Discussed* military draft and war in Viet Nam with Massachusetts Selective Service manpower officer at high school and college forums throughout greater Boston, *1968-69*.

PERSONAL

Born [redacted] (b)(6) *Partner of Juan Alex Leger since 3/11/90*. Alex administers systems and programs for NOAH, an internationally renowned Web site (NOAH: New York On-Line Access to Health) providing consumer health and disease prevention information to hundreds of thousands of people throughout the world in Spanish as well as English.

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3570

Date Rcvd: 02-06-97

From: Andrea Bastulli

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ✓

Assigned To: [Signature] / Tiffany

RCVD: _____ DONE: _____

Recommendations/Instructions:

get info from CDC &
send to

ID# 545, 811, 809, 195

To Support Staff: _____

Date of Response: 3-17-97

THE WHITE HOUSE

WASHINGTON

MAR 17 1997

Ms. Andrea Bastulli
28682 Forest Road
Willowick, OH 44095

Dear Ms. Bastulli:

Thank you for your letter of January 31, the Office of National AIDS Policy at this time do not have information in regards to Mandatory AIDS Testing.

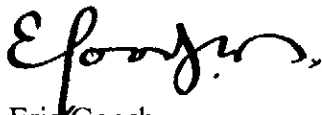
The following organizations may be able to assist you with information regarding Mandatory AIDS Testing.

AIDS Clearinghouse	1-800-458-5231
AIDS Hotline	1-800-342-AIDS
CDC National AIDS World Wide Web Site	http://cdcnac.aspensys.com :86.

Terry McGovern, Esq; Director of Litigation HIV Law Project 841 Broadway, Suite 608 New York, New York 10003	(212) 674-7590 (212) 674-7450 (Fax)
--	--

We hope that these organizations will be able to help you, and good luck with your project.

Sincerely,



Dr. Eric Goosby
Acting Director
Office of National AIDS Policy

Office of National AIDS Policy
750 17th St. N.W. Rm. 600
Washington, D.C. 20503

January 31, 1997

Dear Sir or Madame,

I am a senior at Eastlake North High School. I am currently working on a project about Mandatory AIDS Testing for my American Government class. Could you please answer the following questions?

-What is your organization's view on Mandatory AIDS Testing?

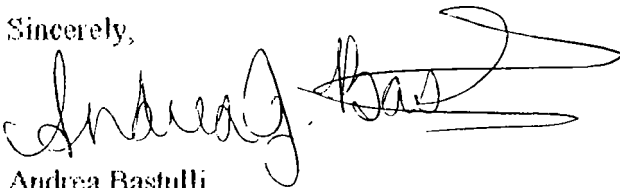
-What do you see are the pros and/or cons of Mandatory AIDS Testing?

-If kept anonymous, do you think Mandatory AIDS Testing could be helpful to the individual taking the test?

If you would happen to have any other information that you might think I'd find helpful, I'd appreciate it very much.

Thank you for your time.

Sincerely,

A handwritten signature in cursive script, appearing to read "Andrea Bastulli", with a long horizontal flourish extending to the right.

Andrea Bastulli
28682 Forest Rd.
Willowick, OH 44095

Office of
National AIDS Policy

Correspondence Routing Slip

FILE COPY

Tracking Number: G35 72

Date Rcvd: 02-07-97

From: Wepatt Craft

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ☒

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97

COPY.

12-4-96 / 2-3-97

EDITOR

THE WALL STREET JOURNAL
200 LIBERTY STREET
New York, N.Y. 10036

DIRECTOR

OFFICE OF NATIONAL
AIDS Policy

RE: "Still NEEDED: AN AIDS VACCINE" 12-3-96

GENTLEMEN:

THE ARTICLE by H.R. Shepherd AND The numerous letters praising Mr. Sanford for his "courage" leave me, AN ordinary CANCER patient, cold! AIDS (why is it capitalized?) is basically (95%) transmitted by wilful misbehavior of individuals — junkies using the same needle for injection and homosexuals engaging in anal intercourse. AIDS can easily be avoided: it is not a disease easily catchable. ANAL INTERCOURSE, i.e. Butt Fling

As a 67 year old man who in June 1996 underwent A RADICAL NEPHROURETERECTOMY to remove my left kidney AND ureter for STAGE III TRANSITIONAL CELL CANCER of the ureter, who just completed four months of unpleasant MVAC chemotherapy AND who will start five weeks of radiation of the surgical bed in January, I have little sympathy for junkies AND homosexuals who contract AIDS by their selfish, wilful lifestyles. Even with AIDS, a person may live ten years or more while those of us with ordinary CANCER will mostly die within one to three years.

As a man who had lived a very healthy lifestyle, I did nothing to contract a rare CANCER—it just occurred—why?

THE AIDS ACTIVISTS ARE DOING A FINE JOB politically to secure more funding to find a cure. Unfortunately, a cure for the routine, ordinary CANCERS that kill 555,000 of us yearly is not being sought with the same urgency. My CANCER treatments, paid for by Medicare AND Medi-GAP insurance, now approaches \$50,000⁰⁰. I'd estimate that costs for the AVERAGE CANCER patient is at least \$150,000⁰⁰ from inception to death! A "Manhattan Project" to find cures would seem to be cost effective.

THE ADMINISTRATION IS ALLOWING the Pentagon generals to spend 750 BILLION taxpayer dollars for 3000 basically useless "advanced all service fighter" planes—not even a fraction of this amount will be spent on CANCER research. We spend AND HAVE spent billions (trillions?) fighting wars in which only 50-60,000 servicemen were killed in a 4-20 year period while accepting, as a matter of course, the yearly deaths of 555,000 citizens from CANCER. If 555,000 servicemen died yearly in a war, the government would topple!

It is clear that our NATIONAL priorities are out of order. Why CAN'T any really big shot government figure, including the President, see this? But AS Stalin reportedly SAID, "the untimely death of one man is a tragedy, the death of one million is a statistic". Is that what we CANCER victims are — just a statistic?

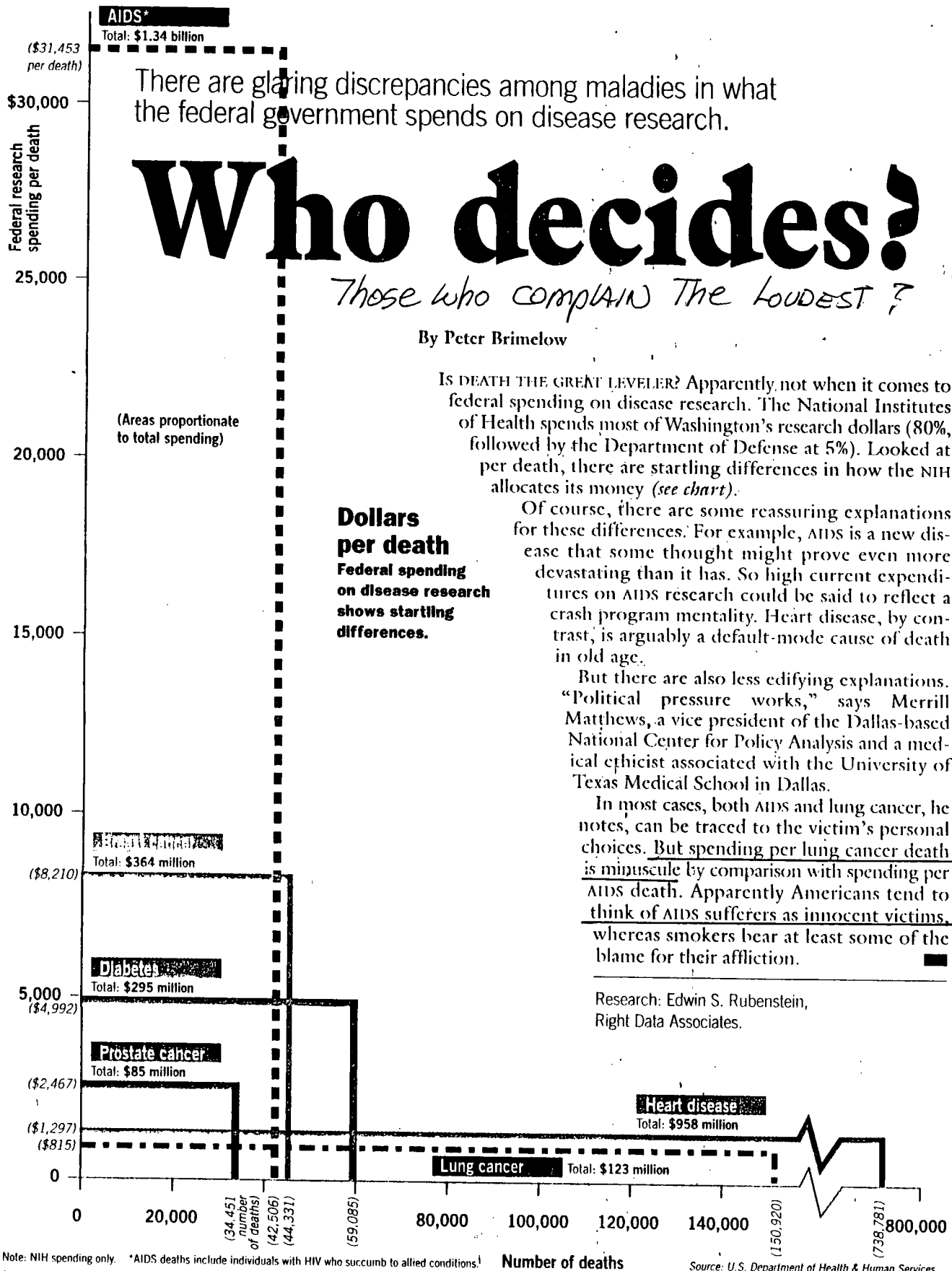
Very truly yours

WYATT E. CRAFT

WYATT E. CRAFT
1100 WEST BROW RD.
LOOKOUT MT., TN 37350

Copy: President Clinton
AND OTHERS.

Is it your "policy" that homosexuals have AN INALIENABLE "RIGHT" to ENGAGE IN PROMISCUOUS, RANDOM, ANAL INTERCOURSE, i.e., BUTT FUCKING, AND WHEN THEY CONTRACT AIDS, WE TAXPAYERS ARE SUPPOSED TO CARE FOR THEM? Why don't you tell it like it is? How this "disease" is REALLY transmitted — with the method being known since 1986 —



Why don't you start A program To Tell
Homosexuals To STOP BUTT FING & Junkies
To STOP SHARING Needles — The BASIC WAY
AIDS IS TRANSMITTED — BY WILFUL ACTION —
of stupid individuals — AIDS IS NOT AN
"epidemic" — REAL CANCER IS!

Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: G3583

Date Rcvd: 02-19-97

From: Paul Di Donato

SAN FRANCISCO AIDS FOUNDATION

Staff Action:

Reviewed By Jeff: _____ Reviewed By: ^{EG}~~Patsy~~ ✓

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

EG has attachments.

To Support Staff: _____

Date of Response: 2-24-97



SAN FRANCISCO AIDS FOUNDATION

P.O. BOX 426182, SAN FRANCISCO, CALIFORNIA 94142-6182

February 12, 1997

Ms. Patricia S. Fleming
750 17th St., NW, Ste. 106D
Washington, DC 20503

Dear Ms. Fleming:

I am pleased to be able to supply you with a copy of The San Francisco AIDS Foundation's "A New Era For HIV/AIDS Care, Treatment and Services- An Agenda for California Government in 1997-98", as well as "Moving Towards A New Era- An HIV/AIDS Policy Agenda for San Francisco."

I hope that you will find these documents to be a useful tool as we continue our work together. These agendas provide an overview of the HIV/AIDS epidemic in California and outlines basic legislative and funding issues at the state and local level. It also provides recommendations that the San Francisco AIDS Foundation has to ensure that Californians living with HIV/AIDS have adequate healthcare, access to treatments and appropriate services.

With promising new HIV therapies giving many individuals new hope, it is crucial that we remain vigilant to ensure that people with HIV/AIDS have the appropriate programs necessary to live longer lives with maximum quality of life. We must be creative and responsive to the community as we all work together to address the ever changing challenges presented by this epidemic.

If you have any questions, please feel free to contact our office at 415/487-3080 and I will gladly talk with you and give you any necessary information.

Sincerely,

Paul Di Donato
Acting Director for Public Policy

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3571

Date Rcvd: 02-07-97

From: Andrea Friend

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ✓

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

PF to be

To Support Staff: _____

Date of Response: 2-14-97

n:\corresli

FILE COPY

**Office of
National AIDS Policy**

Correspondence Routing Slip

Tracking Number: G3596

Date Rcvd: 02-24-97

From: Callie B. Gass
National AIDS Fund

Staff Action:

Reviewed By Eric: _____ Reviewed By: FF

Assigned To: _____

RCVD: _____ DONE. ✓

Recommendations/Instructions:

To Support Staff: _____

Date of Response: 3-14-97

n:\corresli

Friday, 3/14
11:30-3:00 P
15 mins
VM/3/11/97
Q

February 20, 1997

Patsy Fleming
Office of National AIDS Policy
750 17th Street, NW, Suite 600
Washington, DC 20503

Dear Patsy:

Just over a year ago the National AIDS Fund underwent a merger with the National Leadership Coalition on AIDS. The merger brought together the strengths of community partnerships with the experience and skills of business and labor leaders committed to ending the HIV/AIDS epidemic.

In order to sustain and enhance our effectiveness in fighting the epidemic, the Fund is conducting a strategic planning process. This process will result in a vision and mission statement, and an operational plan so that the Fund may better focus its resources on the critical and ever-changing dynamics of the epidemic.

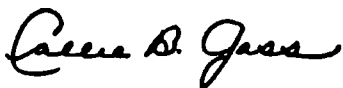
In this phase of the strategic planning process, the Fund is collecting survey and interview input from key national and community leaders that are knowledgeable resources on the epidemic.

You have been identified as such a leader and we want to invite you to participate in a brief, focused telephone interview. I've included a background piece on the Fund for your review.

My assistant Jeane Wellman will be calling you within the next two weeks to arrange this interview. We hope to complete the interviews by March 15.

Your opinions and views are critical to the process we are undertaking and we hope you will be able to participate in this interview.

Sincerely,



Callie B. Gass
Acting Director of Programs & Partnerships

NATIONAL AIDS FUND

The National AIDS Fund A Legacy of Service

The National AIDS Fund – the nation's foremost grantmaking organization dedicated to eliminating HIV/AIDS as a major health and social problem – was created in 1988 by The Ford Foundation and other leading national foundations and corporations. The Fund works in partnership with communities to provide care and to prevent new infections through education, research and outreach. Throughout its history, the Fund has increased the nation's capacity to respond to the epidemic by building alliances and generating contributions for HIV/AIDS programs at the national and local levels.

The Fund has generated almost \$50 million to local communities for HIV/AIDS programs, which have supported more than 2,400 HIV/AIDS programs in 31 states. It also provides program and technical assistance for hundreds of local educational, direct service and other HIV/AIDS programs. Many of these initiatives are designed to reach women, adolescents and ethnic and racial minorities.

Working through community partners, the Fund invests in the ingenuity of local leaders, making resources available to communities in ways local leaders determine most appropriate and effective in responding to local needs. By establishing strong partnerships with organizations or coalitions within communities, the Fund seeks to create self-sustaining local systems that generate dollars, engage leadership, answer needs and energize their community's response to the HIV/AIDS epidemic.

A Community Partner may be a community foundation, a regional association of grant makers, or a local chapter of the United Way. They are the convening authority, the entity with which the Fund contracts, and which serves as fiscal agent for funding. Once the Partner is established, it receives grant funding from the National AIDS Fund and secures matching funds from within its own community. HIV/AIDS organizations within that locale apply to the Partner for support funding and grants are awarded by the Partner. Even before the Ryan White Care Act made federal funding available to states, the Community Partners were working to coordinate local planning efforts, identify local matching dollars and distribute funding through a community-wide process.

Last year, 36 Community Partnership Sites raised \$8.6 million from a network of 720 national and local philanthropies, businesses and other community-based funders. Fund-supported programs provided direct care and services to almost 500,000 individuals.

The Fund also works with the nation's employers to manage AIDS in the workplace and educate employees about HIV/AIDS prevention. The Fund provides businesses a national network of leading corporate, government and nonprofit experts who deal with HIV/AIDS policy issues, and it publishes a broad range of HIV/AIDS publications for both managers and employees. It also offers on-site problem-solving and manager/employee training programs, as well as access to its Workplace Resource Center, which contains up-to-date information, publications and other cutting-edge resources for dealing with AIDS in the workplace. The Fund now includes among its membership more than 200 of the nation's largest corporations and labor organizations.

The National AIDS Fund has a full-time staff of 21 and is committed to minimizing overhead and administrative expenses, thus ensuring the maximum amount possible is channeled into programs where the need is greatest. Thus the Fund has spent, on average, less than 5% of its income each year on fundraising costs, and continues to lead the nonprofit world in maximizing the amount it provides Community Partners for local distribution.

Leadership of the Fund is provided by a 30-member Board of Trustees who are drawn from Fund Community Partner sites, the business world, AIDS service organizations, the health care and social service communities and other nonprofit organizations. Guidance is provided by four standing committees of the Board: Executive, Finance, Nominating and Audit. Other committees include, but are not limited to, Development, Evaluation, Communications, Policy Leadership and Community Partnership.

Current national funders include Borden, Inc., Chevron, USA, Inc.; Council of Fashion Designers of America - Vogue Initiative/New York City AIDS Fund of The New York Community Trust; Elton John AIDS Foundation; The Ford Foundation; Glaxo Wellcome; The Henry J. Kaiser Family Foundation; Levi Strauss Foundation; The May Department Stores Company; Melville Corporation; Metropolitan Life Foundation; New York Life Foundation; Philip Morris Companies Inc.; Prudential Foundation; The Starr Foundation; Until There's A Cure Foundation and the Xerox Corporation. In addition, more than 20 corporate and foundations supporters have made significant donations to the Fund.

Current Community Partnership sites include: Albany, NY; Annandale, VA; Atlanta, GA; Birmingham, AL; Boston, MA; Cedar Rapids, IA; El Paso, TX; Camarillo, CA; Charlotte, NC; Chicago, IL; Cleveland, OH; Dayton, OH; Detroit, MI; Ft. Lauderdale, FL; Ft. Worth, TX; Greensboro, NC; Harrisburg, PA; Hartford, CT; Indianapolis, IN; Kansas City, MO; Little Rock, AR; Los Angeles, CA; Miami, FL; Minneapolis, MN; Morristown, NJ; Nashville, TN; New York, NY; Phoenix, AZ; Portland, ME; Richmond, VA; Sacramento, CA; San Diego, CA; San Francisco, CA; Santa Fe, NM; Tacoma, WA; Tucson, AZ; Tulsa, OK; Washington, DC and Wichita, KS.

The National AIDS Fund is a 501(c)(3) nonprofit organization, incorporated under the laws of the State of Ohio.

For more information about the National AIDS Fund, contact the Communications Department at (202) 408-4848. E-Mail: NAIDSFUND@aol.com

To Patsy

Date 03 11 Time 2:41

WHILE YOU WERE OUT

M. Jean Willmar

of National AIDS Fund

Phone 408-4848 x220

Area Code	Number	Extension
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Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3562

Date Rcvd: 03-03-97

From: David C. Harvey

AIDS Policy Center Letter Sent to Toby A. Donofield

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ☒

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97



AIDS Policy Center
For Children, Youth & Families

918 Sixteenth Street, NW
Suite 201
Washington, DC 20006
Tel. (202) 785-3564
Fax (202) 785-3579
E-mail APCCYF@aol.com

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Ft. Lauderdale, FL
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Miami, FL
Paula Van Ness
Silver Spring, MD
David C. Harvey, MSW
Executive Director

January 14, 1997

Ms. Toby A. Donenfeld
Deputy Assistant for Domestic Policy
Office of the Vice President
Old Executive Office Building
Washington, DC 20501

Dear Ms. Donenfeld:

On behalf of AIDS Policy Center for Children, Youth and Families, we would like to thank you for meeting with us regarding the issues of drug access for children and pregnant women living with HIV/AIDS.

As the AIDS epidemic moves into the second decade, access to promising new drug treatments has given new hope to people living with this life-threatening illness. However, this hope is not as bright for the thousands of children and women who also live with HIV/AIDS.

As you know, there are currently nine drugs approved by the FDA for use in HIV/AIDS care; of those nine, only three are approved for use in pediatric HIV/AIDS care. FDA approval is imperative because if the drug is not approved by the FDA, there is a chance that the drug may not be paid for by Medicaid (the medical service provider to 90% of children with HIV/AIDS), by the AIDS Drug Assistance Program (ADAP), or by many private insurance plans.

We hope that the Vice President will continue his commitment to all people living with HIV/AIDS, including children and their families, by acting on the following items:

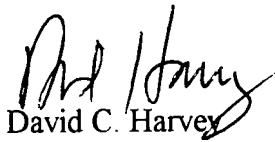
- **Continuing to work with the FDA to expedite and facilitate increased participation of children, adolescents, and pregnant women in HIV/AIDS clinical drug trials conducted by the pharmaceutical industry.**
- **Continuing to monitor the production of a report that was requested by the 104th Congressional Appropriations Committee that asked the Secretary of HHS to report on the status of clinical trials for HIV/AIDS drugs for children, adolescents, and pregnant women. As you will remember, this report was transferred to the NIH and had a December 31, 1996 deadline. We sincerely hope that this report will be completed by late winter as was discussed in this meeting.**

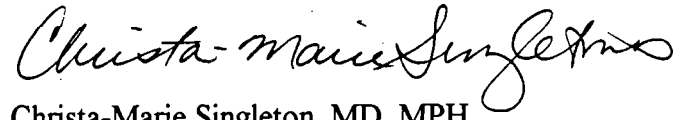
- **Seeking a public forum to raise public awareness of this problem, using the Keystone Project as a model. We also hope that the Vice President will seek other opportunities to speak about this issue whenever possible.**

Again, we sincerely appreciate the opportunity to have discussed this issue with you and your staff. As we are part of two large organizational coalitions that monitor this issue, National Organizations Responding to AIDS and the AIDS Drug Assistance Program Working Group, we would welcome the opportunity to bring the views of other groups to your attention.

Thank you again for meeting with us as well as representatives from the FDA and HHS to discuss this issue. Please do not hesitate to contact us for further information. We look forward to meeting with you again in the near future.

Sincerely yours,


David C. Harvey
Executive Director


Christa-Marie Singleton, MD, MPH
Senior Policy Analyst

cc: Greg Simon
Patsy Fleming
Bill Schultz
Deborah Von Zinkernagle
Sheri Saltzberg

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3585

Date Rcvd: 02-19-97

From: Kenneth D. Johnson

Staff Action:

Reviewed By ~~Jeff~~: _____ Reviewed By: ^{EG}~~Patsy~~ ✓

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR File

To Support Staff: _____

Date of Response: 2-20-97

KENNETH D. JOHNSON, ESQ.

6514 Milva Lane
Springfield, VA 22150
703-913-5396

February 12, 1997

Jeffery W. Levi
Deputy Director
Office of National AIDS Policy
750 - 17th Street, N.W.
Room 600
Washington, D.C. 20503

Dear Mr. Levi:

Enclosed is my application for an Attorney-Advisor position in the Office of National AIDS Policy.

My strengths include six years of civil litigation experience, including three years of administrative hearing and trial work involving private sector and Federal employment matters. I am thoroughly familiar with the Rehabilitation Act, 29 U.S.C. §§ 701, *et seq*, and the Americans with Disabilities Act, 42 U.S.C. §§ 12101 *et seq*, having argued disability rights cases before the Equal Employment Opportunity Commission, the Merit Systems Protection Board and the U.S. District Court for the District of Columbia.

I currently am a member of the National AIDS Fund and the D.C. Bar Task Force on Sexual Orientation and the Legal Workplace. Since December 1994, I have been a Volunteer Attorney/Mentor (Federal Employee Rights) for the Whitman-Walker Clinic Legal Services Department. I formerly served on the Board of Directors of the Gay and Lesbian Bar Association (1995-96) and the Downtown Cluster of Congregations (1994-96). In 1993, I became an American Red Cross-certified HIV Prevention Instructor.

I would welcome the opportunity to serve as an Attorney-Advisor in the Office of National AIDS Policy. At your convenience, I am available to meet with you or a member of your staff to discuss my qualifications.

Very truly yours,



Kenneth D. Johnson

KENNETH D. JOHNSON

6514 Milva Lane
Springfield, VA 22150
703-913-5396

OBJECTIVE SENIOR TRIAL ATTORNEY / ATTORNEY-ADVISOR

SUMMARY Six years of civil litigation experience, including two years of environmental insurance coverage practice and three years of administrative hearing and trial work involving private sector and Federal employment matters. Admitted to the District of Columbia, Pennsylvania and California Bars.

EMPLOYMENT KATOR, SCOTT, HELLER & HURON

8/93 - present *Title:* Associate. *Duties:* Represented management or employees in litigation involving personnel matters, including allegations of discrimination, misconduct or poor performance. For plaintiff employees, negotiated seven six-figure settlements. For defendant employers, successfully filed 10 motions to dismiss Title VII complaints. Conducted over 30 depositions. Examined, cross-examined and defended administrative hearing and trial witnesses. Practiced before District of Columbia and Federal courts, the Merit Systems Protection Board and the Equal Employment Opportunity Commission.

O'MELVENY & MEYERS

9/90 - 7/93 *Title:* Associate. *Duties:* Served on the Exxon *Valdez* oil spill litigation defense team. Represented insurance companies in environmental coverage disputes. Drafted research memoranda, answers, interrogatories, requests for admissions, document requests and dispositive motions.

THE HONORABLE DAMON J. KEITH UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

9/88 - 9/90 *Title:* Law Clerk. *Duties:* Prepared 17 draft long-form opinions for the Court and over 50 draft short-form opinions. Interviewed, trained and supervised first-year law clerks.

CALTRANS: THE CALIFORNIA STATE DEPARTMENT OF TRANSPORTATION

10/83 - 8/85 *Title:* Assistant Right of Way Agent. *Duties:* Relocated individuals with disabilities and families displaced by the Century Freeway. Assisted displacees in purchasing replacement housing from private sellers and the California Department of Housing.

EDUCATION HARVARD LAW SCHOOL

9/85 - 6/88 J.D. conferred, June 1988.
Harvard Black Law Students' Association, September 1985 - June 1988.
Harvard Law Review, August 1986 - June 1988.

CALIFORNIA STATE UNIVERSITY, FULLERTON

9/78 - 5/83 B.A. conferred, May 1983. *Major:* Political Science. *Minor:* Speech Communication.
Academic Debate Team, September 1978 - May 1983.
Class Rank: Top 2%.

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

KENNETH W. DOSSEY
10511 Assembly Drive
Fairfax, VA 22030

Plaintiff,

v.

ROBERT E. RUBIN
SECRETARY OF THE TREASURY
1500 Pennsylvania Ave., N.W.
Washington, DC 20220

Defendant.

)
)
)
) CASE NUMBER 1:96CV02561
)
) JUDGE: Thomas Penfield Jackson
)
) DECK TYPE: EEOC
)
) DATE STAMP: 11/12/96
)
)
)
)

**COMPLAINT FOR RELIEF
FROM DISCRIMINATION IN EMPLOYMENT**

Jurisdiction

1. This is an action under the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794a, and 42 U.S.C. § 1981a, seeking damages and other relief for defendant's (i) failure to accommodate plaintiff's disability (legal blindness), (ii) toleration of harassment against plaintiff because of his disability, thereby giving rise to a hostile work environment, (iii) discrimination against plaintiff on the basis of his disability, which has resulted among other things in a continuing denial of promotional opportunities, and (iv) retaliation against plaintiff for opposing defendant's discriminatory practices. This Court has jurisdiction under 29 U.S.C. § 794a and 42 U.S.C. § 2000e-5 and § 2000e-16, which also provide for venue in this District.

Parties

2. Plaintiff Kenneth W. Dossey, a citizen of the United States, has been employed by the Internal Revenue Service ("IRS"), United States Department of the Treasury, since October 1980. From August 1987 to the present, plaintiff has been employed by the IRS in the District of Columbia.

3. Defendant Secretary of the Treasury is the head of the agency in which plaintiff serves. The Department of the Treasury has more than 500 employees. Defendant is sued in his official capacity.

Plaintiff's IRS Career and His Impaired Vision

4. Plaintiff received a Bachelor of Science degree from Western Kentucky University in May 1980.

5. In 1978, before he entered Federal service, plaintiff lost all vision in his left eye. Plaintiff's vision in his right eye remained 20/200 until 1993. His right eye vision has since deteriorated, and since January 1993 he has undergone six major eye surgeries, including three on the optic nerve. Plaintiff is legally blind.

6. In October 1980, plaintiff entered Federal service through the Bureau of the Blind under a 700-hour Handicapped Appointment as a WAE-4 Invoice and Budget Clerk at the IRS Service Center in Cincinnati, Ohio. Shortly after the appointment ended, plaintiff was placed into a permanent position as a GS-7 Budget Analyst. Plaintiff was promoted to GS-9 Budget Analyst in May 1981 and in April 1985 was promoted to GS-11

Office Automation Analyst in the IRS Information Systems Division in Dallas, Texas. In August 1987, plaintiff was promoted to GS-12 Management Analyst at the IRS National Office in Washington, D.C., and in August 1988 he became a GS-13. The 1988 promotion was the last that plaintiff has received, even though he has been qualified for promotion to GS-14 since 1989. Plaintiff has at all times performed his duties in an entirely competent fashion.

Defendant's Failure to Accommodate Plaintiff's Disability

7. Plaintiff is a disabled individual who, with reasonable accommodation, can perform the essential functions of his position. To do his work, plaintiff uses adaptive equipment designed for the visually impaired, including but not limited to a tape recorder, 14X magnification glasses, a personal computer with a 26-inch monitor, magnification computer software and voice computer software. In addition, plaintiff occasionally requires administrative leave, as his disability sometimes precludes his use of public transportation during inclement weather.

8. In January 1993, plaintiff's 26-inch computer monitor began to malfunction, and he requested as a reasonable accommodation that IRS provide him with different and additional adaptive computer hardware and software, as well as training in the use of the new equipment. When after more than one year IRS failed to provide plaintiff with the requested adaptive equipment and training, he contacted the Department of Treasury's Regional Complaint Center and later memorialized his requests for

reasonable accommodation in eight formal EEO complaints, dated December 5, 1994, December 13, 1994, June 20, 1995 (two complaints), September 11, 1995, April 12, 1996 (two complaints), and July 9, 1996, respectively. Defendant has yet to provide plaintiff with the reasonable accommodation that he requested and needs, including adaptive equipment, training and clerical support and assistance.

9. Defendant's failure to provide plaintiff with the reasonable accommodation that he requested has caused him to suffer migraine headaches and has contributed to the deterioration of the vision in his right eye.

10. As an additional accommodation, plaintiff in March 1993 requested a hardship transfer to an IRS facility located closer to his parents and extended family, who could then provide plaintiff with convalescent care after his surgeries, transportation and other personal assistance. IRS failed to grant plaintiff's request for a hardship transfer, and he memorialized his request for such reasonable accommodation in two formal EEO complaints, dated December 5, 1994 and December 13, 1994.

Hostile Work Environment Suffered by Plaintiff

11. In addition to failing to grant plaintiff's requests for reasonable accommodation in a consistent and timely manner, defendant has subjected plaintiff to an unreasonably abusive and hostile work environment. Plaintiff is often excluded from work team meetings and office social events. Moreover, defendant's

employees and supervisors have continuously made derogatory comments about plaintiff's vision impairment. For example, an IRS supervisor commented to plaintiff during a work discussion: "what do you care, you can't see it anyway." Other employees routinely have asked plaintiff if he saw a document and then laughingly have commented that they are "asking a blind man if he can see something." Plaintiff sometimes gets ink on his nose while trying to read documents at close range, and employees often make derogatory comments about substances on his nose. One supervisor has questioned the severity of plaintiff's vision impairment, and another has yelled at plaintiff in front of his co-workers and has asserted that plaintiff's only problem is incompetence. In fact, plaintiff is quite competent and with reasonable accommodation performs exceptionally well. Two supervisors have stated that placing plaintiff in charge of a project would be like asking the "blind to lead the blind." Other supervisors have refused to consider plaintiff's request for reasonable accommodation and have questioned whether he could perform any work at all, with one stating: "Well, we'll find something for [plaintiff] to do, even if it's just copying." Another supervisor forbade plaintiff from using a tape recorder as a means of taking notes, even though he had been using a recorder for this purpose throughout his career at IRS, and still another made an exceptionally vulgar remark to plaintiff in a staff meeting.

12. Plaintiff has complained about his hostile work environment in at least six formal EEO complaints, dated December

13, 1994, June 20, 1995 (two complaints), April 12, 1996 (two complaints) and July 9, 1996. Defendant, however, has taken no action to end the disability-related slurs and continuous harassment directed at plaintiff. Instead, defendant has tolerated and condoned this harassment, which has been sufficiently severe or pervasive as to alter the conditions of plaintiff's employment and to create an abusive working environment.

Defendant's Discrimination Against Plaintiff

13. Because of plaintiff's disability, defendant has since 1989 engaged in a continuing practice of refusing to promote him to the GS-14 level. Plaintiff is well qualified for promotion and since 1989 has applied for GS-14 positions over ten times, including applying for a GS-14 Management Analyst position in August 1995 under Vacancy Announcement No. 95-Q-628-N. Plaintiff has been rejected for promotion on each occasion.

14. In October 1993 plaintiff was transferred from the Tax Systems Modernization Project Office to the Office of Facilities Policy, but the programs on which he was working (including contract administration and budget) were not transferred with him, although he was assured that they would be. The transfer and elimination of duties meant that plaintiff was denied promotion to GS-14 when positions in his former Office were upgraded noncompetitively through desk audit after he left. The desk audit resulted among other things in the noncompetitive promotion of a former subordinate of plaintiff to GS-14.

Defendant's transfer of plaintiff from his former Office had the purpose and effect of denying him promotion to GS-14 because of his disability.

Defendant's Retaliation Against Plaintiff

15. Plaintiff's disability (legal blindness) and his protected activity -- his requests for reasonable accommodation, applications for a hardship transfer and formal EEO complaints -- have long been common knowledge to his supervisors. After responding to plaintiff's EEO complaints and the inquiries of EEO investigators, plaintiff's supervisors began to punish him not only for his disability but also for opposing defendant's discriminatory employment practices.

16. Defendant's retaliatory treatment of plaintiff has included, but has not been limited to, the following:

- A. since 1994 plaintiff has received unfair performance appraisals which have failed accurately to reflect the quality of his work and have precluded him from receiving substantial performance awards;
- B. in September 1994, plaintiff was involuntarily removed from the Department of the Treasury's Transportation Management Task Group;
- C. around September 1994, plaintiff was involuntarily removed from his work assignments -- the Parking, Flexiplace, Public Transportation Initiative, Childcare, Ridesharing and Fitness Centers programs -- even though he had substantial knowledge of those

programs and had invested a substantial amount of time and effort in analyzing them;

- D. from November 1994 through March 1995, plaintiff, unlike his similarly situated co-workers, was precluded from traveling to Pennsylvania and Georgia to visit the work sites which were the subject of his analyses;
- E. plaintiff has been denied temporary details which would have allowed him to secure on-the-job training and experience in grade 14 supervisory positions;
- F. plaintiff has been unfairly denied promotion to GS-14 positions;
- G. defendant has refused to process plaintiff's EEO complaints in a timely and evenhanded manner and has refused to grant him reasonable administrative leave to deal with those complaints; and
- H. plaintiff has been subjected to unwarranted disciplinary action.

17. Defendant's actions itemized above were the product both of discrimination against plaintiff and of retaliation against plaintiff for challenging discrimination and requesting reasonable accommodation for his disability.

Damages

18. All prerequisites to suit have been satisfied. Because of the actions of defendant described herein, plaintiff has suffered economic loss, including loss of past and future pay and other compensation. Plaintiff has also suffered nonpecuniary

loss, including migraine headaches, deterioration of vision, emotional pain, suffering, inconvenience, mental anguish and loss of enjoyment of life.

COUNT ONE
FAILURE TO PROVIDE REASONABLE ACCOMMODATION

19. Paragraphs 1-18 are realleged.

20. Defendant's failure to provide plaintiff with requested reasonable accommodations on a consistent and timely basis constitutes discrimination based on disability, in violation of the Rehabilitation Act.

COUNT TWO
HOSTILE WORK ENVIRONMENT

21. Paragraphs 1-18 are realleged.

22. Defendant's supervisors and employees have subjected plaintiff to repeated disability-related slurs and harassment sufficiently pervasive as to alter the terms and conditions of his employment. The hostile work environment suffered by plaintiff, coupled with defendant's toleration and condonation of that environment, constitutes a violation of the Rehabilitation Act.

COUNT THREE
DISABILITY DISCRIMINATION

23. Paragraphs 1-18 are realleged.

24. Defendant's refusal to provide plaintiff with equal opportunities for advancement and compensation, including the

continuing refusal to promote plaintiff to a GS-14 position, constitutes discrimination against plaintiff because of his disability in violation of the Rehabilitation Act.

COUNT FOUR
RETALIATION

25. Paragraphs 1-18 are realleged.

26. Defendant's punishment of plaintiff for protesting discrimination and requesting reasonable accommodation for his disability constitutes retaliation for plaintiff's protected activity in violation of the Rehabilitation Act.

RELIEF SOUGHT

Plaintiff asks the Court to grant him the following relief:

1) Declare that defendant's actions constituted retaliation and discrimination on the basis of plaintiff's disability, in violation of the Rehabilitation Act;

2) Order defendant to: (a) promote plaintiff to GS-14 retroactive to the date of his earliest application; (b) grant plaintiff such further promotions as have been enjoyed by similarly situated employees; (c) pay plaintiff front and back pay, including all increases, bonuses and benefits, due him under (a) and (b) above; and (d) reinstate any benefits, including leave, which plaintiff has been required to use because of defendant's unlawful conduct;

3) Order defendant to provide plaintiff with on-the-job training, formal training, mentoring and career development assistance;

4) Order defendant to provide plaintiff those reasonable accommodations needed to allow him to enjoy the privileges and benefits of employment equal to those enjoyed by non-disabled employees, including adaptive equipment, training and clerical support and assistance;

5) Order defendant to pay plaintiff compensatory damages, in an amount to be determined at trial;

6) Order defendant to pay prejudgment interest on all monetary amounts awarded;

7) Order defendant to remove all negative information connected with defendant's discriminatory and retaliatory actions from plaintiff's personnel file, to increase his performance evaluations to accurately reflect his performance and to pay him all performance awards that have been unfairly denied;

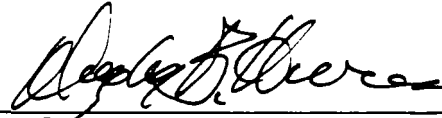
8) Order defendant to cease and desist from all discrimination and retaliation against plaintiff;

9) Order defendant to pay plaintiff's costs, including reasonable attorneys' fees, for this action and for the administrative proceedings he was required to exhaust before bringing this action; and

10) Order such other and additional relief as the Court deems just and equitable.

JURY DEMAND

Plaintiff requests trial by jury.



Douglas B. Huron 89326
Kenneth D. Johnson 428458
KATOR, SCOTT, HELLER & HURON
1275 K Street, N.W.
Suite 950
Washington, DC 20005
202 898-4800

Attorneys for Plaintiff

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KENNETH DERICK JOHNSON

THE SUPREME COURT
1986 TERM

III. FEDERAL STATUTES AND REGULATIONS

- A. *Aid to Families with Dependent Children—Treatment of
Child Support Income.* Bowen v. Gilliard

Reprinted From
HARVARD LAW REVIEW
Vol. 101, No. 1, November 1987

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Cambridge, Mass., U.S.A.

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Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3582

Date Rcvd: 02-14-97

From: David C. Harvey
NATIONAL AIDS (NORA)

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97

n:\corresli



Co-chairs

David Harvey
AIDS POLICY CENTER FOR
CHILDREN, YOUTH AND
FAMILIES

Miguelina Maldonado
NATIONAL MINORITY AIDS
COUNCIL

3 February 1997

Patricia Fleming
Office of National AIDS Policy
750 17th Street, NW
Suite #600
Washington, DC 20503

Executive Committee

Val Bias
NATIONAL HEMOPHILIA
FOUNDATION

Callie Gass
NATIONAL AIDS FUND

Rose Gonzalez
AMERICAN NURSES
ASSOCIATION

Byron J. Harris
NATIONAL ALLIANCE OF STATE
AND TERRITORIAL AIDS
DIRECTORS

Christine Lubinski
AIDS ACTION COUNCIL

Jane Silver
AMERICAN FOUNDATION FOR
AIDS RESEARCH

Winnie Stachelberg
HUMAN RIGHTS CAMPAIGN

Dear Ms. Fleming:

We are pleased to invite you and Jeff Levi to attend the February 10, 1997 meeting of the National Organizations Responding to AIDS (NORA) coalition to thank you for serving as the National AIDS Policy Director at the White House. The meeting will begin at 12:30pm and will be held in the first floor conference room of the Academy of Educational Development, located at 1255 23rd Street, NW, Washington, DC. Lunch will be served.

We look forward to seeing you at the NORA meeting and honoring your contribution in the fight against AIDS.

Sincerely,

David C. Harvey
NORA Co-chair

Miguelina Maldonado
NORA Co-chair

NORA

A coalition convened by
AIDS Action Council

1875 Connecticut Ave., NW
Suite 700
Washington, DC 20009
202 986 1300
202 986 1345 fax

"A coalition of over 175 organizations responding to AIDS with resolve and action."

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: 63592

Date Rcvd: 2/27/97

From: David C. Harvey, Executive
Director of AIDS Policy Center

Staff Action:

Reviewed By Eric: _____ Reviewed By: _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

Personal notes to PR

To Support Staff: _____

Date of Response: 2-24-97

n:\corresli

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3575

Date Rcvd: 02-11-97

From: MATHORISO Tsosane

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ☒

Assigned To: LaHoma

RCVD: _____ DONE: _____

Recommendations/Instructions:

Please forward to LaHoma

To Support Staff: _____

Date of Response: 2-19-97

HA TSOSANE

P.O. BOX 1117

MASERU 100

LESOTHO

2nd AUGUST 1996

DIRECTOR

DEPARTMENT OF AIDS

AMERICA

DEAR SIR/MADAM.

I have read from one of the magazine of July that, in America ten men with HIV were cured and regaining their health.

I have my sister who is HIV positive, and I really need help for her. I am willing to pay for medications as long as her life can be saved.

I do not want her name to be published.
Please.

Thank you.

Sincerely yours

MATHORISO TSOSANE

(MATHORISO)

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G35 86

Date Rcvd: 02-20-97

From: MARY Kilpatrick

NYU Law School, Bisexual, Gay & Lesbian
Law Students Association

Staff Action:

Reviewed By ~~Jeff~~: _____ Reviewed By: EG ✓

Assigned To: _____

Declined 2/25/97
C

RCVD: _____ DONE: _____

Recommendations/Instructions:

Decline

To Support Staff: _____

Date of Response: 2-25-97

n:\corresli

NYU LAW SCHOOL
BISEXUAL, GAY AND LESBIAN LAW STUDENTS ASSOCIATION

240 Mercer Street, New York, NY 10012 • (212) 998-6574

Patricia Fleming
Office of National AIDS Policy
750 17th Street NW
Washington, DC 20500
February 6, 1997

Dear Ms. Fleming:

I am writing on behalf of the Bisexual, Gay, and Lesbian Law Students Association at New York University School of Law to ~~invite you to~~ participate in a symposium we are sponsoring on April 3, 1997. The working title for our event is "Slicing the Health Care Pie: How can we ethically pay for new AIDS treatments?"

As members of communities that have been devastated by AIDS, we are concerned with finding ways to provide promising new treatments for those whose lives depend on them. As member of the legal community, we want to use our skills in this effort. It is vitally important, however, that we understand how decisions are made regarding who has access to health care and how much care any one person or group of persons receives. Only with a better understanding of the decision-making process can lawyers put their advocacy skills to best use. ~~We are asking you to~~ join our panel of academics, policy-makers, administrators, health care providers, patient advocates, and businesspersons to debate whether treatments like the protease inhibitors should be given top priority in today's public health care budget. Understanding how to approach these issues will be all too important as medical science discovers new treatments for all illnesses and governments continue to struggle with financing health care.

We hope our symposium will be a debate that will result in better decision-making about spending medical resources. Your participation will help us reach that goal. Please reply to this invitation by February 20, 1997. For questions or further information, please call me at 718-654-6460.

Sincerely,



Mary Kilpatrick
Symposium Committee
Bisexual, Gay and Lesbian Law School Association
New York University School of Law

FILE COPY

PF

Office of
National AIDS Policy
Correspondence Routing Slip

Tracking Number: G3589

Date Rcvd: 02-21-97

From: Philip R. Lee, M.D.

DEPARTMENT OF HEALTH AND
HUMAN SERVICES

Staff Action:

Reviewed By Jeff: _____ Reviewed By: ^{EG}~~Patsy~~ _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

Personal note to PR

To Support Staff: _____

Date of Response: 2-24-97

n:\corresli

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3584

Date Rcvd: 02-19-97

From: Marianne Levine

Staff Action:

Reviewed By Jeff: _____ Reviewed By: ^{EG} Patsy _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

No position

To Support Staff: _____

Date of Response: 5-9-97

n:\corresli

506 E. Stoughton # 24
Champaign, IL 61820
(217) 351-3078

February 10, 1997

Patsy Fleming
Office of National AIDS Policy
750 17th., N.W.
Washington, D.C. 20503

Dear Ms. Fleming:

I would like to express my interest in applying my relevant experience and background to an entry-level position at Office of National AIDS Policy.

I will be graduating this May from University of Illinois at Urbana-Champaign with a Bachelor of Arts in Psychology and a Bachelor of Science in Political Science. I possess a strong background in HIV/AIDS issues. As you will note, I was a co-founder and a president of Campus AIDS Coalition, the first student-oriented AIDS prevention organization at the University of Illinois.

I have launched a comprehensive AIDS education program which still functions today. In one year, I have increased membership from five to sixty people. I have also served on both World AIDS Day and AIDS Awareness Month committees, and helped implement activities for both of the events. I was an official spokesperson for a student body on the issues of HIV/AIDS. After I resigned from the position, I have become an advisor for the organization.

As my resume indicates I also exhibit a strong background in a variety of social issues such as women's issues and gay/lesbian issues. I also possess a broad psychological research background. Currently, I am in the process of conducting an empirical study titled "*Media's Influence on Social Attitudes toward Gay Men and Lesbians*". I have strong leadership and public speaking training. I am fluent in Russian and have working knowledge of Ukrainian and French.

Enclosed please find a copy of my resume, which summarizes my experience and qualifications. I will be glad to furnish any additional information that you desire, and you may reach me at (217) 351-3078 to discuss opportunities. I look forward to speaking with you

Sincerely,



Marina Levina

Enc. resume

School Address :
506 E. Stoughton #24
Champaign, IL 61820
(217) 351-3078

Marina Levina

Permanent Address :
255 Old Oak Ct W.
Buffalo Grove, IL 60089
(847) 465-9624

Education

Fall 1993 - **University of Illinois at Urbana-Champaign** - Champaign, IL
May 1997 Bachelor of Arts in Psychology / Bachelor of Arts in Political Science
Grade Point Average : 3.4/4.00
Summer 1995 **Institute of European Studies** - Paris, France
Grade Point Average : 3.5/4.00

Honors

Dean's List - Fall 1993 and Fall 1995
Psychology Department Honors Program

Lead for Illinois - Sophomore Leadership Honorary
Sachem - Junior Activity Honorary

Experience

Fall 1996-present **A Woman's Fund** - Urbana, IL
Child Assault Prevention Project (C.A.P.P.) Facilitator
• Facilitate child assault prevention workshop for kindergarten - sixth grade children
• Provide women and children related services at a local domestic violence shelter

Spring 1996-present **Psychology Department at the University of Illinois** - Champaign, IL
Research Supervisor
• Initiate and conduct an empirical study as a part of the Honors Program.
• Supervise a team of research assistants.

Fall 1995 - present **Education and Social Science Library** - Urbana, IL
Student Assistant
• Cover the circulation desk. Answer reference questions. Shelf books.

Fall 1995-Fall 1996 **Campus AIDS Coalition** - Urbana, IL
Co-Founder and President
• Launched the first student AIDS prevention organization. Implemented a comprehensive AIDS education program.
• Helped organize and execute World AIDS Day and AIDS Awareness Month activities

Spring 1994 - present **Office of Women's Programs** - Champaign, IL
Campus Acquaintance Rape Education (C.A.R.E.) Program Facilitator
• Facilitate sexual assault education and prevention workshops
• Served on Sexual Assault Awareness month committee

Summer 1995 **North Suburban YMCA** - Northbrook, IL
Assistant Executive Secretary
• Assisted the Executive Secretary and Chief Financial Officer with administrative, clerical work.

Summer 1994 **North Suburban YMCA** - Northbrook, IL
Summer Camp Desk Supervisor
• Supervised activities of 600 children. Served as a liaison between the camp and campers' parents.

Skills

- Strong knowledge of IBM and Macintosh. Experience with Microsoft Word, AmiPro, Excel, and WordPerfect.
- Typing : 40 WPM. Avid reader and writer. Excellent public speaking skills.
- Verbal and written fluency in Russian; verbal fluency in Ukrainian; verbal and written knowledge of French.

Activities

- Krannert Center for the Performing Arts Student Association - Director of Tours
- Krannert Center's Annual Student Theater Production - Play Director
- "Inner Voices" Social Issues Theater Troupe - Actor
- Alpha Phi Omega National Service Fraternity - Leadership Committee Chairperson

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3567

Date Rcvd: 02-04-97

From: Richard Marlenk, M.D.
Leading for Life

Staff Action: Eric

Reviewed By Jeff: _____ Reviewed By: Patsy ✓

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-18-97

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Program Sponsors

Harvard AIDS Institute
National Minority AIDS Council
The Balm in Gilead Inc.
W.E.B. Du Bois Institute
The Henry J. Kaiser Family Foundation

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William Julius Wilson

Secretariat

Harvard AIDS Institute
8 Story Street
Cambridge, MA 02138
phone: 617-495-0478
fax: 617-495-2863

January 31, 1997

Dear Patsy,

The new year is well under way and we wanted to keep you up to date on what has been happening with the *Leading for Life* campaign:

- The Harvard AIDS Institute is: 1) pulling together final program descriptions on "programs that work" for the national report Update: the Challenge of HIV in Communities of Color ; 2) preparing an advertorial to appear in the *Washington Post*, with the support of Maurice Tempelsman, chair of the HAI's International Advisory Council, and the Kaiser Family Foundation; and 3) along with National Medical Fellowships, Inc., hosting fourth year medical students as part of the Arthur Ashe Program in AIDS Care this October.
- Dr. Randall Morgan, through his position as president of the National Medical Association, has been speaking on the *Leading for Life* campaign and on the HIV/AIDS crisis facing African Americans. Please see his attached speech.
- Hopefully, Congresswomen Maxine Waters, along with Congressmen Louis Stokes, Albert Wynn, and others, will be bringing the *Leading for Life* campaign to the attention of the Congressional Black Caucus.
- To date there has been coverage in more than 50 broadcast and print media outlets on *Leading for Life* and the call to address the disproportionate impact of AIDS in our country.
- Tom Morgan and the National Association of Black Journalists will be helping with outreach and dissemination of the *Leading for Life* Meeting Report which is due out in February.
- And you should have received a complimentary copy of the Journal of the International Association of Physicians in AIDS Care which features an article by Phill Wilson on *Leading for Life*.

These are activities that have been or will be undertaken in the spirit of the *Leading for Life* Call for Action. Please let us know of any other activities in this regard. The official Meeting Report will be sent out in February, in conjunction with Black History Month. Also, please find attached the job description for a new *LFL* Outreach Coordinator. The position is currently being funded for one year and the individual will serve as an "information broker" for the campaign. If possible, please post the position and encourage qualified individuals to apply.

All the best to you,

Ric
Richard Marlink, M.D.

Richard Marlink, M.D.

HIV/AIDS IN AFRICAN AMERICANS

THE ROLE OF THE NATIONAL MEDICAL ASSOCIATION IN DIAGNOSIS TREATMENT AND ERADICATION

ADDRESS BY:
RANDALL MORGAN, JR., M.D.
PRESIDENT
NATIONAL MEDICAL ASSOCIATION
OCTOBER 31, 1996
CHARLESTON, S.C.

"When in the course of human events. . ." is a familiar phrase in American history. Those who represented the leadership of the United States expressed to the world that independence from Great Britain and all that it stood for was paramount. Two hundred and twenty years later circumstances again call for a group of people to declare themselves independent of an adversary. This time, however, America is declaring war on HIV/AIDS. Our African-American soldiers have been falling in increasing numbers. Last year alone, over 30,000 died with AIDS related conditions.

In 1994, one in three deaths in African-American males and one in five deaths in African American females was directly related to HIV/AIDS. So, it is our duty and responsibility as a people to be among the most articulate in declaring freedom from AIDS and then to be the most active in making that freedom happen.

The National Medical Association, as a major healthcare leader in the African-American community, must lead the way in this battle for independence. There are numerous physicians in the NMA who have long recognized the potential for community devastation which AIDS possesses. Unfortunately, it has taken the statistics of the past five (5) years to bring that message into focus for the majority of the membership. I count myself as one of the recently converted.

The National Medical Association, through its 101 years of existence, has often found itself at the apex of major healthcare issues that affect our community. This is as it should be because the association has great concern for the patient and his or her family as well as for the physician provider.

HIV/AIDS is a major public health challenge because of the profound effect it has upon the entire family. AIDS literally tears families apart, as does violence, a fact stated recently by Dr. Alvin Poussaint of Harvard University, Department of Psychiatry. He has, along with others, called for a "major declaration of motion and movement" to propel us forward in our attempts to eradicate this dreaded disease.

On October 22, 1996, I attended an event which has had and will have a major impact on the rest of my life. Hopefully it will also positively impact the other 200 attendees. The *Leading for Life* Conference was a gathering of national African-American leadership at the Harvard Faculty Club in Cambridge, Massachusetts. The sponsors included the Harvard AIDS Institute, the National Minority AIDS Council, the Balm in Gilead, Inc., the W.E.B. Du Bois Institute and the Henry J. Kaiser Family Foundation.

It was stated that the equivalent of two large classrooms of young African-American men and women are being infected with HIV each day. By any standard, this is a crisis which is placing increasing demands on the resources of our community each day. The meeting was therefore convened to develop a consensus approach to keep our communities viable and productive.

The goals for the meeting were:

- 1) to review the current epidemiological information;
- 2) to discuss the barriers to effective community engagement surrounding HIV/AIDS;
- 3) to develop a broad consensus on efforts to improve prevention, education, and services within our communities; and
- 4) to identify potential efforts that will catalyze local and national organizations to respond to AIDS.

This meeting was powerful because it was not a medical meeting of and by physicians to impart the latest clinical information. It was a meeting of people of the African-American community. There were brilliant academicians, statisticians, public health experts and clergy. However, there were also HIV infected men and women who are making a significant impact on the treatment and support of those who have the disease.

The emphasis was on the team approach to problem solving. The physician's role in this team is to become more informed about the early manifestation of HIV/AIDS; to offer early intervention for these individuals; to seek early referral to specialized treatment centers and to coordinate the family support opportunities that are available.

Some physicians are and will be involved in the clinical research that eventually will lead to a cure of this disease. Some physicians have great knowledge and skill about the medical therapeutics in HIV/AIDS, which keeps the patient complication free and productive as long as possible. Some physicians are teachers who can impart knowledge about HIV prevention, diagnosis and treatment to healthcare providers of all types and training in the community. But all physicians, and particularly African-American physicians are charged with the responsibility of relating in an informed way with the HIV/AIDS patient and his or her family or significant supporter.

In the past, physicians have not taken this responsibility seriously or personally. To a great extent, this has been a result of lack of knowledge and in certain cases, a result of medical specialty training and interests. The Leading for Life Conference has demanded that all African-American physicians, as community leaders, have the responsibility to provide leadership on the local level as we perform our daily jobs. I, as an orthopaedic surgeon, must not avoid treatment of HIV infected patients, but rather provide exemplary treatment in my discipline and provide seamless care with other providers to minimize the impact on the entire disease process.

This, then, represents a slightly different type of "informed consent." In this case, as physicians become more informed about HIV/AIDS and those individuals who are infected, those physicians will consent to provide care to the best of their ability.

What then have been the barriers to community and professional activism on the part of African-Americans in the fight against AIDS? The most obvious barrier is lack of awareness of the extent of AIDS in the African-American and other communities of color. In the past ten years, the U.S. epidemic has expanded from one primarily affecting white gay men to one in which more than half of those

diagnosed are people of color. African-Americans, who compose 13 percent of the U.S. population, now account for 40 percent of all people with AIDS in the United States.

In spite of these statistics, AIDS is not a black problem or black disease. According to Robert Fullilove, Associate Dean at the Columbia University School of Public Health, "A better model for examining what's going on with HIV in communities of color is not related to race, but to social realities that are the legacies of slavery and segregation." Factors such as poverty, denial and the constant thread of racism combine with the HIV virus to kill.

Studies of the past thirty years in poorer communities of color have demonstrated several trends that have resulted in limited education and employment opportunities, including a loss of jobs, the expansion of an underground economy and the increased availability of drugs. The use of IV drugs in many African-American communities has led to increasingly high rates of HIV transmission.

Other contributing factors unique to the African-American community distrust of the medical community has its root in past injustices such as the Haitian-HIV controversy of 1980 or the Tuskegee Syphilis Study which occurred between the years 1932 and 1972. As there is increasing evidence that HIV/AIDS is disproportionately affecting the African-American and Latino communities, there are many who have great fear that there is little concern for the victims and their families by the white power establishment.

There also exists in the African-American community a sense of fatalism. This is evidenced by a lack of enthusiasm for any positive causes. There is a definite attitude that things cannot get better; that we cannot overcome.

Disenchantment with the medical services environment also contributes to the epidemic. Lack of funds and lack of self-expression often exclude African-Americans from the best treatment centers. Lack of access to the advances in care for the person with HIV infection, at a time when new drug therapy is available, makes the situation hopeless for many in our communities.

In spite of the dreary statistics, we all know too well AIDS is a preventable disease. Increased community involvement at every level is essential to the efforts to bring this epidemic under control. Organizations of leadership including the church have suffered from inherent attitudes of homophobia and addictophobia, which have been obstacles to more sincere involvement.

African-Americans often refuse to acknowledge and accept homosexuality in our families and in our communities. In such an uncomfortable environment for some, it is no wonder that leaders have been slow to identify with the reality of the epidemic. The church must lead the way to provide caring and comfort for the many who are afflicted along with their families.

Males of color are infected with the HIV virus primarily through sex with other men or IV drug use. Women of color, on the other hand, are infected by sex with infected men or IV drug use. The most unfortunate group are those children of color who are infected during the intrauterine period by the mother. There are new methods of treatment for the pregnant female with HIV infection to lessen the transmission of the virus. Only testing and treatment is necessary, but the compliance level is low.

In a report to President Clinton submitted in March, 1996, by the Office of National AIDS Policy entitled Youth and HIV/AIDS, An American Agenda, six action steps were identified by scientists, educators, healthcare providers and community leaders for immediate impact on the epidemic:

- 1) Young people, parents, schools and communities must be integral partners in developing, delivering, and evaluating HIV prevention approaches for adolescents;

- 2) Innovative, creative prevention efforts aimed at young people must be encouraged, adequately funded, and evaluated, and--when found to be effective--broadly disseminated;
- 3) Comprehensive HIV/AIDS education--as part of comprehensive health education--should be available to all young people in all fifty states and U.S. territories;
- 4) Routine counseling and voluntary HIV testing should be made more accessible, developmentally appropriate, and affordable to young people;
- 5) HIV-positive adolescents should be linked to a continuum of care and services that will extend their life span and provide them with the information and skills they need to reduce the likelihood of further transmission;
- 6) Adolescent-specific biomedical and behavioral research should be increased to enhance our knowledge of the progress of HIV disease in adolescents and of effective AIDS prevention approaches.

The National Medical Association has been on the front-line of the advocacy efforts for our patients who have HIV/AIDS. We have many clinical experts across the United States who have developed treatment programs, developed grants for education of providers and published extensively on Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).

In 1987, the NMA House of Delegates passed a broad resolution that:

- 1) Endorsed the efforts of federal, state and local public health officials to develop health education programs to increase knowledge on the part of the public on how to prevent the transmission of AIDS;
- 2) Strongly supported increased government funding and support for basic clinical research into the causes, prevention and treatment of AIDS in the black community;
- 3) Supported efforts to disseminate educational information on AIDS to all physicians, particularly black physicians and to the public through publications, information packages and educational programs; and
- 4) To endorse an expansion of health education and preventative programs, especially to communities of color, to reduce the spread of AIDS.

In 1990, the NMA opposed testing for AIDS of selective ethnic groups based solely on race. The association has supported mandatory testing for exposure to AIDS in:

- 1) blood donors
- 2) military personnel, and
- 3) immigrants.

All other blood testing for exposure to the AIDS virus should be voluntary.

Finally, the NMA firmly supports the reporting of cases of HIV-infection to the local department of health, with the knowledge of the patient. The patient should also be encouraged to notify at-risk partners.

Much has happened in the past 15 years since AIDS was first recognized as a clinical entity with no known cure. There is still no cure and even though the incidence in white males shows a steady decline, the incidence in African men, women and children is increasing and has reached epidemic proportions.

In closing, I think it quite appropriate to share with you the Call for Action of the *Leading for Life* conference.

A CALL FOR ACTION: THE *LEADING FOR LIFE* APPEAL

WHEREAS, AIDS is the leading cause of death for African Americans aged 25 to 44, greater than homicide, heart disease, and accidents combined;

WHEREAS, it is estimated that 300,000 to 500,000 African Americans are already infected with HIV; and, in less than four years, African Americans will account for the majority of all people with AIDS in the United States;

WHEREAS, African Americans account for over half of all children with AIDS, over half of all women with AIDS, and one-third of all men with AIDS; and,

WHEREAS, HIV/AIDS has a direct and devastating economic, social, and emotional impact on our communities and families and is inextricably linked to other socioeconomic maladies.

Now, therefore, we call on our community, our families, members of religious congregations, schools, businesses, political and cultural groups, the criminal justice system and community-based organizations to join together in a national emergency effort to better inform African American families about HIV/AIDS prevention education, care, and treatment issues, including the following actions:

Specifically, we call upon African American athletes, entertainers, artists, business, health clinics, hospitals, and social, cultural, educational, religious, and labor leaders—in addition to federal, state, and local governments—to support, develop, and enhance community-based programs developed by African Americans for their communities at the local level; and

We call upon African American elected leaders and government officials to become actively engaged in HIV/AIDS prevention and public policy issues; and

We call upon our communities and leaders to address and speak out against homophobia, sexism, racism, addiction, and "addicti-phobia"; and

We call upon the Congressional Black Caucus to hold hearings and take a leadership role on the impact of HIV/AIDS on our community; and

We call upon journalists to place HIV/AIDS as a critical issue in reporting news items that affect our communities; and

We call upon our national organizations to place HIV/AIDS at the top of their policy agendas, and to become actively engaged in public policy and community efforts to ensure fair access to all treatment and care services for African Americans affected by HIV/AIDS.

Furthermore, we affirm the responsibilities of federal, state, and local governments, and all branches thereof, to address HIV/AIDS in a fair and equitable manner; and

We appeal to the President of the United States to convene an emergency meeting of the appropriate cabinet-level officials and community leaders to address AIDS within African American communities; and

We appeal to African American local elected officials to join together with advocates and persons with HIV/AIDS to create specific strategies for protecting the health of those impacted by HIV/AIDS, and other chronic diseases, as they implement Medicaid, health care, and welfare reform; and

We appeal to all African American, and other, public office-holders to inform the community specifically regarding their policies and actions in support of HIV/AIDS prevention, care, and research.

Furthermore, we acknowledge the important role that individual, corporate, and private philanthropy has had on improving the lives of all Americans affected by HIV/AIDS.

Thus, we appeal to the Council on Foundations, the Association of Black Foundation Executives, Funders Concerned About AIDS, and other philanthropic interests to join together and create a special committee to address enhancing HIV/AIDS research, prevention, care, and treatment within communities of color; and

We acknowledge the challenge of these difficult issues, we welcome the expertise of those communities historically affected by HIV/AIDS, and we welcome all to join us in prayer, education, advocacy, and political action.

Finally, we call upon all African Americans to reach out, hand-in-hand, to others locally and globally, to advocate, care, and affirm our commitment to the health of our communities. If we fail, our children will face the upcoming millennium with sorrow in their hearts, rather than the hope of a new generation. And, we will have to ask, "Did we do all we could to stop the deaths and the devastation?"

Our communities deserve our leadership!

Adopted by American African leaders at the Leading for Life summit on October 22, 1996, in Cambridge, Massachusetts.

In the book Brother's Keeper, edited by Rod Terry, it was stated about brotherhood the following, "Black men in particular must strive to form stronger bonds with each other. Embracing and supporting our brothers does not compromise our masculinity."

The spirit of community is essential as we seek to protect ourselves and our children from the consequences of HIV/AIDS as was stated by Dr. Martin Luther King, Jr., "We must learn to live together as brothers, or we will perish together as fools."

OUTREACH COORDINATOR

Reporting to the executive director of the Harvard AIDS Institute, coordinates outreach for *Leading for Life*, a campaign to raise awareness about the impact of HIV/AIDS on communities of color. Conducts research on how the epidemic affects communities of color; conducts outreach to relevant organizations and communities; researches and communicates about access and barriers to care. Drafts, produces, and disseminates reports and other programmatic materials. Responds to external requests for information; writes and produces press materials; develops media lists and contacts; schedules media interviews; develops media source materials; drafts remarks and editorials for program organizers. Provides routine support by coordinating meeting logistics, managing/maintaining data, wordprocessing, etc. Special projects as assigned.

Bachelor's degree preferred; five years of related experience (public relations, community organizations); experience working with communities of color preferred; excellent interpersonal, organizational, and oral/written communications skills; must be accurate and detail-oriented; must be able to meet deadlines, handle complex materials, follow through on assignments, and work with minimal supervision; proficiency with Microsoft Word and FileMaker Pro on the Macintosh preferred.

NOTE: This is a temporary, one-year, grant-funded position, which may continue beyond the first year, depending on funding. Please send resume and cover letter to Ellen Carpenter, Harvard School of Public Health, 677 Huntington Avenue, Rm. 111, Boston, MA 02115.

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number:

G3574

Date Rcvd:

02-10-97

From:

Joseph McCormack

Staff Action:

Reviewed By Jeff:

Reviewed By: Patsy

Assigned To:

RCVD:

DONE:

Recommendations/Instructions:

Job announcement

To Support Staff:

Date of Response:

2-14-97

FILL COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G-3591

Date Rcvd: 02-21-97

From: Andrea S. Mitchell

Staff Action:

Reviewed By Jeff: _____ Reviewed By: ^{EG}~~Patsy~~ _____

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

Personal note to PF

To Support Staff: _____

Date of Response: 2-24-97

n:\corresli

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3580

Date Rcvd: 02-14-97

From: Philip A. Newbold
The Healthcare Forum

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ☒

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR
1088

To Support Staff: _____

Date of Response: 2-14-97

FILE COPY

**Office of
National AIDS Policy**

Correspondence Routing Slip

Tracking Number: G3599

Date Rcvd: 03-28-97

From: Vicente L. Rodriguez, CMP
National Skills Building Conference Report

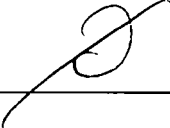
Staff Action:

Reviewed By Eric: _____ **Reviewed By:** _____

Assigned To: _____

RCVD: _____ **DONE:** _____, DA

Recommendations/Instructions:

NR 

To Support Staff: _____

Date of Response: 4-1-97

n:\corresli

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3578

Date Rcvd: 02-12-97

From: John S. Roberts

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ✓

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97

Structure protein p17 999 of HIV
9590 inactivated at this point

Vol. 165, No. 3, 1989

BIOCHEMICAL AND BIOPHYSICAL RESEARCH COMMUNICATIONS

I assume you
Received my
letter of
February 3, 1997.

J.S.R.
~~My assumption~~
~~is that a~~
~~blank space~~
~~indicates that~~
~~something~~
~~did not happen~~

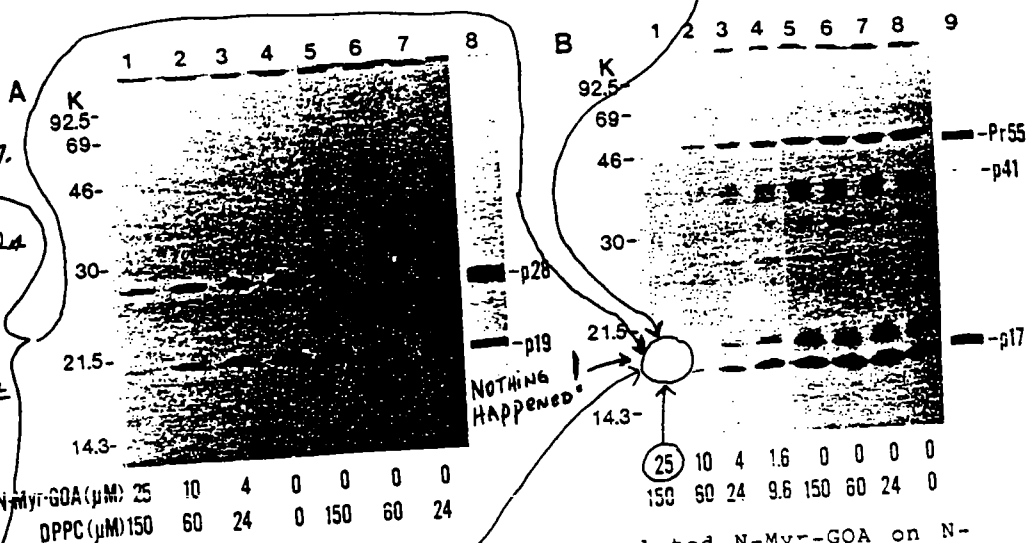


Fig. 2. Effects of the liposome-encapsulated N-Myr-GOA on N-myristoylation of the retroviruses' gag proteins. MT-2 and CEM/LAV cells were preincubated with the liposome-encapsulated N-Myr-GOA or the control liposome for 6 hr, labeled with [³H]myristate for 16 hr, and lysed in the lysis buffer. The cell lysates were performed for SDS-PAGE analysis. The other experimental details are described in "Materials and Methods". (A) The MT-2 cell lysates: lanes 1 to 3, the liposome-encapsulated N-Myr-GOA, 25, 10 and 4 μM; lane 4, control without the liposome; lanes 5 to 7, the control liposome; lane 8, immunoprecipitate of control with an ATL patient serum. (B) The CEM/LAV cell lysates: lanes 1 to 4, the liposome-encapsulated N-Myr-GOA, 25, 10, 4 and 1.6 μM; lanes 5 to 7, the control liposome; lane 8, control without the liposome; lane 9, immunoprecipitate of control with anti-p17 monoclonal antibody. The molecular weights (K; kilodalton) are indicated on the left and the positions of the gag proteins are indicated on the right.

February 7, 1997

25 μM

Attention → acetaldehyde was required to inactivate HIV in your test tube experiments? Could it have been less than 25 μM because 'pure' acetaldehyde, CH₃CHO, is more soluble than diethyl acetal, H₂NCH₂CH₃CH(OC₂H₅)₂.

Table 1. Estimation of [³H]myristoylated proteins of HTLV-I and HIV-1 in the cells treated with N-Myr-GOA

N-Myr-GOA ^a (μM)	MT-2 cell lysates			CEM/LAV cell lysates		
	p19 (%)	p28 (%)	Pr53 (%)	p17 (%)	p41 (%)	Pr55 (%)
0	3,444(100)	4,198(100)	1,229(100)	2,985(100)	2,700(100)	2,931(100)
1.6	NT*	NT	NT	2,173(73)	1,521(56)	1,778(61)
4	1,216(35)	1,719(41)	594(48)	1,532(53)	1,301(48)	1,560(53)
10	878(25)	1,287(31)	496(40)	631(21)	553(20)	617(21)
25	375(11)	642(15)	156(13)	157(5)	151(6)	205(7)

^a N-Myr-GOA was used as the liposome form.

[#] Net cpm's were determined by subtracting cpm of background (n=5) from that of sample.

^{\$} [³H]myristoylated proteins were extracted from the gel of SDS-PAGE analysis as shown in Fig. 2.

* Not tested.

Result: Yield for compound containing diethylacetal
Result: Yield for 'pure' acetaldehyde be 100%?
This number represents almost 95%
Would this be 0 with 'pure' acetaldehyde?

A Compound Containing a form of
acetaldehyde-diethyl acetal-inactivated
the structure protein p17^{gag} of HIV at this point

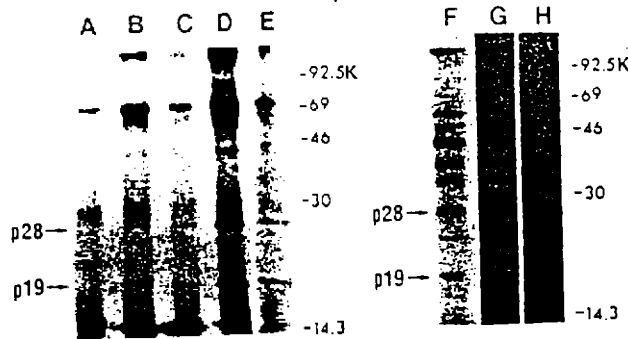


Fig. 1. Detection of NH₂-terminal myristoyl proteins in HTLV-I and MT-2 cell lysates. Virion lysates (lanes A to E; E, NH₂OH-treated), cell lysates (lanes F to H; G, NH₂OH-treated), and the immunoprecipitate (28) of a cell lysate (lane H) with antiserum to ATL from a patient were analyzed by 14% SDS-PAGE (29), followed by fluorography (30). The experimental details are given in the text. The arrows indicate p28K and p19K. Molecular markers are shown on the right.

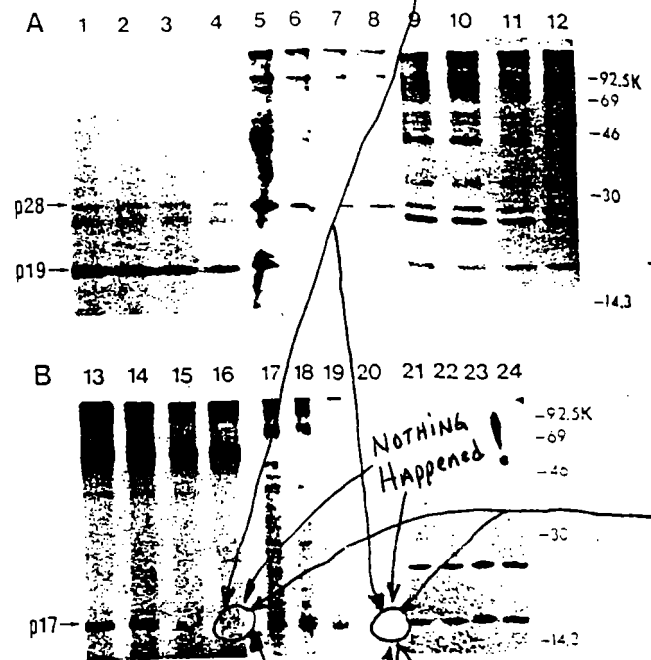


Fig. 3. Effect of N-Myr-GOA on protein myristoylation of HTLV-I and HIV. A shows the effect of N-Myr-GOA on protein myristoylation of HTLV-I (lanes 1 to 4) and MT-2 (lanes 5 to 8), and the incorporation of [¹⁴C]leucine into HTLV-I (lanes 9 to 12) at various concentrations: 0 μ M; lanes 1, 5, and 9; 50 μ M; lanes 2, 6, and 10; 100 μ M; lanes 3, 7, and 11; 200 μ M; lanes 4, 8, and 12. B illustrates the effect of N-Myr-GOA on the protein myristoylation of HIV (lanes 13 to 16) and CEM LAV (lanes 17 to 20), and the incorporation of [¹⁴C]leucine into HIV (lanes 21 to 24) at various concentrations: 0 μ M; lanes 12, 17, and 21; 10 μ M; lanes 14, 18, and 22; 40 μ M; lanes 15, 19, and 23; 200 μ M; lanes 16, 20, and 24. The experimental details are given in the text. The other experimental conditions were the same as in Fig. 1.

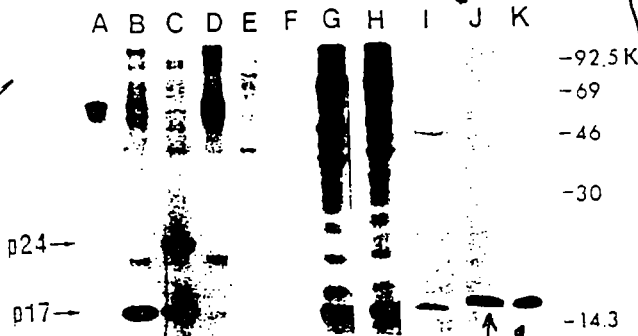


Fig. 2. Detection of NH₂-terminal myristoyl proteins in HIV and CEM LAV cell lysates. Virion lysates (lanes A to C) from CEM LAV cell medium, lysates (lanes D and E) of the fraction corresponding to virions from the CEM cell medium cultivated under identical conditions, the cell lysates of CEM LAV (lanes F and G) and CEM (lane H), the immunoprecipitates (28) of the CEM LAV cell lysate (lane I) and the virion lysate (lane J), and the NH₂OH-treated virion lysate (lane K) were applied. The arrows indicate p17K and p24K. Molecular weight markers are shown on the right. CEM LAV cells (approximately 1.1×10^7 cells, 10 ml/75 cm²) were grown in RPMI 1640 medium supplemented with 5% fetal calf serum at 37°C for 0 h (lanes A and F) and 24 h (other lanes) under a humidified 5% CO₂ atmosphere. The cells were incubated with either [¹⁴C]-myristate (25 μ Ci; lanes B and D), [³H]-myristate (100 μ Ci; lanes I to K) or DL-[¹⁴C]leucine (5 μ Ci; lanes C and E). The other experimental conditions were the same as in Fig. 1.

(p28K and p19K; indicated by arrows in the fluorogram) increased with increasing incubation time (0 h, lane A; 3 h, lane B; 6 h, lane C; and 9 h, lane D), and the same proteins were observed in the MT-2 cell lysates (Fig. 1, lanes F to H). The radioactive proteins were positively identified as NH₂-terminal myristoyl proteins, p28^{gag} and p19^{gag}, because both proteins were resistant to NH₂OH-treatment (lanes E and G), and radiolabeled proteins that were immunoprecipitated with the antiserum to ATL were detected (lane H). The band observed at a position corresponding to 69K in the case of the HTLV-I lysate in Fig. 1, lane D (before NH₂OH-treatment), seems not to be myristate covalently bound through an amide bond, because the radioactivity was remarkably decreased after

NH₂OH-treatment (lane E). MT-2 (13) and MT-2-related T-cell lines (26, 27) produced both p19K, which is a gag protein of HTLV-I, and p28K, which was shown to be a fusion product of the gag-Px gene of HTLV-I.

CEM/LAV cells were grown under identical conditions in the case of HTLV-I producing MT-2 cells. The cells were incubated with either radiolabeled myristate or radiolabeled leucine. The experimental details are given in the legend to Fig. 2. A protein (p17K) labeled with [¹⁴C]-myristate (Fig. 2, lane B), and both p17K and p24K labeled with [¹⁴C]leucine (lane C) in HIV can be easily detected in the fluorogram. Alternatively, neither protein myristoylation (lane D) nor synthesis (lane E) of proteins p17K and p24K, the latter being a processing product of a precursor gag protein (28), occurred in CEM cells (HIV noninfected and nonproducing cells). Myristoylation of p17K in the CEM/LAV cell lysate (lane G) was found to be ambiguous in the fluorogram because unknown proteins generated from the CEM cell lysate (lane H) migrated very close to p17^{gag}. A radiolabeled myristoyl protein that was immunoprecipitated with an anti-p17^{gag} monoclonal antibody (Cellular Products, Inc., U.S.A.), however, was clearly detected at a position corresponding to p17K in the cases of the cells (lane I) and virion lysate (lane J). This protein was also resistant to NH₂OH-treatment (lane K). Thus the results revealed that p17^{gag} in HIV is an NH₂-terminal myristoyl protein.

What is the NH₂OH Treatment?

What is
a virion lysate? Biochem

may assumption is that a blank space indicates that something did not happen

Columns
J and K
are
crystal clear

P17^{gag}

February 7, 1997

What is a
virion lysate

On page 5 of my 35 page 'file' I questioned: "Am I right or wrong? If I am right, could we say the same description would apply to a VIRAL BODY when it is at this stage? Then, anything that had the power of 'antimyristoylation' would prevent a unit of a life from reaching that stage of development wherein it divided (replicated) itself."

John S. Roberts
P.O. BOX H
HOBART, IN 46342

219-763-1933

February 7, 1997

Myristoylation
of p17 strongly
inhibited at
this point

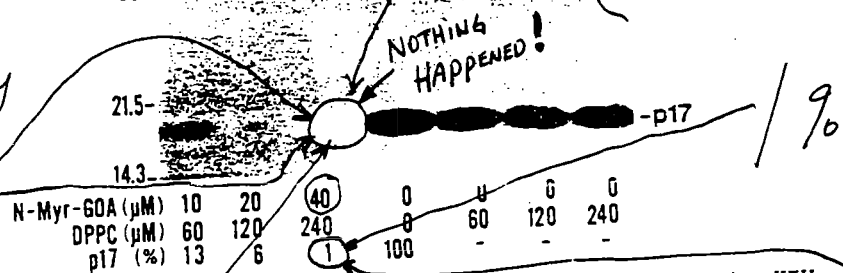


Fig. 4. SDS-PAGE analysis of [^{3} H]myristoylated proteins in the HIV-1-infected MT-4 cells treated with the liposome-encapsulated N-Myr-GOA. Infection of HIV-1 to MT-4 cells and treatment with the liposomes were performed as described in Fig. 3. The infected cells were labeled with [^{3} H]myristate for 16 hr at 2 days postinfection, lysed in the lysis buffer, and submitted to SDS-PAGE analysis. The other experimental details are described in "Materials and Methods". Lanes 1 to 3: the liposome-encapsulated N-Myr-GOA, 10, 20 and 40 μM; lane 4: untreated; lanes 5 to 7: the control liposomes. The molecular weights (K; kilodalton) are indicated on the left, and the position of p17 is indicated on the right. Each content of [^{3} H]myristoylated p17 in the gel after SDS-PAGE analysis is expressed in percent (%).

Am I correct
about this?
99% of the
HIV protein
p17^{gag}
failed to
myristolate?

MT-4 cells. There was, however, no reduction of the viral replication in the HIV-1-producing CEM/LAV cells treated with N-Myr-GOA (data not shown), which nevertheless prevented the myristoylation of gag proteins in the cells (Fig. 2 and Table 1). The reason why there was a difference between the result in HIV-1-infected MT-4 cells and that in HIV-1-producing CEM/LAV cells is still not known. One possibility may be concerned that a number of anti-HIV drugs, such as azidothymidin, are effective in an in vitro system of the susceptible T cell lines infected with HIV-1, but not effective generally in a system of persistently infected cell lines, such as CEM/LAV(27). A recent report showed that a substitution of an alanine for the glycine of the gag precursor protein of HIV-1 abolished the myristoylation of the mutant precursor protein and also prevented virus particle release(28).

In this report, we have investigated the myristoylation of the viral structural proteins and the replication of the virus in HIV-1-infected cells which were treated with newly synthesized N-myristoyl glycinal diethylacetal (N-Myr-GOA). N-Myr-GOA markedly

P.S. February 7, 1997: Perhaps the ingestion of alcohol ^{should} be eliminated entirely; perhaps it would be best if 'pure' acetaldehyde were mixed with distilled water and then be administered to the patient; in this way the amount could be more accurately quantified.

February 3, 1997

TO: Patricia S. Fleming
DIRECTOR
Office of National Aids Policy
The White House

If my hunch about the toxic poison 'acetaldehyde' is true, then a world of pain, anguish and misery will begin to end for HIV/AIDS sufferers. All they have to do is to obtain an inexpensive nutrient from any health food store, an inexpensive chemical from any physician and an inexpensive beverage from any supermarket. The following pages will afford you a beginning introduction to my research - J.S.R.

- AIDS -

IS AIDS REALLY A PROBLEM ?
DOES ANYONE TRULY CARE ?

"KNOCK, KNOCK, KNOCK ! SHAKESPEARE, MACBETH, ACT 2,
WHO'S THERE, i' THE NAME OF SCENE 3, LINES 3 & 4
BEELZEBUB ?"

CAN I AWAKEN ANYONE ?

"DOUBLE, DOUBLE TOIL AND TROUBLE, MACBETH, ACT 4, SCENE 1,
FIRE BURN AND CALDRON BUBBLE." LINES 10 & 11

"FOR A CHARM OF POWERFUL TROUBLE, MACBETH, ACT 4, SCENE 1,
LIKE A HELL BROTH BOIL AND BUBBLE." LINES 18 & 19

"THEN THE CHARM IS FIRM AND GOOD." MACBETH, ACT 4, SCENE 1,
LINE 38

"AND EVERYONE SHALL SHARE i' THE GAINS." MACBETH, ACT 4,
SCENE 1, LINE 40

AT SOME TIME, BETWEEN NOVEMBER 1, 1993 AND AUGUST 9, 1995, ONE OF THE MOST AMAZING SCIENTIFIC DISCOVERIES OF THE 20th CENTURY OCCURRED AT THE NATIONAL INSTITUTES OF HEALTH (NIH), BETHESDA, MARYLAND.

THROUGHOUT MOST OF 1993 THE NIH THOUGHT THAT THE CHEMICAL COMPOUND 'ACETALDEHYDE' WAS A NORMAL METABOLITE OF THE HUMAN BODY FORMED DURING NORMAL BODY FUNCTIONING AND -

"...WOULD HAVE NO EFFECT ON HIV OR AIDS." NIH LETTER TO ME DATED JANUARY 26, 1993

"...WILL HAVE NO EFFECT ON HIV INFECTION." NIH LETTER TO ME DATED MARCH 24, 1993

"...WOULD NOT SIGNIFICANTLY HINDER HIV INFECTION." NIH LETTER TO ME DATED
SEPTEMBER 22, 1993

"AS THERE IS CURRENTLY NO SCIENTIFIC BASIS TO BELIEVE THAT
ACETALDEHYDE HAS ANY ANTI-HIV ACTIVITY, THE NIH IS NOT PURSUING
THE DEVELOPMENT OR PRECLINICAL EVALUATION OF THIS AGENT." NIH LETTER TO
CONGRESSMAN VISCLOSKEY
DATED JUNE 18, 1993

How to Make an American Quilt

The craft of quilting dates from colonial times in this country. Pieced quilts were sewn from precious scraps of scarce fabric. Album quilts, recording milestones like births or marriages, became popular in the 1800s. And quilting bees continue to bring together artisans with a common goal: creating patterns in cloth that reflect the patterns of our lives. In 1987, two men began what would become America's biggest ongoing quilting bee. So far, 40 countries and all 50 states have contributed. Using the traditions of quilting—and materials ranging from lace and fur to Legos and car keys—each panel recalls the story of one life lost to AIDS. Almost 10 years along, the quilt covers 16 acres and honors 45,000 dead. Quilts are supposed to keep you warm; this one is chilling. □



Photographed in
Washington, D.C.

by ROBERT GIROUX
REUTERS-ARCHIVE PHOTOS

"LIFE" MAGAZINE
DECEMBER, 1996 ISSUE

"TO DATE, THE NIH HAS NOT IDENTIFIED ANY COMPELLING DATA OR A
CONVINCING RATIONALE TO PURSUE ACETALDEHYDE AS AN ANTI-HIV AGENT."

NIH LETTER TO ME DATED NOVEMBER 1, 1993

THEN, AT SOME TIME DURING THE 21 $\frac{1}{4}$ MONTHS AFTER NOVEMBER 1, 1993, THE NIH
MADE THE DISCOVERY THAT -

"...ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
IN TEST TUBE EXPERIMENTS..." NIH LETTER TO CONGRESSMAN VISCLOSKY DATED
AUGUST 9, 1995

BY JUXTAPOSING ITS OWN WORDS, I COULD MAKE THIS STATEMENT:

"THE NATIONAL INSTITUTES OF HEALTH (NIH) HAS DISCOVERED THAT
ACETALDEHYDE, A NORMAL METABOLITE OF THE HUMAN BODY FORMED DURING
NORMAL BODY FUNCTIONING, HAS THE POWER TO INACTIVATE HIV
IN TEST TUBE EXPERIMENTS."

THERE IS ONLY ONE PROBLEM WITH ACETALDEHYDE - IT IS HIGHLY TOXIC,
AND THIS IS WHY THE NIH DOES NOT WISH TO UTILIZE IT IN ITS CLINICAL TRIALS.

AS JACK WHITESCARVER, Ph.D. , DEPUTY DIRECTOR, OFFICE OF AIDS RESEARCH, NIH,
STATED IN HIS AUGUST 9, 1995 LETTER TO CONGRESSMAN VISCLOSKY (DR. WHITESCARVER'S
COMPLETE LETTER IS INCLUDED IN MY 35 PAGE 'FILE'):

"THE HIGH TOXICITY OF ACETALDEHYDE MAKES IT A SIGNIFICANTLY LESS DESIRABLE
CANDIDATE FOR USE IN INDIVIDUALS WHO SUFFER FROM SEVERELY WEAKENED
IMMUNE SYSTEMS AND WHO ARE PRONE TO CONTRACTING NUMEROUS OPPORTUNISTIC
INFECTIONS AND MALIGNANCIES."

FROM THIS POINT ON I WOULD LIKE TO FOCUS UPON A POSSIBLE WAY TO AMELIORATE
OR NEGATE ACETALDEHYDE'S TOXICITY IN THE HUMAN BODY.

FIRST OF ALL, I AM GOING TO ASSUME THAT ACETALDEHYDE 'INACTIVATES' HIV
IN THE HUMAN BODY AS WELL AS THE TEST TUBE.

WOULDN'T IT BE WONDERFUL IF RESEARCHERS COULD FIND A WAY BY WHICH
ACETALDEHYDE'S TOXICITY COULD BE DONE AWAY WITH ENTIRELY.

IF A WAY MIGHT BE FOUND THEN ACETALDEHYDE COULD BE UTILIZED AS A 'MAGIC BULLET'
TO INACTIVATE THE AIDS VIRUS - HIV.

I WISH I COULD USE A STRONGER WORD THAN 'INACTIVATE'; I WISH I COULD SAY
'KILL', 'DESTROY' OR 'OBLITERATE' WHEN REFERRING TO HIV; HOWEVER, I HAVE COME
TO LEARN THAT 'INACTIVATE' IS THE CORRECT BIOLOGICAL TERM TO USE; PERHAPS 'CRIPPLE'
WOULD BE A MORE APT WORD; IF WE CAN'T KILL IT, WE CAN AT LEAST HOPE TO CRIPPLE
THIS GHASTLY BIT OF LIFE.

IT MIGHT SOUND IMPOSSIBLE, BUT I WISH TO SUGGEST THAT A WAY HAS ALREADY
BEEN FOUND BY WHICH ACETALDEHYDE'S TOXICITY IN THE HUMAN BODY MIGHT BE NEGATED - ENTIRELY.

THE RESEARCH OCCURRED 22 YEARS AGO, AND IN MY OPINION, IS ONE OF THE MOST
SIGNIFICANT SCIENTIFIC STUDIES EVER PUBLISHED.

IT WAS PUBLISHED IN "AGENTS AND ACTIONS", VOLUME 5/2, 1975, PAGES 164 - 173,
AND THE RESEARCHERS WERE HERBERT SPRINCE, CLARENCE M. PARKER, GEORGE G. SMITH
AND LEON J. GONZALES; THE TITLE OF THE RESEARCH IS:

'PROTECTIVE ACTION OF ASCORBIC ACID AND SULFUR COMPOUNDS AGAINST
ACETALDEHYDE TOXICITY: IMPLICATIONS IN ALCOHOLISM AND SMOKING.'

THE TEST SUBJECTS WERE MALE ALBINO RATS.
THIS QUOTATION SHOULD ALWAYS BE KEPT IN MIND -

" AS CHARLES F. WURSTER, A TRUSTEE OF THE ENVIRONMENTAL DEFENSE FUND, HAS POINTED OUT, LABORATORY EXTRAPOLATIONS FROM ANIMAL DATA ARE ADMITTEDLY NOT PRECISE, BUT THEY REMAIN THE BEST INDICATORS AVAILABLE FOR ESTIMATING HUMAN RESPONSE." PAGE 37, MORE MISINFORMATION BY TOM BURNAM, LIPPINCOTT & CROWELL, NEW YORK, 1980

IF I HAD READ ABOUT ANY BIOLOGICAL EXPERIMENT WHICH HAD ACHIEVED A 100% RESULT, THE INDICATION TO ME WOULD BE THAT A UNIQUE PHENOMENON OF SINGULAR SIGNIFICANCE HAD OCCURRED.

HERE IS WHAT HAD HAPPENED -

22 GROUPS OF RATS WERE INVOLVED; THE LARGEST HAD 50 AND THE SMALLEST HAD 10. ALL OF THE RATS WERE ADMINISTERED A 'TOXIC ORAL DOSE' OF ACETALDEHYDE; HOWEVER, 30-45 MINUTES BEFORE THIS HAPPENED, THEY WERE ORALLY ADMINISTERED A 'TEST COMPOUND'; ONE EXCEPTION - ONE GROUP WAS ADMINISTERED INTRAPERITONEALLY.

THE CONSTITUENT OR CONSTITUENTS OF THE TEST COMPOUNDS VARIED WITH EACH GROUP. SPRINCE'S ABSTRACT STATES:

"...PROTECTION AGAINST ACETALDEHYDE (i.e. ANESTHESIA AND LETHALITY) WAS STUDIED IN RATS BY ORAL INTUBATION OF TEST COMPOUNDS 30-45 MINUTES PRIOR TO ORAL INTUBATION OF A STANDARDIZED ORAL LD 90 DOSE (18 MILLIMOLES/KILOGRAM) OF ACETALDEHYDE. ANIMALS WERE MONITORED FOR ANESTHESIA (LOSS OF RIGHTING REFLEXES) AND LETHALITY FOR 72 HOURS..."

AFTER 72 HOURS, DEATH HAD OCCURRED IN VARYING NUMBERS IN 19 OF THE GROUPS; HOWEVER, IN 3 GROUPS, DEATH DID NOT OCCUR AT ALL.

WHAT WERE THE 'TEST COMPOUNDS' OF THESE 3 GROUPS ?

1. TEST COMPOUND N-ACETYL-L-CYSTEINE: 20 OUT OF 20 OF THE RATS SURVIVED THE TOXIC DOSE OF ACETALDEHYDE. THE WORST THING THAT HAPPENED WAS THAT 2 RATS BECAME ANESTHETIZED. WOULD IT BE FAIR IF I WERE TO SAY THAT THIS PARTICULAR NUTRIENT AFFORDED THIS GROUP OF RATS 'A 100% SAFETY FACTOR' AGAINST THE DANGERS OF ACETALDEHYDE POISONING ?
2. TEST COMPOUND L-CYSTEIC ACID . H₂O: 16 OUT OF 16 OF THE RATS SURVIVED THE TOXIC DOSE OF ACETALDEHYDE. THE WORST THING THAT HAPPENED WAS THAT 2 RATS BECAME ANESTHETIZED. WOULD IT BE FAIR IF I WERE TO SAY THAT THIS PARTICULAR NUTRIENT AFFORDED THIS GROUP OF RATS 'A 100% SAFETY FACTOR' AGAINST THE DANGERS OF ACETALDEHYDE POISONING ?
3. TEST COMPOUND (A COMBINATION) L-ASCORBIC ACID (VITAMIN C), L-CYSTEINE FB AND THIAMIN . HCL: 30 OUT OF 30 OF THE RATS SURVIVED THE TOXIC DOSE OF ACETALDEHYDE. THE WORST THING THAT HAPPENED WAS THAT 3 RATS BECAME ANESTHETIZED. WOULD IT BE FAIR IF I WERE TO SAY THAT THESE PARTICULAR NUTRIENTS, IN COMBINATION, AFFORDED THIS GROUP OF RATS 'A 100% SAFETY FACTOR' AGAINST THE DANGERS OF ACETALDEHYDE POISONING ?

WITH THE EXCEPTION OF L-ASCORBIC ACID (VITAMIN C), I BELIEVE THAT ALL OF THESE ARE SULFUR COMPOUNDS.

MY LOCAL HEALTH FOOD STORE STOCKS OR COULD ORDER THE CONSTITUENTS IN GROUPS 1 & 3; THEY ARE EXTREMELY INEXPENSIVE WHEN COMPARED WITH MEDICINES WHICH HAVE BEEN EMPLOYED THUS FAR IN THE TREATMENT OF HIV/AIDS PATIENTS; HOWEVER IT DID NOT STOCK NOR COULD IT FIND FROM WHENCE THE CONSTITUENT IN GROUP 2 COULD BE OBTAINED; HOWEVER, THIS IS NOT CRITICAL; IF YOU REFER TO THE FIRST PAGE OF MY LETTER (ATTACHED) TO MS. FLEMING YOU WILL SEE THAT I THINK THE BEST NUTRIENT TO UTILIZE IS -

N-ACETYL-L-CYSTEINE.

FROM MY PERSPECTIVE, THE RESULTS OF THE SPRINCE STUDY DEMONSTRATE HOW NATURE HAS PROVIDED US WITH A WONDROUS LOOPHOLE THROUGH WHICH WE CAN UTILIZE ACETALDEHYDE'S TOXICITY TO OUR OWN ADVANTAGE.

THE CULMINATION OF MY RESEARCH IS CONTAINED WITHIN -

1. A 35 PAGE FILE DATED JANUARY 1, 1996
2. AN 18 PAGE LETTER TO LEANNA J. STANDISH, ND, Ph.D.
DIRECTOR, BASTYR UNIVERSITY AIDS RESEARCH CENTER
SEATTLE, WASHINGTON. (THE LETTER IS DATED JULY 22, 1996)

IF YOU WISH TO OBTAIN THIS CULMINATION, MAIL \$5.00 (U.S.) TO

JOHN S. ROBERTS
POST OFFICE BOX H
HOBART, INDIANA 46342

AFTER READING IT, YOU WILL SEE MY BASIS FOR THE FOLLOWING STATEMENT -

IN MY OPINION, A WORLD OF SUFFERING, MISERY AND PAIN COULD BE ALLEVIATED IF HIV/AIDS PATIENTS ONLY KNEW THAT HELP WAS AT HAND AT THEIR LOCAL HEALTH FOOD STORE (N-ACETYL-L-CYSTEINE), AT THEIR LOCAL PHYSICIAN (ANTABUSE) AND AT THEIR LOCAL SUPER-MARKET (WINE).

IN MY RESEARCH I DESCRIBE HOW THESE THREE ELEMENTS CAN BE COMBINED FOR THE BENEFIT OF THE PATIENT.

I FIRST HAD THIS HUNCH BACK ON JANUARY 1, 1993, AND I AM STILL CONVINCED OF IT TODAY -

ACETALDEHYDE WILL PROVE TO BE A FIRM AND GOOD CHARM OF POWERFUL TROUBLE FOR ONE OF MANKIND'S MOST FORMIDABLE ENEMIES - HIV.

COPIES TO:

PRESIDENT CLINTON
PATRICIA S. FLEMING, DIRECTOR,
NATIONAL AIDS POLICY OFFICE
THE WHITE HOUSE
CONGRESSMAN PETER J. VISCLOSKY
HAROLD VARMUS, M.D., DIRECTOR,
NATIONAL INSTITUTES OF HEALTH
AND ALL OF THE PARTIES DELINEATED ON 'THE LISTING' (ATTACHED)



"AND EVERYONE SHALL SHARE i' THE GAINS."

THE FOLLOWING POST SCRIPT IS DIRECTED TO
CONGRESSMAN VISCLOSKY AND DR. VARMUS.

DR. VARMUS, WITH ALL DUE RESPECT TO YOU - HOWEVER - IF I WERE PRESIDENT CLINTON'S DIRECTOR OF NATIONAL AIDS POLICY, 'THE AIDS CZAR', I WOULD ORDER YOU TO IMPLEMENT IMMEDIATELY CLINICAL TRIALS BASED UPON THE PROCEDURES (MILD APPLICATION, INTENSIVE APPLICATION) WHICH I DESCRIBE IN MY RESEARCH (ATTACHED).

ALAS, I AM NOT 'THE AIDS CZAR'.

NEVERTHELESS, AT THIS TIME, I WISH TO GARNER SOME MORE INFORMATION FROM THE NATIONAL INSTITUTES OF HEALTH.

I WOULD APPRECIATE IT IF YOU WOULD FORWARD TO CONGRESSMAN VISCLOSKY AND MYSELF A COPY OF THE LABORATORY LOG WHICH DETAILS THE MANNER IN WHICH THE TEST TUBE EXPERIMENTS WERE CONDUCTED AT THE NIH WHEREIN THE DISCOVERY WAS MADE THAT ACETALDEHYDE CAN INACTIVATE HIV.

IF YOU HAVE THE TIME, I WOULD APPRECIATE IT IF YOU COULD MAKE ANY COMMENTS, CLARIFICATIONS AND/OR EMENDATIONS TO LABORATORY NOTATIONS WHICH CONGRESSMAN VISCLOSKY AND I, BEING LAYMEN, MIGHT NOT BE ABLE TO UNDERSTAND.

AS PART OF MY 'INTERNET' ADVERTISEMENT (ATTACHED) I INCLUDED A LETTER TO ME FROM THE CENTERS FOR DISEASE CONTROL.

IN ANSWER TO MY QUESTION:

"DOES ACETALDEHYDE DESTROY HIV IN THE TEST TUBE ?"

THE CDC ANSWERED:

"ALL THE ALDEHYDES ARE CAPABLE OF INACTIVATING HIV; HOWEVER, THEIR ACTUAL EFFECTIVENESS DEPENDS ON THE CONCENTRATION USED."

THE NIH HAS STATED:

"...ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN TEST TUBE EXPERIMENTS..."

DR. VARMUS, WHAT CONCENTRATION OF ACETALDEHYDE WAS NEEDED TO INACTIVATE EFFECTIVELY HIV ? WOULD YOU PLEASE HIGHLIGHT THIS FACT ON THE LABORATORY LOG FOR CONGRESSMAN VISCLOSKY AND MYSELF.

THIS INFORMATION WILL BE USEFUL FOR ME TO HAVE WHEN (AND IF) I EVER CONVINCE ANYONE IN 'THE AIDS COMMUNITY' (CRIA, AmFAR, PROJECT INFORM, ETC, ... SEE 'THE LISTING' ATTACHED) TO IMPLEMENT CLINICAL TRIALS BASED UPON PROCEDURES DESCRIBED IN MY RESEARCH.

I WISH TO SUPPLY SUCH A PARTY WITH ALL DATA REFLECTING EXPERIMENTATION WITH ACETALDEHYDE UPON HIV WHICH WAS CONDUCTED AT THE NIH BETWEEN

NOVEMBER 1, 1993 - AUGUST 9, 1995.

DR. VARMUS, COULD YOU SUPPLY CONGRESSMAN VISCLOSKY AND MYSELF WITH ALL PERIODICAL, JOURNAL AND BOOK REFERENCES WHEREIN ACETALDEHYDE AND HIV/AIDS ARE MENTIONED TOGETHER.

AS FOR MYSELF, MY SEARCH PROVED FRUITLESS UNTIL DECEMBER 21, 1995 (SEE PAGE 3 OF MY FILE).

THROUGHOUT 1993, 1994 AND 1995, I FREQUENTLY SEARCHED THROUGH THE CUMULATED INDEX MEDICUS LODGED ON THE SHELVES OF THE INDIANA UNIVERSITY LIBRARY - NORTHWEST CAMPUS - GARY.

I WAS AT A DEAD END UNTIL, IN LATE 1995, SOMEBODY TOLD ME ABOUT THE 'AIDSLINE DATA BASE' OF THE NATIONAL LIBRARY OF MEDICINE.

WITH THE KIND ASSISTANCE OF THE LIBRARIAN AT THE INDIANA UNIVERSITY SCHOOL OF MEDICINE - NORTHWEST CAMPUS - GARY, I WAS ABLE TO OBTAIN FROM THAT LIBRARY'S COMPUTER THE TWO ABSTRACTS WHICH I PLACED IN MY INTERNET ADVERTISEMENT (ATTACHED).

PLEASE LOOK BACK A FEW PARAGRAPHS, AND YOU WILL SEE THAT I HAVE UNDERLINED THE LETTER SEQUENCES (ACETAL & HIV) WHICH I BELIEVE GENERATED BOTH OF THESE ABSTRACTS.

I EVENTUALLY OBTAINED COPIES OF THE COMPLETE ARTICLES. BOTH ARTICLES WERE WRITTEN BY THE SAME RESEARCHERS - AKIRA TASHIRO, SHOZO SHOJI AND YUKIHO KUBOTA -, AND IN 1989 WERE ASSOCIATED WITH THE DEPARTMENT OF BIOCHEMISTRY, FACULTY OF PHARMACEUTICAL SCIENCES, KUMAMOTO UNIVERSITY, KUMAMOTO 862, JAPAN.

THANK GOODNESS FOR THE ABSTRACTS; THE ARTICLES THEMSELVES ARE SO SCIENTIFICALLY COMPLEX THAT I CANNOT UNDERSTAND THEM.

DR. VARMUS, I DON'T KNOW WHAT YOU ARE GOING TO BE ABLE TO COME UP WITH, BUT I WOULD VENTURE TO SAY THAT THESE ARE THE ONLY TWO ARTICLES PUBLISHED IN ALL THE WORLD'S LITERATURE WHEREIN 'ACETAL' AND 'HIV' ARE MENTIONED TOGETHER.

HOWEVER, THERE MIGHT JUST BE ONE OTHER POSSIBILITY; SEE PAGE 3 OF MY FILE. AS YOU CAN SEE, I NOTED PUBLICATION OF THIS BOOK -

DISULFIRAM AND ITS METABOLITE DIETHYLDITHIOCARBAMATE:
PHARMACOLOGY AND STATUS IN THE TREATMENT OF ALCOHOLISM,
HIV INFECTIONS, AIDS AND HEAVY METAL TOXICITY. 1st ed.
BY P.K. GESSNER AND T. GESSNER, CHAPMAN & HALL PUBLISHERS, 1992
LONDON AND NEW YORK, 452 PAGES

AND I STATED:

" AS I HAVE MENTIONED, THE BOOK, DISULFIRAM AND ITS METABOLITE DIETHYLDITHIOCARBAMATE HAS BEEN WRITTEN AND IS CURRENTLY AVAILABLE. I CALLED A LOCAL BOOKSTORE AND FOUND OUT THAT THE TOTAL PRICE IS \$148.00; I WILL TRY TO OBTAIN A COPY OF THIS BOOK THROUGH INTER-LIBRARY LOAN.

I DISLIKE GAMBLING, BUT, I WOULD BE WILLING TO BET THAT THE WORD, 'ACETALDEHYDE', IS NEVER MENTIONED ON ANY ONE OF THE 452 PAGES OF THIS BOOK. HOW MUCH TO BET? LET'S SAY \$148.00; IF I AM RIGHT, I WILL KEEP THE MONEY; IF I AM WRONG, I WILL DONATE THE \$148.00 TO CRIA."

I STILL HAVE NOT SEEN THIS BOOK, AND THE BET IS STILL ON.

CRIA DOES NOT WISH TO ACCEPT ANY DONATIONS FROM ME, SO WHOEVER IS THE FIRST TO NOTIFY ME THAT 'ACETALDEHYDE' DOES APPEAR IN THIS BOOK HAS JUST WON \$148.00; JUST SEND ME A COPY OF THE PAGE OR PAGES.

AND THE ULTIMATE IRONY IS THAT 'ACETALDEHYDE' IS NEVER MENTIONED IN THE FRENCH STUDY WHICH I ALWAYS REFER TO IN MY RESEARCH - "THE LANG STUDY". IN MY OPINION, THOSE FRENCH SCIENTISTS WERE JUST 'BLIND' IN NOT REALIZING THE CAUSE OF THEIR POSITIVE RESULTS.

ON PAGE 17 OF THEIR BOOK, AGAINST THE ODDS; THE STORY OF AIDS DRUG DEVELOPMENT, POLITICS & PROFITS, THE AUTHORS PETER S. ARNO, Ph.D., AND KARYN L. FEIDEN MAKE THIS STATEMENT:

"BETWEEN 1987 AND 1991 THE NATIONAL CANCER INSTITUTE TESTED 40,000 CHEMICAL COMPOUNDS AT FACILITIES IN FREDERICK, MARYLAND, AND BIRMINGHAM, ALABAMA, TO SEE IF ANY COULD DISABLE THE AIDS VIRUS. DESPITE THE ODDS AGAINST FINDING A BREAKTHROUGH DRUG, RESEARCHERS CONTINUE TO SCREEN FOR COMPOUNDS THAT CAN INHIBIT HIV AT EACH STEP IN THE INFECTION PROCESS: WHEN IT BINDS TO THE CD4 MOLECULE; WHEN IT PENETRATES THE HELPER T CELL; WHEN IT TRANSCRIBES ITS GENETIC CODE INSIDE; AND WHEN IT REPLICATES. A MORE PROMISING DIRECTION FOR FUTURE RESEARCH IS TARGETED DRUG DEVELOPMENT - THAT IS, DESIGNING AN EFFECTIVE DRUG ON THE KNOWN BIOLOGICAL STRUCTURE OF HIV."

IN ITS LETTER TO ME (SEE MY ATTACHED INTERNET ADVERTISEMENT) THE CDC STATED:

"CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) OFFICIALS ARE UNAWARE OF A STUDY TO LOOK AT '40,000 COMPOUNDS' TO INACTIVATE HIV. HOWEVER, WITHIN THE NATIONAL INSTITUTES OF HEALTH (NIH) A GROUP OF RESEARCHERS ARE EXAMINING VARIOUS CHEMICALS FOR THERAPEUTIC USE, ALTHOUGH NOT INACTIVATION."

IN HIS LETTER TO CONGRESSMAN VISCLOSKY (SEE PAGE 32 OF MY FILE) DR. WHITESCARVER STATED:

"THERE ARE MANY AGENTS KNOWN TO BE ACTIVE AGAINST HIV. RESEARCHERS AT THE NATIONAL CANCER INSTITUTE HAVE IDENTIFIED OVER 3,000 COMPOUNDS THAT ARE ACTIVE AGAINST HIV, AND THE NIH CURRENTLY IS DEVELOPING AND EVALUATING THE MOST PROMISING ONES."

DR. VARMUS, HAVE ANY OF THESE 3,000 COMPOUNDS YET BEEN IDENTIFIED WHICH CAN INACTIVATE HIV AS EFFECTIVELY AS ACETALDEHYDE ?

AND IF SO, DR. VARMUS, DO THEY OR DOES IT HAVE THE SAME UNIQUE QUALITY WHICH ACETALDEHYDE HAS OF BEING

'A NORMAL METABOLITE OF THE HUMAN BODY FORMED DURING NORMAL BODY FUNCTIONING' ?

CONGRESSMAN VISCLOSKY AND DR. VARMUS, THANK YOU FOR GIVING THIS MATTER YOUR ATTENTION.

MY OBJECTIVE WILL CONTINUE TO BE TO MOTIVATE SOMEONE/SOMEWHERE WITH MEDICAL AUTHORITY AND MEDICAL WHEREWITHAL (AND WILL) TO IMPLEMENT CLINICAL TRIALS EMPLOYING THE PROCEDURES WHICH I DESCRIBE IN MY RESEARCH.

J.S.R.

Table I. Estimation of [³H]myristoylated proteins of HTLV-I and HIV-1 in the cells treated with N-Myr-GOA

P.P.S.

N-Myr-GOA ^Q (μ M)	Net cpm [#] of [³ H]myristoylated proteins ^S					
	MT-2 cell lysates			CEM/LAV cell lysates		
	p19 (%)	p28 (%)	Pr53 (%)	p17 (%)	p41 (%)	Pr55 (%)
0	3,444(100)	4,198(100)	1,229(100)	2,985(100)	2,700(100)	2,931(100)
1.6	NT*	NT	NT	2,173(73)	1,521(56)	1,778(61)
4	1,216(35)	1,719(41)	594(48)	1,582(53)	1,301(48)	1,560(53)
10	878(25)	1,287(31)	496(40)	631(21)	553(20)	617(21)
25	375(11)	642(15)	156(13)	157(5)	161(6)	205(7)

^Q N-Myr-GOA was used as the liposome form.

[#] Net cpm's were determined by subtracting cpm of background (n=5) from that of sample.

^S [³H]myristoylated proteins were extracted from the gel of SDS-PAGE analysis as shown in Fig.2.

* Not tested.

1150

AFTER I TYPED THE PRECEDING SEVEN PAGES I LOOKED AGAIN AT THE TWO ABSTRACTS WHICH I INCLUDED ON MY INTERNET ADVERTISEMENT (SEE ATTACHED).
ON PAGE 3 OF MY 'FILE' I STATED:

" ACETOALDEHYDE IS THE SAME THING AS ACETALDEHYDE.
AFTER YOU READ THESE ABSTRACTS YOU MUST WONDER - HAS ANY CHEMICAL YET BEEN DISCOVERED THAT CAN INACTIVATE HIV AS EFFECTIVELY AS ACETALDEHYDE?
USE WHATEVER WORD YOU WANT - 'DESTROY' OR 'INACTIVATE' - ACETALDEHYDE WILL DO IT TO THE VIRUS WHICH CAUSES AIDS - HIV.
MIGHT I BE MORE CORRECT AND ACCURATE IF I WERE TO SAY, 'HIV CANNOT REPLICATE WHEN ACETALDEHYDE IS PRESENT'."

HOWEVER, THE MORE I COMPARED THESE ABSTRACTS THE MORE I BEGAN TO WONDER WHETHER A MISTAKE HAD BEEN MADE IN THE BOTTOM ONE.

THE PRIMARY COMPOUND UNDER CONSIDERATION IN BOTH ABSTRACTS IS 'N-Myr-GOA'.
THE TOP ABSTRACT DESCRIBES IT THUSLY:

'N-myristoyl glycinal diethylacetal'.

WHEREAS THE BOTTOM ABSTRACT STATES:

'N-MYRISTOYL (N-Myr-) glycinal (aminoacetoaldehyde, GO) diethylacetal (A)'.

IS THE INCLUSION OF THE WORD, 'aminoacetoaldehyde', IN THE BOTTOM ABSTRACT A MISTAKE? IF IT IS, IT IS A MOST FORTUITOUS ONE BECAUSE IF I HAD JUST SEEN THE TERM, 'N-myristoyl glycinal diethylacetal', IN BOTH ABSTRACTS, I DON'T KNOW IF THEY WOULD HAVE MADE AN IMPRESSION UPON ME BECAUSE I WOULD NOT HAVE RECOGNIZED THE FACT THAT 'diethylacetal' IS A FORM OF ACETALDEHYDE.

THE FORMULA FOR 'PURE' ACETALDEHYDE IS CH₃CHO, AND IT IS SOLUBLE IN WATER, ALCOHOL, ETHER, ACETONE AND BENZENE.

THE FORMULA FOR DIETHYLACETAL IS CH₃CH(OC₂H₅)₂, AND IT IS SOLUBLE IN WATER, ALCOHOL, ETHER AND ACETONE.

(On January 31, I became aware of the relationship between the last two sentences of the top abstract and the 5th Column of the Chart.)

I TRIED AGAIN TO READ THE TWO ARTICLES THEMSELVES TO SEE IF I COULD MAKE ANY SENSE OUT OF THEM.

THE TABLE AT THE TOP OF THE PRECEDING PAGE COMES FROM THE ARTICLE UPON WHICH THE TOP ABSTRACT IS BASED. THE LAST TWO SENTENCES OF THAT ~~ARTICLE~~ STATE:

ABSTRACT

"In this system, N-Myr-GOA substantially inhibited more than 90% of the N-myristoylation of p17 gag protein produced in the HIV-1-infected MT-4 cells. These results suggest that the N-myristoylation of p17 gag protein of HIV-1 may be essential in its structural assembly or maturation."

LOOK AT THE FIFTH COLUMN OF THE TABLE. I AM GOING TO ASSUME THAT THIS COLUMN REFLECTS THESE TWO SENTENCES OF THE ABSTRACT; IF SO, THE FIGURE IS ALMOST 95%.

THIS IS WHAT IT IS ALL ABOUT, ISN'T IT ?

ISN'T THIS THE WAY THE AIDS VIRUS - HIV CAN BE CRIPPLED ?

WHAT IF 'PURE' ACETALDEHYDE HAD BEEN USED INSTEAD ?

PLEASE NOTE ON THE FIRST PAGE OF MY INTERNET ADVERTISEMENT I QUESTIONED ON APRIL 9, 1996:

"WHAT MIGHT HAPPEN IF ACETALDEHYDE ITSELF AND ALONE WERE UTILIZED? POSSIBLY, COULD A 100% RESULT BE GENERATED?"

WOULD THE BOTTOM FIGURE IN THE COLUMN BE 0 INSTEAD OF 157 ?
IF SO, THE RESULT WOULD HAVE BEEN 100%; ISN'T THAT SO ?

ON PAGE 5 OF MY FILE I STATED:

" AM I RIGHT OR WRONG? IF I AM RIGHT, COULD WE SAY THAT THE SAME DESCRIPTION WOULD APPLY TO A VIRAL BODY WHEN IT IS AT THIS STAGE? THEN, ANYTHING THAT HAD THE POWER OF 'ANTIMYRISTOYLATION' WOULD PREVENT A UNIT OF LIFE FROM REACHING THAT STAGE OF DEVELOPMENT WHEREIN IT DIVIDED (REPLICATED) ITSELF."

DOESN'T IT ALL HAVE SOMETHING TO DO WITH STRUCTURE PROTEIN, p17gag, OF HIV ?
AM I RIGHT OR WRONG? - THE REPLICATION OF HIV CAN BE STOPPED AT THIS POINT.
I WOULD LIKE TO QUOTE THE CONCLUDING PARAGRAPHS OF THE TWO ARTICLES:

" IN THIS REPORT, WE HAVE INVESTIGATED THE MYRISTOYLATION OF THE VIRAL STRUCTURAL PROTEINS AND THE REPLICATION OF THE VIRUS IN HIV-1-INFECTED CELLS WHICH WERE TREATED WITH NEWLY SYNTHESIZED N-MYRISTOYL GLYCINAL DIETHYLACETAL (N-Myr-GOA). N-Myr-GOA MARKEDLY INHIBITS THE MYRISTOYLATION OF THE VIRAL STRUCTURAL PROTEINS, AND ALSO CAUSES NOTICEABLE INHIBITION OF THE PRODUCTION OF THE MATURE VIRUS IN THE HIV-1-INFECTED MT-4 CELLS. THE RESULTS PRESENTED HERE SUGGEST THAT THE N-MYRISTOYLATION OF THE OF THE STRUCTURAL GAG PROTEINS OF HIV-1 MAY BE ESSENTIAL FOR ITS STRUCTURAL ASSEMBLY OR MATURATION."

" FROM THE PRESENT RESULTS, THE NH₂-TERMINAL MYRISTOYLATION OF STRUCTURE PROTEIN p19gag IN HTLV-1 WAS CONFIRMED AND THAT OF STRUCTURE PROTEIN p17gag IN HIV WAS ESTABLISHED. THE MYRISTATE WAS SHOWN TO BE LINKED COVALENTLY TO THE NH₂-TERMINAL GLYCINE RESIDUE OF THE PROTEINS IN THE SAME MANNER AS IN OTHER MYRISTOYL PROTEINS (1-20). THE PROTEIN MYRISTOYLATION OF

pl9gag AND pl7gag WAS INHIBITED BY N-Myr-GOA, WHICH MAY BE REGARDED AS AN INHIBITOR OF PROTEIN N-MYRISTOYL TRANSFERASE. THE ROLE OF PROTEIN MYRISTOYLATION HAS REMAINED UNKNOWN SO FAR, BUT PROTEIN MYRISTOYLATION, ESPECIALLY OF STRUCTURE PROTEINS OF HUMAN RETROVIRUSES, MAY BE VERY IMPORTANT FOR THE PROLIFERATION AND CAPSID FORMATION OF VIRUSES."

MY ONLY QUESTION AT THIS POINT IS, "WHY DIDN'T THE RESEARCHERS USE 'PURE' ACETALDEHYDE?"

WOULDN'T PURE ACETALDEHYDE BE MORE EFFECTIVE BECAUSE OF ITS SOLUBILITY ? IT IS VERY SOLUBLE, WHEREAS, THE TOP ABSTRACTS ARTICLE STATES:

"N-Myr-GOA WAS SELECTED AS AN ANTIMYRISTOYLATING AGENT, BUT IT IS DIFFICULT TO SOLUBILIZE IN THE MEDIUM. THEREFORE, WE PREPARED THE LIPOSOME-ENCAPSULATED N-Myr-GOA WITH THE EXPECTATION THAT IT WOULD INCORPORATE MORE EASILY INTO THE CELLS."

AM I CORRECT ABOUT THIS HUNCH? - THE SOLUBILITY FACTOR.

LET ME CONCLUDE WITH A FEW QUOTES FROM THE CULMINATION OF MY RESEARCH. ON PAGE 8 OF MY LETTER TO DR. STANDISH I STATED: (SPRINCE'S WORDS)

"TO THE BEST OF OUR KNOWLEDGE, OUR FINDINGS DEMONSTRATE FOR THE FIRST TIME THAT DIRECT (SPRINCE'S EMPHASIS) PROTECTIVE ACTION AGAINST ACETALDEHYDE TOXICITY AND LETHALITY CAN BE OBTAINED WITH CERTAIN NATURALLY-OCCURRING METABOLITES....."

HOPEFULLY, THE FOLLOWING QUOTES WILL GIVE US A CLUE AS TO HOW THE BODY MIGHT BE PROTECTED AGAINST ACETALDEHYDE'S TOXICITY WITH THE USE OF N-ACETYL-L-CYSTEINE - QUOTES ARE FROM PAGES 7 & 8 OF MY FILE.

"ACETYL COENZYME A (Co A), ACETYL DERIVATIVE OF COENZYME A, A SULFUR-CONTAINING NUCLEOTIDE, THAT IS A PRECURSOR IN THE METABOLISM OF FATTY ACIDS, CARBOHYDRATES, AND PROTEINS, BEING AN IMPORTANT INTERMEDIATE IN THE KREBS' CYCLE. COENZYME A FUNCTIONS AS A CARRIER OF THE 2-CARBON ACETYL GROUP, WHICH IS ATTACHED TO THE SULFUR GROUP."

"THE FORMULA FOR ACETALDEHYDE IS CH_3CHO . IT CONTAINS TWO CARBON ATOMS."

"N-ACETYL CYSTEINE IS A MORE STABLE FORM OF THE SULFUR AMINO ACID L-CYSTEINE, AND IS A POWERFUL ANTIOXIDANT. IT IS AN EXCELLENT PRECURSOR OF GLUTATHIONE, ANOTHER MAJOR ANTIOXIDANT. GLUTATHIONE IS ALSO THE PRECURSOR, WITH SELENIUM, OF GLUTATHIONE PEROXIDASE, ONE OF THE MOST IMPORTANT ANTIOXIDANT ENZYMES IN THE BODY."

"BIOCHEMICALLY, IT HAS ALREADY BEEN SUGGESTED THAT CYSTEINE CAN PROTECT COENZYME A AGAINST ACETALDEHYDE INHIBITION BY COMPLEXING PREFERENTIALLY WITH ACETALDEHYDE. PRESUMABLY, REDUCED GLUTATHIONE, HOMOCYSTEINE, AND N-ACETYL-CYSTEINE COULD ALSO COMPLEX WITH ACETALDEHYDE BY VIRTUE OF THEIR FREE (-SH) GROUPS."

"FINALLY, IT IS IMPORTANT, TOO, TO REMEMBER THAT CYSTEINE BY COMPLEXING WITH ACETALDEHYDE MAY PROTECT THE (-SH) GROUPS OF COENZYME A AND REDUCED LIPIC ACID, BOTH OF WHICH ARE ASSOCIATED WITH THIAMIN PYROPHOSPHATE ACTIVITY....."

" AM I CORRECT ABOUT THIS? - THERE SEEMS TO BE SOME SORT OF AN INTRINSIC AND UNIQUE BIOCHEMICAL RELATIONSHIP THAT COULD BE SAID TO EXIST BETWEEN ACETYL-COENZYME A AND ACETALDEHYDE."

J.S.R.



April 9, 1996

To: Anyone concerned about HIV/AIDS

Today I placed this advertisement on the Internet (<http://www.netnitco.net/rob/aids.html>) -

AIDS

The AIDS virus, HIV, can be crippled by the chemical **Acetaldehyde**. Is a longer life possible? Can death be delayed? - Perhaps -

Mail \$5.00 (US) to Roberts, PO Box H, Hobart, IN 46342 to obtain 35 pages of medical research. ~~Any profit would be donated to CRIA (Community Research Initiative on AIDS) of New York City.~~

ON 9-11-96, CRIA REQUESTED THIS DELETION

Since January 1993 I have continually suggested to various scientists, government officials and organizations that the chemical known as "Acetaldehyde" might be effective in combating the virus which causes AIDS - HIV.

In February 1995 the Centers For Disease Control (CDC) acknowledged to me (*see below*) that HIV could be "inactivated" in the test tube by Acetaldehyde.

In December 1995 I became aware of two brief summaries (*see below*) of the research of three Japanese scientists; the research was published in 1988 and 1989.

These scientists focused upon a chemical compound known as "N-Myr-GOA" (N-Myristoyl Glycinal Diethylecetal); **Acetaldehyde** (Acetoaldehyde) is a component of this chemical.

A figure of "more than 90%" effectiveness is attributed to this chemical as far as severely inhibiting the viral replication of HIV - the cause of AIDS; in other words, a way exists by which this deadly virus can be **crippled**.

What might happen if Acetaldehyde **itself** and **alone** were utilized? Possibly, could a 100% result be generated?

It is my goal to have someone/somewhere with medical expertise and/or authority to apply to the Office of Alternative Medicine (National Institutes of Health) for a \$30,000 grant to explore the possibilities of a procedure which I call:

"A Mild Application of Unmetabolized Acetaldehyde to Inactivate HIV".

This is the basis of the "Mild Application" - the patient would take a pill (Antabuse) everyday and include a lot of fruit, such as apples and oranges, in his or her diet.

I will continue to assume that I am correct in the statements of scientific fact which I have made thus far; as of this date, not one of the various scientists, government officials and organizations to whom I have mailed my research since January 1993 has told me to the contrary or proved otherwise.

If you are interested in seeing all of my research, send to me \$5.00 (US), and I will mail it to you immediately.

Yours truly,

John S. Roberts,
Post Office Box H
Hobart, IN 46342
(219) 763-1933

(from the Department of Health & Human Services - Public Health Service, Centers for Disease Control, Atlanta, GA 30333, February 1, 1995)

John S. Roberts
Post Office Box H
Hobart, IN 46342

Dear Mr. Roberts:

Your letter to Dr. James Curran regarding acetaldehyde and human immunodeficiency virus (HIV) has been forwarded to this office for reply.

Below are responses to your specific questions regarding Acetaldehyde:

1. *Does acetaldehyde destroy HIV in the test tube?*
All the aldehydes are capable of inactivating HIV; however, their actual effectiveness depends on the concentration used.
2. *Was acetaldehyde on that list of 40,000 compounds tested at Frederick, Maryland and Birmingham, Alabama to see if any could disable HIV?*
Centers for Disease Control and Prevention (CDC) officials are unaware of a study to look at "40,000 Compounds" to inactivate HIV. However, within the National Institutes of Health (NIH) a group of researchers are examining various chemicals for therapeutic use, although not inactivation.

Regarding your hypothesis on the Lang study, I suggest that you contact the researchers involved in that study to discuss your questions concerning their findings. CDC does not have the authority to initiate a clinical trial; within the Public Health Service, the NIH conducts their clinical trials. Further information on clinical trials may be obtained from NIH.

I hope this information is useful to you.

Sincerely,
Information Specialist,
Technical Information Activity
Division of HIV/AIDS

SI MED/90121228

AU Tashiro A

AU Shoji S

AU Kubota Y

TI **Antimyristoylation of the gag proteins in the human immunodeficiency virus-infected cells with N-myristoyl glycinal diethylacetal resulted in inhibition of virus production.**

AB The gag proteins of human retroviruses such as human immunodeficiency virus (**HIV-1**) are specifically myristoylated in their amino termini (1, 2, 3). N-myristoyl glycinal diethylacetal (N-Myr-GOA) and other N-Myr-compounds (N-Myr-Gly-GOA, N-Myr-Gly-Gly-GOA and N-Myr-Gly-Gly-Gly-GOA) were newly synthesized and investigated for activity of antimyristoylation of these gag proteins and for influence on **viral replication**. Of the N-Myr-compounds tested, N-Myr-GOA most **severely inhibited** the protein myristoylation; N-Myr-Gly-GOA also inhibited it, but moderately. Furthermore, it was observed that N-Myr-GOA at 20 microM caused **noticeable inhibition** (about 80%) of the production of mature HIV in the HIV-1-infected MT-4 cells. In this system, **N-Myr-GOA substantially inhibited more than 90%** of the N-myristoylation of p17 gag protein produced in the HIV-1-infected MT-4 cells. These results suggest that the N-myristoylation of p17 gag protein of HIV-1 may be essential in its structural assembly or maturation.

SO Biochem Biophys Res Commun. 1989 Dec 29, 165(3):1145-54

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SI MED/89033966

AU Shoji S

AU Tashiro A

AU Kubota Y

TI **Antimyristoylation of gag proteins in human T-cell leukemia and human immunodeficiency viruses with N-myristoyl glycinal diethylacetal.**

AB N-Myristoyl (N-Myr-) glycinal (amino**acetoaldehyde**, GO) diethylacetal (A), which is abbreviated as N-Myr-GOA, and other N-Myr-compounds (N-Myr-Gly-GOA, N-Myr-Gly-Gly-GOA, and N-Myr-Gly-Gly-Gly-GOA) were newly synthesized and then employed for NH₂-terminal antimyristoylation of structure proteins in the human T-cell leukemia virus (HTLV-I) and the human immunodeficiency virus (HIV). The protein myristoylation of structure proteins p19gag, of HTLV-I, and p17gag, of HIV, was determined separately, using radiolabeled myristic acid, in vitro. The radiolabeled proteins, after immunoprecipitation with an antiserum to adult T-cell leukemia (ATL) or the anti-p17gag monoclonal antibody of HIV, were identified as p19gag of HTLV-I and p17gag of HIV by fluorography after SDS-polyacrylamide gel electrophoresis (SDS-PAGE). The protein myristoylation was resistant to NH₂OH-treatment. Of the N-Myr-compounds tested, N-Myr-GOA **remarkably prevented** the myristoylation of p19gag and p17gag, but N-Myr-Gly-Gly-GOA and N-Myr-Gly-Gly-Gly-GOA did not.

SO J Biochem (Tokyo). 1988 May; 103(5):747-9.

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40 ACCESSES SINCE JULY 10th 1996

THE LISTING

ON SEPTEMBER 1, 1996, I WROTE 'AN OPEN LETTER' (ATTACHED) TO PATRICIA S. FLEMING, DIRECTOR, OFFICE OF NATIONAL AIDS POLICY, THE WHITE HOUSE; I CLIPPED ON TO THAT LETTER THE CULMINATION OF MY HIV/AIDS RESEARCH; IT CONSISTED OF -

1. MY 35 PAGE 'FILE' ENTITLED, AIDS - CAN DEATH BE DELAYED? - PERHAPS, DATED JANUARY 1, 1996

2. MY 18 PAGE LETTER TO LEANNA J. STANDISH, ND, Ph.D., DIRECTOR, BASTYR UNIVERSITY AIDS RESEARCH CENTER, SEATTLE, WASHINGTON, DATED JULY 22, 1996

THROUGHOUT THE MONTH OF SEPTEMBER, 1996, I MAILED THIS THREE PART PACKET TO VARIOUS PARTIES THROUGHOUT THE UNITED STATES AND THE WORLD.

AS YOU CAN SEE, AT THE VERY END OF MY LETTER TO MS. FLEMING I APPENDED A 'P.P.S.'; IT STATES:

"I HOPE TO HAVE MS. FLEMING'S RESPONSE AT SOME TIME WITHIN THE NEXT FEW WEEKS. IF YOU WOULD LIKE TO SEE IT, JUST LET ME KNOW, AND I WILL MAIL A COPY OF IT TO YOU."

AS OF THIS DATE, FEBRUARY 3, 1997, OTHER THAN THE LETTERS (ATTACHED) WHICH CONGRESSMAN VISCLOSKY WROTE TO MS. FLEMING ON MY BEHALF, NO ONE OF ANY OF THOSE LISTED BELOW HAS WRITTEN OR TELEPHONED ME REQUESTING TO SEE A COPY OF MS. FLEMING'S RESPONSE.

HERE IS THE LISTING -

1. PRESIDENT CLINTON
2. ACT-UP, TREATMENT AND DATA COMMITTEE, 135 WEST 29th STREET, 10th FLOOR, N.Y., N.Y.
3. AIDS ACTION COUNCIL (AAC), 1875 CONNECTICUT AVE., NW., SUITE 700, WASHINGTON, D.C.
4. AIDS CLINICAL TRIAL GROUP, UNIVERSITY OF MIAMI, DEPARTMENT OF PEDIATRICS, MIAMI, FL
5. AIDS CLINICAL TRIALS UNIT, ALBERT EINSTEIN COLLEGE OF MEDICINE, BRONX, N.Y.
6. AIDS CLINICAL TRIALS UNIT, STANFORD UNIVERSITY SCHOOL OF MEDICINE, STANFORD, CA
7. AIDS CLINICAL TRIALS UNIT, UNIVERSITY OF CALIFORNIA SAN DIEGO, SAN DIEGO, CA
8. AIDS CLINICAL TRIALS UNIT, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MN
9. AIDS CLINICAL TRIALS UNIT, UNIVERSITY OF ROCHESTER, ROCHESTER, NY
10. AIDS CLINICAL TRIALS UNIT SUBSITE, ALBANY MEDICAL COLLEGE, ALBANY, NY
11. AIDS CLINICAL TRIALS UNIT SUBSITE, WAKE FOREST UNIVERSITY, WINSTON-SALEM, NC
12. AIDS, MEDICINE AND MIRACLES, P.O. BOX 9130, BOULDER, CO
13. AIDS NATIONAL INTERFAITH NETWORK (ANIN), 110 MARYLAND AVE., WASHINGTON, D.C.
14. AIDS RESEARCH CONSORTIUM, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA
15. AIDS TREATMENT NEWS, P.O. BOX 411256, SAN FRANCISCO, CA
16. AMERICAN ASSOCIATION OF NATUROPATHIC PHYSICIANS (AANP), SEATTLE, WA
17. AMERICAN FOUNDATION FOR AIDS RESEARCH (AmFAR), 733 THIRD AVE., N.Y.N.Y
18. AMERICAN MEDICAL ASSOCIATION, DEPARTMENT OF HIV, 515 NORTH STATE ST., CHICAGO, IL
19. ARNO, PETER S., Ph.D., MONTEFIORE MEDICAL CENTER, N.Y., N.Y.
20. BLACK TECHNOLOGIES ADVANCEMENT, 1190 SARATOGA AVE., SUITE. 210, SAN JOSE, CA
21. BONAVENTURE HOUSE, P.O. BOX 148187, CHICAGO, IL
22. BRUDNOY, DAVID, RADIO STATION WBZ, BOSTON, MA
23. CDC NATIONAL AIDS CLEARINGHOUSE, CORRESPONDENCE SPECIALIST 'SM', ROCKVILLE, MD
24. CENTER FOR ASTHMA AND ALLERGY RESEARCH, UNIVERSITY OF SOUTH FLORIDA, TAMPA, FL
25. CENTER FOR CLINICAL AIDS RESEARCH AND EDUCATION, UCLA, LOS ANGELES, CA
26. CENTRE FOR HIV RESEARCH, UNIVERSITY OF EDINBURGH, EDINBURGH, SCOTLAND
27. COLLEGE OF PHARMACY, UNIVERSITY OF TENNESSEE MEMPHIS, MEMPHIS, TN
28. COMMUNITY RESEARCH INITIATIVE ON AIDS (CRIA), 275 SEVENTH AVE., N.Y., N.Y.

29. CONSUMER HEALTH INFORMATION RESEARCH INSTITUTE (CHIRI), INDEPENDENCE, MO
30. COORDINATING CENTER FOR AIDS IN EUROPE, UNIVERSITY OF COPENHAGEN, DENMARK
31. CREWDSSEN, JOHN, 'THE CHICAGO TRIBUNE', WASHINGTON, D.C. BUREAU, WASHINGTON
32. CRITICAL PATH AIDS PROJECT, 2062 LOMBARD ST., PHILADELPHIA, PA
33. 'CURRENT HEALTH 2', EDITORIAL OFFICES, 60 REVERE DRIVE, NORTHBROOK, IL
34. DAVID B., GARY, INDIANA
35. DeGROOT, PROFESSOR ANNE, M.D., BROWN UNIVERSITY, PROVIDENCE, RI
36. GALLANT, DONALD M., M.D., TULANE UNIVERSITY SCHOOL OF MEDICINE, NEW ORLEANS, LA
37. GOLD, DAVID, GMHC, N.Y., N.Y.
38. GOULD, STEPHEN JAY, HARVARD UNIVERSITY, CAMBRIDGE, MA
39. HARVARD AIDS INSTITUTE, CAMBRIDGE, MA
40. HASELTINE, DR. WILLIAM A., DANA-FARBER CANCER INSTITUTE, BOSTON, MA
41. HEALY, BERNADINE, M.D., CLEVELAND CLINIC FOUNDATION, CLEVELAND, OH
42. HEMLOCK SOCIETY U.S.A., EUGENE, OR
43. HIRSCH, DR. MARTIN S., DIRECTOR OF AIDS RESEARCH, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MA
44. HIV/AIDS CENTER, VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA
45. HIV COMPUTER LINK, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND, OH
46. HIV/AIDS CLINIC, UNIVERSITY OF NEW MEXICO, ALBUQUERQUE, NM
47. HIV NEUROBEHAVIORAL RESEARCH CENTER, UNIVERSITY OF CALIFORNIA SAN DIEGO, SAN DIEGO, CA
48. HOLLAND, DR., INDIANA UNIVERSITY SCHOOL OF BIOLOGY, BLOOMINGTON, IN
49. HOWARD BROWN MEMORIAL CLINIC, CHICAGO, IL
50. INFECTIOUS DISEASES DIVISION, BROWN UNIVERSITY CONSORTIUM, PAWTUCKET, RI
51. INTERNATIONAL AIDS SOCIETY (CNTM), WASHINGTON, D.C.
52. INTERNATIONAL ASSOCIATION OF PHYSICIANS IN AIDS CARE (IAPAC), CHICAGO, IL
53. JONAS, WAYNE B., M.D., DIRECTOR, OFFICE OF ALTERNATIVE MEDICINE, NIH, BETHESDA, MD
54. KANKI, PROFESSOR PHYLLIS J., DVM, SD, HARVARD SCHOOL OF PUBLIC HEALTH, CAMBRIDGE, MA
55. KAPLAN CANCER CENTER, NEW YORK UNIVERSITY SCHOOL OF MEDICINE, N.Y.N.Y.
56. KRAMER, LARRY, N.Y., N.Y.
57. the KUPONA NETWORK, 4611 S. ELLIS, CHICAGO, IL
58. LAKE COUNTY AIDS TASK FORCE, 275 WEST 29th AVE., LAKE STATION, IN
59. LANG, JEAN-MARIE, HÔPITAL HAUTEPIERRE, STRASBOURG, FRANCE
60. 'MAGIC' JOHNSON, LOS ANGELES LAKERS BASKETBALL TEAM, LOS ANGELES, CA
61. MANKES, PROFESSOR RUSSELL F., Ph.D., THE ALBANY MEDICAL COLLEGE, ALBANY, N.Y.
62. MAYO CLINIC, ATTN: HIV CLINIC, ROCHESTER, MN
63. MRC AIDS SECRETARIAT, MEDICAL RESEARCH COUNCIL, LONDON, ENGLAND
64. MONTAGNIER, DR. LUC, 25 RUE DU DOCTEUR ROUX, INSTITUT PASTEUR, PARIS, FRANCE
65. MURPHY, PROFESSOR ROBERT L., M.D., NORTHWESTERN UNIVERSITY SCHOOL OF MEDICINE, CHICAGO
66. NATIONAL CENTRE IN HIV EPIDEMIOLOGY AND CLINICAL RESEARCH, DARLINGHURST, AUSTRALIA
67. NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION (NAPARE), CHICAGO
68. NATIONAL GAY AND LESBIAN TASK FORCE (NGLTF), WASHINGTON, D.C.
69. NEW LIFE ALTERNATIVES, LANSING, IL
70. NORRIS, J., GEORGIA
71. PALACIO, HERMINIA, M.D., MPlI, PROFESSOR, AIDS PROGRAM SAN FRANCISCO GENERAL HOSPITAL
72. PASSWATER, RICHARD A., Ph.D., SOLGAR NUTRITIONAL RESEARCH CENTER, BERLIN, MD
73. PAUL, WILLIAM E., M.D., DIRECTOR, OFFICE OF AIDS RESEARCH, NIH, WASHINGTON
74. PEDIATRIC AIDS FOUNDATION, SANTA MONICA, CA
75. PEDIATRIC AIDS CLINICAL TRIALS UNIT, BAYLOR COLLEGE OF MEDICINE, HOUSTON, TX
76. PEDIATRIC AIDS FOUNDATION, RESEARCH DIVISION (PAF), NOVATO, CA
77. PEDIATRIC AIDS CLINICAL TRIALS UNIT, MOUNT SINAI SCHOOL OF MEDICINE, N.Y., N.Y.
78. PEDIATRIC AIDS CLINICAL TRIALS UNIT, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD
79. PEDIATRIC AIDS CLINICAL TRIALS UNIT, UCLA, LOS ANGELES, CA

80. PITT TREATMENT EVALUATION UNIT, UNIVERSITY OF PITTSBURGH MEDICAL CENTER, PITTSBURGH, PA
81. POSITIVE IMAGES AND WELLNESS, INCORPORATED (PIW), SILVER SPRING, MD
82. PROJECT INFORM, SAN FRANCISCO, CA
83. RYAN WHITE MEMORIAL FOUNDATION, NOBLESVILLE, IN
84. STANDISH, LEANNA J., ND, Ph.D., DIRECTOR, BASTYR UNIVERSITY AIDS RESEARCH CENTER, SEATTLE
85. SATCHER, DAVID, M.D., Ph.D., DIRECTOR, CENTERS FOR DISEASE CONTROL, ATLANTA, GA
86. SHOJI, SHOZO, DEPARTMENT OF BIOCHEMISTRY, KUMAMOTO UNIVERSITY, KUMAMOTO, JAPAN
87. STRUCTURAL BIOLOGY AND TARGETED DRUG DESIGN FOR AIDS STUDY, UCSF, SAN FRANCISCO
88. TPAN/FASN, 1258 WEST BELMONT AVE., CHICAGO, IL
89. TONY BROWN PRODUCTIONS, N.Y., N.Y.
90. VACCINE EVALUATION UNIT, VANDERBILT UNIVERSITY, NASHVILLE, TN
91. VACCINE EVALUATION UNIT, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD
92. VARMUS, HAROLD, M.D., DIRECTOR, NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD
93. VOLBERDING, PROFESSOR PAUL A., M.D., DIRECTOR, AIDS PROGRAM, UCSF, SAN FRANCISCO
94. WEIZMANN INSTITUTE OF SCIENCE, ISRAEL
95. WHITESCARVER, JACK, Ph.D., DEPUTY DIRECTOR, OFFICE OF AIDS RESEARCH, NIH, BETHESDA, MD
96. WISTAR INSTITUTE, PHILADELPHIA, PA
97. WOLINSKY, PROFESSOR STEVEN M., M.D., NORTHWESTERN UNIVERSITY SCHOOL OF MEDICINE, CHICAGO
98. WYETH-AYERST LABORATORIES, PHILADELPHIA, PA

NO ONE OF ANY OF THOSE LISTED ABOVE HAS WRITTEN OR TELEPHONED ME TELLING ME THAT I HAD MADE ANY MISSTATEMENT OF SCIENTIFIC OR MEDICAL FACT THROUGHOUT THE COURSE OF MY RESEARCH.

THE PACKETS WHICH I MAILED TO THE PEDIATRIC AIDS CLINICAL TRIALS UNIT, BAYLOR COLLEGE OF MEDICINE, HOUSTON AND THE KUPONA NETWORK, CHICAGO WERE RETURNED UNDELIVERABLE.

THE AMERICAN ASSOCIATION OF NATUROPATHIC PHYSICIANS RETURNED ITS PACKET WITH THIS NOTATION: "THANK YOU FOR THIS INFORMATION, HOWEVER WE DON'T FUND RESEARCH & DON'T HAVE ACCESS TO GROUPS THAT DO FUND IT. I HAVE RETURNED THESE COPIES TO KEEP YOUR COSTS DOWN. GOOD LUCK."

ON SEPTEMBER 11, 1996, COMMUNITY RESEARCH INITIATIVE ON AIDS (CRIA) WROTE REQUESTING: "YOU MENTION THAT ANY PROFIT, I ASSUME FROM THE \$5.00 FEE, WOULD BE DONATED TO CRIA. ALTHOUGH WE APPRECIATE YOUR INTENTION, WE WOULD LIKE TO HAVE OUR NAME REMOVED FROM YOUR ADVERTISEMENT. AS A POLICY, WE DO NOT CHARGE FOR INFORMATION THAT WE PROVIDE ABOUT HIV INFECTION AND WOULD NOT WANT TO RECEIVE PROCEEDS FROM YOUR ADVERTISEMENT."

I HAVE COMPLIED WITH CRIA'S REQUEST.

I ASSUME THAT ALL OF THE OTHER PARTIES LISTED ABOVE RECEIVED THEIR PACKETS.

THE NEW YORKER, DECEMBER 16, 1996

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One of the dominant themes of Crichton's work has been a conservative skepticism about institutional claims to knowledge—groups of people claiming to know what's good for us. This first surfaced as skepticism about the claims of medicine. Crichton began writing in 1966, as a means of paying his way through Harvard Medical School. In his underrated memoir, "Travels" (1988), he describes his gradual disillusionment with medicine and his eventual abandonment of it after finishing med school. He now holds this unexpectedly Nietzschean belief: "We are directly responsible for any illness that happens to us."

The related idea that science claims to know more, and to be able to do more, than it actually can is a basic tenet all the way through Crichton's work; the primal scene occurs as early as "The Andromeda Strain"—published in 1969, the year he abandoned medicine. The novel has a character called Leavitt, who has cooked up something called the Rule of 48. Crichton writes:

For years it was stated that men had forty-eight chromosomes in their cells; there were pictures to prove it, and any number of careful studies. In 1953, a group of American researchers announced to the world that the human chromosome number was forty-six. Once more, there were pictures to prove it, and studies to confirm it. But these researchers also went back to reexamine the old pictures, and the old studies—and found only forty-six chromosomes, not forty-eight.

Leavitt's Rule of 48 said simply, "All Scientists Are Blind."

THE WHITE HOUSE
WASHINGTON

JAN 14 1997

Mr. John S. Roberts
Post Office Box H
Hobart, IN 46342

Dear Mr. Roberts:

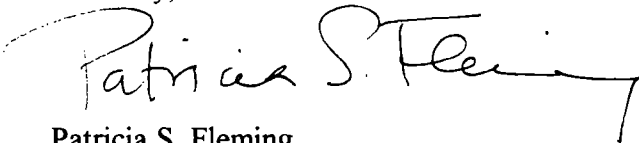
I have received the package of information you sent me regarding the study of acetaldehyde as a treatment for HIV disease. The package contains a copy of a letter I sent you on October 18, 1995 in response to your letter to me dated September 18, 1995.

As I stated in my letter, I believe that promising opportunities for treatments for HIV disease should be pursued. However, I must leave it to those scientists who are trained in this field of study to decide which proposals merit investigation. In the Federal government, those scientists are found at the National Institutes of Health (NIH).

It appears that you have contacted the right person -- Dr. Jack Whitescarver in the Office of AIDS Research at NIH. I can add nothing more to what Dr. Whitescarver has communicated to you.

I regret that I cannot be of further assistance.

Sincerely,



Patricia S. Fleming
Director
National AIDS Policy Office

cc: The Honorable Peter J. Visclosky

January 24, 1997

Ms. Fleming,
Attached is my letter of January 18 to Congressman Visclosky. After reading it, I hope that you will direct the NIH to initiate a clinical trial based upon my research. If I don't hear from you by February 3, I shall assume that you wish to stand by this letter of January 14. John S. Roberts 219-763-1933
Copies to Congressman Visclosky, CARMENA PARRIS, Richard SORIAN
Dwayne Lawler, DAVID ROZMANICH.

JANUARY 18, 1997

THE HONORABLE PETER J. VISCLOSKY
UNITED STATES HOUSE OF REPRESENTATIVES
2464 RAYBURN BUILDING
WASHINGTON, D.C. 20515-1401

DEAR CONGRESSMAN VISCLOSKY,

THIS IS TO REMIND YOU THAT ON FEBRUARY 3, 1997, I WILL MAIL OUT TO VARIOUS PARTIES THROUGHOUT THE UNITED STATES AND THE WORLD MY NEXT LETTER CONCERNING MY HIV/AIDS RESEARCH.

BY THAT TIME, IF EITHER YOU OR I HAVE NOT YET RECEIVED A RESPONSE, WHETHER IT BE POSITIVE OR NEGATIVE, TO MY SEPTEMBER 1, 1996 LETTER (ATTACHED) TO MS. FLEMING FROM MS. FLEMING, THIS JANUARY 18 LETTER AND ALL OF THE ATTACHED LETTERS, INCLUDING THE SEPTEMBER 1 LETTER, WILL BE ATTACHED TO THAT FEBRUARY 3 LETTER.

IN THAT FEBRUARY 3 LETTER I SHALL ALSO INCLUDE THESE FACTS -

IN JANUARY, 1993, I SUGGESTED TO THE NATIONAL INSTITUTES OF HEALTH (NIH) THAT THE CHEMICAL COMPOUND 'ACETALDEHYDE' MIGHT BE EFFECTIVE IN 'DESTROYING' THE AIDS VIRUS - HIV.

THROUGHOUT 1993 (JANUARY 26 - NOVEMBER 1) IN REPLIES TO BOTH CONGRESSMAN VISCLOSKY (1) AND MYSELF (4) THE NIH MAINTAINED THAT ACETALDEHYDE WOULD HAVE NO EFFECT ON HIV.

IN THE WORDS OF THE NIH:

"ACETALDEHYDE IS A NORMAL METABOLITE OF THE HUMAN BODY THAT WOULD NOT SIGNIFICANTLY HINDER HIV INFECTION."

IN A DECEMBER 13, 1994 LETTER TO ME AND IN AN AUGUST 9, 1995 LETTER TO CONGRESSMAN VISCLOSKY, THE NIH REVISED ITS EVALUATION OF ACETALDEHYDE.

IN ITS REVISED EVALUATION THE NIH ACKNOWLEDGED THE FACT THAT:

"...ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN TEST TUBE EXPERIMENTS..."

IT IS MY ASSUMPTION THAT ACETALDEHYDE WOULD ALSO 'INACTIVATE' HIV IN THE HUMAN BODY.

IN THAT FEBRUARY 3 LETTER I AM GOING TO DELVE INTO GREATER DETAIL ABOUT THESE FACTS AND OTHER THINGS.

COPIES TO:

MS. FLEMING, THE WHITE HOUSE

CARMENA PARRIS, AIDE TO MS. FLEMING

RICHARD SORIAN, AIDE TO MS. FLEMING

DWAYNE LAWLER, WASHINGTON OFFICE OF CONGRESSMAN VISCLOSKY

DAVID ROZMANICH, GARY OFFICE OF CONGRESSMAN VISCLOSKY

P.S. TO MS. PARRIS AND MR. SORIAN - IF MS. FLEMING MAILES OUT HER RESPONSE BEFORE FEBRUARY 3, WOULD YOU PLEASE LET ME KNOW - 219-763-1933.

P.S. TO DAVID ROZMANICH - IF YOU RECEIVE MS. FLEMING'S RESPONSE BEFORE FEBRUARY 3, WOULD YOU PLEASE LET ME KNOW - 219-763-1933.

YOURS TRULY,
JOHN S. ROBERTS
POST OFFICE BOX H
HOBART, INDIANA 46342
219-763-1933

THANK YOU,
J.S.R.

PETER J. VISCLOSKY
1ST DISTRICT INDIANA

COMMITTEE ON APPROPRIATIONS
CONGRESSIONAL STEEL CAUCUS
EXECUTIVE COMMITTEE CHAIRMAN
NORTHEAST-MIDWEST
CONGRESSIONAL COALITION
MIDWEST VICE-CHAIR
WHIP-AT-LARGE

Congress of the United States
House of Representatives
Washington, DC 20515-1401

January 3, 1997

2464 RAYBURN BUILDING
WASHINGTON, DC 20515-1401
(202) 225-2461

215 WEST 35TH AVENUE
GARY, IN 46408
TTY-TDD SERVICE AVAILABLE
(219) 884-1177

PORTAGE CITY HALL
6070 CENTRAL AVENUE
PORTAGE, IN 46368
(219) 763-2904

VALPARAISO CITY HALL
166 LINCOLNWAY
VALPARAISO, IN 46383
(219) 464-0315

Ms. Patricia Fleming
Director
National AIDS Policy Office
750 17th Street, N.W. Suite 600
Washington, D.C. 20503

Dear Ms. Fleming:

On December 10, 1996, I wrote you in regard to my constituent, Mr. John Roberts. A copy of said letter is enclosed for your reference.

I would greatly appreciate being advised as to the status of this matter at your earliest convenience.

Thank you in advance for your courtesies in this regard and should you have any questions, please feel free to call on my District Director, Mr. David Rozmanich, at the Gary District Office.

Sincerely,


Peter J. Visclosky
Member of Congress

PJV:rm

PETER J. VISCLOSKY
1ST DISTRICT, INDIANA

COMMITTEE ON APPROPRIATIONS
CONGRESSIONAL STEEL CAUCUS
EXECUTIVE COMMITTEE CHAIRMAN
NORTHEAST-MIDWEST
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166 LINCOLNWAY
VALPARAISO, IN 46383
(219) 464-0315

December 10, 1996

Ms. Patricia S. Fleming
Director, Office of National Aids Policy
750 17th Street, NW
Suite 600
Washington, D.C. 20503

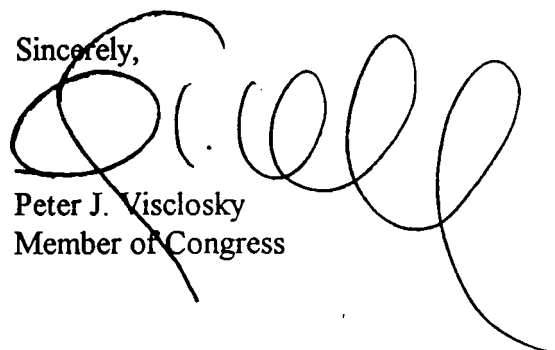
Dear Ms. Fleming:

I am writing on behalf of my constituent, Mr. John Roberts. Enclosed please find literature submitted to me concerning the HIV virus and the AIDS disease. Mr. Roberts believes he is putting forth a viable measure to halt the dreaded disease. In fact, Mr. Roberts feels that his proposition contains the "magic bullet" that can "cripple" HIV.

On September 1, 1996, Mr. Roberts had written you with his concerns and has yet to have received a response. I ask that you please review the enclosed material and issue a reply to both Mr. Roberts and myself.

If you have any questions concerning this matter, I urge you to contact me or my District Director, David Rozmanich, at 219-884-1177. Thank you for your time and kind attention to this matter.

Sincerely,



Peter J. Visclosky
Member of Congress

PJV:dsr

SEPTEMBER 1, 1996

AN OPEN LETTER TO:

PATRICIA S. FLEMING
DIRECTOR
OFFICE OF NATIONAL AIDS POLICY
THE WHITE HOUSE
WASHINGTON

COPY WITH ENCLOSURES TO: _____

DEAR MS. FLEMING,

JUST TO BE SURE THAT YOU RECEIVE IT, I HAVE SENT DUPLICATE PACKETS OF MY RESEARCH TO YOU. ONE I HAVE SENT BY REGULAR MAIL AND THE OTHER ONE BY CERTIFIED MAIL. BOTH PACKETS WERE DIRECTED TO YOUR ADDRESS AT 750 17th St. N.W., SUITE 600, WASHINGTON, D.C. (202-632-1090). ZIP - 20503.

AS YOU CAN SEE, THE PACKET CONTAINS THIS LETTER TO YOU, MY JULY 22, 1996 LETTER TO DR. STANDISH AND MY 35 PAGE "FILE" DATED JANUARY 1, 1996.

AFTER READING THESE DOCUMENTS YOU WILL SEE WHY I AM CONVINCED THAT I HAVE DISCOVERED A "MAGIC BULLET" TO "CRIPPLE" HIV, THE VIRUS WHICH IS THE ROOT CAUSE OF AIDS. THE MAGIC BULLET IS THE CHEMICAL COMPOUND KNOWN AS "ACETALDEHYDE".

IF I HAD HIV/AIDS AND WAS TOLD THAT I MIGHT BE HELPED IMMEASURABLY BY OBTAINING A CERTAIN NUTRIENT FROM MY LOCAL HEALTH FOOD STORE, BY HAVING MY PHYSICIAN PRESCRIBE FOR ME A CERTAIN CHEMICAL AND BY HAVING THAT SAME PHYSICIAN ADMINISTER A PARTICULAR PROCEDURE TO ME ONCE A WEEK IN HIS OFFICE, I WOULD NOT LET 24 HOURS LAPSE BEFORE AT LEAST TRYING TO FIND OUT ALL OF THE DETAILS.

THE CORE OF THE HEALING PROCESS IS SIMPLY THIS -

1. N-ACETYL CYSTEINE ("NAC") WOULD HELP RESTORE APOPTOSIS BACK TO NORMAL LEVELS.
2. NAC WILL AFFORD THE BODY 100% PROTECTION AGAINST THE TOXIC EFFECTS OF UNMETABOLIZED ACETALDEHYDE.
3. UNMETABOLIZED ACETALDEHYDE WILL POISON HIV, THEREBY "INACTIVATING" IT.

MS. FLEMING, IN YOUR LETTER (SEE PAGE 13 OF MY FILE) YOU STATE:

"IT IS IMPORTANT TO ASSESS ANY POTENTIAL AVENUE OF RESEARCH.....

SHOULD ANY NEW INFORMATION DEVELOP, I ENCOURAGE YOU TO SHARE IT WITH THE NIH."

MS. FLEMING, I AM SENDING THIS PACKET TO NUMEROUS PEOPLE INCLUDING -

1. WILLIAM E. PAUL, M.D., DIRECTOR, OFFICE OF AIDS RESEARCH,
NATIONAL INSTITUTES OF HEALTH
2. JACK WHITESCARVER, Ph.D., DEPUTY DIRECTOR, OFFICE OF AIDS RESEARCH,
NATIONAL INSTITUTES OF HEALTH

HOWEVER, MS. FLEMING, I FEEL THAT THE ULTIMATE DECISION ABOUT THIS MATTER RESTS IN YOUR HANDS.

PRESIDENT HARRY S. TRUMAN KEPT A SIGN ON HIS WHITE HOUSE DESK WHICH STATED:

"THE BUCK STOPS HERE."

MS. FLEMING, IN MY OPINION, "THE BUCK" HAS LANDED UPON YOUR DESK.

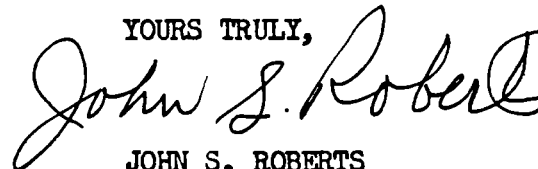
IF YOU THINK THAT MY IDEAS HAVE POTENTIAL VALIDITY, ARE YOU PREPARED TO DIRECT DR. PAUL TO IMPLEMENT IMMEDIATELY (STARTING TOMORROW, FOR INSTANCE) A CLINICAL TRIAL OF THE PROCEDURE WHICH I DESCRIBE IN MY "HYPOTHETICAL CONVERSATION WHICH I WOULD HAVE WITH MY PHYSICIAN IF I HAD HIV/AIDS" (STARTING ON PAGE 7 OF MY JULY 22 LETTER)? IT IS MY HOPE THAT AFTER 18 WEEKS OF SUCH A TRIAL, THE PATIENTS WOULD SHOW AN INCREASE IN THEIR T-CELL COUNT.

IF YOU DO NOT FEEL THAT SUCH A COMMAND FALLS WITHIN THE SCOPE OF YOUR AUTHORITY, THEN THE CONCEPT OF AN "AIDS CZAR" IS JUST A FICTION, IS IT NOT?

IN CONCLUSION, MS. FLEMING, DO YOU THINK THAT MY IDEAS HAVE PRACTICAL MERIT? IF SO, HOW SOON ARE YOU PREPARED TO INITIATE A CLINICAL TRIAL? TOMORROW?

IF YOU DO NOT THINK THAT MY IDEAS HAVE PRACTICAL MERIT, MS. FLEMING, COULD I KNOW OF THE SCIENTIFIC REASONING UNDERLYING YOUR JUDGEMENT?

YOURS TRULY,



JOHN S. ROBERTS
POST OFFICE BOX H
HOBART, INDIANA 46342
219-763-1933

P.S. IF THE TRIAL IS UNDERTAKEN -

1. THE PATIENTS SHOULD AVOID FOODS CONTAINING NITRITES. CERTAIN PREPARED MEATS SUCH AS HOT DOGS AND BACON CONTAIN NITRITES. THE PHYSICIANS' DESK REFERENCE, PAGE 2642, 49th EDITION, 1995 STATES:

"IN RATS, SIMULTANEOUS INGESTION OF DISULFIRAM AND NITRITE IN THE DIET FOR 78 WEEKS HAS BEEN REPORTED TO CAUSE TUMORS, AND IT HAS BEEN SUGGESTED THAT DISULFIRAM MAY REACT WITH NITRITES IN THE RAT STOMACH TO FORM A NITROSAMINE, WHICH IS TUMORIGENIC. DISULFIRAM ALONE IN THE RATS' DIET DID NOT LEAD TO SUCH TUMORS. THE RELEVANCE OF THIS FINDING TO HUMANS IS NOT KNOWN AT THIS TIME."

(IT IS MY HUNCH THAT HUMANS WOULD BE AFFECTED IN A SIMILAR MANNER - j.s.r)

2. THE PATIENTS SHOULD NOT DRINK CITY WATER.

SUPER-NUTRITION, PAGE 115 STATES: "CHLORINE IS AN OXIDANT, TOO; MOST OF US DRINK CHLORINATED WATER WHICH CONSUMES VITAMIN E IN OUR BODY."

"GOOD HOUSEKEEPING", PAGE 84, AUGUST, 1996 STATES: "VITAMIN E'S BENEFITS APPEAR TO BE LARGELY RELATED TO ITS ANTIOXIDANT PROPERTIES."

P.P.S. I HOPE TO HAVE MS. FLEMING'S RESPONSE AT SOME TIME WITHIN THE NEXT FEW WEEKS. IF YOU WOULD LIKE TO SEE IT, JUST LET ME KNOW, AND I WILL MAIL A COPY OF IT TO YOU

JULY 22, 1996

LEANNA J. STANDISH, ND, PhD
DIRECTOR
EASTYR UNIVERSITY AIDS RESEARCH CENTER
144 N.E. 54th STREET
SEATTLE, WASHINGTON 98105-9916

DEAR DR. STANDISH,

THANK YOU FOR YOUR RECENT LETTER, DATED JUNE 27, 1996 (ATTACHED).

ALSO ATTACHED ARE CONGRESSMAN VISCLOSKY'S LETTER TO YOU, DATED JULY 10, 1996; MY LETTER TO CONGRESSMAN VISCLOSKY, DATED JUNE 23, 1996; MY LETTER TO YOU, DATED MAY 11, 1996; AND PROFESSOR MANKES' LETTER TO ME DATED 16 APRIL, 1993.

I HAVE ALSO INCLUDED IN THIS ENVELOPE THE DOCUMENT WHICH I HAVE REFERRED TO AS MY "FILE". IN MY LETTER TO CONGRESSMAN VISCLOSKY IT IS ITEM NUMBER 8.

AS YOU CAN SEE, IT IS DATED JANUARY 1, 1996 AND IS 35 PAGES LONG.

DR. WHITESCARVER'S COMPLETE LETTER, DATED AUGUST 9, 1995, TO CONGRESSMAN VISCLOSKY COMPRISES PAGES 32 and 33 OF MY FILE.

DR. STANDISH, I WOULD LIKE TO AFFORD YOU A LITTLE BIT OF HISTORY -

BECAUSE OF MY EFFORTS, THE NATIONAL INSTITUTES OF HEALTH, ONE OF THE MOST RENOWNED MEDICAL RESEARCH FACILITIES IN THE WORLD REVISED ITS EVALUATION OF A CERTAIN CHEMICAL.

FOR THE PAST 28 YEARS I HAVE BEEN A LIBRARIAN AT THE LAKE RIDGE SCHOOL SYSTEM OF GARY, INDIANA. IN OCTOBER I WILL BE 60.

THROUGHOUT MY COLLEGE YEARS I NEVER TOOK A COURSE IN BIOLOGY OR ANY OF THE MEDICAL SCIENCES. THE ONLY CHEMISTRY COURSE WHICH I DID TAKE I ALMOST FLUNKED.

I BARELY KNOW THE DIFFERENCE BETWEEN A T-CELL AND A T-BAG.

NEVERTHELESS, BECAUSE OF MY EFFORTS, THE NATIONAL INSTITUTES OF HEALTH REVISED ITS EVALUATION OF THE CHEMICAL COMPOUND, "ACETALDEHYDE".

THE FOLLOWING PASSAGE COMES FROM 100 QUESTIONS AND ANSWERS ABOUT AIDS -
A GUIDE FOR YOUNG PEOPLE BY MICHAEL THOMAS FORD, MACMILLAN PUBLISHING,
NEW YORK, 1992, PAGE 5:

"IN EARLY 1981, FIVE PREVIOUSLY HEALTHY YOUNG GAY MEN WERE SEEN AT A CLINIC IN LOS ANGELES. EACH HAD SYMPTOMS THAT APPEARED TO BE THE RESULT OF DAMAGED IMMUNE SYSTEMS. THIS WAS UNUSUAL BECAUSE NONE OF THE MEN HAD ANYTHING IN THEIR MEDICAL HISTORIES TO EXPLAIN THEIR CONDITIONS. SHORTLY AFTER THESE CASES WERE REPORTED, IN JUNE OF THAT YEAR, OTHER PHYSICIANS AROUND THE COUNTRY BEGAN TO REALIZE THAT THEY, TOO, WERE SEEING SIMILAR CASES IN YOUNG MEN."

SINCE THE BEGINNING OF THE AIDS PANDEMIC, SCIENTIFIC RESEARCHERS HAVE BEEN FRANTICALLY SEARCHING FOR A SUBSTANCE WHICH MIGHT HALT THE DEADLY MULTIPLICATION (REPLICATION) OF THE AIDS VIRUS - HIV.

THE PROBLEM IS BEST EXPRESSED BY PETER S. ARNO, Ph.D. AND KARYN L. FEIDEN IN THEIR BOOK, AGAINST THE ODDS; THE STORY OF AIDS DRUG DEVELOPMENT, POLITICS & PROFITS, PAGE 17:

"BETWEEN 1987 AND 1991 THE NATIONAL CANCER INSTITUTE TESTED 40,000 CHEMICAL COMPOUNDS AT FACILITIES IN FREDERICK, MARYLAND AND BIRMINGHAM, ALABAMA, TO SEE IF ANY COULD DISABLE THE AIDS VIRUS. DESPITE TO ODDS AGAINST FINDING A BREAKTHROUGH DRUG, RESEARCHERS CONTINUE TO SCREEN FOR COMPOUNDS THAT CAN INHIBIT HIV AT EACH STEP IN THE INFECTION PROCESS: WHEN IT BINDS TO THE CD4 MOLECULE; WHEN IT PENETRATES THE HELPER T CELL; WHEN IT TRANSCRIBES ITS GENETIC CODE INSIDE; AND WHEN IT REPLICATES. A MORE PROMISING DIRECTION FOR FUTURE RESEARCH IS TARGETED DRUG DEVELOPMENT - THAT IS, DESIGNING AN EFFECTIVE DRUG ON THE KNOWN BIOLOGICAL STRUCTURE OF HIV."

ON JANUARY 1, 1993 I READ A SHORT ARTICLE IN THE GARY POST TRIBUNE ABOUT THE RESEARCH OF PROFESSOR RUSSELL F. MANKES OF THE ALBANY MEDICAL COLLEGE, NEW YORK.

THE RESEARCH CONCERNED THE CAUSE OF A "HANGOVER"; PROFESSOR MANKES CONCLUDED:

"THE HEADACHE, UPSET STOMACH AND BAD AFTERTASTE THAT ACCOMPANY A HANGOVER COME FROM THE TOXIC BY-PRODUCT OF ALCOHOL, A CHEMICAL CALLED ACETALDEHYDE....."

AFTER READING THIS ARTICLE, IT OCCURRED TO ME THAT ACETALDEHYDE MIGHT BE EFFECTIVE IN DESTROYING THE AIDS VIRUS (I HAVE SINCE LEARNED THAT THE CORRECT BIOLOGICAL TERM TO USE IS "INACTIVATE" AND NOT "DESTROY" WHEN REFERRING TO A VIRUS). THROUGHOUT 1993 I CONTINUALLY SUGGESTED TO THE NATIONAL INSTITUTES OF HEALTH THAT ACETALDEHYDE MIGHT BE EFFECTIVE IN "DESTROYING" HIV, THE AIDS VIRUS. THROUGHOUT 1993 THE NATIONAL INSTITUTES OF HEALTH DID NOT AGREE WITH ME. THIS IS WHAT THEY HAD TO SAY ABOUT ACETALDEHYDE:

"THE MOLECULES YOU SUGGEST ARE NORMAL METABOLITES FORMED DURING NORMAL BODY FUNCTIONING, AND WOULD HAVE NO EFFECT ON HIV OR AIDS."
NATIONAL INSTITUTES OF HEALTH (NIH) LETTER TO ME DATED JANUARY 26, 1993

"HOWEVER, ACETALDEHYDE IS A NORMAL METABOLITE OF THE HUMAN BODY AND WILL HAVE NO EFFECT ON HIV INFECTION."
NIH LETTER TO ME DATED MARCH 24, 1993

"ACETALDEHYDE, HOWEVER, ONLY HAS BEEN ASSOCIATED WITH SOME OF THE SIDE EFFECTS OF DTC, e.g., FATIGUE AND NAUSEA. AS THERE IS CURRENTLY NO SCIENTIFIC BASIS TO BELIEVE THAT ACETALDEHYDE HAS ANY ANTI-HIV ACTIVITY, THE NIH IS NOT PURSUING THE DEVELOPMENT OR PRECLINICAL EVALUATION OF THIS AGENT."
NIH LETTER TO CONGRESSMAN VISCLOSKEY DATED JUNE 18, 1993

"ACETALDEHYDE IS A NORMAL METABOLITE OF THE HUMAN BODY THAT WOULD NOT SIGNIFICANTLY HINDER HIV INFECTION."
NIH LETTER TO ME DATED SEPTEMBER 22, 1993

"TO DATE, THE NIH HAS NOT IDENTIFIED ANY COMPELLING DATA OR A CONVINCING RATIONALE TO PURSUE ACETALDEHYDE AS AN ANTI-HIV AGENT."
NIH LETTER TO ME DATED NOVEMBER 1, 1993

THESE PASSAGES COME FROM THE LETTERS OF FOUR DIFFERENT SCIENTISTS EMPLOYED AT THE TIME BY THE NATIONAL INSTITUTES OF HEALTH.

NEVERTHELESS, AFTER 1993 I CONTINUED TO MAIL UPDATES OF MY RESEARCH TO BOTH THE NATIONAL INSTITUTES OF HEALTH AND MISCELLANEOUS PRIVATE CITIZENS, SCIENTISTS, GOVERNMENT OFFICIALS AND ORGANIZATIONS WHO I THOUGHT MIGHT BE CONCERNED ABOUT THE PROBLEM OF HIV/AIDS; AS OF MARCH 21, 1996 THE FIGURE TOTALLED 70.

ON DECEMBER 13, 1994 THE NATIONAL INSTITUTES OF HEALTH SENT TO ME A LETTER IN WHICH THIS STATEMENT WAS MADE:

"THE KNOWN TOXICITY OF ACETALDEHYDE WOULD HAVE LIKELY PREVENTED EVALUATION EVEN IF THE AGENT HAD SHOWN ANTI-HIV ACTIVITY IN THE DRUG SCREEN PROGRAM SPONSORED BY THE NATIONAL CANCER INSTITUTE."

ON FEBRUARY 1, 1995 THE CENTERS FOR DISEASE CONTROL WROTE TO ME A LETTER IN WHICH THEY ANSWERED MY QUESTION, "DOES ACETALDEHYDE DESTROY HIV IN THE TEST TUBE?" THUSLY:

"ALL THE ALDEHYDES ARE CAPABLE OF INACTIVATING HIV; HOWEVER, THEIR ACTUAL EFFECTIVENESS DEPENDS ON THE CONCENTRATION USED."

AND IN HIS AUGUST 9, 1995 LETTER TO CONGRESSMAN VISCLOSKY (SEE PAGE 32 OF MY FILE) DR. WHITESCARVER STATED:

"THE FACT THAT ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN TEST TUBE EXPERIMENTS....."

AT THIS POINT IN TIME I AM GOING TO ASSUME THAT ACETALDEHYDE NOT ONLY "INACTIVATES" HIV IN THE TEST TUBE BUT ALSO IN THE HUMAN BODY.

THERE IS ONLY ONE PROBLEM WITH ACETALDEHYDE - IT IS HIGHLY TOXIC; REFER TO PROFESSOR MANKES' LETTER.

DR. STANDISH, IN YOUR LETTER YOU ASK:

"I THOUGHT DR. WHITESCARVER'S RESPONSE TO YOUR LETTER WAS PROBABLY ON THE MARK. HOW DO YOU REPLY TO HIS CRITICISMS?"

ON PAGES 25 AND 26 OF MY FILE I RESPONDED TO SOME OF THE CRITICISMS MADE BY DR. WHITESCARVER, BUT, CORRECT ME IF I AM WRONG DR. STANDISH, I THINK THAT THE SPECIFIC CRITICISMS YOU HAVE IN MIND AT THE PRESENT TIME ARE THOSE WHICH I DELINEATED IN MY MAY 11, 1996 LETTER TO YOU. FOR CLARITY SAKE, LET ME REPEAT THEM AGAIN:

"THE FACT THAT ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN TEST TUBE EXPERIMENTS DOES NOT NECESSARILY MAKE IT A GOOD CANDIDATE FOR ANTI-HIV THERAPY IN HUMANS."

"THE HIGH TOXICITY OF ACETALDEHYDE MAKES IT A SIGNIFICANTLY LESS DESIRABLE CANDIDATE FOR USE IN INDIVIDUALS WHO SUFFER FROM SEVERELY WEAKENED IMMUNE SYSTEMS AND WHO ARE PRONE TO CONTRACTING NUMEROUS OPPORTUNISTIC INFECTIONS AND MALIGNANCIES."

IN HIS LETTER (PAGE 32 OF MY FILE) DR. WHITESCARVER ALSO STATES:

"MR. ROBERTS, HOWEVER, INSISTS THAT THE TOXICITY COULD BE AMELIORATED BY THE ADMINISTRATION OF SULFUR AMINO ACIDS AND VITAMIN C. HE CITES RESEARCH CONDUCTED TWENTY YEARS AGO IN NORMAL, UNINFECTED MICE. THIS RESEARCH, HOWEVER, IS NOT APPLICABLE TO HUMANS INFECTED WITH HIV."

DR. STANDISH, WHEN ANY SCIENTIFIC STUDY OBTAINS A 100% RESULT, ISN'T THIS AN INDICATION THAT SOMETHING OF SINGULAR IMPORTANCE MAY HAVE OCCURRED? REFER TO PAGE 34 OF MY FILE; SPECIFICALLY LOOK AT COMBINATION CB3 OF TABLE 2 - ALL OF THE RATS, 30 OUT OF 30, 100%, WERE PROTECTED AGAINST A LETHAL DOSE OF ACETALDEHYDE.

IT IS MY ASSUMPTION THAT RATS AND MONKEYS ARE USED IN BIOLOGICAL EXPERIMENTS BECAUSE IF CERTAIN RESULTS ARE ACHIEVED WITH THEM, THESE SAME RESULTS MAY OCCUR IN HUMAN BEINGS.

AS A MATTER OF FACT, JUST RECENTLY - JULY 17, I SAW A BRIEF REPORT ON THE TELEVISION NEWS OF A SCIENTIFIC STUDY WHICH UTILIZED RATS TO DEMONSTRATE THAT NICOTINE WAS JUST AS ADDICTIVE AS HEROIN AND COCAINE. I MIGHT BE WRONG, BUT I THINK THAT THE SUBSTANCE RELEASED IN THE RATS' BRAINS WAS "DOPAMINE". THE CLEAR INDICATION OF THE STUDY WAS THAT HUMAN BEINGS WERE ADDICTED IN A SIMILAR MANNER.

I'LL NEVER FORGET A TELEVISION INTERVIEW WITH ONE OF THE MOST POPULAR SINGERS OF OUR TIME - RAY CHARLES. HE SAID IT WAS EASIER FOR HIM TO KICK THE HEROIN HABIT THAN TO GIVE UP SMOKING.

I AM ABOUT TO LIST THREE STUDIES. THE AUTHOR CONCLUDES ONE OF THEM ("COMPARISON OF PROTECTION.....") WITH THESE WORDS:

"FINALLY, IT SHOULD BE NOTED THAT OUR EXPERIMENTS WERE CARRIED OUT ONLY IN ANIMALS (RATS). FURTHER ANIMAL EXPERIMENTATION IS NECESSARY BEFORE ANY EXTRAPOLATION OF THESE FINDINGS FOR HUMAN USE CAN BE CONSIDERED."

I AM GOING TO ASSUME THAT HUMAN BEINGS WOULD BE PROTECTED AS EASILY AND AS FULLY AGAINST THE HARMFUL EFFECTS OF ACETALDEHYDE POISONING AS WERE THE RATS IN THESE STUDIES PROVIDING OF COURSE THAT THEY (THE HUMANS) INGEST THE PARTICULAR SUBSTANCES WHICH THE AUTHOR MENTIONS.

THE PARTICULAR AUTHOR, OR SHOULD I SAY SCIENTIFIC RESEARCHER, TO WHOM I AM REFERRING IS HERBERT SPRINCE, OR SHOULD I SAY HERBERT SPRINCE AND ASSOCIATES.

IN MY OPINION, THE RESEARCH THAT "THEY" HAVE DONE IS SOME OF THE MOST OVERLOOKED OF THE 20th CENTURY. IT COULD BE OF VITAL IMPORTANCE TO MILLIONS OF PEOPLE THROUGHOUT THE WORLD.

IN MY OPINION, ANY PERSON WHO IS ADDICTED TO SMOKING AND/OR DRINKING WILL MOST LIKELY NOT GIVE UP THEIR HABIT SIMPLY BECAUSE THEY KNOW THAT IT IS BAD FOR HIS OR HER HEALTH.

P.S. DR. SPRINCE'S ASSOCIATES WERE CLARENCE M. PARKER, GEORGE G. SMITH AND LEON J. GONZALES. THE WORLD OF SMOKERS AND DRINKERS OWES THEM AN IMMENSE DEBT OF GRATITUDE.

HOWEVER, WOULDN'T IT BE BENEFICIAL FOR THAT PERSON TO KNOW THAT HE OR SHE COULD SLOW DOWN THE RATE AT WHICH THEY ARE CAUSING THEIR BODY TO DETERIORATE, BECAUSE OF THEIR BAD HABITS, BY SIMPLY SUPPLEMENTING THEIR DIET WITH NATURAL FOODS SUCH AS VITAMIN C, CYSTEINE AND THIAMINE (VITAMIN B1).

I'LL BET THAT VERY, VERY FEW PROBLEM SMOKERS AND DRINKERS ARE AWARE OF THIS FACT.

HERE ARE THREE OF THE MAJOR SPRINCE STUDIES. I HAVE INCLUDED THE COMPLETE ABSTRACT OF THE FIRST ONE IN MY FILE (SEE PAGE 23). EVERY SMOKER AND DRINKER SHOULD MEMORIZE THE FIRST TWO SENTENCES OF THAT ABSTRACT -

"ACETALDEHYDE IS A TOXIC SUBSTANCE COMMON TO HEAVY DRINKING OF ALCOHOL AND HEAVY SMOKING OF CIGARETTES. IT HAS BEEN IMPLICATED THEREBY IN DISEASES OF THE CARDIOVASCULAR, RESPIRATORY, AND CENTRAL NERVOUS SYSTEMS." P.S.

THE SPRINCE STUDIES -

'PROTECTIVE ACTION OF ASCORBIC ACID AND SULFUR COMPOUNDS AGAINST ACETALDEHYDE TOXICITY: IMPLICATIONS IN ALCOHOLISM AND SMOKING', "AGENTS AND ACTIONS", VOL. 5/2 (1975)

'COMPARISON OF PROTECTION BY L-ASCORBIC ACID, L-CYSTEINE, AND ADRENERGIC-BLOCKING AGENTS AGAINST ACETALDEHYDE, ACROLEIN, AND FORMALDEHYDE TOXICITY: IMPLICATIONS IN SMOKING', "AGENTS AND ACTIONS", VOL. 9/4 (1979)

'PROTECTIVE ACTION OF SULFUR COMPOUNDS AGAINST ALDEHYDE TOXICANTS IN CIGARETTE SMOKE', "EUROPEAN JOURNAL OF RESPIRATORY DISEASES", (1985) 66. SUPPL. 139. 102-112

AGAIN, IT IS MY ASSUMPTION THAT THE HUMAN BODY COULD BE PROTECTED AGAINST THE TOXICITY OF ACETALDEHYDE BY INGESTING THE FOLLOWING NATURAL NUTRIENTS IN THE AMOUNTS SPECIFIED:

	mm/kg
L-ASCORBIC ACID (VITAMIN C)	2.0
L-CYSTEINE FB (A FREE FORM AMINO ACID)	1.0
THIAMIN.HCL (VITAMIN B1)	.3

I LIKE TO REFER TO THIS AS "THE SPRINCE RATIO".

THIS MORNING I WENT TO MY LOCAL HEALTH FOOD STORE AND CHECKED OUT THE PRICES. HERE THEY ARE:

L-ASCORBIC ACID, 250 CAPSULES, \$16.63 (EACH CAPSULE CONTAINS 500mg)
 L-CYSTEINE FB, 60 CAPSULES, \$13.95 (EACH CAPSULE CONTAINS 500mg)
 60 CAPSULES OF THE GENERIC BRAND COST \$6.95
 THIAMIN.HCL, 200 TABLETS, \$7.15 (EACH TABLET CONTAINS 100mg)

AS I WAS DRIVING HOME FROM THE HEALTH FOOD STORE I REMEMBERED THAT THERE WAS ANOTHER SUBSTANCE IN THE SPRINCE STUDY ('PROTECTIVE ACTION OF ASCORBIC ACID.....') WHICH GENERATED A 100% RESULT. IN FACT, WHEN I LOOKED AT THE STUDY AGAIN I SAW THAT THERE WAS TWO NOT ONE : N-ACETYL-L-CYSTEINE AND L-CYSTEIC ACID.H₂O. FOR CLARITY SAKE, I HAVE ATTACHED TABLE 1 OF THIS STUDY. I HAVE LABELLED THE TWO "100%".

P.S. THE LAST SENTENCE, TOO, SHOULD BE MEMORIZED - "OUR FINDINGS COULD POINT THE WAY TO A POSSIBLE BUILD-UP OF NATURAL PROTECTION AGAINST THE CHRONIC BODY INSULT OF ACETALDEHYDE ARISING FROM HEAVY DRINKING OF ALCOHOL AND HEAVY SMOKING OF CIGARETTES."

nds against Smoking¹⁾

GONZALES
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the foregoing, it is evident that acetaldehyde is a toxic substance common to heavy alcohol drinking and heavy cigarette smoking and implicated in cardiovascular and pulmonary disease [4]. Therefore it becomes important to search for in vivo protectants against its adverse effects. Such protectants (particularly, naturally-occurring ones) could be of potential therapeutic value as preventives for tissues chronically exposed to elevated acetaldehyde levels.

In the previous publications from this laboratory [1-3], details were presented of the protective action in rats of L-cysteine free base (FB), thiamin · HCl, and L-2-methylthiazolidine-4-carboxylic acid against acetaldehyde toxicity and lethality at a carefully standardized LD 90 dose level. This study presents our findings on the protective action of related sulfur compounds and ascorbic acid against acetaldehyde toxicity in rats at the same standardized LD 90 dose level.

Materials and methods

The following is a brief outline of the methodology used; details are set forth in our previous publication [1]. Carworth Farms (CFE) strain male albino rats 90 ± 5 days old and weighing 365 ± 20 grams were deprived of food, but not water, overnight. Next morning, they were reweighed just prior to test for calculation of dosages of the test compounds. Compounds tested and the doses used are listed in Tables 1 and 2 under 'results'. Test compounds were freshly prepared as solutions or fine suspensions in physiological (0.9%) saline purged with nitrogen gas to protect against undesirable oxidation. Dilutions were made to concentrations convenient for oral intubation of the desired dose at convenient volumes (1-2.5 ml). Acetaldehyde was always freshly distilled just before use.

For initial screening, 30 rats per day were generally tested in equal groups (5 rats/group). Such tests were made in duplicate on two consecutive days to give a minimum of 10 rats/group tested. When a given test compound showed definite protection, these tests were replicated with more rats to the total number indicated in Table 1. Test compounds or combinations thereof were intubated orally 30-45 minutes prior to oral intubation of

Table 1

Protective action of L-ascorbic acid and sulfur compounds against anesthetic and lethal effects of acetaldehyde in the rat. (Toxic oral dose of acetaldehyde used was LD 90 = 18 mM/kg.)

Compounds tested (oral dose)	Dose (mM/kg)	% anesthetized after 3-10 minutes	% dead after 3 hours	24 hours	72 hours
Control (saline)	-	96 (48/50)	54 (27/50)	90 (45/50)	90 (45/50)
<i>Reduced forms</i>					
L-Ascorbic acid	2.0	53 (8/15)	27 (4/15)	27 (4/15)	27 (4/15) ✓
L-Cysteine (FB)	2.0	20 (5/25)	8 (2/25)	20 (5/25)	20 (5/25) ✓
DL-Homocysteine (FB)	2.0	60 (6/10)	50 (5/10)	60 (6/10)	60 (6/10)
L-Glutathione (Rd.)	2.0	47 (7/15)	0 (0/15)	33 (5/15)	33 (5/15)
N-Acetyl-L-cysteine	2.0	10 (2/20)	0 (0/20)	0 (0/20)	0 (0/20) 100%
<i>Oxidized forms</i>					
L-Dehydroascorbic acid	2.0	80 (8/10)	20 (2/10)	70 (7/10)	70 (7/10)
L-Cystine	2.0	87 (13/15)	47 (7/15)	93 (14/15)	93 (14/15)
DL-Homocystine	2.0	90 (9/10)	30 (3/10)	90 (9/10)	100 (10/1)
L-Glutathione (Ox.)	2.0	80 (8/10)	10 (1/10)	80 (8/10)	80 (8/10)
DL-Thioctic acid	2.0	60 (6/10)	60 (6/10)	70 (7/10)	70 (7/10)
<i>Other sulfur compounds</i>					
Thiamin · HCl	2.0	10 (2/20)	0 (0/20)	10 (2/20)	10 (2/20) ✓
L-MTCA	2.0	25 (5/20)	5 (1/20)	25 (5/20)	25 (5/20)
Taurine	2.0	45 (9/20)	15 (3/20)	45 (9/20)	45 (9/20)
Cysteamine · HCl	2.0	53 (8/15)	33 (5/15)	67 (10/15)	67 (10/15)
Sodium metabisulfite	2.0	5 (1/20)	0 (0/20)	5 (1/20)	5 (1/20) ✓
L-Cystic acid · H ₂ O	2.0	13 (2/16)	0 (0/16)	0 (0/16)	0 (0/16) 100%

Compounds tested were intubated orally 30-45 minutes prior to oral intubation of 18 mM/kg of acetaldehyde (LD 90 dose). Doses are expressed in mM/kg. After intubation, rats were observed over a 24-72 hour period for anesthetic effects (loss of elevation and righting reflexes) and lethal response (deaths). Figures in parentheses = No. of rats anesthetized or dead/No. of rats tested. Anesthesia (loss of righting reflexes) with acetaldehyde generally occurred within 3-10 minutes and lasted for 5-15 minutes. Deaths were recorded at 3, 24, and 72 hours.

in vivo, body levels elevated by both heavy and heavy cigarette smoking. The relationship of acetaldehyde to both alcohol and heavy smoking is clearly stated in the 1970 literature [4], and is strengthened by establishing that heavy smokers [10, 11], acetaldehyde has a toxic cardiomyopathy action [15, 16], in ethnic populations with a high incidence of alcoholic cerebellar degeneration [19], and in the reaction [20] used in the study of heavy smokers. Medically, this relationship is of greater importance than the disulfiram-like interaction which occurs with a number of drugs [21]. It may play a role in the development of 'smoker's disease' [22-24]. In the study of heavy smoking, acetaldehyde is not only in cardiac disease but also in pulmonary disease by way of the cilia of the respiratory tract. It is related to the damage to the tracheobronchial tree and its content in cigarette tar has been shown with the 'free lung cell' [8]. This response is characterized by numbers of macrophages in cigarette smoke and significant exposure to the development of pulmonary disease [8]. From

ONLY EXPERIENCE COULD TELL WHICH OF THE THREE ("THE SPRINCE RATIO", N-ACETYL-L-CYSTEINE, L-CYSTEIC ACID.H₂O) WOULD BE THE MOST EFFECTIVE IN TREATING HUMAN BEINGS. HOWEVER, AT THIS TIME I WANT TO FOCUS UPON N-ACETYL-L-CYSTEINE.

REFER TO PAGE 10 OF MY FILE WHEREIN I HAVE INCLUDED PASSAGES OF AN INTERVIEW WHICH DR. RICHARD A. PASSWATER HAD WITH DR. LUC MONTAGNIER. AFTER YOU READ THIS PAGE, AND AFTER YOU HAVE CONSIDERED WHAT I HAVE WRITTEN THUS FAR, I ASK YOU THIS - COULD THIS BE THE SCENARIO? -

N-ACETYL-L-CYSTEINE WOULD SERVE A TWO FOLD FUNCTION:
NOT ONLY WOULD IT RESTORE APOPTOSIS BACK TO NORMAL LEVELS,
BUT IT WOULD ALSO PROTECT THE BODY AGAINST THE HARMFUL
EFFECTS OF ACETALDEHYDE POISONING.

ONLY EXPERIENCE WOULD TELL, AND THAT IT WHY IT IS SO VITAL TO HAVE A CLINICAL TRIAL.

BY THE WAY, DR. PASSWATER DEFINES 'APOPTOSIS' THUSLY:

"DEVELOPMENTAL OR PROGRAMMED CELL DEATH CHARACTERIZED BY MEMBRANE BLEBS, EXTENSIVE CHROMATIN CONDENSATION, AND DNA FRAGMENTATION. PLAYS A ROLE IN NEGATIVE SELECTION OF DEVELOPING T CELLS AND THE KILLING OF TARGETS BY CYTOTOXIC T LYMPHOCYTES."

HIS COMPLETE INTERVIEW WITH DR. MONTAGNIER CAN BE FOUND ON PAGES 50-65 OF "WHOLE FOODS", SEPTEMBER, 1995.

IN YOUR LETTER YOU QUESTIONED:

"WE ADVERTISED EXTENSIVELY THROUGHOUT THE U.S. IN BOTH THE CONVENTIONAL AND ALTERNATIVE MEDICAL/SCIENTIFIC/AIDS ACTIVIST COMMUNITIES KNOW THAT WE WERE LOOKING FOR EXCELLENT RESEARCH PROJECTS IN ALTERNATIVE MEDICINE AND AIDS. WHY DIDN'T YOU APPLY?"

DR. STANDISH, IT WAS NOT UNTIL I RECEIVED THE LETTER DATED JANUARY 25, 1996 FROM THE CDC NATIONAL AIDS CLEARINGHOUSE (SEE ATTACHMENT TO MY FEBRUARY 11, 1996 LETTER) THAT I BECAME AWARE OF THE EXISTENCE OF THE OFFICE OF ALTERNATIVE MEDICINE.

IN YOUR LETTER YOU STATE:

"I MUST SAY THAT THE WAY YOU PRESENT YOUR IDEAS MAKES IT DIFFICULT TO EVALUATE THEM OBJECTIVELY."

TO FACILITATE MATTERS, I HAVE COMPOSED A HYPOTHETICAL CONVERSATION WHICH I WOULD HAVE WITH MY PHYSICIAN IF I HAD HIV/AIDS.

I KNOW IN MY MAY 11, 1996 LETTER TO YOU I ASKED THAT YOU GIVE CONSIDERATION TO ONLY "A MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV"; HOWEVER, MY HYPOTHETICAL CONVERSATION WILL EMPLOY ELEMENTS OF BOTH THE "MILD" AND "INTENSIVE" APPLICATION.

THE NUMBER IN PARENTHESIS WILL INDICATE THE PAGE OF MY FILE ON WHICH THE DATA TO WHICH I REFER OCCURS.

GOOD MORNING DOCTOR. I WOULD LIKE TO PRESENT YOU WITH SOME RESEARCH I HAVE DONE RELATIVE TO HIV/AIDS. I CALL IT MY 35 PAGE FILE.

I WOULD LIKE FOR YOU TO CONTINUE ON IN YOUR ADMINISTRATION OF MEDICINES TO ME TO HELP ME FIGHT OFF THE INROADS WHICH OPPORTUNISTIC INFECTIONS MIGHT BE MAKING UPON MY BODY.

HOWEVER, I WOULD LIKE FOR YOU TO PRESCRIBE ANTABUSE FOR ME SO THAT I CAN START TAKING IT ON A DAILY BASIS.

AS I SAID IN MY FILE (8) IT IS MY ASSUMPTION THAT ANTABUSE WOULD NOT PROVE TO BE A DETRIMENT -

"THE PRESENCE OF ANTABUSE IN THE LIVER WOULD NOT HINDER THE EFFECT WHICH MEDICINES MIGHT HAVE IN WARDING OFF THE OPPORTUNISTIC INFECTIONS ENGENDERED BY HIV/AIDS."

DOCTOR, WITH ANTABUSE IN MY LIVER I THINK WE CAN BEGIN THE ATTACK ON THE VIRUS WHICH IS THE CAUSE OF ALL MY PROBLEMS - HIV.

DOCTOR, I HAVE BECOME AWARE OF A CHEMICAL WHICH CAN INACTIVATE HIV; IT IS CALLED ACETALDEHYDE.

BOTH THE NATIONAL INSTITUTES OF HEALTH AND CENTERS FOR DISEASE CONTROL HAVE ACKNOWLEDGED THAT ACETALDEHYDE WILL INACTIVATE HIV IN THE TEST TUBE (21).

DOCTOR, I AM GOING TO MAKE THE ASSUMPTION THAT ACETALDEHYDE WILL INACTIVATE HIV IN THE HUMAN BODY.

BASICALLY, DOCTOR, MY CONVERSATION WITH YOU TODAY WILL PRETTY MUCH DUPLICATE WHAT I HAVE WRITTEN IN MY FILE. HOWEVER, THERE WILL BE ONE MAJOR VARIANCE - TWO WEEKS FROM NOW I DO NOT WANT TO START OFF WITH THE 100 PROOF LIQUOR AS I ORIGINALLY STATED (24); INSTEAD, I WANT TO START OFF WITH A LIGHT WINE (12% ALCOHOL).

ALSO, I WANT THE TRIAL TO LAST 18 WEEKS, NOT 16 WEEKS AS I ORIGINALLY SUGGESTED (23).

FOR THE FIRST TWO WEEKS, BY TAKING A DAILY DOSAGE OF ANTABUSE, NOT TO EXCEED 500 mg (24), I ASSUME I WILL SUFFICIENTLY "PLUG UP" MY LIVER. FOR THE REMAINDER OF THE TRIAL PERIOD - 16 WEEKS - I WILL TAKE A DAILY ANTABUSE DOSAGE OF 250mg (24).

DURING THIS INITIAL TWO WEEK "PLUG UP" PERIOD I WILL BE CAREFUL NOT TO DRINK ALCOHOL OF ANY KIND WHATSOEVER. I UNDERSTAND THAT BY SO DOING I COULD MAKE MYSELF DEATHLY ILL. IN ADDITION, I WILL BE CAREFUL TO AVOID "HIDDEN ALCOHOLS" SUCH AS THAT FOUND IN AFTERSHAVE LOTIONS, CERTAIN SAUCES, FERMENTED VINEGAR, MARINADES, DESSERTS AND OTHER FOODS PREPARED WITH ANY ALCOHOL (26).

HOWEVER, I WILL IMMEDIATELY BEGIN TO INCLUDE IN MY DIET SUCH FOODS AS APPLES AND ORANGES (9) AND WILL DO SO FOR THE ENTIRE 18 WEEK PERIOD OF THE TRIAL. I UNDERSTAND THAT THIS COULD MAKE ME A LITTLE BIT NAUSEOUS, BUT IT SHOULDN'T BE TOO BAD; THE NAUSEA, OF COURSE, WOULD WELL UP BECAUSE OF THE SLIGHT, INCREASED (26) AMOUNT OF UNMETABOLIZED ACETALDEHYDE FLOWING IN MY BLOODSTREAM. DOCTOR, THIS CONSTITUTES THE BASIS OF "A MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV".

IN TWO WEEKS, DOCTOR, I WANT TO COME BACK TO YOUR OFFICE AND HAVE YOU BEGIN THE TREATMENT WHICH I CALL "AN INTENSIVE APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV".

THE PROCEDURE WILL RESULT IN THE RELEASE OF A CONSIDERABLE AMOUNT OF POISONOUS ACETALDEHYDE INTO MY BLOODSTREAM.

YOU MIGHT BE RELUCTANT TO DO IT, BUT DOCTOR, I HAVE COME ACROSS SOME RESEARCH WHICH, I THINK, WILL AFFORD ME PROTECTION AGAINST THE TOXICITY OF ACETALDEHYDE.

THE RESEARCH TO WHICH I REFER HAS BEEN DONE BY HERBERT SPRINCE AND HIS ASSOCIATES (22-23).

SPRINCE HAS DISCOVERED AN AMAZING FACT OF NATURE (22); I WISH TO QUOTE IT AGAIN AT THIS TIME BECAUSE IT IS SO INTRIGUING:

"TO THE BEST OF OUR KNOWLEDGE, OUR FINDINGS DEMONSTRATE FOR THE FIRST TIME THAT DIRECT (SPRINCE'S EMPHASIS) PROTECTIVE ACTION AGAINST ACETALDEHYDE TOXICITY AND LETHALITY CAN BE OBTAINED WITH CERTAIN NATURALLY-OCCURRING METABOLITES, NAMELY L-ASCORBIC ACID, L-CYSTEINE, AND THIAMIN, PREFERABLY IN COMBINATION AT REDUCED DOSE LEVELS."

I CALL THIS "THE SPRINCE RATIO":

L-ASCORBIC ACID (VITAMIN C)	2.0
L-CYSTEINE FB (A SULFUR COMPOUND)	1.0
THIAMINE.HCL (A SULFUR COMPOUND)	.3

AND PLANNED ON USING THESE NUTRIENTS IN MY TRIAL (24).

HOWEVER, ON JULY 22 A FACT OCCURRED TO ME THAT CAUSED ME TO CHANGE MY MIND - I REMEMBERED THAT ANOTHER NUTRIENT IN THE SPRINCE STUDY ALSO AFFORDED 100% PROTECTION AGAINST THE LETHALITY OF ACETALDEHYDE POISONING; THAT NUTRIENT IS

N-ACETYL-L-CYSTEINE.

FOR CONVENIENCE SAKE, IT IS CALLED "NAC".

ON PAGE 7 OF MY FILE I DEFINED IT; HERE IS THE FIRST SENTENCE OF THAT DEFINITION:

"N-ACETYL CYSTEINE IS A MORE STABLE FORM OF THE SULFUR AMINO ACID L-CYSTEINE, AND IS A POWERFUL ANTIOXIDANT."

DR. LUC MONTAGNIER WHOSE LABORATORY DISCOVERED HIV IS GIVING IT SERIOUS CONSIDERATION (10).

THEREFORE, BY USING THIS NUTRIENT AND EMPLOYING ACETALDEHYDE COULDN'T WE POSSIBLY LAND A ONE/TWO KNOCKOUT PUNCH AGAINST THE DEADLINESS OF HIV; TO SUMMARIZE:

1. NAC WOULD HELP TO RESTORE APOPTOSIS BACK TO NORMAL LEVELS (10).
2. NAC WILL AFFORD 100% PROTECTION AGAINST THE TOXIC EFFECTS OF UNMETABOLIZED ACETALDEHYDE (SEE SPRINCE TABLE 1 ATTACHED TO MY JULY 22 LETTER TO DR. STANDISH).
3. UNMETABOLIZED ACETALDEHYDE WILL INACTIVATE HIV (21).

IF THIS INDEED WOULD OCCUR, I WOULD LIKE TO REPEAT THE TWO PARAGRAPHS AT THE BOTTOM OF PAGE 10 OF MY FILE; I HAVE MADE ONE SLIGHT REVISION TO THE SECOND PARAGRAPH:

"I WOULD LIKE TO CONCLUDE MY RESEARCH BY SUGGESTING THAT ANTIOXIDANTS AND UNMETABOLIZED ACETALDEHYDE MIGHT BE OF SOME CONSIDERABLE BENEFIT TOWARD RESTORING HIV/AIDS PATIENTS TO A MODICUM OF GOOD HEALTH.

"THERE IS NO DOUBT IN MY MIND, WHATSOEVER, THAT ACETALDEHYDE, IN COMBINATION WITH N-ACETYL-L-CYSTEINE (NAC), WILL EVENTUALLY BE SHOWN TO BE THE MOST USEFUL POISON EVER DEvised BY NATURE FOR THE BENEFIT OF MANKIND."

THE CURRENT PRICE FOR NAC AT THE HEALTH FOOD STORE IS \$3.90 FOR 30 CAPSULES. EACH CAPSULE CONTAINS 600 mg.

BY THE WAY, DOCTOR, AS A MATTER OF GOOD HEALTH I WILL START TAKING NAC ON A DAILY BASIS. DR. MONTAGNIER, WITH HIS APPLICATION OF IT, DID NOT START TO SEE GOOD RESULTS UNTIL AFTER SIX MONTHS (10).

OF COURSE, AS YOU ARE ABOUT TO SEE, DOCTOR, WHEN I COME TO YOUR OFFICE ONCE A WEEK YOU WILL PROBABLY HAVE ME TAKE DOUBLE, TRIPLE OR QUADRUPLE MY NORMAL DAILY AMOUNT OF NAC.

HERE THEN, DOCTOR, IS THE "INTENSIVE APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV" WHICH I WANT YOU TO ADMINISTER TO ME -

THE PROCEDURE WILL PROBABLY TAKE ALL MORNING OR ALL AFTERNOON (ABOUT 4 HOURS) (24). THE FIRST THING YOU WOULD DO, DOCTOR, IS TO HAVE ME SWALLOW MY INCREASED "DOSAGE" OF NAC - AND HERE I WILL LEAVE IT TO YOUR EXPERTISE TO DETERMINE THE AMOUNT. IN THE SPRINCE STUDY, 2.0 mM/kg (MILLIMOLES/KILOGRAM) OF NAC WAS ADMINISTERED TO THE RATS. EACH OF THE NAC CAPSULES CONTAINS 600 mg. I DO NOT KNOW HOW TO EQUATE GRAMS WITH MOLES.

30 TO 45 MINUTES LATER (24), DOCTOR, I WANT YOU TO GIVE TO ME 15 mL ($\frac{1}{2}$ oz) OF UNFORTIFIED WINE TO DRINK. I THINK THE ALCOHOL CONTENT WILL BE ABOUT 12%.

IF MY LIVER WERE NOT "PLUGGED UP" WITH ANTABUSE IT WOULD QUICKLY METABOLIZE ALL OF THE ACETALDEHYDE THAT WOULD HAVE BEEN GENERATED BY DRINKING THIS WINE; I THINK THAT 18.6 MINUTES WOULD BE THE MAXIMUM TIME INVOLVED (35).

HOWEVER, SINCE MY LIVER IS PLUGGED UP, LET'S ASSUME THAT 4 HOURS IS NEEDED TO DO THE JOB; IN OTHER WORDS, POISONOUS, TOXIC, LETHAL UNMETABOLIZED ACETALDEHYDE WILL BE FLOWING THROUGHOUT MY BODY FOR AN UNUSUALLY LONG PERIOD OF TIME.

HOWEVER, DOCTOR, I WILL NOT BE WORRIED ABOUT THIS BECAUSE THE RESEARCH OF HERBERT SPRINCE AND HIS ASSOCIATES HAS SHOWN THAT N-ACETYL-L-CYSTEINE AFFORDS 100% PROTECTION AGAINST ACETALDEHYDE POISONING.

THIS THEN WOULD BE THE SCENARIO - FOR THE FOUR HOUR PERIOD MY BODY WOULD BE PROTECTED AGAINST THE TOXICITY OF ACETALDEHYDE WHILE AT THE SAME TIME THIS TOXICITY WOULD BE "INACTIVATING" MILLIONS OF AIDS VIRUSES - HIV. THE WORST THING THAT MIGHT HAPPEN TO ME DURING THE FOUR HOUR PERIOD IS THAT I MIGHT BECOME A LITTLE BIT SLEEPY.

THE IMPORTANT THING WE HAVE TO TAKE INTO CONSIDERATION, DOCTOR, IS HOW QUICKLY IS NAC METABOLIZED? IF IT IS METABOLIZED WITHIN $\frac{1}{2}$ HOUR, MY "PROTECTIVE CUSHION" AGAINST THE TOXICITY OF ACETALDEHYDE WILL EVAPORATE. IF FOUR HOURS IS NEEDED TO METABOLIZE IT, I HAVE NOTHING TO WORRY ABOUT.

THIS THEN MIGHT BE THE "BUSY SCENARIO" - EVERY $\frac{1}{2}$ HOUR, OR EVERY HOUR, OR EVERY $1\frac{1}{2}$ HOUR, OR EVERY TWO HOURS I WOULD HAVE TO REPLENISH MY BODY WITH A "DOSE" OF NAC. I MIGHT HAVE TO BE AWAKENED TO DO SO. THAT IS WHY IT WILL BE NECESSARY FOR YOU TO KEEP YOUR EYE ON ME, DOCTOR, DURING THE ENTIRE FOUR HOUR PERIOD.

DURING MY NEXT THREE VISITS, DOCTOR, I WOULD LIKE FOR YOU TO REPEAT THIS PROCEDURE. IF I SUFFER NO ILL EFFECTS FROM THIS PROCEDURE, I WANT YOU TO CHANGE IT THUSLY:

WEEKS 5,6,7,8: ALCOHOL AMOUNT - 1 oz. OF UNFORTIFIED WINE (12% ALCOHOL)
 WEEKS 9,10,11,12: ALCOHOL AMOUNT - $\frac{1}{2}$ oz. OF FORTIFIED WINE (18% ALCOHOL)
 WEEKS 13,14,15,16: ALCOHOL AMOUNT - 1 oz. OF FORTIFIED WINE (18% ALCOHOL)

IF AFTER 16 WEEKS OF THIS TREATMENT, AND IF I AM AMENABLE TO IT, IT WOULD BE MY EVENTUAL GOAL, DOCTOR, TO COME TO YOUR OFFICE ONCE A WEEK, AND YOU WOULD ADMINISTER TO ME 1 oz. OF 100 PROOF LIQUOR (50% ALCOHOL); HOPEFULLY, NO ILL EFFECTS WOULD OCCUR, AND MILLIONS UPON MILLIONS OF AIDS VIRUSES WOULD BE "INACTIVATED".

WHAT GOOD RESULTS MIGHT OCCUR? DOCTOR, IT IS MY CONJECTURE THAT ACETALDEHYDE WAS THE OPERATIVE FORCE IN A FRENCH HIV STUDY WHICH WAS DETAILED IN "THE LANCET", SEPTEMBER 24, 1988, PAGES 702-706.

HERE ARE THE RESULTS OF THAT STUDY RELATIVE TO SOME OF THE PATIENTS WHO HAD DITIOCARB (RELATED TO ANTABUSE) IN THEIR LIVERS:

1. CD 4+ (T-CELL) COUNT INCREASED
2. ENLARGED SPLEEN AND LYMPH NODES SHRANK
3. DIARRHEA DISAPPEARED
4. WEIGHT RESUMPTION OCCURRED
5. PERSISTENT FEVERS DISAPPEARED
6. IMPROVEMENT IN CLINICAL STATUS IN 42% OF THE PATIENTS

WELL, THAT'S ABOUT IT, DOCTOR; JUST A FEW THINGS BEFORE I GO -

I'LL CONTINUE TO EAT ALOT OF FRUIT (9).

I'LL SUPPLY MY BODY WITH ZINC (27).

DOCTOR, COULD A DIETARY DEFICIENCY OF ZINC CONTRIBUTE TO THE DEVELOPMENT OF ALCOHOLISM? (27)

DOCTOR, IN THE INTERVIEW HE HAD WITH DR. PASSWATER, DR. MONTAGNIER ALSO MENTIONED ZINC ALONG WITH THESE NUTRIENTS - SELENIUM, BETA CAROTENE, VITAMINS A, C AND E, ENZYMES SUPEROXIDE DISMUTASE (SOD) AND CATALASE, AND PROTEINS SUCH AS METALLOTHIONINE. (10) DOCTOR, I AM GOING TO INCLUDE THESE NUTRIENTS INTO MY DIET. I AM NOT A SMOKER, BUT IF I WERE, I WOULD BE SURE TO INCLUDE AN ABUNDANT AMOUNT OF VITAMIN C BECAUSE:

"..... EACH CIGARETTE SMOKED DESTROYS AN ESTIMATED 25 mg OF VITAMIN C; THIS MAY BE AS MUCH AS MANY PEOPLE OBTAIN IN THEIR DIET. THE RDA IS ONLY 50 mg." (27)

DOCTOR, I READ AN INFORMATIVE BOOK ABOUT VITAMIN C; IT IS:

THE HEALING FACTOR - VITAMIN C AGAINST DISEASE BY IRWIN STONE
 GROSSET & DUNLAP, NEW YORK, 1972

OH, BY THE WAY DOCTOR, DO YOU KNOW THE MEANING OF THE TERM - "ZINC FINGERS"?
COULD A DIETARY DEFICIENCY OF ZINC EXACERBATE HIV/AIDS? (9)

DOCTOR, ON PAGE 3 OF MY FILE I BET \$148.00 THAT THE WORD, "ACETALDEHYDE",
IS NEVER MENTIONED ON ANY OF THE 452 PAGES OF THE BOOK -

DISULFIRAM AND ITS METABOLITE (3)

DOCTOR, I STILL HAVE MY \$148.00.

DOCTOR, WAS I CORRECT ABOUT MY UNDERSTANDING OF THE RESEARCH OF THE
THREE JAPANESE RESEARCHERS? (3,4,5)

THEIR ACETALDEHYDE CONTAINING COMPOUND INHIBITED MORE THAN 90%
OF THE N-MYRISTOYLATION OF P17 GAG PROTEIN PRODUCED IN THE HIV-1-INFECTED
MT-4 CELLS. (4)

IF THEY HAD USED "PURE" ACETALDEHYDE - CH_3CHO - WOULD A 100% RESULT
HAVE BEEN ACHIEVED? IF SO, WHY DIDN'T THEY USE "PURE" ACETALDEHYDE?

IN ANY EVENT, WAS I RIGHT WHEN I MADE THIS STATEMENT:

"IN OTHER WORDS, HIV, WHICH IS THE VIRUS WHICH IS THE ROOT CAUSE OF AIDS,
CANNOT BEGIN TO MULTIPLY AS LONG AS A CERTAIN COMPOUND CONTAINING
ACETALDEHYDE IS PRESENT." (5)

AND FINALLY, DOCTOR, WHAT DO YOU THINK ABOUT THE COMMENTS I MADE ON PAGE 27? -

1. AVOID SUGAR
2. INCLUDE MOLASSES (RICH IN IRON)
3. AVOID FOOD ADDITIVES SUCH AS MSG
4. INCLUDE VINEGAR
5. INCLUDE GARLIC

I WOULD LIKE TO MENTION AGAIN THE BOOKS I LISTED ON PAGE 27 -

SUPER-NUTRITION BY DR. PASSWATER
SUGAR BLUES BY WILLIAM DUFTY

DOCTOR, IN CONCLUSION I WOULD LIKE TO REPEAT A STATEMENT WHICH DR. MONTAGNIER
MADE TO DR. PASSWATER:

"I AM CONVINCED THAT OXIDATIVE STRESS IS INDEED INVOLVED IN THE
PROGRESSION FROM HIV INFECTION TO THE AIDS STAGE. I BELIEVE,
THEREFORE, THAT ANTIOXIDANTS ARE NECESSARY IN THE TREATMENT.
BUT ANTIOXIDANTS ARE NOT SUFFICIENT BY THEMSELVES." (10)

I WISH TO SUGGEST THAT THE ADDITIONAL FACTOR THAT DR. MONTAGNIER IS LOOKING FOR
IS UNMETABOLIZED ACETALDEHYDE.

DOCTOR, THANK YOU AGAIN FOR YOUR HELP AND COOPERATION. I'LL SEE YOU AGAIN
NEXT WEEK.

WELL, THAT'S ABOUT IT, DR. STANDISH.

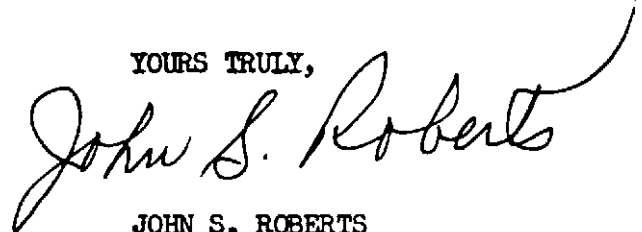
THANKS FOR YOUR TIP ABOUT THE DIVISION OF RESEARCH GRANTS AT THE NIH, A LEAD WHICH I WILL PURSUE.

IN ADDITION, I WILL CONTINUE IN MY EFFORT TO MAKE THE PUBLIC AWARE OF MY RESEARCH BY MAILING THIS LETTER TO MISCELLANEOUS PRIVATE CITIZENS, SCIENTISTS, GOVERNMENT OFFICIALS AND ORGANIZATIONS.

IF YOU, DR. WHITESCARVER, CONGRESSMAN VISCLOSKY OR PROFESSOR MANKES HAVE ANY COMMENTS OR CRITICISMS, PLEASE MAIL THEM TO ME WITHIN THE NEXT FEW WEEKS, AND I WILL ATTACH THEM TO THIS LETTER.

AT THE VERY LATEST, SEPTEMBER 1, I WISH TO MAIL COPIES OF THIS LETTER TO THE "70" WHICH I HAVE ALREADY MENTIONED, AND OTHERS IN OUR SOCIETY WHO I THINK MIGHT BE CONCERNED ABOUT THE PROBLEM OF HIV/AIDS.

YOURS TRULY,



JOHN S. ROBERTS
POST OFFICE BOX H
HOBART, INDIANA 46342
219-763-1933

COPIES TO:

CONGRESSMAN PETER J. VISCLOSKY, WASHINGTON, D.C. AND GARY, INDIANA
JACK WHITESCARVER, Ph.D., NATIONAL INSTITUTES OF HEALTH, BETHESDA, MARYLAND
PROFESSOR RUSSELL F. MANKES, Ph.D., THE ALBANY MEDICAL COLLEGE, ALBANY, NEW YORK

BASTYR

UNIVERSITY

Research Department
144 N.E. 54th Street
Seattle, Washington 98105-9916
FAX (206) 517-3599

John S. Roberts
P.O. Box H.
Hogart, IN 46342
June 27, 1996

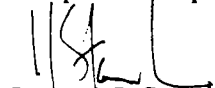
Dear Mr. Roberts,

Thank you for your persistent energy in trying to get the AIDS research community to take seriously your ideas about acetaldehyde and Antabuse. I cannot fully assess the validity of your ideas since I do not have in my possession a document from you that you refer to as your "file". I must say that the way you present your ideas makes it difficult to evaluate them objectively. Nevertheless, I am not one to dismiss even crazy sounding ideas without carefully going over the facts. I thought Dr. Whitescarver's response to your letter was probably on the mark. How do you reply to his criticisms?

The NIH funded Bastyr University AIDS Research Center recently distributed \$105,000 for two small AIDS studies in alternative medicine. That \$105,000 was the total allocation in our budget for funding extramural research. We advertised extensively throughout the U.S. in both the conventional and alternative medical/scientific/AIDS activist communities know that we were looking for excellent research projects in alternative medicine and AIDS. Why didn't you apply?

If our AIDS Research Center is refunded by the NIH in 1997, we will have funding for more extramural research studies. In which case, I urge you to write a sound scientific proposal, have it fairly evaluated by scientific review. If your idea is worthy of pursuit and you can construct a sound experimental design to test your hypothesis, then the Center may be able to fund the kind of study you feel is so urgently needed. I recommend that you contact the Division of Research Grants at the NIH (phone 301- 435- 0714) and ask them for a grant proposal form called the PHS-398 that you will need to complete in order to obtain any NIH funding. I think that the rigor required to complete a reasonable NIH style grant proposal will help you clarify your ideas and make them more accessible, and therefore more powerful to other scientists and physicians.

I hope this helps.



Leanna J. Standish, ND, PhD

Director

Bastyr University AIDS Research Center

cc: U.S. Representative Peter J. Viscloski
Jack Whitescarver, PhD Deputy director OAR, NIAID

PETER J. VISCLOSKY
1ST DISTRICT, INDIANA

COMMITTEE ON APPROPRIATIONS
CONGRESSIONAL STEEL CAUCUS
EXECUTIVE COMMITTEE CHAIRMAN
NORTHEAST-MIDWEST
CONGRESSIONAL COALITION
MIDWEST VICE-CHAIR
WHIP-AT-LARGE

Congress of the United States
House of Representatives
Washington, DC 20515-1401

2464 RAYBURN BUILDING
WASHINGTON, DC 20515-1401
(202) 225-2461

215 WEST 35TH AVENUE
GARY, IN 46408
TTY-TDD SERVICE AVAILABLE
(219) 884-1177

PORTAGE CITY HALL
6070 CENTRAL AVENUE
PORTAGE, IN 46368
(219) 763-2904

VALPARAISO CITY HALL
166 LINCOLNWAY
VALPARAISO, IN 46383
(219) 464-0315

July 10, 1996

Dr. Leanna Standish
Bastyr University
144 NE 54th Street
Seattle, Washington 98105

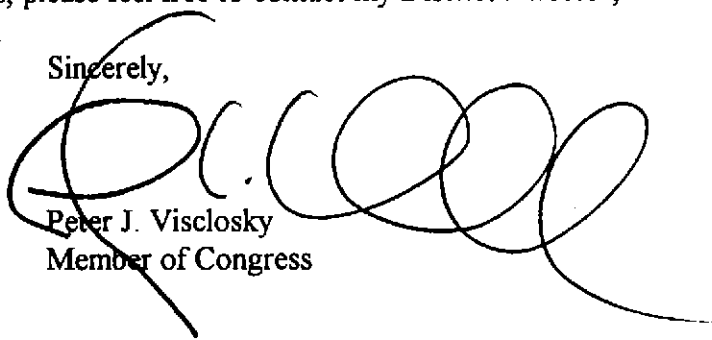
Dear Dr. Standish:

Enclosed please find correspondence submitted to my office by my constituent, John S. Roberts.

Mr. Roberts has done research and has described two procedures through which HIV might be "inactivated" by acetaldehyde. He has sent material to you outlining his findings. Mr. Roberts is asking my office to request a response to his claim. Any information which you could provide John Roberts would be greatly appreciated.

Should you have any questions, please feel free to contact my District Director, David Rozmanich, at (219) 884-1177.

Sincerely,


Peter J. Visclosky
Member of Congress

PJV:dsr

JUNE 23, 1996

THE HONORABLE PETER J. VISCLOSKY
UNITED STATES HOUSE OF REPRESENTATIVES
2464 RAYBURN BUILDING
WASHINGTON, D.C. 20515-1401

DEAR CONGRESSMAN VISCLOSKY,

AS YOU CAN SEE, I HAVE SENT THIS LETTER TO YOU BY CERTIFIED MAIL; I HAVE ALSO PERSONALLY DELIVERED A COPY OF IT TO YOUR GARY, INDIANA OFFICE.

I HAVE ALSO SENT A COPY OF IT BY CERTIFIED MAIL TO BOTH DR. LEANNA STANDISH, CENTER FOR ALTERNATIVE MEDICINE RESEARCH IN HIV/AIDS, NATIONAL INSTITUTES OF HEALTH AND JACK WHITESCARVER, Ph.D., DEPUTY DIRECTOR, OFFICE OF AIDS RESEARCH, NATIONAL INSTITUTES OF HEALTH.

CONGRESSMAN VISCLOSKY, I NEED YOUR HELP.

WOULD YOU PLEASE REQUEST OF DR. STANDISH THAT SHE RESPOND TO MY LETTER OF MAY 11, 1996 (ATTACHED).

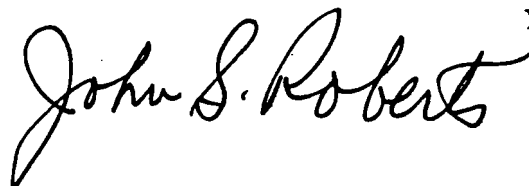
IF SHE THINKS THAT MY "MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV" MIGHT BE VIABLE, COULD SHE MAIL TO ME THE NAMES OF RESEARCHERS WHOM I MIGHT CONTACT TO ASK TO APPLY FOR A \$30,000 GRANT FROM HER OFFICE; OF COURSE, I WOULD NOT BE THE RECIPIENT OF ANY FUNDING WHATSOEVER.

IF SHE DOES NOT THINK THAT MY "MILD PROCEDURE" IS VIABLE, COULD SHE AFFORD ME THE RATIONALE BEHIND HER CONCLUSION.

TO RECAPITULATE, ON MAY 11 OR MAY 12 I MAILED TO DR. STANDISH AND DR. WHITESCARVER A PACKET CONTAINING THE FOLLOWING (I PERSONALLY DELIVERED SAID PACKET TO YOUR GARY OFFICE):

1. THE MAY 11 LETTER TO DR. STANDISH.
2. A FOUR PAGE ADVERTISEMENT WHICH I PLACED ON "THE INTERNET" DATED APRIL 9, 1996.
3. A 3 PAGE LETTER CONTAINING THE NAMES AND ADDRESSES OF MISCELLANEOUS PRIVATE CITIZENS, SCIENTISTS, GOVERNMENT OFFICIALS AND ORGANIZATIONS WHO I THOUGHT MIGHT BE INTERESTED IN MY HIV/AIDS RESEARCH; THE TOTAL FIGURE TO DATE IS 70. LETTER DATED 3/21/96.
4. A THREE PAGE LETTER TO "CURRENT HEALTH 2" DATED FEBRUARY 29, 1996.
5. A FIVE PAGE LETTER TO THE LAKE COUNTY AIDS TASK FORCE, DATED FEBRUARY 25, 1996.
6. AN EIGHT PAGE LETTER TO BOTH THE DIRECTORS OF THE NATIONAL INSTITUTES OF HEALTH AND THE OFFICE OF ALTERNATIVE MEDICINE (NIH), DATED FEBRUARY 11, 1996.
7. A FOUR PAGE LETTER TO WYETH-AYERST LABORATORIES (THE COMPANY WHICH OWNS THE PATENT AND MANUFACTURING RIGHTS TO "ANTABUSE"), DATED JANUARY 27, 1996.
8. A THIRTY FIVE PAGE FILE OF MY RESEARCH RELATIVE TO HIV/AIDS, DATED JANUARY 1, 1996.

IF, BY HAPPENSTANCE, THIS PACKET DID NOT COME TO THE ATTENTION OF ANY OF YOU, JUST LET ME KNOW (219-763-1933), AND I WILL MAIL IT TO YOU IMMEDIATELY.



YOURS TRULY,
JOHN S. ROBERTS
POST OFFICE BOX H
HOBART, INDIANA 46342

MAY 11, 1996

DR. LEANNA STANDISH
CENTER FOR ALTERNATIVE MEDICINE RESEARCH IN HIV/AIDS
NATIONAL INSTITUTES OF HEALTH
EASTYR UNIVERSITY
114 NE 54th STREET
SEATTLE, WASHINGTON 98105

DEAR DR. STANDISH,

TODAY IT OCCURRED TO ME THAT I SHOULD WRITE THIS LETTER TO YOU.

THROUGHOUT 1993 THE NATIONAL INSTITUTES OF HEALTH TOLD BOTH ME AND CONGRESSMAN PETER J. VISCLOSKEY OF INDIANA THAT ACETALDEHYDE WOULD HAVE NO EFFECT UPON THE AIDS VIRUS - HIV.

IN DECEMBER, 1994 AND AUGUST, 1995 THE NATIONAL INSTITUTES OF HEALTH (NIH) CHANGED ITS POSITION (SEE PAGE 28 OF MY FILE).

TO BE MORE SPECIFIC - IN HIS LETTER TO CONGRESSMAN VISCLOSKEY (SEE PAGES 32 AND 33 OF MY FILE) JACK WHITESCARVER, Ph.D., DEPUTY DIRECTOR OF THE OFFICE OF AIDS RESEARCH, NIH, STATED:

"THE FACT THAT ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN TEST TUBE EXPERIMENTS DOES NOT NECESSARILY MAKE IT A GOOD CANDIDATE FOR ANTI-HIV THERAPY IN HUMANS."

"THE HIGH TOXICITY OF ACETALDEHYDE MAKES IT A SIGNIFICANTLY LESS DESIRABLE CANDIDATE FOR USE IN INDIVIDUALS WHO SUFFER FROM SEVERELY WEAKENED IMMUNE SYSTEMS AND WHO ARE PRONE TO CONTRACTING NUMEROUS OPPORTUNISTIC INFECTIONS AND MALIGNANCIES."

IN MY RESEARCH I DESCRIBE TWO PROCEDURES BY WHICH HIV MIGHT BE "INACTIVATED" BY ACETALDEHYDE.

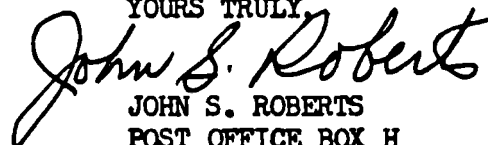
AT THIS TIME I AM NOT SUGGESTING THAT YOU GIVE CONSIDERATION TO THE "INTENSIVE APPLICATION" OF UNMETABOLIZED ACETALDEHYDE; HOWEVER, I WOULD APPRECIATE IT IF YOU WOULD GIVE CONSIDERATION TO

"A MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV".

IF YOU THINK THAT A CLINICAL TRIAL IS FEASIBLE, COULD YOU FORWARD TO ME THE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ANY "AIDS ACTIVISTS" WHO MIGHT HAVE THE INTEREST AND WHEREWITHAL TO INITIATE SUCH A TRIAL; A LICENSED PHYSICIAN WOULD BE NECESSARY IN ORDER TO PRESCRIBE ANTABUSE.

IF YOU DON'T THINK THAT SUCH A TRIAL IS FEASIBLE, I WOULD APPRECIATE RECEIVING FROM YOU THE RATIONALE BEHIND YOUR CONCLUSION.

YOURS TRULY,



JOHN S. ROBERTS
POST OFFICE BOX H
HOBART, INDIANA 46342
219-763-1933

COPIES WITH ENCLOSURES TO:

CONGRESSMAN PETER J. VISCLOSKEY, INDIANA
JACK WHITESCARVER, Ph.D., DEPUTY DIRECTOR, OFFICE OF AIDS RESEARCH,
NATIONAL INSTITUTES OF HEALTH

AND _____



The Albany Medical College

Albany New York 12208

DEPARTMENT OF PHARMACOLOGY & TOXICOLOGY
THE NEIL HELLMAN MEDICAL RESEARCH BUILDING, A-136
(518) 445-5303
FAX (518) 445-5799

Mr. John S. Roberts
POB H
Hobart , IN 46342

16 April, 1993

Dear Mr. Roberts,

I received a package of correspondence from and to you relative to acetaldehyde and HIV today. I am really not sure why it was sent to me as I am not an AIDS researcher, my area of expertise lies in Toxicology, specifically alcohol. From your correspondence it appears that you have developed the hypothesis that acetaldehyde may be a useful adjunct to therapy for HIV infected individuals. It appears that this hypothesis has generally been dismissed by the NIH, specifically by Dr. John Bader..

From my perspective I would like to add a degree of caution to your continued efforts. Acetaldehyde, a highly toxic intermediate of alcohol metabolism, could in fact cause damage to viruses. However, the danger lies in the specificity of the toxicity. The therapeutic drugs which are being developed (such as AZT, DDC, etc.) rely on the principal of selective (or specific) toxicity, they cause death or damage to the infectious agent or diseased cell at doses which do not significantly affect normal function. A chemical that kills the patient while it kills the virus or cancer is not a useful drug. In the case of acetaldehyde, as you so rightly pointed out, it is toxic (and severely so) to a wide variety of human organ systems at exceedingly low dose levels. We believe it may also target the T-cells of the immune system and produce a lessening of their function, something which would be very dangerous in an HIV infected human. I do not dismiss your hypothesis, only add a note of caution to your quest.

It is important to remember that the more we learn about the basic biology of a disease process, the more likely we are to find a cure. I would urge you to continue your efforts, particularly with members of congress, to increase funding for medical research generally since, as amply illustrated by your letters, we cannot determine from where the next advance will come (perhaps the cure for AIDS will be found by research on the genetics of the fruit fly!!).

If I may be of any assistance to you please do not hesitate to write.

Sincerely,


Russell F. Mankes, Ph.D.
Associate Professor



An Institution of the Albany Medical Center

JANUARY 1, 1996

AIDS - CAN DEATH BE DELAYED? - PERHAPS
COPYRIGHT © 1996
BY
JOHN S. ROBERTS

*ADVERTISEMENT REVISION, 1/11/96:

TO: _____

AIDS
THE AIDS VIRUS, HIV,
CAN BE CRIPPLED BY THE
CHEMICAL, ACETALDEHYDE.
IS A LONGER LIFE POSSIBLE?
CAN DEATH BE DELAYED?
- PERHAPS -

I AM GOING TO ASSUME THAT WHOEVER READS THIS FILE IS CONCERNED
ABOUT THE PROBLEM OF AIDS.

IT IS MY HOPE THAT THE MEDIA WILL PROMOTE THE FOLLOWING ADVERTISEMENT
FREE OF CHARGE AS A PUBLIC SERVICE FOR AN INDETERMINATE PERIOD OF TIME:

~~AIDS - CAN DEATH BE DELAYED? -~~
~~PERHAPS~~

MAIL \$5.00 TO ROBERTS, P.O. BOX H,
HOBART, IN 46342 TO OBTAIN 35 PAGES
OF MEDICAL RESEARCH

P.S. - ~~ANY PROFIT WOULD BE DONATED TO CRIA (COMMUNITY RESEARCH INITIATIVE ON AIDS)~~
~~OF NEW YORK CITY.~~

ON PAGE 17 OF THEIR BOOK, AGAINST THE ODDS; THE STORY OF AIDS DRUG DEVELOPMENT,
POLITICS & PROFITS, THE AUTHORS PETER S. ARNO, Ph.D., AND KARYN L. FEIDEN
MAKE THIS STATEMENT:

"BETWEEN 1987 AND 1991 THE NATIONAL CANCER INSTITUTE TESTED 40,000
CHEMICAL COMPOUNDS AT FACILITIES IN FREDERICK, MARYLAND, AND
BIRMINGHAM, ALABAMA, TO SEE IF ANY COULD DISABLE THE AIDS VIRUS.
DESPITE THE ODDS AGAINST FINDING A BREAKTHROUGH DRUG, RESEARCHERS
CONTINUE TO SCREEN FOR COMPOUNDS THAT CAN INHIBIT HIV AT EACH STEP
IN THE INFECTION PROCESS: WHEN IT BINDS TO THE CD4 MOLECULE; WHEN IT
PENETRATES THE HELPER T CELL; WHEN IT TRANSCRIBES ITS GENETIC CODE
INSIDE; AND WHEN IT REPLICATES. A MORE PROMISING DIRECTION FOR
FUTURE RESEARCH IS TARGETED DRUG DEVELOPMENT - THAT IS, DESIGNING
AN EFFECTIVE DRUG ON THE KNOWN BIOLOGICAL STRUCTURE OF HIV."

ON JANUARY 1, 1993 I BECAME AWARE OF THE TOXIC CHEMICAL COMPOUND KNOWN AS

"ACETALDEHYDE".

P.S. On 9/11/96 CRIA Requested this deletion.

ON JANUARY 11, 1993 I WROTE A LETTER IN WHICH I ASKED THIS QUESTION OF DR. LUC MONTAGNIER, THE DISCOVERER OF THE VIRUS WHICH CAUSES AIDS - HIV:

"HAS ANY RESEARCH EVER BEEN CONDUCTED TO SEE WHETHER ACETALDEHYDE MIGHT BE EFFECTIVE IN DESTROYING THE AIDS VIRUS?"

I MAILED A COPY OF THIS LETTER TO DR. JOHN P. BADER OF THE NATIONAL INSTITUTES OF HEALTH AND RANDY SHILTS (RECENTLY DECEASED, A VICTIM OF AIDS) OF THE SAN FRANCISCO CHRONICLE AND THE AUTHOR OF AND THE BAND PLAYED ON, A BOOK ABOUT THE DEVELOPMENT OF THE AIDS EPIDEMIC.

ON JANUARY 19, 1993 I WROTE A LETTER TO CONGRESSMAN PETER J. VISCLOSKY OF INDIANA IN WHICH I MADE THESE UNDER-LINED STATEMENTS:

"THE HUMAN BODY CAN BE POISONED WITH A HIGHLY TOXIC SUBSTANCE AND STILL SURVIVE AND THE NAME OF THAT SUBSTANCE IS ACETALDEHYDE."

"IT IS MY HYPOTHESIS THAT WHILE ACETALDEHYDE IS POISONING THE BODY, IT WILL AT THE SAME TIME DESTROY THE AIDS VIRUS."

I MAILED COPIES OF THIS LETTER TO DR. MONTAGNIER, DR. BADER AND RANDY SHILTS. ON JANUARY 26, 1993 DR. BADER WROTE TO ME A LETTER IN WHICH HE STATED:

"THE MOLECULES YOU SUGGEST ARE NORMAL METABOLITES FORMED DURING NORMAL BODY FUNCTIONING, AND WOULD HAVE NO EFFECT ON HIV OR AIDS."

THROUGHOUT 1993 OTHER SCIENTISTS AT THE NATIONAL INSTITUTES OF HEALTH MAINTAINED THIS POSITION.

ON DECEMBER 13, 1994 DON LUCKETT, A PROGRAM ANALYST WITH THE NATIONAL INSTITUTES OF HEALTH, WROTE TO ME A LETTER IN WHICH HE STATED:

"THE KNOWN TOXICITY OF ACETALDEHYDE WOULD HAVE LIKELY PREVENTED EVALUATION EVEN IF THE AGENT HAD SHOWN ANTI-HIV ACTIVITY IN THE DRUG SCREEN PROGRAM SPONSORED BY THE NATIONAL CANCER INSTITUTE."

ON FEBRUARY 1, 1995 AN "INFORMATION SPECIALIST" OF THE CENTERS FOR DISEASE CONTROL WROTE TO ME A LETTER IN WHICH THIS STATEMENT IS MADE; THE PARENTHESIS IS MINE:

"ALL THE ALDEHYDES ARE CAPABLE OF INACTIVATING HIV (IN THE TEST TUBE); HOWEVER, THEIR ACTUAL EFFECTIVENESS DEPENDS ON THE CONCENTRATION USED."

ON AUGUST 9, 1995 DR. JACK WHITESCARVER WROTE A LETTER TO CONGRESSMAN VISCLOSKY IN WHICH HE STATED THE LATEST POSITION OF THE NATIONAL INSTITUTES OF HEALTH RELATIVE TO ACETALDEHYDE:

"THE FACT THAT ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN TEST TUBE EXPERIMENTS DOES NOT NECESSARILY MAKE IT A GOOD CANDIDATE FOR ANTI-HIV THERAPY IN HUMANS."

DR. WHITESCARVER'S COMPLETE LETTER IS INCLUDED IN THIS FILE.

MY KNOWLEDGE OF BIOLOGY IS MINIMAL; I BARELY KNOW THE DIFFERENCE BETWEEN A GENE AND A CHROMOSOME; HOWEVER, I AM GOING TO ASSUME THAT THE WORDS "DESTROY" AND "INACTIVATE" ARE ALMOST SYNONYMOUS.

OTHER THAN THE DIFFERENCE OF OPINION I HAD WITH THE NATIONAL INSTITUTES OF HEALTH IN 1993 REGARDING THE NATURE OF ACETALDEHYDE, NO ONE TO WHOM I HAVE MAILED MY RESEARCH (SEE PAGE 30) HAS WRITTEN OR CALLED TO TELL ME THAT I HAVE MADE ANY MIS-STATEMENTS OF SCIENTIFIC OR MEDICAL FACT.

ON DECEMBER 21, 1995 I WENT TO THE LIBRARY AT THE INDIANA UNIVERSITY SCHOOL OF MEDICINE, NORTHWEST CAMPUS, GARY. I WANTED TO SEE WHAT REFERENCES MIGHT BE PULLED UP ON THE COMPUTER RELATIVE TO "DISULFIRAM" AND HIV OR AIDS. THE "AIDSLINE DATA BASE" OF THE NATIONAL LIBRARY OF MEDICINE WAS UTILIZED; THE LIBRARIAN KINDLY HELPED ME OUT.

THE PRINTER WHIPPED OUT A FEW ABSTRACTS; UNFORTUNATELY, THE WORDS, "KEYSTONE CONFERENCE" WERE NOT MENTIONED IN ANY OF THEM; HOWEVER, THE PRINT-OUT DID REVEAL THAT A BOOK ENTITLED:

DISULFIRAM AND ITS METABOLITE DIETHYLDITHIOCARBAMATE:
PHARMACOLOGY AND STATUS IN THE TREATMENT OF ALCOHOLISM,
HIV INFECTIONS, AIDS AND HEAVY METAL TOXICITY. 1st ed.
BY P.K. GESSNER AND T. GESSNER, CHAPMAN & HALL PUBLISHERS, 1992
LONDON AND NEW YORK, 452 PAGES

HAS BEEN WRITTEN.

AS I LEFT THE LIBRARY AND STARTED TO DRIVE HOME, SOMEWHAT DISAPPOINTED, I THOUGHT OF SOMETHING ELSE WHICH I WANTED TO FIND OUT FROM THE COMPUTER. I DROVE AROUND THE BLOCK, PARKED THE CAR AND WENT BACK INTO THE LIBRARY. THE LIBRARIAN WAS ABOUT TO LEAVE FOR THE DAY, BUT AGAIN SHE KINDLY HELPED ME OUT.

THIS TIME I REQUESTED THAT SHE ENTER THE WORDS "ACETALDEHYDE" AND HIV OR AIDS. AGAIN, THE PRINTER WHIPPED OUT THE ABSTRACTS.

ON THE FOLLOWING PAGE I HAVE INCLUDED TWO OF THEM. I DID NOT REALIZE THEIR SIGNIFICANCE UNTIL I RE-READ THEM A FEW TIMES; THE UNDER-LINING IS MINE. I AM INDEBTED TO THESE JAPANESE RESEARCHERS - A. TASHIRO, S. SHOJI AND Y. KUBOTA. ACETOALDEHYDE IS THE SAME THING AS ACETALDEHYDE.

AFTER YOU READ THESE ABSTRACTS YOU MUST WONDER - HAS ANY CHEMICAL YET BEEN DISCOVERED THAT CAN INACTIVATE HIV AS EFFECTIVELY AS ACETALDEHYDE?

USE WHATEVER WORD YOU WANT - "DESTROY" OR "INACTIVATE" - ACETALDEHYDE WILL DO IT TO THE VIRUS WHICH CAUSES AIDS - HIV.

MIGHT I BE MORE CORRECT AND ACCURATE IF I WERE TO SAY, "HIV CANNOT REPLICATE WHEN ACETALDEHYDE IS PRESENT".

AS I HAVE MENTIONED, THE BOOK, DISULFIRAM AND ITS METABOLITE DIETHYLDITHIOCARBAMATE HAS BEEN WRITTEN AND IS CURRENTLY AVAILABLE. I CALLED A LOCAL BOOKSTORE AND FOUND OUT THAT THE TOTAL PRICE IS \$148.00; I WILL TRY TO OBTAIN A COPY OF THIS BOOK THROUGH INTER-LIBRARY LOAN.

I DISLIKE GAMBLING, BUT, I WOULD BE WILLING TO BET THAT THE WORD, "ACETALDEHYDE", IS NEVER MENTIONED ON ANY ONE OF THE 452 PAGES OF THIS BOOK. HOW MUCH TO BET? LET'S SAY \$148.00; IF I AM RIGHT, I WILL KEEP THE MONEY; IF I AM WRONG, I WILL DONATE THE \$148.00 TO CRIA.

y
PROG:

3

SI - MED/90121218

AU - Tashiro A

AU - Shoji S

AU - Kubota Y

TI - Antimyrystoylation of the gag proteins in the human immunodeficiency virus-infected cells with N-myristoyl glycinal diethylacetal resulted in inhibition of virus production.

AB - The gag proteins of human retroviruses such as human immunodeficiency virus (HIV-1) are specifically myristoylated in their amino termini (1, 2, 3). N-myristoyl glycinal diethylacetal (N-Myr-GOA) and other N-Myr-compounds (N-Myr-Gly-GOA, N-Myr-Gly-Gly-GOA and N-Myr-Gly-Gly-Gly-GOA) were newly synthesized and investigated for activity of antimyrystoylation of these gag proteins and for influence on viral replication. Of the N-Myr-compounds tested, N-Myr-GOA most severely inhibited the protein myristoylation; N-Myr-Gly-GOA also inhibited it, but moderately. Furthermore, it was observed that N-Myr-GOA at 20 microM caused noticeable inhibition (about 80%) of the production of mature HIV in the HIV-1-infected MT-4 cells. In this system, N-Myr-GOA substantially inhibited more than 90% of the N-myristoylation of p17 gag protein produced in the HIV-1-infected MT-4 cells. These results suggest that the N-myristoylation of p17 gag protein of HIV-1 may be essential in its structural assembly or maturation.

SO - Biochem Biophys Res Commun. 1989 Dec 29;165(3):1145-54.

4

SI - MED/89033966

AU - Shoji S

AU - Tashiro A

AU - Kubota Y

TI - Antimyrystoylation of gag proteins in human T-cell leukemia and human immunodeficiency viruses with N-myristoyl glycinal diethylacetal.

AB - N-Myristoyl (N-Myr-) glycinal (aminoacetaldehyde, GO) diethylacetal (A), which is abbreviated as N-Myr-GOA, and other N-Myr-compounds (N-Myr-Gly-GOA, N-Myr-Gly-Gly-GOA, and N-Myr-Gly-Gly-Gly-GOA) were newly synthesized and then employed for NH₂-terminal antimyrystoylation of structure proteins in the human T-cell leukemia virus (HTLV-I) and the human immunodeficiency virus (HIV). The protein myristoylation of structure proteins p19gag, of HTLV-I, and p17gag, of HIV, was determined separately, using radiolabeled myristic acid, in vitro. The radiolabeled proteins, after immunoprecipitation with an antiserum to adult T-cell leukemia (ATL) or the anti-p17gag monoclonal antibody of HIV, were identified as p19gag of HTLV-I and p17gag of HIV by fluorography after SDS-polyacrylamide gel electrophoresis (SDS-PAGE). The protein myristoylation was resistant to NH₂OH-treatment. Of the N-Myr-compounds tested, N-Myr-GOA remarkably prevented the myristoylation of p19gag and p17gag, but N-Myr-Gly-Gly-GOA and N-Myr-Gly-Gly-Gly-GOA did not.

SO - J Biochem (Tokyo). 1988 May;103(5):747-9.

SS 2 /C?

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THE ABSTRACTS OF THE RESEARCH OF THESE JAPANESE SCIENTISTS CONTAIN A WORD WHICH I HAVE NEVER HEARD OF BEFORE - MYRISTOYLATION. I HAVE CONSULTED SEVERAL DICTIONARIES BUT HAVE COME UP EMPTY HANDED.

I AM GOING TO MAKE A SURMISE AS TO WHAT THIS WORD MEANS BY EXAMINING ITS DERIVATION.

THE WORLD BOOK DICTIONARY STATES THAT "MYRISTIC" IS "OF OR DERIVED FROM THE NUTMEG." THIS IS TRACED BACK TO MEDIEVAL LATIN IN WHICH "MYRISTICA" MEANS NUTMEG TREE.

A PHOTOGRAPH OF NUTMEGS APPEARS ON THE FOLLOWING PAGE.

ON THE FOLLOWING PAGE IS ALSO A PHOTOGRAPH OF CELL DIVISION. DOESN'T STAGE 3, THE METAPHASE, LOOK LIKE A NUTMEG? I AM GOING TO SURMISE THAT MYRISTOYLATION DESCRIBES THE APPEARANCE OF THE CELL AT THIS STAGE - IT LOOKS LIKE A NUTMEG, AND IT IS READY TO DIVIDE.

AM I RIGHT OR WRONG? IF I AM RIGHT, COULD WE SAY THAT THE SAME DESCRIPTION WOULD APPLY TO A VIRAL BODY WHEN IT IS AT THIS STAGE? THEN, ANYTHING THAT HAD THE POWER OF "ANTIMYRISTOYLATION" WOULD PREVENT A UNIT OF LIFE FROM REACHING THAT STAGE OF DEVELOPMENT WHEREIN IT DIVIDED (REPLICATED) ITSELF.

THEN AGAIN, I COULD BE ENTIRELY WRONG ABOUT THIS. ANOTHER ABSTRACT I READ SAID THAT MYRISTOYLATION HAS TO DO WITH "LIPID MODIFICATION".

IN ANY EVENT, THESE JAPANESE ABSTRACTS TELL US THAT ACETALDEHYDE IS PART OF A COMPOUND, ABBREVIATED (N-MYR-GOA), THAT "REMARKABLY PREVENTED" MYRISTOYLATION WITH THE RESULT THAT "VIRAL REPLICATION" WAS "SEVERELY INHIBITED".

IN OTHER WORDS, HIV, WHICH IS THE VIRUS WHICH IS THE ROOT CAUSE OF AIDS, CANNOT BEGIN TO MULTIPLY AS LONG AS A CERTAIN COMPOUND CONTAINING ACETALDEHYDE IS PRESENT.

THERE IS ONLY ONE PROBLEM WITH ACETALDEHYDE - IT IS A POISON CAPABLE OF CAUSING DEATH.

AS DR. WHITESCARVER STATED IN HIS LETTER:

"THE HIGH TOXICITY OF ACETALDEHYDE MAKES IT A SIGNIFICANTLY LESS DESIRABLE CANDIDATE FOR USE IN INDIVIDUALS WHO SUFFER FROM SEVERELY WEAKENED IMMUNE SYSTEMS AND WHO ARE PRONE TO CONTRACTING NUMEROUS OPPORTUNISTIC INFECTIONS AND MALIGNANCIES."

WHAT IF THE DEADLY NATURE OF ACETALDEHYDE COULD SOMEHOW BE NULLIFIED? I THINK THE MEANS IS AT HAND - I HAVE LABELLED IT "THE SPRINCE RATIO". PLEASE REFER TO PAGE 34.

I WISH TO ASK A SIMPLE QUESTION - WHY DIDN'T ALL OF THOSE 30 RATS DIE AFTER BEING POISONED WITH A LETHAL DOSE OF ACETALDEHYDE? (I AM SPECIFICALLY REFERRING TO "TABLE 2", COMBINATION GROUP "CB3") OR PERHAPS THE BETTER QUESTION TO ASK IS - HOW WERE ALL THOSE 30 RATS ABLE TO LIVE AFTER BEING POISONED WITH A LETHAL DOSE OF ACETALDEHYDE?

I THINK THE ANSWER SOMEHOW INVOLVES ASCORBIC ACID (VITAMIN C), CYSTEINE AND THIAMIN; I THINK THE ANSWER ALSO INVOLVES "ACETYL COENZYME A" - SEE PAGE 7.

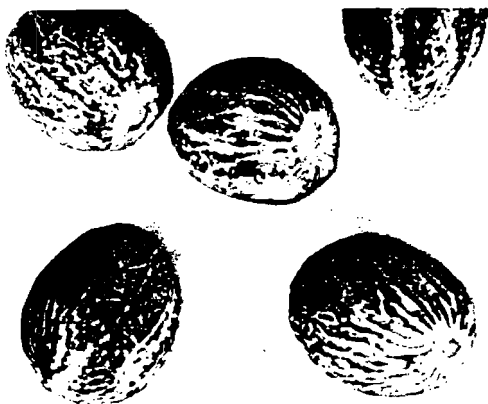
SPRINCE'S RESEARCH, "PROTECTIVE ACTION OF ASCORBIC ACID (VITAMIN C - j.s.r.) AND SULFUR COMPOUNDS AGAINST ACETALDEHYDE TOXICITY: IMPLICATIONS IN ALCOHOLISM AND SMOKING", STATES:

- A. "CURRENTLY, THE PHYSICIANS' DESK REFERENCE OF 1974 RECOMMENDS A HIGH DOSE OF ASCORBIC ACID (1g) FOR MANAGEMENT OF THE SEVERE EFFECTS OF THE DISULFIRAM-ETHANOL REACTION." p.168
(THIS REACTION IS CAUSED BY UNMETABOLIZED ACETALDEHYDE; IN 1995 THE RECOMMENDATION IS STILL 1g - j.s.r.)

GENETICS

TRAIT TRANSMISSION IN THE DIVISION OF BODY CELLS

NUTMEG is the kernel of a tropical fruit, which is widely used as a spice. When the fruit is ripe it looks like a golden-yellow pear hanging among shiny, gray-green leaves. The tree grows to be as much as 70 feet high and is an evergreen. The trees originally grew in the Molucca (Spice) Islands, but they have been successfully raised in all of the East Indies, the West Indies,



J. R. Watkins Co.

Kernels of Nutmeg provide the spice used in cooking. A membrane covering the kernel provides mace, another spice.

Brazil, Ceylon, and India. Nutmeg trees have long, pointed leaves with well-marked veins. The pale-yellow flowers droop in clusters, and look like lilies of the valley.

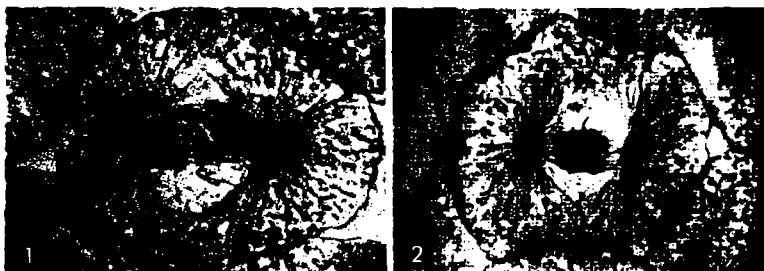
As the fruit ripens, the fleshy part becomes rather hard, somewhat like candied fruit. It finally splits open at the top, showing a bright-scarlet membrane, which partly covers the nut. The spice called *mace* comes from this membrane. The kernels are the familiar household nutmegs.

Nutmeg trees do not begin bearing until they are about nine years old. Each tree produces from 1,500 to 2,000 nuts yearly. The fleshy part of the fruit is often preserved and eaten like candy. A clear oil, called *oil of mace*, is made from the kernel.

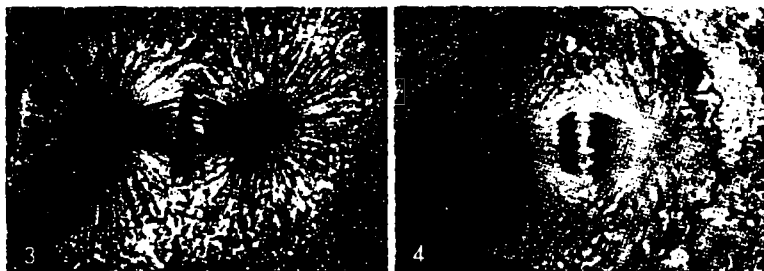
Scientific Classification. Nutmeg trees belong to the nutmeg family, *Myristicaceae*. They are genus *Myristica*, species *M. fragrans*.

HAROLD NORMAN MOLDENKE

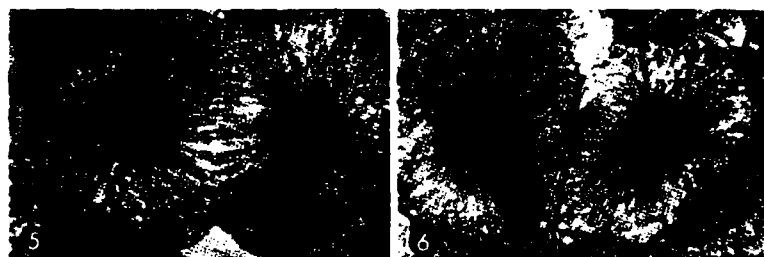
See also MACE.



First, strands of deoxyribonucleic acid (DNA), which carry genetic "messages" and appear as granular chromatin, thicken, shorten, and duplicate themselves. Centrioles and asters take up positions at opposite ends of the cell, or poles. 1. As the beginning stage, or prophase, continues, the DNA strands and associated nucleoproteins form visible chromosomes. 2. At the end of the prophase, the chromosomes are linked to the poles by a football-shaped series of fibers called the spindle.



These micrographs show the first steps in cell division. 3. In the metaphase, the chromosomes form a flat plate, here seen edgewise. It lies at the middle of the spindle, whose fibers now are clearly visible. The original chromosomes and their duplicates lie along the plane. 4. In the anaphase, the two sets of chromosomes are pulled apart by the spindle fibers, allowing one set of chromosomes to go into each cell.

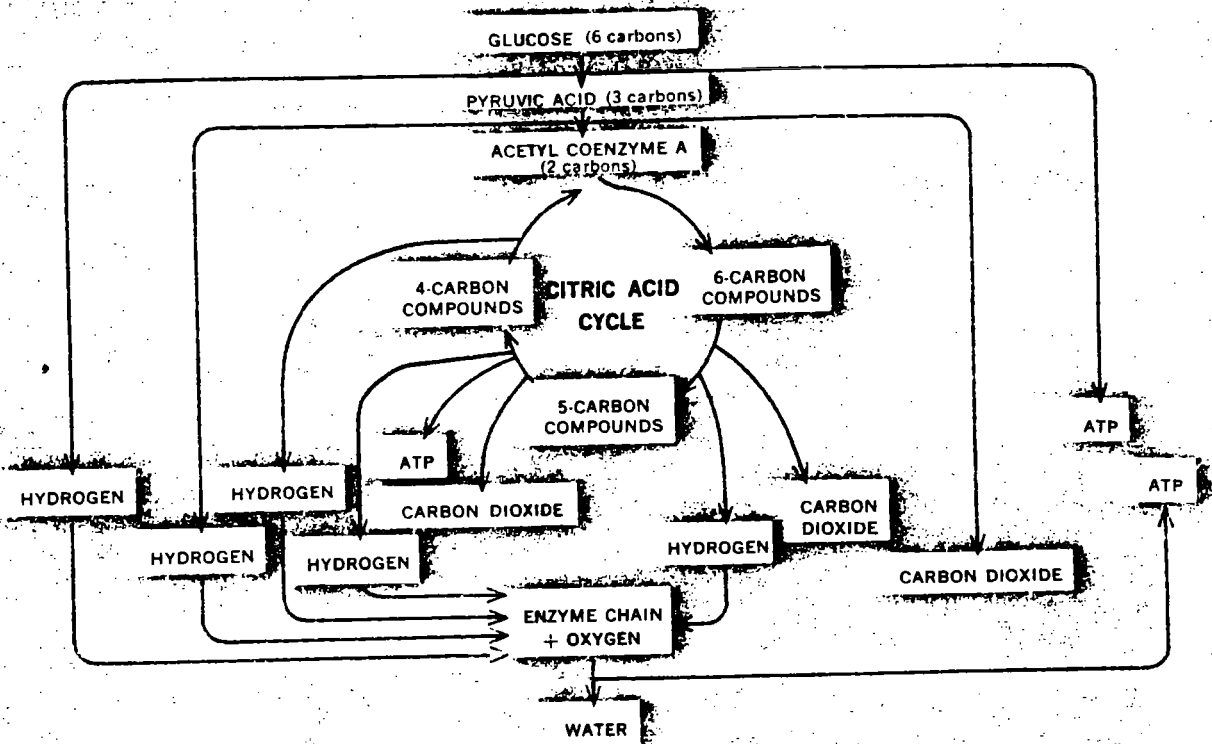


Cell division is completed in the telophase. 5. The two sets of chromosomes are drawn to their respective poles, and the spindle begins to disappear. The cell membrane pinches at mid-cell. 6. The membrane has pinched so far that the cell will soon be divided, and the chromosomes are starting to spread and thin.

THE WORLD BOOK ENCYCLOPEDIA
VOLUME 14, PAGE 465
1973 EDITION

COMPTON'S ENCYCLOPEDIA
VOLUME 11, PAGE 43d
1975 EDITION

INTERNAL RESPIRATION



"AN ADULT MAN, FOR EXAMPLE, IS COMPOSED OF MORE THAN 100 TRILLION DIFFERENT CELLS."
MERIT STUDENTS ENCYCLOPEDIA, VOLUME 4, PAGE 278, 1990 EDITION

"INTERNAL RESPIRATION OCCURS INSIDE EVERY LIVING CELL. IT CONSISTS OF A SERIES OF CHEMICAL REACTIONS IN WHICH THE ENERGY IN FOOD MOLECULES IS RELEASED A STEP AT A TIME."

MERIT STUDENTS ENCYCLOPEDIA, VOLUME 15, PAGE 592, 1990 EDITION

THE FORMULA FOR ACETALDEHYDE IS CH_3CHO . IT CONTAINS TWO CARBON ATOMS.

"ACETYL COENZYME A (Co A), ACETYL DERIVATIVE OF COENZYME A, A SULFUR-CONTAINING NUCLEOTIDE, THAT IS A PRECURSOR IN THE METABOLISM OF FATTY ACIDS, CARBOHYDRATES, AND PROTEINS, BEING AN IMPORTANT INTERMEDIATE IN THE KREBS' CYCLE. COENZYME A FUNCTIONS AS A CARRIER OF THE 2-CARBON ACETYL GROUP, WHICH IS ATTACHED TO THE SULFUR GROUP."

THE RANDOM HOUSE ENCYCLOPEDIA, PAGE 1880, 1977

N-ACETYL CYSTEINE IS A MORE STABLE FORM OF THE SULFUR AMINO ACID L-CYSTEINE, AND IS A POWERFUL ANTIOXIDANT. IT IS AN EXCELLENT PRECURSOR OF GLUTATHIONE, ANOTHER MAJOR ANTIOXIDANT. GLUTATHIONE IS ALSO THE PRECURSOR, WITH SELENIUM, OF GLUTATHIONE PEROXIDASE, ONE OF THE MOST IMPORTANT ANTIOXIDANT ENZYMES IN THE BODY.

- B. "BIOCHEMICALLY, IT HAS ALREADY BEEN SUGGESTED THAT CYSTEINE CAN PROTECT COENZYME A AGAINST ACETALDEHYDE INHIBITION BY COMPLEXING PREFERENTIALLY WITH ACETALDEHYDE. PRESUMABLY, REDUCED GLUTATHIONE, HOMOCYSTEINE, AND N-ACETYL-CYSTEINE COULD ALSO COMPLEX WITH ACETALDEHYDE BY VIRTUE OF THEIR FREE (-SH) GROUPS." p.168
- C. "THIAMIN COULD ALSO SERVE AS A PROTECTANT AGAINST ACETALDEHYDE FOR SOME VERY GOOD REASONS. THUS, AS COCARBOXYLASE (PYROPHOSPHATE) IT IS BELIEVED TO COMPLEX NORMALLY WITH ACETALDEHYDE TO EVENTUALLY FORM ACETYL COENZYME A BY WAY OF THE LIPOIC (THIOCTIC) ACID PATHWAY." p.16
- D. "THIS POSSIBILITY IS SUPPORTED BY REPORTS THAT ASCORBIC ACID HAS A THIAMIN-SPARING ACTION IN VIVO WHICH MAY DUE TO THIAMIN DISULFIDE ACTIVATION IN TISSUES BY CYSTEINE." p.169
- E. "FINALLY, IT IS IMPORTANT, TOO, TO REMEMBER THAT CYSTEINE BY COMPLEXING WITH ACETALDEHYDE MAY PROTECT THE (-SH) GROUPS OF COENZYME A AND REDUCED LIPOIC ACID, BOTH OF WHICH ARE ASSOCIATED WITH THIAMIN PYROPHOSPHATE ACTIVITY. THUS, COMBINATIONS OF ASCORBIC ACID, CYSTEINE, AND THIAMIN IN CERTAIN RATIOS COULD FUNCTION MORE EFFECTIVELY THAN ANY OF THESE COMPOUNDS ALONE AS PROTECTANTS AGAINST ACETALDEHYDE." p.16

AM I CORRECT ABOUT THIS? - THERE SEEMS TO BE SOME SORT OF AN INTRINSIC AND UNIQUE BIOCHEMICAL RELATIONSHIP THAT COULD BE SAID TO EXIST BETWEEN ACETYL-COENZYME A AND ACETALDEHYDE.

ACETALDEHYDE IN COMBINATION WITH ASCORBIC ACID, CYSTEINE AND THIAMIN MIGHT EVENTUALLY BE RECOGNIZED AS THE MOST FELICITOUS, UNIQUE AND USEFUL POISON KNOWN TO MAN.

WHEN YOU READ THIS FILE YOU WILL NOTE THAT I HAVE DESCRIBED TWO PROCEDURES:

"A MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV."

"AN INTENSIVE APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV."

THREE YEARS AGO I HAD A HUNCH ABOUT ACETALDEHYDE. IT IS MY PRESENT HUNCH THAT THE "INTENSIVE APPLICATION" COULD BE ADMINISTERED SAFELY; THE ONLY SIDE EFFECT MIGHT BE THAT THE PATIENT OR PATIENTS WOULD BECOME A LITTLE BIT SLEEPY.

HOWEVER, IN CASE THE MEDICAL COMMUNITY WOULD STILL CONSIDER THE "INTENSIVE APPLICATION" TOO RISKY TO IMPLEMENT, I WISH THEN TO CONCLUDE BY FOCUSING UPON THE "MILD APPLICATION". ALTHOUGH THEY WOULD NOT BE AS DRAMATIC AS THOSE (WHICH I THINK WOULD BE) ENGENDERED BY THE "INTENSIVE APPLICATION", THERE SHOULD, NEVERTHELESS, BE SOME POSITIVE RESULTS.

FIRST, I AM GOING TO MAKE THREE ASSUMPTIONS -

1. IN AND OF ITSELF, ALONG AS ALCOHOL IS NOT DRUNK, THERE IS NO HARM IN "PLUGGING UP" THE LIVER WITH ANTABUSE.
2. THE PRESENCE OF ANTABUSE IN THE LIVER WOULD NOT HINDER THE EFFECT WHICH MEDICINES MIGHT HAVE IN WARDING OFF THE OPPORTUNISTIC INFECTIONS ENGENDERED BY HIV/AIDS.

3. THERE IS ENOUGH ACETALDEHYDE IN THE FOODS LISTED BY THE "JOURNAL OF APPLIED TOXICOLOGY", OCTOBER, 1991, PAGE 374 TO DO SOME GOOD. TO QUOTE THIS JOURNAL AGAIN:

'ACETALDEHYDE HAS BEEN IDENTIFIED IN OAK LEAVES, TOBACCO, APPLES, BROCCOLI, COFFEE, GRAPES, GRAPEFRUIT, ORANGES, LEMONS, ONIONS, PEACHES, PEARS, PINEAPPLES, RASPBERRIES, STRAWBERRIES ANY MANY SPICES. EUROPEAN BEERS HAVE BEEN FOUND TO CONTAIN AS MUCH AS 13.5 mg/l(-1). THE ACCEPTABLE DAILY INTAKE RECOMMENDED BY FAO/WHO IS 0.0-2.5 mg kg(-1) BODY WEIGHT.'

THE PATIENT WILL TRY TO INCLUDE AS MANY OF THESE FOODS AS IS PRACTICAL INTO HIS OR HER DIET; THE PATIENT MIGHT BECOME NAUSEOUS FROM TIME TO TIME, BUT THIS IS TO BE EXPECTED. THE UNMETABOLIZED ACETALDEHYDE FLOWING IN THE BLOODSTREAM WOULD BE THE CAUSE OF THIS NAUSEA.

WHAT THEN DOES THE "MILD APPLICATION" INVOLVE? THE ANSWER IS SIMPLY THIS - GOOD HEALTH AND NUTRITIONAL HABITS.

IN MY FILE I MENTION THAT CIGARETTE SMOKING SHOULD BE AVOIDED BECAUSE IT DEPLETES THE BODY OF VITAMIN C. I NOW THINK THAT IT IS IMPRACTICAL TO ASK A PERSON TO STOP SMOKING; INSTEAD, I WOULD RECOMMEND THAT HE OR SHE SUPPLEMENT THEIR DIET WITH VITAMIN C TABLETS. HOWEVER, A SMOKER MIGHT HAVE TO BE VERY CAREFUL; REMEMBER THAT THE "JOURNAL OF APPLIED TOXICOLOGY" LISTED TOBACCO AS CONTAINING ACETALDEHYDE, AND TOO MUCH SMOKING, WITH ANTABUSE IN THE LIVER, MIGHT HAVE A SERIOUS SIDE EFFECT UNLESS THE BODY WAS BEING REPLENISHED WITH ASCORBIC ACID (VITAMIN C), CYSTEINE AND THIAMINE.

ORANGE JUICE, OF COURSE, CONTAINS AN ABUNDANT SUPPLY OF VITAMIN C. CYSTEINE AND THIAMINE CAN BE OBTAINED, WITHOUT PRESCRIPTION, FROM ANY HEALTH FOOD STORE.

WITH THE "MILD APPLICATION" THE PATIENT WILL EASILY ACQUIRE VITAMIN C, AND, UPON REFLECTION, I THINK IT WOULD DO NO HARM TO INCLUDE ALSO CYSTEINE AND THIAMINE IN THE DIET; THESE INGREDIENTS ARE, OF COURSE, ABSOLUTELY ESSENTIAL IN THE "INTENSIVE APPLICATION".

IN MY FILE I RECOMMEND THAT ZINC TABLETS BE TAKEN. I HAVE SINCE DISCOVERED THAT CASHEWS ARE RICH IN ZINC.

I THINK A DIETARY DEFICIENCY IN ZINC MIGHT PREDISPOSE A DRINKER TO BECOME AN ALCOHOLIC; SEE PAGE 27 OF MY FILE.

HERE ARE TITLES OF THREE ABSTRACTS RELATIVE TO ZINC WHICH I FOUND IN THE "JOURNAL OF CELLULAR BIOCHEMISTRY", SUPPLEMENT 21B, 1995, APRIL 2-23, 1995 OF THE KEYSTONE SYMPOSIA ON MOLECULAR & CELLULAR BIOLOGY:

'A NOVEL ZINC FINGER PROTEIN LOCALIZED IN DISCRETE NUCLEAR DOMAINS IN DEVELOPING OLIGODENDROCYTES' p.139

'RETROVIRAL NUCLEOCAPSID PROTEINS WITH CCCC OR CCHH TYPE Zn++ FINGERS FUNCTION IN RNA PACKAGING BUT RENDER VIRUS PARTICLES NON-INFECTIONOUS' p.190

'A NEW CLASS OF ANTI-VIRAL DRUGS ATTACK HIGHLY CONSERVED ZINC FINGERS IN RETROVIRAL NUCLEOCAPSID PROTEINS' p.191

IT IS MY HUNCH THAT A DIETARY DEFICIENCY OF ZINC WILL EXACERBATE HIV/AIDS.

WHEN INTERVIEWED BY DR. PASSWATER ("WHOLE FOODS"/SEPTEMBER, 1995, pp. 50-65) DR. MONTAGNIER, THE DISCOVERER OF HIV, MENTIONED THE FOLLOWING NUTRIENTS ON PAGE 56 - SELENIUM, ZINC, BETA CAROTENE, VITAMINS A, C AND E, ENZYMES SUPEROXIDE DISMUTASE (SOD) AND CATALASE, AND PROTEINS SUCH AS METALLOTHIONINE.

ON PAGE 56 DR. PASSWATER ALSO ASKED THIS QUESTION OF DR. MONTAGNIER:

"WHAT SORTS OF INVESTIGATIONS HAVE BEEN MADE WITH NAC (N-ACETYL CYSTEINE j.s.r. OR OTHER ANTIOXIDANTS SUCH AS LIPOIC ACID AND CURCUMIN AS POSSIBLE MEDIATORS OF THE PROGRESSION TO AIDS?"

TO WHICH DR. MONTAGNIER REPLIED:

"WE STARTED SOME OPEN TRIALS WITH NAC FOLLOWING THE WORK OF THE HERZENBERGS AT STANFORD AND THAT OF DROGE IN GERMANY. IN HIV INFECTED PATIENTS, THE GLUTATHIONE SYSTEM IS DEPRESSED EVEN AT EARLY STAGES. THE RATIONALE IS TO RESTORE THE OXIDATIVE PROTECTION SYSTEM BACK TO NORMAL.

"WHEN WE TREAT PATIENTS FOR LESS THAN SIX MONTHS WITH NAC, WE DON'T SEE MUCH CHANGE. HOWEVER, WHEN THE NAC TREATMENT IS LONGER THAN SIX MONTHS, NAC WILL RESTORE APOPTOSIS (DEVELOPMENTAL OR PROGRAMMED CELL DEATH - j.s.r.) BACK TO NORMAL LEVELS. THIS IS A PRELIMINARY RESULT, AND WE WILL REPEAT THE STUDY IN OUR NEW APPLIED RESEARCH LABORATORY. WE PLAN TO OPEN A NEW RESEARCH CENTER AT THE END OF THIS YEAR FOR HIV ASYMPTOMATIC PATIENTS; THERE WE WILL FOLLOW A BATTERY OF LABORATORY MARKERS AND TREAT PATIENTS ACCORDINGLY.

"I AM CONVINCED THAT OXIDATIVE STRESS IS INDEED INVOLVED IN THE PROGRESSION FROM HIV INFECTION TO THE AIDS STAGE. I BELIEVE, THEREFORE, THAT ANTIOXIDANTS ARE NECESSARY IN THE TREATMENT. BUT ANTIOXIDANTS ARE NOT SUFFICIENT BY THEMSELVES."

I WOULD LIKE TO CONCLUDE MY RESEARCH BY SUGGESTING THAT ANTIOXIDANTS AND UNMETABOLIZED ACETALDEHYDE MIGHT BE OF SOME CONSIDERABLE BENEFIT TOWARD RESTORING HIV/AIDS PATIENTS TO A MODICUM OF GOOD HEALTH.

THERE IS NO DOUBT IN MY MIND, WHATSOEVER, THAT ACETALDEHYDE, IN COMBINATION WITH ASCORBIC ACID, CYSTEINE AND THIAMINE WILL EVENTUALLY BE SHOWN TO BE THE MOST USEFUL POISON EVER DEvised BY NATURE FOR THE BENEFIT OF MANKIND.

John S. Robert

NOVEMBER 18, 1995

MR. RICK LOFTUS, RESEARCH ASSOCIATE
CRIA
COMMUNITY RESEARCH INITIATIVE ON AIDS
275 SEVENTH AVENUE
NEW YORK, NY 10001-6708

DEAR MR. LOFTUS,

RECENTLY I HAD ACCESS TO "THE INTERNET". I CAN'T QUITE REMEMBER WHAT I EXACTLY TYPED IN, BUT I THINK IT WAS A COMBINATION OF "KEYSTONE", "AIDS" AND/OR "HIV". EVENTUALLY I BECAME AWARE OF THE NAME, "ANNE DE GROOT".

I CALLED HER, AND SHE GAVE ME THE NAME OF "L.E. HENDERSON" OF FREDERICK, MARYLAND; SHE SPECIFICALLY MENTIONED ABSTRACT D4-127 OF THE "JOURNAL OF CELLULAR BIOCHEMISTRY", SUPPLEMENT 21B, 1995.

SHE ALSO GAVE ME THE ADDRESS AND TELEPHONE NUMBER OF THE KEYSTONE SYMPOSIA IN SILVERTHORNE, COLORADO.

I CALLED DR. LOUIS E. HENDERSON AND DR. JIM BENNETT, DIRECTOR OF THE KEYSTONE SYMPOSIA, AND NEITHER ONE OF THEM IS AWARE OF DISULFIRAM (ANTABUSE) BEING USED IN THE TREATMENT OF HIV/AIDS.

DR. HENDERSON'S ABSTRACT, PAGE 191 IS ENTITLED:

"A NEW CLASS OF ANTI-VIRAL DRUGS ATTACK HIGHLY CONSERVED
ZINC FINGERS IN RETROVIRAL NUCLEOCAPSID PROTEINS".

I DON'T KNOW WHETHER THIS HAS ANY RELEVANCE, BUT IN MY OWN RESEARCH I POINTED OUT THE FACT THAT ZINC WAS AN ESSENTIAL COMPONENT IN THE DIET OF ANYONE WHO DRANK ALCOHOL -

§
"AS ABSORBED ALCOHOL IS PASSED THROUGH THE LIVER BY THE CIRCULATING BLOOD, IT IS ACTED UPON BY ADH (ALCOHOL DEHYDROGENASE),
A ZINC-CONTAINING ENZYME FOUND CHIEFLY IN THE LIVER CELLS....."

ENCYCLOPAEDIA BRITANNICA, MACROPAEDIA, VOLUME 1, PAGE 438, 1974 EDITION

COULD A DIETARY DEFICIENCY OF ZINC EXACERBATE HIV/AIDS?

MR. LOFTUS, AT THIS POINT IN TIME I AM INTRIGUED AS TO THE SOURCE OF YOUR INFORMATION -

".....PRESENTATIONS ON DISULFIRAM ATTRACTED MUCH ATTENTION.....".

SOON, I AM GOING TO FORWARD TO MS. PATRICIA S. FLEMING AND OTHERS AN UPDATE TO MY RESEARCH. IF I HAD SPECIFIC DATA FROM YOU IT WOULD BE MOST HELPFUL.

UNLESS I HEAR DIFFERENTLY FROM YOU I AM GOING TO ASSUME THAT THE "PRESENTATIONS ON DISULFIRAM" DELINEATED POSITIVE RESULTS SIMILAR TO THOSE

FOUND IN THE LANG STUDY ("THE LANCET", SEPTEMBER 24, 1988, PAGES 702-706);
IN THIS CLINICAL TRIAL, LANG EMPLOYED A CHEMICAL "COUSIN" OF DISULFIRAM (ANTABUSE) -
DITIOCARB; TO SUMMARIZE LANG'S FINDINGS:

1. 42% OF THE DITIOCARB RECIPIENTS SHOWED IMPROVEMENT IN THEIR CLINICAL STATUS AS COMPARED TO 5% IN THE PLACEBO GROUP.
2. THE CD4+ CELL COUNT INCREASED IN SOME OF THE PATIENTS.
3. ENLARGED SPLEEN AND LYMPH NODES SHRANK IN SOME OF THE PATIENTS.
4. DIARRHEA DISAPPEARED IN SOME OF THE PATIENTS.
5. SOME OF THE PATIENTS REGAINED WEIGHT.
6. PERSISTENT FEVERS DISAPPEARED IN SOME OF THE PATIENTS.

IF I AM CORRECT ABOUT MY ASSUMPTION THAT THE "PRESENTATIONS ON DISULFIRAM"
DID INDEED LIST POSITIVE RESULTS, THIS THEN JUST MIGHT BE A TANGENTIAL CORROBORATION
OF A HYPOTHESIS WHICH I PROPOSED TO CONGRESSMAN PETER J. VISCLOSKEY OF INDIANA
IN A LETTER DATED JANUARY 19, 1993; IN THAT LETTER I STATED:

"THE HUMAN BODY CAN BE POISONED WITH A HIGHLY TOXIC SUBSTANCE
AND STILL SURVIVE AND THE NAME OF THAT SUBSTANCE IS ACETALDEHYDE."

"IT IS MY HYPOTHESIS THAT WHILE ACETALDEHYDE IS POISONING THE BODY,
IT WILL AT THE SAME TIME DESTROY THE AIDS VIRUS."

SINCE 1993 I HAVE BECOME AWARE THAT THE CORRECT BIOLOGICAL TERM IS
"INACTIVATE" NOT "DESTROY" WHEN REFERRING TO A VIRUS.

BOTH THE NATIONAL INSTITUTES OF HEALTH AND THE CENTERS FOR DISEASE CONTROL
HAVE ACKNOWLEDGED TO ME THAT ACETALDEHYDE CAN INACTIVATE HIV.

IN MY RESEARCH I DESCRIBED TWO PROCEDURES ("INTENSIVE" AND "MILD")
WHEREIN I THOUGHT ACETALDEHYDE MIGHT BE SAFELY EMPLOYED TO INACTIVATE HIV.

MY PRESENT GOAL IS TO TRY TO CONVINCE SOMEONE/SOMEWHERE WITH MEDICAL
EXPERTISE AND/OR AUTHORITY TO CONDUCT A 16 WEEK CLINICAL TRIAL OF THE
"MILD" PROCEDURE; TO RECAPITULATE IT BRIEFLY - IN THIS PROCEDURE THE PATIENT
WOULD TAKE ANTABUSE TABLET ONCE A DAY, WOULD REFRAIN FROM DRINKING ALCOHOL,
WOULD REFRAIN FROM EATING ANYTHING WITH SUGAR IN IT, WOULD REFRAIN FROM SMOKING
CIGARETTES (SMOKING DEPLETES THE BODY OF VITAMIN C), WOULD REFRAIN FROM EATING
FOODS WITH FOOD ADDITIVES SUCH AS MSG (MONOSODIUM GLUTAMATE), WOULD TAKE
ZINC SUPPLEMENTS AND WOULD MAKE THESE FOODS PART OF HIS OR HER DIET - APPLES,
BROCCOLI, GRAPES, GRAPEFRUIT, ORANGES, LEMONS, ONIONS, PEACHES, PEARS,
PINEAPPLES, RASPBERRIES AND STRAWBERRIES.

IF MY HYPOTHESIS IS CORRECT, AND SINCE THESE FOODS NATURALLY CONTAIN
ACETALDEHYDE, THERE SHOULD BE SOME SLIGHT IMPROVEMENT IN THE PATIENT'S HEALTH
AFTER 16 WEEKS OF THIS REGIMEN.

YOURS TRULY,

John S. Roberts

JOHN S. ROBERTS
POST OFFICE BOX 7
HOBART, INDIANA 46342
219-763-1933

COPIES TO:

MS. PATRICIA S. FLEMING, THE WHITE HOUSE
CONGRESSMAN PETER J. VISCLOSKEY
PROFESSOR ANNE DE GROOT, M.D., BROWN UNIVERSITY
LOUIS E. HENDERSON, Ph.D., FREDERICK CANCER RESEARCH DEVELOPMENT CENTER
JAMES BENNETT, Ph.D., DIRECTOR, KEYSTONE SYMPOSIA

THE WHITE HOUSE
WASHINGTON

OCT 18 1995

Mr. John S. Roberts
Post Office Box H
Hobart, IN 46342

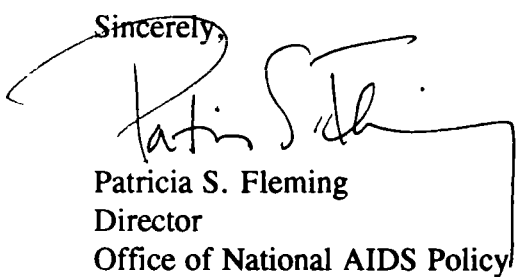
Dear Mr. Roberts:

Thank you for your letter of September 18. I appreciate your interest in finding a cure for AIDS. This is a goal we all share most strongly.

It is important to assess any potential avenue of research. In their correspondence with you, the Office of AIDS Research at the National Institutes of Health has expressed its views regarding the potential of your proposed approach. Should any new information develop, I encourage you to share it with the NIH.

Thanks again for your interest.

Sincerely,



Patricia S. Fleming
Director
Office of National AIDS Policy

n:g1926

OCTOBER 1, 1995

MR. RICK LOFTUS, RESEARCH ASSOCIATE
CRIA
COMMUNITY RESEARCH INITIATIVE ON AIDS
275 SEVENTH AVENUE
NEW YORK, NY 10001-6708

DEAR MR. LOFTUS,

THANK YOU FOR YOUR LETTER OF SEPT. 21, 1995 (COPY ATTACHED).

IN MY LETTER WHICH I WRITE TO YOU TODAY I SHALL BE REFERRING TO A SEPTEMBER 4, 1995 LETTER WHICH I MAILED TO CONGRESSMAN PETER J. VISCLOSKEY OF INDIANA AND VARIOUS OTHER SCIENTISTS, GOVERNMENT OFFICIALS AND ORGANIZATIONS; IT CONSISTS OF 17 PAGES.

IF PERCHANCE ANY OF THOSE TO WHOM I MAIL A COPY OF THIS LETTER (OCTOBER 1) DID NOT RECEIVE THAT SEPTEMBER 4 LETTER, JUST LET ME KNOW, AND I WILL MAIL TO THEM A COPY OF IT.

IN YOUR LETTER YOU STATE:

"YOU ARE PROBABLY AWARE THAT PRESENTATIONS ON DISULFIRAM ATTRACTED MUCH ATTENTION DURING THE MOST RECENT KEYSTONE CONFERENCE ON AIDS PATHOGENESIS, THIS PAST SPRING."

I AM NOT AWARE OF THE "KEYSTONE CONFERENCE" AND ITS FINDINGS RELATIVE TO DISULFIRAM (ANTABUSE). WAS THE WORD "ACETALDEHYDE" EVER MENTIONED DURING THIS CONFERENCE? ON PAGE 7 OF MY SEPTEMBER 4 LETTER I STATED:

"THUS FAR, I HAVE FAILED TO TURN UP ONE INSTANCE IN ANY OF THE PUBLISHED LITERATURE WHEREIN 'ACETALDEHYDE' IS MENTIONED IN THE SAME CONTEXT WITH 'HIV' AND/OR 'AIDS' AND/OR 'DITIOCARB';"

WERE THE PRESENTATIONS AT THE KEYSTONE CONFERENCE PUBLISHED? IF SO, I WOULD BE MOST INTERESTED IN KNOWING THE SOURCE. MR. LOFTUS, ANY HELP WHICH YOU COULD AFFORD ME WOULD BE MUCH APPRECIATED.

IT IS MY PRESENT GOAL TO INTEREST SOMEONE/SOMEWHERE WITH MEDICAL EXPERTISE AND/OR AUTHORITY IN LAKE AND PORTER COUNTY, INDIANA AND COOK COUNTY, ILLINOIS TO INITIATE A CLINICAL TRIAL OF THE PROCEDURE WHICH I CALL ON PAGE 7 OF MY SEPTEMBER 4 LETTER -

"A MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV".

MY ULTIMATE GOAL, OF COURSE, IS TO HAVE INITIATED A CLINICAL TRIAL OF THE PROCEDURE WHICH I CALL ON PAGE 4 OF MY SEPTEMBER 4 LETTER -

"AN INTENSIVE APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV".

IF SUCH A TRIAL EVER WOULD PROVE TO BE SUCCESSFUL, I SHALL BE INDEBTED TO PROFESSOR RUSSELL F. MANKES OF THE ALBANY MEDICAL COLLEGE AND RICHARD A. PASSWATER, Ph.D. OF THE SOLGAR NUTRITIONAL RESEARCH CENTER.

A JANUARY 1, 1993 NEWSPAPER ARTICLE, WHICH QUOTED PROFESSOR MANKES, MADE ME AWARE OF ACETALDEHYDE. AND, AS I STATED ON PAGE 4 OF MY SEPTEMBER 4 LETTER:

"AS RICHARD A. PASSWATER, Ph.D., STATED ON PAGE 128 OF HIS BOOK, SUPER-NUTRITION (DIAL PRESS, 1975; POCKET BOOK, 1976):

'A COMBINATION OF CERTAIN SULFUR AMINO ACIDS AND VITAMIN C GAVE 100 PERCENT PROTECTION AGAINST A STANDARD LETHAL DOSE OF ACETALDEHYDE IN LABORATORY RATS.' "

RECENTLY, DR. PASSWATER WAS KIND ENOUGH TO MAIL TO ME A COPY OF AN INTERVIEW HE HAD ON MAY 3, 1995 WITH DR. LUC MONTAGNIER, THE DISCOVERER OF HIV.

I HAVE ATTACHED A COPY OF THE FIRST PAGE, AND THE COMPLETE ARTICLE CAN BE FOUND ON PAGES 50-65, "WHOLE FOODS", SEPTEMBER, 1995.

MR. LOFTUS, IN YOUR LETTER YOU STATE:

".....THE USE OF SULPHYDRYL-CONTAINING COMPOUNDS TO INHIBIT HIV IS AN APPROACH THAT IS BEING TAKEN SERIOUSLY BY A NUMBER OF INVESTIGATORS NATIONWIDE."

THIS IS JUST A TANGENTIAL REFERENCE; HOWEVER, I WOULD LIKE TO POINT OUT THAT "THE SPRINCE RATIO", WHICH I MENTION OF PAGE 4 OF MY SEPTEMBER 4 LETTER, INCLUDES TWO SULFUR CONTAINING COMPOUNDS. AGAIN, "THE SPRINCE RATIO":

L-ASCORBIC ACID (VITAMIN C)	2.0
L-CYSTEINE FB (A SULFUR COMPOUND)	1.0
THIAMINE.HCL (A SULFUR COMPOUND)	.3

COULD ALL OF THIS HAVE SOMETHING TO DO WITH THE "INTERNAL RESPIRATION" OF EACH CELL WHICH INVOLVES THE "CITRIC ACID CYCLE" AND "ACETYL COENZYME A"?

"ACETYL COENZYME A (Co A), ACETYL DERIVATIVE OF COENZYME A, A SULFUR-CONTAINING NUCLEOTIDE, THAT IS A PRECURSOR IN THE METABOLISM OF FATTY ACIDS, CARBOHYDRATES, AND PROTEINS, BEING AN IMPORTANT INTERMEDIATE IN THE KREBS' CYCLE. COENZYME A FUNCTIONS AS A CARRIER OF THE 2-CARBON ACETYL GROUP, WHICH IS ATTACHED TO THE SULFUR GROUP." (UNDERLINING MINE)

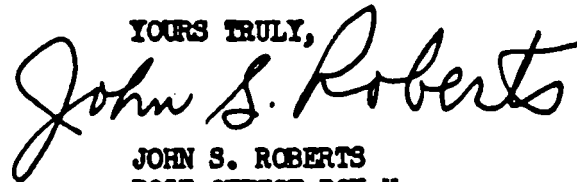
THE RANDOM HOUSE ENCYCLOPEDIA, PAGE 1880, 1977 EDITION

MR. LOFTUS, THANKS AGAIN FOR YOUR LETTER, AND, NEEDLESS TO SAY, I AM MOST CURIOUS TO KNOW THE FINDINGS OF THE KEYSTONE CONFERENCE REGARDING DISULFIRAM (ANTABUSE).

P.S. PROFESSOR MANKES' REFERENCE TO ACETALDEHYDE HAD TO DO WITH A "HANGOVER".

"THE HEADACHE, UPSET STOMACH AND BAD AFTERTASTE THAT ACCOMPANY A HANGOVER COME FROM THE TOXIC BY-PRODUCT OF ALCOHOL, A CHEMICAL CALLED ACETALDEHYDE, SAID RUSSELL MANKES, ASSOCIATE PROFESSOR OF TOXICOLOGY AND PHARMACOLOGY AT THE ALBANY MEDICAL COLLEGE". DR. PASSWATER'S REFERENCE TO ACETALDEHYDE WAS IN THE CONTEXT OF A PARAGRAPH ENTITLED "VITAMIN C DETOXIFIES POISONS".

YOURS TRULY,



JOHN S. ROBERTS
POST OFFICE BOX H
HOBART, INDIANA 46342
219-763-1933

COPIES TO:

PRESIDENT CLINTON, THE WHITE HOUSE
CONGRESSMAN PETER J. VISCLOSKEY, INDIANA
MS. PATRICIA S. FLEMING, NATIONAL AIDS POLICY COORDINATOR, THE WHITE HOUSE
PROFESSOR RUSSELL F. MANKES, Ph.D., THE ALBANY MEDICAL COLLEGE, NEW YORK
RICHARD A. PASSWATER, Ph.D., SOLGAR NUTRITIONAL RESEARCH CENTER, BERLIN, MARYLAND
JEAN-MARIE LANG, HÔPITAL HAUTEPIERRE, STRASBOURG, FRANCE
JACK WHITESCARVER, Ph.D., NATIONAL INSTITUTES OF HEALTH, OFFICE OF AIDS RESEARCH
DAVID SATCHEL, M.D., Ph.D., DIRECTOR, CENTERS FOR DISEASE CONTROL, ATLANTA
MS. JEANNE WHITE, PRESIDENT, RYAN WHITE MEMORIAL FOUNDATION, NOBLESVILLE, INDIANA
AMFAR, NEW YORK CITY, ATTENTION: JEFFREY LAURENCE, M.D., AND ELIZABETH TAYLOR
PEDIATRIC AIDS FOUNDATION, SANTA MONICA, CALIFORNIA
BERNADINE HEALY, M.D., CLEVELAND CLINIC FOUNDATION
MS. BRENDA LEIN, PROJECT INFORM, SAN FRANCISCO
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DAVID ROSS, VOLUNTEER SERVICES, MUSEUM OF SCIENCE AND INDUSTRY, CHICAGO
PROFESSOR PAUL A. VOLBERDING, M.D., DIRECTOR, AIDS PROGRAM, SAN FRANCISCO GENERAL HOSPITAL
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NORTHWESTERN UNIVERSITY MEDICAL SCHOOL, CHICAGO
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DONALD P. FRANCIS, M.D., D.Sc., MEDICAL AFFAIRS DEPARTMENT, GENETECH, SAN FRANCISCO
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F. RITCHEY EIBEL AND JOHN H. BETJEMANN, THE METHODISTS HOSPITALS, NORTHWEST INDIANA
MRS. JOYCE NORRIS, ACWORTH, GEORGIA
ROBERT ERB, LAKE COUNTY AIDS TASK FORCE, INDIANA
DR. LUC MONTAGNIER, INSTITUT PASTEUR, PARIS

AND _____

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Sept. 21, 1995

Mr. John S. Roberts
 POB H
 Hobart IN 46342

Dear Mr. Roberts,

Thank you for your information regarding disulfiram and acetaldehydes for HIV infection.

As you may know, CRIA is involved in a number of independent clinical trials of potential AIDS treatments for all people with HIV. We are studying salicylic acid derivatives as anti-HIV agents, as well as cyclophosphamide to inhibit HIV-associated B-cell hyperactivity. While ongoing work prevents us from initiating any new trials at the moment, we are always on the lookout for new ideas.

You are probably aware that presentations on disulfiram attracted much attention during the most recent Keystone conference on AIDS pathogenesis, this past spring. While I am not aware of any human trials having sprung from this research--at least not yet-- the use of sulfhydryl-containing compounds to inhibit HIV is an approach that is being taken seriously by a number of investigators nationwide.

Sincerely,

Rick Loftus, research associate

Community Research Initiative on AIDS

275 Seventh Avenue, New York, NY 10001-6708 Phone: 212/924-3934 Fax: 212/924-3936

HEALTH CONNECTION

Antioxidant Nutrients and AIDS: Exploring the Possibilities

An interview with Dr. Luc Montagnier,
the discoverer of HIV.

BY RICHARD A. PASSWATER, PH.D.



It doesn't seem like too many years ago that we learned of a dreadful new and mysterious disease that threatened to wipe out mankind. Little was known about this new disease, except that it was spreading rapidly. Some projected that it would be killing us by the millions within a few years and bankrupting our health care system along the way.

Fortunately, this hasn't happened, and a large part of the reason why it has not is due to Dr. Luc Montagnier of the Pasteur Institute in Paris. He and his colleagues discovered the cause of the disease we now call Acquired Immune Deficiency Syndrome (AIDS) and determined how it's transmitted.

AIDS was formally recognized as a new disease on June 5, 1981 when the Centers for Disease Control (CDC) reported that five Los Angeles men had developed an unexplained immune deficiency. It is characterized as the breakdown of the body's immune system due to the decrease of selected cells in the immune system. This decrease results in defects in immune function which then allows "opportunistic" infections that cannot infect people with healthy immune systems to readily infect and soon kill AIDS patients.

During 1980, there were a few reports of certain diseases such as rare cancers and infections leading to quick

"wasting" of the patient and rapid death.^{1,2} There particularly was an increase in cases of *Pneumocystis carinii* pneumonia and herpes simplex. This was followed by an increase in the incidence of Kaposi's sarcoma.

The CDC established a task force led by Dr. James Curran to look for other cases, present and past, and to learn what they could about these alarming new reports. At that time, the earliest confirmed case they could find occurred in 1978. As the number of similar reports increased, they were recognized as a common disorder of the immune system in 1981. It was

changes; this is often used as a marker of the disease progress.

Thanks to the research of Dr. Montagnier and his colleagues, the cause of this mysterious disease which behaved differently from normal viral or bacterial infections, was uncovered relatively quickly in 1983.³ As a result, most of us don't have to worry about this disease and we don't give much thought to Dr. Montagnier's discovery. As an example, you can receive a blood transfusion today and not have to worry about Human Immune Deficiency Virus (HIV) which is the virus that causes AIDS, being transmit-

**'I estimate that Dr. Montagnier's
discovery has saved more than
two million lives worldwide and about
400,000 in America.'**

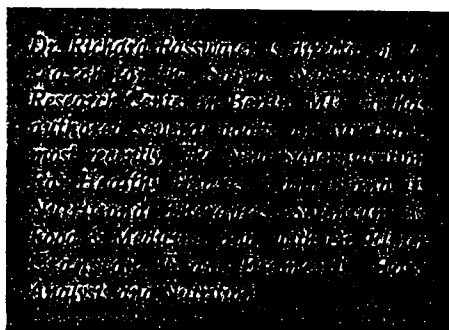
found that these patients had a depletion of certain white blood cells that play a critical role in defending the body against invading organisms. These cells were formerly called T4-helper lymphocytes, but now by international convention are called CD4 lymphocytes. (CD stands for cluster of differentiation markers.) Because immunology knowledge is rapidly expanding and terminology is perplexing and changing, a glossary for the relevant terms used in this discussion is provided on Page 63.

Later investigation has identified several other immune changes, but the depletion of CD4 lymphocytes has been related to AIDS ever since its first description. With the dramatic reduction in the number of CD4 lymphocytes, the ratio of CD4 to CD8 cells

ted to you in the blood you receive. The fact that a test had been developed to detect HIV in blood was a comforting thought to me when I needed blood a few years ago.

Even those who are at high risk owe a huge "thank you" to Dr. Montagnier because his discovery of both HIV-1 and HIV-2 strains of the virus has led to protective preventive measures.

HIV is an unusual virus. It is a retrovirus which means that it reverses the normal pattern of replication. Its genetic material contains only RNA instead of DNA. Retroviruses depend on an enzyme called reverse transcriptase to use the genetic material in the white blood cells that they infect to make the proteins needed for the virus to survive. In essence, the HIV turns the



DATE: _ _ _ _ _

TO: _ _ _ _ _
 _ _ _ _ _
 _ _ _ _ _

ATTENTION: ANYONE WHO MIGHT BE CONCERNED ABOUT AIDS

I WANT TO MAKE YOU AWARE OF MY RESEARCH PERTAINING TO HIV/AIDS (SEE ATTACHED).
 MY CURRENT GOAL IS TO CONVINCE SOMEONE/SOMEWHERE WITH MEDICAL EXPERTISE
 AND/OR AUTHORITY TO INITIATE A CLINICAL TRIAL THAT WOULD USE THE CHEMICAL
 KNOWN AS "ANTABUSE".

THE PURPOSE OF SUCH A TRIAL WOULD BE TO SEE IF THE SUFFERING OF CHILDREN
 AFFLICTED WITH AIDS COULD BE ALLEVIATED BY UTILIZING A PROCEDURE THAT I CALL:

"A MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV".

MY KNOWLEDGE OF BIOLOGY AND DISEASES IS MINIMAL; HOWEVER, I AM GOING
 TO ASSUME THAT THE SYMPTOMS OF HIV/AIDS INFECTION WHICH APPEAR IN CHILDREN
 WOULD BE SIMILAR TO THOSE APPEARING IN ADULTS.

THE SYMPTOMS OF WHICH I SPEAK ARE:

1. ENLARGED SPLEEN AND LYMPH NODES
2. DIARRHEA
3. WEIGHT LOSS
4. PERSISTENT FEVER

IF MY THINKING IS CORRECT, A SLIGHT DIMINUTION OF THESE SYMPTOMS
 SHOULD APPEAR DURING THE COURSE OF THE TRIAL (16 WEEKS).

IN ADDITION, THERE MIGHT BE A SLIGHT INCREASE IN THE CD4-POSITIVE
 LYMPHOCYTES (T-HELPER CELLS).

JOHN S. ROBERTS
 POST OFFICE BOX H
 HOBART, INDIANA 46342
 219-763-1933

SEPTEMBER 4, 1995

THE HONORABLE PETER J. VISCLOSKY
HOUSE OF REPRESENTATIVES
2464 RAYBURN BUILDING
WASHINGTON, D.C. 20515-1401

DEAR CONGRESSMAN VISCLOSKY,

ATTACHED IS A COPY OF YOUR LETTER TO ME DATED AUGUST 22, 1995.

I AM NOT ASKING YOU TO PROCEED ANY FURTHER ON MY BEHALF.

I WANT TO THANK YOU FOR THE HELP YOU HAVE AFFORDED ME OVER THE PAST 3½ YEARS.

I WRITE THIS LETTER SOLELY FOR THE PURPOSE OF ESTABLISHING IT AS THE MEANS BY WHICH I HOPE TO INFLUENCE SOMEONE/SOMEWHERE WITH MEDICAL EXPERTISE AND/OR AUTHORITY TO INITIATE A CLINICAL TRIAL WHICH WOULD UTILIZE THE CHEMICAL COMMONLY KNOWN AS "ANTABUSE". THE OBJECTIVE OF SUCH A TRIAL WOULD BE TO SEE IF THE INCREASED AMOUNT OF UNMETABOLIZED ACETALDEHYDE IN THE BLOODSTREAM, DUE TO THE PRESENCE OF ANTABUSE IN THE LIVER, WOULD HAVE ANY EFFECT ON INACTIVATING THE VIRUS WHICH CAUSES AIDS - HIV.

BEFORE I PROCEED FURTHER, I AM GOING TO ASSUME THAT SOMEONE MIGHT READ THIS LETTER AND NOT KNOW WHAT ANTABUSE IS AND WHAT IT DOES. I WISH TO OFFER A BRIEF EXPLANATION.

IN ORDER TO QUENCH THE ALCOHOLIC'S CRAVING FOR A DRINK, PHYSICIANS PRESCRIBE ANTABUSE.

IT IS HOPED THAT IF THE ALCOHOLIC KNOWS, IN THE BACK OF HIS MIND, WHAT TERRIBLE CONSEQUENCES WILL ENSUE IF HE TAKES A DRINK, WHILE ANTABUSE IS IN HIS SYSTEM, HE WILL REFRAIN FROM DRINKING - HENCE THE TERM, "AVOIDANCE THERAPY".

HERE IS WHAT COULD HAPPEN IF YOU COMBINE ALCOHOL AND ANTABUSE -

"DISULFIRAM (ANTABUSE) IS A DRUG TO TREAT ALCOHOLISM. WHEN ALCOHOL IN THE BLOODSTREAM INTERACTS WITH DISULFIRAM, IT CAUSES A FLUSHED FACE, SEVERE HEADACHE, CHEST PAINS, SHORTNESS OF BREATH, NAUSEA, VOMITING, SWEATING AND WEAKNESS. SEVERE REACTIONS MAY CAUSE DEATH....."

PAGE 976, COMPLETE GUIDE TO PRESCRIPTION & NON-PRESCRIPTION DRUGS,
H. WINTER GRIFFITH, M.D., THE PUTNAM PUBLISHING GROUP, NEW YORK, 1993

LET'S SUPPOSE THE ALCOHOLIC HAS BEEN TAKING ANTABUSE ON A DAILY BASIS BUT ONE DAY DECIDES -

"AH, TO HELL WITH IT. I'M GOING TO TAKE A DRINK. I DON'T GIVE A DAMN WHAT ANYONE SAYS OR THINKS."

HE COULD STOP TAKING ANTABUSE, BUT HE WOULD HAVE TO WAIT ABOUT A WEEK BEFORE HE COULD START DRINKING AND NOT BE IN DANGER OF EXPERIENCING "THE ANTABUSE REACTION". IT TAKES THE BODY ABOUT A WEEK'S TIME TO "FLUSH OUT" COMPLETELY ALL OF THE ANTABUSE THAT HAS BEEN SWALLOWED.

SCIENTIFICALLY, I COULD SAY THAT WHEN A PATIENT SWALLOWS ANTABUSE "RAPID INTRACELLULAR PENETRATION" TAKES PLACE IN THE LIVER; IN ADDITION, ANTABUSE HAS A SLOW RATE OF METABOLISM - UP TO SEVEN DAYS.

I AM NOT GOING TO SAY THIS. FROM NOW ON I WILL SAY - WHEN A PERSON SWALLOWS ANTABUSE HE "PLUGS UP" HIS LIVER WITH ANTABUSE. AS I WRITE THIS LETTER I AM NOT AWARE OF ANY ILL EFFECTS WHICH WOULD BE CAUSED BY PLUGGING UP THE LIVER WITH ANTABUSE, OTHER THAN THE FACT THAT ALCOHOL SHOULD BE AVOIDED.

WHAT OCCURS IN THE BODY WHEN ANTABUSE IS IN THE LIVER AND A DRINK IS DRUNK? WHAT CAUSES THE SEVERE REACTION TO ALCOHOL?

ALCOHOL IS BROKEN DOWN (METABOLIZED) IN THE FOLLOWING WAY:

"AS ABSORBED ALCOHOL IS PASSED THROUGH THE LIVER BY THE CIRCULATING BLOOD, IT IS ACTED UPON BY ADH (ALCOHOL DEHYDROGENASE), A ZINC-CONTAINING ENZYME FOUND CHIEFLY IN THE LIVER CELLS. THE ALCOHOL MOLECULE IS CONVERTED BY THIS ACTION TO ACETALDEHYDE, ITSELF A HIGHLY TOXIC SUBSTANCE, BUT THIS IS IMMEDIATELY ACTED UPON BY ANOTHER ENZYME, ALDEHYDE DEHYDROGENASE, AND CONVERTED TO ACETATE, MOST OF WHICH ENTERS THE BLOODSTREAM AND IS ULTIMATELY OXIDIZED TO CARBON DIOXIDE AND WATER."

PAGE 438, ENCYCLOPAEDIA BRITANNICA, MACROPAEDIA, VOLUME 1, 1974 EDITION

THE "JOURNAL OF APPLIED TOXICOLOGY", OCTOBER, 1991, PAGE 374 STATES THAT "THE HALF-LIFE OF ACETALDEHYDE IN THE BLOOD WAS ESTIMATED AS 3.1 MIN."; THIS FIGURE WAS DERIVED FROM EXPERIMENTS UPON RATS, BUT I AM ASSUMING THAT IT IS NEARLY THE SAME FOR HUMAN BEINGS.

I AM NOT GOING INTO SCIENTIFIC DETAIL, BUT I WILL SAY THAT BY UTILIZING THIS HALF-LIFE FIGURE THE CONCLUSION IS THAT ACETALDEHYDE "A HIGHLY TOXIC SUBSTANCE" IS QUICKLY CHANGED (METABOLIZED) IN THE HUMAN BODY INTO SOMETHING HARMLESS WITHIN $\frac{1}{2}$ HOUR'S TIME.

WHEN THE LIVER IS PLUGGED UP WITH ANTABUSE, THIS CANNOT HAPPEN. ACETALDEHYDE CANNOT BE QUICKLY CHANGED INTO SOMETHING HARMLESS. IT REMAINS "UNMETABOLIZED" AND FLOWS THROUGH THE BLOODSTREAM AS A TOXIC POISON FOR A PERIOD OF HOURS.

THIS IS WHAT CAUSES THE SEVERE REACTION TO ALCOHOL WHEN ANTABUSE IS PLUGGING UP THE LIVER - A TOXIC POISON, ACETALDEHYDE, IS FLOWING IN THE BLOOD, AND THE BODY IS TRYING TO COPE WITH IT AS BEST AS IT CAN. SOMETIMES FAILURE RESULTS AND DEATH ENSUES.

ATTACHED IS A COPY OF THE AUGUST 9, 1995 LETTER WHICH JACK WHITESCARVER, Ph.D. SENT TO YOU, CONGRESSMAN VISCLOSKEY.

BOTH THE CENTERS FOR DISEASE CONTROL AND NATIONAL INSTITUTES OF HEALTH HAVE ACKNOWLEDGED THAT HIV, THE VIRUS WHICH CAUSES AIDS, CAN BE INACTIVATED IN THE TEST TUBE BY ACETALDEHYDE -

"ALL THE ALDEHYDES ARE CAPABLE OF INACTIVATING HIV; HOWEVER, THEIR ACTUAL EFFECTIVENESS DEPENDS ON THE CONCENTRATION USED."

CENTERS FOR DISEASE CONTROL LETTER TO ME, DATED FEBRUARY 1, 1995

"THE FACT THAT ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN TEST TUBE EXPERIMENTS DOES NOT NECESSARILY MAKE IT A GOOD CANDIDATE FOR ANTI-HIV THERAPY IN HUMANS."

DR. WHITESCARVER'S LETTER

I AM GOING TO ASSUME THAT THE WORDS "INACTIVATE" AND "DESTROY" ARE ALMOST SYNONYMOUS.

THE KEY QUESTION, OF COURSE, IS:

CAN ACETALDEHYDE "INACTIVATE" HIV IN A LIVING HUMAN BEING?

THE NATIONAL INSTITUTES OF HEALTH IS THE ONLY GOVERNMENTAL AGENCY WHICH CAN INITIATE AND CONDUCT A CLINICAL TRIAL; UNDERSTANDABLY, IT IS UNWILLING TO EXPERIMENT WITH ACETALDEHYDE BECAUSE, AS DR. WHITESCARVER STATES:

"THE HIGH TOXICITY OF ACETALDEHYDE MAKES IT A SIGNIFICANTLY LESS DESIRABLE CANDIDATE FOR USE IN INDIVIDUALS WHO SUFFER FROM SEVERELY WEAKENED IMMUNE SYSTEMS AND WHO ARE PRONE TO CONTRACTING NUMEROUS OPPORTUNISTIC INFECTIONS AND MALIGNANCIES."

LET US SUPPOSE, FOR ARGUMENT'S SAKE, THAT ACETALDEHYDE CAN INACTIVATE HIV IN THE LIVING HUMAN BEING.

THE KEY QUESTION, OF COURSE, IS:

HOW COULD ACETALDEHYDE'S TOXICITY BE AMELIORATED OR NEGATED?

IN LATE JUNE OF THIS YEAR I LOCATED AND READ A SCIENTIFIC STUDY WHICH WAS CONDUCTED 20 YEARS AGO; THE STUDY DEALT WITH EXPERIMENTAL RESEARCH UPON RATS; THE PURPOSE OF THIS RESEARCH WAS TO DETERMINE THE EFFECTIVENESS WHICH CERTAIN SUBSTANCES MIGHT HAVE IN PROTECTING THESE RATS AGAINST THE TOXICITY OF ACETALDEHYDE POISONING; THE NAME OF THE STUDY IS:

"PROTECTIVE ACTION OF ASCORBIC ACID AND SULFUR COMPOUNDS AGAINST ACETALDEHYDE TOXICITY: IMPLICATIONS IN ALCOHOLISM AND SMOKING"

AND IT IS BY HERBERT SPRINCE AND HIS ASSOCIATES, AND IT IS FOUND IN "AGENTS AND ACTIONS" 5(2) 164-73, MAY 75.

MY KNOWLEDGE OF BIOLOGY IS MINIMAL; HOWEVER, IT IS MY IMPRESSION THAT IF A CERTAIN RESULT CAN BE OBTAINED FROM AN EXPERIMENT UPON RATS, THIS SAME RESULT JUST POSSIBLY MIGHT BE ACHIEVED IF HUMAN BEINGS WERE THE OBJECT OF THE EXPERIMENT.

I AM GOING TO ASSUME THAT THE SPRINCE STUDY HAS APPLICABILITY TO THE HUMAN CONDITION. I THINK THAT HIS CONCLUSION AND "RATIO" SHOULD BE GIVEN SERIOUS CONSIDERATION.

THE SPRINCE CONCLUSION:

"TO THE BEST OF OUR KNOWLEDGE, OUR FINDINGS DEMONSTRATE FOR THE FIRST TIME THAT DIRECT (SPRINCE'S EMPHASIS) PROTECTIVE ACTION AGAINST ACETALDEHYDE TOXICITY AND LETHALITY CAN BE OBTAINED WITH CERTAIN NATURALLY-OCCURRING METABOLITES, NAMELY L-ASCORBIC ACID, L-CYSTEINE, AND THIAMIN, PREFERABLY IN COMBINATION AT REDUCED DOSE LEVELS."

"THE SPRINCE RATIO":

L-ASCORBIC ACID (VITAMIN C)	2.0
L-CYSTEINE FB (A SULFUR COMPOUND)	1.0
THIAMINE.HCL (A SULFUR COMPOUND)	.3

I WISH TO QUOTE SPRINCE'S ABSTRACT IN FULL:

"ACETALDEHYDE IS A TOXIC SUBSTANCE COMMON TO HEAVY DRINKING OF ALCOHOL AND HEAVY SMOKING OF CIGARETTES. IT HAS BEEN IMPLICATED THEREBY IN DISEASES OF THE CARDIOVASCULAR, RESPIRATORY, AND CENTRAL NERVOUS SYSTEMS. PROTECTION AGAINST ACETALDEHYDE TOXICITY (i.e. ANESTHESIA AND LETHALITY) WAS STUDIED IN RATS BY ORAL INTUBATION OF TEST COMPOUNDS 30-45 MINUTES PRIOR TO ORAL INTUBATION OF A STANDARDIZED ORAL LD 90 DOSE (18 MILLIMOLES/KILOGRAM) OF ACETALDEHYDE. ANIMALS WERE MONITORED FOR ANESTHESIA (LOSS OF RIGHTING REFLEXES) AND LETHALITY FOR 72 HOURS. A TOTAL OF 18 COMPOUNDS WAS TESTED. L-ASCORBIC ACID AT 2 MILLIMOLES/KILOGRAM (mm/kg) SHOWED MODERATE PROTECTION AGAINST ANESTHESIA AND MARKED PROTECTION AGAINST LETHALITY. GREATEST PROTECTION AGAINST ANESTHESIA AND LETHALITY WAS OBTAINED AT 2mm/kg WITH EACH OF THE FOLLOWING: L-CYSTEINE, N-ACETYL-L-CYSTEINE, THIAMINE.HCL, SODIUM METABISULFITE, AND L-CYSTEIC ACID. A COMBINATION OF L-ASCORBIC ACID WITH L-CYSTEINE, AND THIAMINE.HCL AT REDUCED DOSE LEVELS (2.0, 1.0 AND 0.3 mm/kg, RESPECTIVELY) GAVE VIRTUALLY COMPLETE PROTECTION. A DETAILED LITERATURE REVIEW IS PRESENTED OF THE RATIONALE AND SIGNIFICANCE OF THESE FINDINGS. OUR FINDINGS COULD POINT THE WAY TO A POSSIBLE BUILD-UP OF NATURAL PROTECTION AGAINST THE CHRONIC BODY INSULT OF ACETALDEHYDE ARISING FROM HEAVY DRINKING OF ALCOHOL AND HEAVY SMOKING OF CIGARETTES."

IN ADDITION, I HAVE ATTACHED A COPY OF PAGE 166 OF THE SPRINCE STUDY. LOOK AT COMBINATION "CB3". NONE OF THESE RATS WERE DEAD AFTER 72 HOURS. IN FACT, THE WORST THING THAT OCCURRED TO THEM WAS THAT OUT OF 30 ONLY 3 RATS BECAME ANESTHETIZED AFTER 3-10 MINUTES.

AS RICHARD A. PASSWATER, Ph.D., STATED ON PAGE 128 OF HIS BOOK, SUPER-NUTRITION (DIAL PRESS, 1975; POCKET BOOK, 1976):

"A COMBINATION OF CERTAIN SULFUR AMINO ACIDS AND VITAMIN C GAVE 100 PERCENT PROTECTION AGAINST A STANDARD LETHAL DOSE OF ACETALDEHYDE IN LABORATORY RATS."

AT THIS TIME I WOULD LIKE TO PROPOSE A CLINICAL TRIAL OF A PROCEDURE WHICH I LABEL "AN INTENSIVE APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV".

1. CONDUCT THE CLINICAL TRIAL FOR SIXTEEN WEEKS.
2. FIRST, HAVE THE PATIENT PLUG UP HIS LIVER WITH ANTABUSE; FOLLOW THE REGIMEN RECOMMENDED BY THE PHYSICIANS' DESK REFERENCE, PAGE 2642, 1995 EDITION FOR THE TREATMENT OF ALCOHOLISM:

- A. THE TABLET SHOULD BE "PREFERABLY CRUSHED AND WELL MIXED WITH LIQUID".
- B. "INITIAL DOSAGE SCHEDULE - IN THE FIRST PHASE OF TREATMENT, A MAXIMUM OF 500 mg DAILY IS GIVEN IN A SINGLE DOSE (SWALLOWED) FOR ONE TO TWO WEEKS." (TO BE SURE THE LIVER IS TOTALLY PLUGGED UP, UTILIZE TWO WEEKS; ALSO BE SURE TO TELL THE PATIENT TO AVOID ALCOHOL DURING THIS TIME).
- C. "MAINTENANCE REGIMEN - THE AVERAGE MAINTENANCE DOSE IS 250mg DAILY (RANGE, 125 TO 500mg); IT SHOULD NOT EXCEED 500mg DAILY." (THIS SHOULD BE DONE EVERYDAY THROUGHOUT THE FOURTEEN REMAINING WEEKS OF THE TRIAL).

(OF COURSE, ALL QUANTITIES AND TIME PERIODS WHICH I MENTION IN THIS LETTER ARE ARBITRARY AND SUBJECT TO CHANGE; MEDICAL EXPERTISE WOULD DICTATE WHAT IS BEST; HOWEVER, THERE IS ONE CONSTANT WHICH WILL REMAIN INVARIABLE - THE SPRINCE RATIO.)

(I AM GOING TO ASSUME THAT IT TAKES 4 HOURS FOR A PLUGGED UP LIVER TO METABOLIZE (CHANGE INTO SOMETHING HARMLESS) THE ACETALDEHYDE THAT IS ENGENDERED IN THE HUMAN BODY AFTER 1 Oz. (A SHOT) OF 100 PROOF ALCOHOL IS DRUNK.)

3. THE TRIAL WILL TAKE PLACE AT A PHYSICIAN'S OFFICE OR CLINIC; FOR FOURTEEN WEEKS THE PATIENT WILL REPORT TWICE A WEEK, LET'S SAY MONDAY AND THURSDAY; THE PATIENT WILL BE TOLD THAT TREATMENT WILL LAST ALL MORNING OR ALL AFTERNOON.
4. BEGIN THE TRIAL THUSLY - HAVE THE PATIENT INGEST L-ASCORBIC ACID (VITAMIN C), L-CYSTEINE FB AND THIAMINE.HCL; MEDICAL EXPERTISE WOULD DETERMINE THE AMOUNT; HOWEVER, THE SPRINCE RATIO WOULD BE ADHERED TO.
5. 30 TO 45 MINUTES LATER, ADMINISTER ALCOHOL IN THE MANNER DESCRIBED BY THE PHYSICIANS'DESK REFERENCE, PAGE 2642:
- ".....A DRINK OF 15 mL ($\frac{1}{2}$ oz) OF 100 PROOF WHISKEY, OR EQUIVALENT, IS TAKEN SLOWLY. THIS TEST DOSE OF ALCOHOLIC BEVERAGE MAY BE REPEATED ONCE ONLY, SO THAT THE TOTAL DOSE DOES NOT EXCEED 30 mL (1 oz) OF WHISKEY. ONCE A REACTION DEVELOPS, NO MORE ALCOHOL SHOULD BE CONSUMED. SUCH TESTS SHOULD BE CARRIED OUT ONLY WHEN THE PATIENT IS HOSPITALIZED, OR COMPARABLE SUPERVISION AND FACILITIES, INCLUDING OXYGEN, ARE AVAILABLE."

6. LET US SUPPOSE THAT IT TAKES AN HOUR FOR L-ASCORBIC ACID, L-CYSTEINE FB AND THIAMINE.HCL TO BE METABOLIZED COMPLETELY. WOULDN'T IT BE A GOOD IDEA THEN TO ADMINISTER A "BOOSTER" OF THIS COMBINATION EVERY $\frac{1}{2}$ HOUR DURING THE 4 HOUR PERIOD? - SO THAT THE PROTECTIVE "CUSHION" AFFORDED BY THESE SUBSTANCES AGAINST POISONOUS, UNMETABOLIZED ACETALDEHYDE WOULD NOT BE DISSIPATED. IN THE MEANWHILE, DURING THIS 4 HOUR PERIOD, MILLIONS OF AIDS VIRUSES ARE BEING INACTIVATED BY THIS SAME, POISONOUS, UNMETABOLIZED ACETALDEHYDE.
7. CHECK THE RESULTING "T-HELPER CELL" COUNT AS THE TREATMENT PROGRESSES.

DR. WHITESCARVER STATES:

"MR. ROBERTS CONTENDS THAT THE LANG STUDY PRODUCED POSITIVE RESULTS BECAUSE PATIENTS WHO PARTICIPATED IN THE STUDY MAY HAVE DISREGARDED PROTOCOL PROHIBITIONS ON ALCOHOL CONSUMPTION, WHICH WOULD RAISE LEVELS OF ACETALDEHYDE TO TOXIC LEVELS. DR. LANG, HOWEVER, NEVER SUGGESTED THAT A SIGNIFICANT NUMBER OF HIS PATIENTS DEVIATED FROM THE PROTOCOL REGIMEN."

ON SEVERAL OCCASIONS I MAILED TO JEAN-MARIE LANG, HÔPITAL HAUTEPIERRE, STRASBOURG, FRANCE, COPIES OF MY RESEARCH. I NEVER ELICITED A RESPONSE FROM HIM. IF DR. WHITESCARVER IS PRIVY TO ADDITIONAL INSIGHTS OF DR. LANG OTHER THAN THOSE PUBLISHED IN HIS ARTICLE, I WOULD APPRECIATE KNOWING ABOUT IT.

AN EXAMINATION OF THE LANG ARTICLE REVEALS THAT THE WORDS "WINE", "ALCOHOL" AND "ACETALDEHYDE" NEVER APPEAR.

AN EXAMINATION OF THE LANG ARTICLE REVEALS THAT A SENTENCE LIKE THIS NEVER APPEARS:

"SINCE DITIOCARB IS SIMILAR TO ANTABUSE, WE WARNED OUR PATIENTS TO REFRAIN FROM DRINKING WINE; WE TOLD THEM THAT IF THEY DID DRINK WINE THEY COULD BECOME VERY SICK."

THE LANG STUDY IS A COMPILATION OF RESEARCH WHICH OCCURRED AT SIX DIFFERENT LOCALES IN FRANCE.

WHEN THE SCIENTISTS COMBINED THEIR DATA, THIS IS ONE OF THE FACTS THAT APPEARED - 19% OF THE PATIENTS WHO RECEIVED DITIOCARB EXPERIENCED NAUSEA COMPARED TO 3% WHO RECEIVED PLACEBO.

IN ALL OF THE DESCRIPTIONS WHICH I HAVE READ ABOUT "THE ANTABUSE REACTION" THERE IS ONE WORD THAT INVARIABLY APPEARS - "NAUSEA".

WHEN I NOTICED THIS 19% FIGURE I GOT THE HUNCH THAT SOME OF THESE FRENCH PATIENTS MIGHT HAVE EXPERIENCED THE ANTABUSE REACTION.

THE DRINKING OF WINE SO PERMEATES THE CULTURE OF FRANCE THAT I THINK THE RESEARCHERS SIMPLY FORGOT TO TAKE IT INTO ACCOUNT AS A FACTOR.

DR. WHITESCARVER STATES:

"THERE COULD BE MANY EXPLANATIONS FOR THE PRELIMINARY FINDINGS THAT HAVE LITTLE OR NOTHING TO DO WITH THE PHARMACOLOGICAL ACTIVITY OF DITIOCARB OR ACETALDEHYDE. THERE IS NO EVIDENCE TO DATE TO SUSPECT THAT INCREASED LEVELS OF ACETALDEHYDE WERE RESPONSIBLE FOR THE OBSERVED RESULT."

AFTER THE LANG STUDY, THREE OTHER MAJOR "DOUBLE-BLIND", "PLACEBO-CONTROLLED" STUDIES WERE CONDUCTED RELATIVE TO HIV/AIDS. THE WORD "ACETALDEHYDE" IS NEVER MENTIONED IN ANY OF THESE STUDIES. THUS FAR, I HAVE FAILED TO TURN UP ONE INSTANCE IN ANY OF THE PUBLISHED LITERATURE WHEREIN "ACETALDEHYDE" IS MENTIONED IN THE SAME CONTEXT WITH "HIV" AND/OR "AIDS" AND/OR "DITIOCARB"; IF DR. WHITESCARVER IS AWARE OF SOME UNPUBLISHED STUDIES WHICH EXIST, I WOULD APPRECIATE KNOWING ABOUT THEM.

OF COURSE, IT IS MY HOPE THAT SOMEONE/SOMEWHERE WITH MEDICAL EXPERTISE AND/OR AUTHORITY WILL DECIDE TO CONDUCT A SIXTEEN WEEK CLINICAL TRIAL OF THE AFOREMENTIONED PROCEDURE WHICH I CALL "AN INTENSIVE APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV" WITH A WILLING VOLUNTEER OR VOLUNTEERS.

IF THOSE IN THE MEDICAL COMMUNITY ARE STILL RELUCTANT TO INITIATE THIS TRIAL BECAUSE OF ACETALDEHYDE'S TOXICITY, I HAVE AN ALTERNATIVE PROCEDURE TO SUGGEST. I CALL THIS ONE "A MILD APPLICATION OF UNMETABOLIZED ACETALDEHYDE TO INACTIVATE HIV". THE RESULTS MIGHT NOT BE DRAMATIC, BUT, NEVERTHELESS, THERE SHOULD BE SOME SLIGHT IMPROVEMENT IN THE PATIENT'S HEALTH.

THE SAME "JOURNAL OF APPLIED TOXICOLOGY" WHICH I HAVE CITED STATES:

"ACETALDEHYDE HAS BEEN IDENTIFIED IN OAK LEAVES, TOBACCO, APPLES, BROCCOLI, COFFEE, GRAPES, GRAPEFRUIT, ORANGES, LEMONS, ONIONS, PEACHES, PEARS, PINEAPPLES, RASPBERRIES, STRAWBERRIES AND MANY SPICES."

WHY NOT DO THIS? - PLUG UP THE PATIENT'S LIVER WITH ANTABUSE AND RECOMMEND A DIET RICH IN ORANGE JUICE AND THE FRUITS LISTED BY THIS JOURNAL.

THE IMPORTANT THING TO KEEP IN MIND ABOUT THIS PROCEDURE IS THAT ALCOHOL IS TO BE AVOIDED COMPLETELY. OF COURSE, ALCOHOL CANNOT BE DRUNK AND "HIDDEN ALCOHOLS" ARE TO BE AVOIDED -

1. THE FUMES OF AFTER-SHAVE LOTIONS HAVE BEEN KNOWN TO SET OFF THE ANTABUSE REACTION.
2. WATCH OUT FOR SAUCES, FERMENTED VINEGAR, MARINADES, DESSERTS OR OTHER FOODS PREPARED WITH ANY ALCOHOL.

PROBABLY NO INHERENT DANGER WOULD BE IMPLICIT IN THIS PROCEDURE OTHER THAN THE FACT THAT THE PATIENT MIGHT FEEL NAUSEOUS FROM TIME TO TIME BECAUSE OF THE SLIGHT INCREASED AMOUNT OF UNMETABOLIZED ACETALDEHYDE FLOWING IN HIS BLOODSTREAM BECAUSE OF DRINKING ORANGE JUICE OR EATING FRUIT.

CONDUCT THIS TRIAL FOR SIXTEEN WEEKS. THE PATIENT COULD IMMEDIATELY START DRINKING ORANGE JUICE AND EATING FRUIT; HE WOULD NOT HAVE TO WAIT TWO WEEKS UNTIL HIS LIVER GOT TOTALLY PLUGGED UP.

THE PATIENT WOULD NOT HAVE TO REPORT TWICE A WEEK TO THE PHYSICIAN'S OFFICE OR CLINIC.

IT WOULD BE THE PATIENT'S RESPONSIBILITY TO INCLUDE ORANGE JUICE AND FRUIT IN HIS DIET.

IT WOULD BE THE PATIENT'S RESPONSIBILITY TO SWALLOW HIS ANTABUSE TABLET EVERYDAY.

ONCE A MONTH THE PATIENT COULD REPORT TO HAVE HIS "T-HELPER CELL" COUNT MEASURED. AGAIN, THIS PROCEDURE MIGHT NOT YIELD MUCH OF A RESULT; NEVERTHELESS, THERE SHOULD BE SOME SLIGHT IMPROVEMENT IN THE PATIENT'S HEALTH.

IN BOTH THE "INTENSIVE" AND "MILD" APPLICATIONS, CIGARETTE SMOKING SHOULD BE AVOIDED; SUPER-NUTRITION, PAGE 47, STATES:

".....EACH CIGARETTE SMOKED DESTROYS AN ESTIMATED 25mg OF VITAMIN C; THIS MAY BE AS MUCH AS MANY PEOPLE OBTAIN IN THEIR DIET. THE RDA IS ONLY 50mg."

IN BOTH THE "INTENSIVE" AND "MILD" APPLICATIONS, THE PATIENT SHOULD AVOID GOING INTO A ROOM IN WHICH AIR WICK IS PRESENT; THE "JOURNAL OF APPLIED TOXICOLOGY", TO WHICH I HAVE REFERRED, STATES:

"ACETALDEHYDE IS A PRIMARY COMPONENT IN AIR WICK, A COMMERCIAL ROOM DEODORANT." ACETALDEHYDE IS ALSO EMITTED BY WOOD BURNING, OAK LEAF BURNING, COFFEE ROASTING AND MOTOR VEHICLE EXHAUSTS.

IN THE "INTENSIVE" APPLICATION THE PATIENT SHOULD TAKE ZINC SUPPLEMENTS OR EAT FOODS RICH IN ZINC, NAMELY - BEEF, PORK, LAMB CHOPS, OYSTERS, PEANUTS, BEEF LIVER, BREWER'S YEAST OR WHEAT GERM; BECAUSE AS THE ENCYCLOPAEDIA BRITANNICA STATED:

"AS ABSORBED ALCOHOL IS PASSED THROUGH THE LIVER BY THE CIRCULATING BLOOD, IT IS ACTED UPON BY ADH (ALCOHOL DEHYDROGENASE), A ZINC-CONTAINING ENZYME FOUND CHIEFLY IN THE LIVER CELLS."

(THIS IS JUST A SIDE THOUGHT - COULD A DIETARY DEFICIENCY OF ZINC CONTRIBUTE TO THE DEVELOPMENT OF ALCOHOLISM?)

A FEW DAYS AGO I GOT THIS HUNCH - PATIENTS IN BOTH THE "INTENSIVE" AND "MILD" APPLICATIONS SHOULD AVOID FOODS OR BEVERAGES WHICH CONTAIN SUGAR. ELIMINATE SODA POP, CANDY, PASTRIES AND PACKAGED BREAKFAST CEREALS FROM THE DIET. CHECK THE LABELS OF EVERYTHING THAT IS BOUGHT. IF IT CONTAINS SUGAR OR CORN SYRUP, DON'T BUY IT.

ALL OF THIS MIGHT NOT DO ANY GOOD, BUT THEN AGAIN, IT WON'T DO ANY HARM. FOR THE DELETERIOUS EFFECTS WHICH SUGAR HAS UPON THE HUMAN BODY, REFER TO THE BOOK, SUGAR BLUES, BY WILLIAM DUFTY; PUBLISHER, WARNER BOOKS, 1976.

IT IS ALSO MY HUNCH THAT FOOD ADDITIVES SUCH AS MONOSODIUM GLUTAMATE (MSG) SHOULD BE AVOIDED.

I THINK THAT "INTENSIVE" AND "MILD" PATIENTS WOULD ALSO BENEFIT BY INCLUDING IN THEIR DIET BLACKSTRAP MOLASSES AND APPLE CIDER VINEGAR, THE RAW-UNFILTERED-ORGANIC KIND MADE FROM FRESH WHOLE APPLES; HEALTH FOOD STORES CARRY THIS ITEM.

BLACKSTRAP MOLASSES IS RICH IN IRON. I DON'T HAVE ANY FACTS ABOUT VINEGAR YET; IT'S JUST A HUNCH; BUT I THINK IT COULD BE BENEFICIAL. GARLIC SHOULD BE CONSIDERED TOO.

WELL, I GUESS I BETTER NOT GO OFF ON TOO MUCH OF A TANGENT DISCUSSING DIET. I AM REALLY NOT THAT KNOWLEDGEABLE ABOUT IT. I REPEAT, GOOD BOOKS TO REFER TO ARE SUPER-NUTRITION AND SUGAR BLUES.

I CONSIDER THIS LETTER TO BE THE CONCLUSION TO MY RESEARCH ON HIV/AIDS. IN ALL CANDOR I MUST SAY THAT I AM SOMEWHAT BEMUSED BY THE REPLIES WHICH HAVE COME FROM THE OFFICES OF THE NATIONAL INSTITUTES OF HEALTH (NIH) RELATIVE TO THE CHEMICAL KNOWN AS "ACETALDEHYDE".

THROUGHOUT 1993 NIH STATED:

"ACETALDEHYDE IS A NORMAL METABOLITE OF THE HUMAN BODY"
 "FORMED DURING NORMAL BODY FUNCTIONING"
 "AND WILL HAVE NO EFFECT ON HIV INFECTION"

IN LATE 1994 NIH STATED:

"THE KNOWN TOXICITY OF ACETALDEHYDE WOULD HAVE LIKELY PREVENTED
 EVALUATION EVEN IF THE AGENT HAD SHOWN ANTI-HIV ACTIVITY
 IN THE DRUG SCREEN PROGRAM SPONSORED BY THE NATIONAL CANCER INSTITUTE."

THE NIH NOW STATES, IN 1995:

".....ACETALDEHYDE INACTIVATES THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
 IN TEST TUBE EXPERIMENTS....."

I WISH NOW TO DELINEATE SOME OF THE RESULTS OF THE LANG STUDY; THE FULL
 REFERENCE TO THE ARTICLE IS:

JEAN-MARIE LANG, CHRISTIAN TREPO, MYRIAM KIRSTETTER, ET AL:
 'RANDOMISED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL OF
 DITIOCARB SODIUM ('IMUTHIOL') IN HUMAN IMMUNODEFICIENCY
 VIRUS INFECTION', "THE LANCET", SEPTEMBER 24, 1988, PAGES 702-706.

THE SUMMARY (ABSTRACT) OF THE ARTICLE READS:

"83 PATIENTS WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION
 (CDC GROUPS II, III, OR IV-A WERE RANDOMISED IN A CROSSOVER TRIAL
 OF SODIUM-DIETHYLDITHIOCARBAMATE (DITIOCARB SODIUM, 'IMUTHIOL')
 (10 mg/kg BODY WEIGHT GIVEN ORALLY ONCE A WEEK) AGAINST PLACEBO.
 EACH ARM OF THE TRIAL LASTED 16 WEEKS. THE DISEASE DID NOT PROGRESS
 TO CDC-DEFINED ACQUIRED IMMUNODEFICIENCY SYNDROME IN THE DITIOCARB
 GROUP BUT DID SO IN 4 PATIENTS IN THE PLACEBO GROUP (3 BETWEEN
 WEEK 0 AND 16, 1 BETWEEN WEEK 17 AND 32). DITIOCARB WAS ALSO
 ASSOCIATED TO A SIGNIFICANTLY GREATER EXTENT THAN PLACEBO WITH RELIEF
 OF CONSTITUTIONAL SYMPTOMS, IMPROVEMENT IN CLINICAL STATUS (INCLUDING
 SHRINKAGE OF ENLARGED SPLEEN AND LYMPH NODES), AND IMPROVEMENT
 IN IMMUNE FUNCTION (AS MEASURED BY CD4+ CELL COUNT AND SKIN TEST REACTIVITY).
 WHEN PLACEBO WAS REPLACED BY DITIOCARB, SIMILAR IMPROVEMENTS WERE OBSERVED,
 WHEREAS SYMPTOMS SLOWLY REAPPEARED AND CD4+ CELL LEVELS PROGRESSIVELY
 DECLINED WHEN DITIOCARB TREATMENT WAS REPLACED BY PLACEBO."

IN THE ARTICLE LANG STATES (BY THE WAY, NONE OF THE PATIENTS WERE TAKING
 AZT (ZIDOVUDINE) BECAUSE IT WAS NOT AVAILABLE IN FRANCE AT THE TIME):

"ALL THE 9 PATIENTS IN THE DITIOCARB GROUP WITH A HISTORY OF WEIGHT LOSS
 AT ENTRY REGAINED NORMAL WEIGHT AFTER 16 WEEKS' TREATMENT. THE SPLEEN
 BECAME IMPALPABLE IN 4 OF THE 7 DITIOCARB RECIPIENTS, BUT IN NONE
 OF 8 PLACEBO RECIPIENTS, WITH SPLENOMEGALY AT ENTRY."

"WHEN CHANGE IN CLINICAL STATUS WAS SCORED AS IMPROVED, STABLE, OR WORSE BY THE PHYSICIANS AFTER 16 WEEKS, 42% OF THE DITIOCARB RECIPIENTS HAD IMPROVED COMPARED WITH ONLY 5% IN THE PLACEBO GROUP ($p < 0.01$)."

LANG TABLE II (ATTACHED) HIGHLIGHTS THE "DISAPPEARANCE OF CONSTITUTIONAL SYMPTOMS" AND THEY ARE 'PERSISTENT DIARRHOEA, WEIGHT LOSS, PERSISTENT FEVER'. ALSO NOTE "DISAPPEARANCE OF SPLENOMEGALY".

AND TO TOP IT OFF, THE LANG STUDY SHOWED AN INCREASE IN THE CD4-POSITIVE LYMPHOCYTES (T-HELPER CELLS):

"THE PRESENT FINDINGS, AND THOSE ACCOMPANYING LONG-TERM ADMINISTRATION OF DITIOCARB (3 YEARS), CLEARLY SHOW THAT THE CD4+CELL-DEFECT IS NOT AGGRAVATED. IN FACT, THE REVERSE OCCURRED, WITH DITIOCARB PRODUCING AN INCREASE IN CD4+CELLS AND IMPROVEMENT IN CONSTITUTIONAL SYMPTOMS OF AIDS-RELATED COMPLEX. FURTHERMORE, PRELIMINARY DATA IN A SMALL NUMBER OF PATIENTS INDICATE THAT DITIOCARB DOES NOT ENHANCE HIV REPLICATION IN VITRO OR IN VIVO."

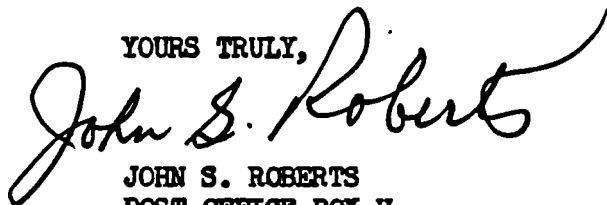
ALSO SEE LANG TABLE III (ATTACHED).

TO SUMMARIZE THE IMPROVEMENTS NOTED BY LANG IN THOSE PATIENTS WHO WERE SWALLOWING DITIOCARB (RELATED TO ANTABUSE):

1. CD4+CELL COUNT INCREASED
2. ENLARGED SPLEEN AND LYMPH NODES SHRANK
3. DIARRHEA DISAPPEARED
4. WEIGHT RESUMPTION OCCURRED
5. PERSISTENT FEVERS DISAPPEARED
6. IMPROVEMENT IN CLINICAL STATUS IN 42% OF THE PATIENTS

IF UNMETABOLIZED ACETALDEHYDE WAS NOT THE CAUSE, WHAT, INDEED, WAS THE CAUSE OF THESE POSITIVE RESULTS?

YOURS TRULY,



JOHN S. ROBERTS
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COPIES TO:

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CONTINUED ON THE NEXT PAGE

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 PROFESSOR PHYLLIS J. KANKI, DVM SD, HARVARD SCHOOL OF PUBLIC HEALTH
 PROFESSOR ROBERT L. MURPHY, M.D., MEDICAL DIRECTOR, HIV/AIDS TREATMENT CENTER,
 NORTHWESTERN UNIVERSITY MEDICAL SCHOOL
 JIM S. WU, RESEARCH TECHNICIAN, CHILDRENS HOSPITAL, BOSTON
 PROFESSOR HERMINIA PALACIO, M.D., MPl, AIDS PROGRAM, SAN FRANCISCO GENERAL HOSPITAL
 DONALD P. FRANCIS, M.D., D.Sc., MEDICAL AFFAIRS DEPARTMENT, GENETECH, SAN FRANCISCO
 MS. BETTY STERN, CHICAGO
 DAVID B., GARY
 MRS. JANE SCHROEDER, MERRILLVILLE
 MS. JEAN LUBECKIS, LANSING, ILLINOIS
 F. RITCHEY EIBEL, VALPARAISO
 JOHN H. BETJEMANN, PRESIDENT, THE METHODISTS HOSPITALS, GARY AND MERRILLVILLE
 MRS. JOYCE NORRIS, ACWORTH, GEORGIA
 DR. LUC MONTAGNIER, INSTITUT PASTEUR, PARIS

AND (updated 1/1/96 - j.s.r.) - "MAGIC" JOHNSON, DR. VARMUS, DR. PAUL, DR. BADER,
 EMBASSY OF JAPAN-WASHINGTON, D.C., DR. GALLANT, PROFESSOR DIETRICH,
 DR. HERSH, PROFESSOR HASELTINE, CHICAGO TRIBUNE, CHICAGO SUN-TIMES,
 DR. NULL, TONY BROWN PRODUCTIONS, BONAVENTURE HOUSE, DR. COHAN
 PAM ZEKMAN, "PLUS VOICE", "POZ", ROBERT ERB, NEW YORK TIMES, NEW YORKER,
 (MARK TAYLOR, JIM GORDON, SCOTT BOSLEY-POST-TRIBUNE), DR. CUTLER,
 DR. FEUERS, HIV TALK RADIO, WYETH-AYERST LABORATORIES, DR. HIRSCH,
 "OUT/LOOK", DR. BAGASRA, DR. HENDERSON, DR. BENNETT, PROFESSOR ANNE DE GROOT

PETER J. VISCLOSKY
1ST DISTRICT, INDIANA

COMMITTEE ON APPROPRIATIONS
CONGRESSIONAL STEEL CAUCUS
EXECUTIVE COMMITTEE CHAIRMAN

NORTHEAST-MIDWEST
CONGRESSIONAL COALITION
MIDWEST VICE-CHAIR

WHIP-AT-LARGE

Congress of the United States
House of Representatives
Washington, DC 20515-1401

August 22, 1995

2464 RAYBURN BUILDING
WASHINGTON DC 20515-1401
(202) 225-2461

215 WEST 35TH AVENUE
GARY, IN 46408
TTY-TDD SERVICE AVAILABLE
(219) 884-1177

PORTAGE CITY HALL
6070 CENTRAL AVENUE
PORTAGE, IN 46368
(219) 763-2904

VALPARAISO CITY HALL
166 LINCOLNWAY
VALPARAISO, IN 46383
(219) 464-0315

Mr. John S. Roberts
Post Office Box H
Hobart, Indiana 46342

Dear John:

I write to apprise you of a reply I have received from the National Institutes of Health (NIH) in response to your proposal for a cure for AIDS.

Enclosed, please find a copy of the letter I received from the NIH's Deputy Director of the Office of AIDS Research, Jack Whitescarver, Ph. D. I regret that this response is not more encouraging, but I believe it clearly addresses your concerns.

Be assured that I will continue to monitor all research efforts in the fight against AIDS with your views in mind. Do not hesitate to let me know if you have any other questions or concerns.

Sincerely,



Peter J. Visclosky
Member of Congress

PJV:clm
Enclosure

NATIONAL INSTITUTES OF HEALTH



William E. Paul, M.D.
Director

Building 31, Room 4C02
31 Center Drive
MSC 2340
Bethesda, MD 20892
TEL: 301 496 0357
FAX: 301 496 4843
E-Mail: wepaul@nih.gov

AUG - 9 1995

The Honorable Peter J. Visclosky
House of Representatives
2464 Rayburn Building
Washington, D.C. 20515-1401

Dear Mr. Visclosky:

The Office of AIDS Research (OAR) has been asked to reply to correspondence you have forwarded to Dr. Harold Varmus, Director of the National Institutes of Health (NIH), from one of your constituents, Mr. John S. Roberts. Mr. Roberts has written numerous letters to various scientists, government officials, and organizations advocating the use of acetaldehyde for the treatment of HIV infection and AIDS. You may recall that the NIH addressed this issue, at your request, in response to a similar letter from Mr. Roberts in June 1993. A copy of this correspondence is enclosed for your convenience.

The fact that acetaldehyde inactivates the human immunodeficiency virus (HIV) in test tube experiments does not necessarily make it a good candidate for anti-HIV therapy in humans. There are many agents known to be active against HIV. Researchers at the National Cancer Institute have identified over 3,000 compounds that are active against HIV, and the NIH currently is developing and evaluating the most promising ones.

The high toxicity of acetaldehyde makes it a significantly less desirable candidate for use in individuals who suffer from severely weakened immune systems and who are prone to contracting numerous opportunistic infections and malignancies. Mr. Roberts, however, insists that the toxicity could be ameliorated by the administration of sulfur amino acids and vitamin C. He cites research conducted twenty years ago in normal, uninfected mice. This research, however, is not applicable to humans infected with HIV.

In an attempt to substantiate his contention, Mr. Roberts repeatedly cites a study conducted in France by Dr. J.M. Lang that produced preliminary data suggesting that the drug Ditiocarb may have activity against HIV infection. This result, however, was not reproduced in later studies. Mr. Roberts contends that the Lang study produced positive results because patients who participated in the study may have disregarded protocol prohibitions on alcohol consumption, which would raise patient levels of acetaldehyde to toxic levels. Dr. Lang, however, never suggested that

Page 2 - The Honorable Peter J. Visclosky

a significant number of his patients deviated from the protocol regimen.

There could be many explanations for the preliminary findings that have little or nothing to do with the pharmacological activity of Ditiocarb or acetaldehyde. There is no evidence to date to suspect that increased levels of acetaldehyde were responsible for the observed result. Consequently, there is little justification for committing limited resources to investigating this possibility at this time. In any case, future support for research in this area would require the submission of a grant application by a competent research scientist. Funding then would be contingent on it passing a dual level of peer review.

The NIH currently is supporting more promising scientific approaches to the development of anti-HIV and AIDS therapies. For instance, a nucleoside analogue known as 3TC has shown promise in combination with other anti-HIV compounds in initial clinical trials. Several HIV protease inhibitors also have shown promise as well as an immune system modulator, interleukin-2. Currently, NIH-sponsored researchers are evaluating over 65 different agents in AIDS clinical trials.

I hope this information will prove useful in addressing the concerns of your constituent. Please contact us again if we can provide any additional assistance.

Sincerely,

A handwritten signature in cursive script, reading "Jack Whitescarver".

Jack Whitescarver, Ph.D.
Deputy Director

Enclosure

Table 2

Protective action of combinations of L-ascorbic acid and certain sulfur compounds against anesthetic and lethal effects of acetaldehyde in the rat. (Toxic oral dose of acetaldehyde used was LD 90 = 18 mM/kg.)

Combinations (CB) tested (oral dose)	Dose (mM/kg)	% anesthetized after 3-10 minutes	% dead after 3 hours	24 hours	72 hours
CB1: L-Cysteine FB	1.0				
Thiamin · HCl	0.3	60 (6/10)	10 (1/10)	60 (6/10)	60 (6/10)
CB2: L-Cysteine FB	2.0				
Thiamin · HCl	0.3	13 (2/15)	0 (0/15)	13 (2/15)	13 (2/15)
CB3: L-Ascorbic acid	2.0				
L-Cysteine FB	1.0	10 (3/30)	0 (0/30)	0 (0/30)	0 (0/30)
Thiamin · HCl	0.3				
CB4: L-Ascorbic acid	2.0				
N-Acetyl-L-cysteine	1.0	15 (3/20)	5 (1/20)	5 (1/20)	5 (1/20)
Thiamin · HCl	0.3				
<i>Intraperitoneal (i.p.) dose</i>					
CB3 (i.p.): Composition same as CB3		33 (5/15)	13 (2/15)	20 (3/15)	20 (3/15)

Combinations of test compounds were prepared as single solutions in saline. Procedural details of intubation and observations made are the same as described in Table 1 footnote, except for Combination CB3 (i.p.). Combination CB3 (i.p.) was administered intraperitoneally once a day for four days prior to dosing with acetaldehyde. On the fourth day, acetaldehyde (18 mM/kg) was intubated orally 30-45 minutes after the last intraperitoneal injection of Combination CB3 (i.p.).

acetaldehyde at the LD 90 dose level carefully standardized for rats of the above strain, sex, age, weight, and overnight treatment and found to be 18 mM/kg as previously reported [1]. Doses were expressed in mM/kg. Rats were observed after intubation over a 72-hour period for anesthetic effects (loss of righting reflexes) and lethal response (deaths). Further details of the test procedure and data obtained are presented in Tables 1 and 2.

The effect of using different routes of drug administration on protectant activity against acetaldehyde was also tested with a combination of ascorbic acid, cysteine, and thiamin (i.e., combination CB3 in Table 2). In this case, the protectant combination CB3 was administered intraperitoneally and the acetaldehyde orally. For details of procedure, see Table 2.

All test compounds listed in Tables 1 and 2 were obtained from the NBC Division of ICN Pharmaceuticals, Inc., with the exceptions listed as follows: DL-thioctic acid (Aldrich), taurine (Schwarz-Mann), cysteamine · HCl (Eastman), sodium metabisulfite (Fisher), and L-MTCA (see Reference 1 for its preparation). Compounds not listed in Table 1 were from the following sources: BAL (Aldrich), DTT (NBC), and DTE (NBC). Acetaldehyde was obtained from the Eastman Kodak Company.

Results

Results are self-evident from Table 1 and Table 2.

From Table 1, it is obvious that the reduced forms of L-ascorbic acid, L-cysteine FB, L-glutathione, and N-acetyl-L-cysteine gave marked protection in rats against the anesthetic and

lethal effects of acetaldehyde. Thus, 72 hours after treatment, lethal values were only 27% for L-ascorbic acid, 20% for L-cysteine FB, and 33% for reduced glutathione compared to 90% for saline controls. Complete protection (zero % lethality) was obtained with N-acetyl-L-cysteine, but only meager protection with DL-homocysteine (60% lethality). Protection against transitory anesthetic effects was best obtained with L-cysteine and its N-acetyl derivative (20% and 10% anesthetized, respectively) in comparison with the saline control (96% anesthetized). The oxidized forms of these compounds showed very little protectant activity against either anesthetic or lethal effects of acetaldehyde. Other sulfur compounds which gave virtually complete protection against anesthetic and lethal effects were sodium metabisulfite ($\text{Na}_2\text{S}_2\text{O}_5$) which resulted in only 5% lethality and L-cysteic acid in zero % lethality. On the other hand, the amines taurine and cysteamine · HCl showed much less protection than their corresponding acids (L-cysteic acid and L-cysteine, respectively). Preliminary screening tests with compounds not listed in Table 1 gave the following results: BAL (2,3-dimercapto-1-propanol) was found to be non-protective at 0.5 mM/kg, a dose not too far removed from its lethal dose level of 1.0 mM/kg. On the other hand, DTT (dithiothreitol) and DTE (dithioerythreitol) at

LANG

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TABLE II—CLINICAL OUTCOME OF HIV INFECTION IN FIRST ARM OF TRIAL

	Active	Placebo	p†
Progression to AIDS	0/38	3/39 (PCP, <i>Mycobacterium</i> , and Kaposi sarcoma)	..
Disappearance of constitutional symptoms* (IV-A patients)	8/11	0/5	<0.001
Lymphadenopathy score	-0.43† (SD 1.94)	+0.43† (SD 1.26)	<0.05
Disappearance of splenomegaly	4/7	0/8‡	<0.05

*Persistent diarrhoea, weight loss, persistent fever.

†Fisher's exact test.

‡Change from baseline.

§No spleen became palpable; two additional spleen enlargements were noted.

LANG

TABLE III—CD4 CELL COUNT DURING THE FIRST ARM OF TRIAL

	Active		Placebo		p*
	Patients tested	Median (mean, SD) count	Patients tested	Median (mean, SD) count	
Baseline	42	415 (405, 111)	41	380 (389, 132)	NS
Week 8	36	479 (517, 172)	39	420 (461, 226)	NS
Week 16	36	522 (542, 215)	38	420 (447, 181)	<0.05

*Student's t test.

LANG

THE LANCET, SEPTEMBER 24, 1988

TABLE IV—SIDE-EFFECTS

Adverse reaction	Percentage of patients with adverse reactions	
	Active (n = 83)	Placebo (n = 79)
Unpleasant taste	41 (32)	4 (3)
Abdominal discomfort	33 (26)	8 (6)
Nausea	19 (15)	3 (2)
Sensation of malaise	10 (8)	1 (1)
Anorexia	9 (7)	1 (1)
Excitement	6 (5)	3 (2)
Somnolence	5 (4)	1 (1)
Vomiting	2 (2)	1 (1)
Rash	0 (0)	0 (0)

Number of patients in parentheses. No patient in either group had >25% drop in haemoglobin concentrations, red or white cell count, or platelet count.

REISINGER

TABLE II—T-HELPER CELL COUNTS PER μ l BLOOD IN PATIENTS WITH INITIAL COUNT BELOW 814/ μ l

Route	Time (mo)	Placebo	DTC
Oral	0	467 (193)	493 (204)
	6	442 (327)	428 (167)
	% loss	5.9 (53.5)	5.4 (37.7)
Intravenous	0	422 (283)	388 (225)
	6	250 (263)	352 (345)
	% loss	51.4 (35.6)	20.8 (30.4)

HALF-LIFE OF ACETALDEHYD.

10
3.1 min → 5

$$6 \times 3.1 = 18.6 \text{ Minu}$$

3.1 min → 2.5

3.1 min → 1.25

3.1 min → .625

⑥ 3.1 min → .313

3.1 min → .157

3.1 min → .079

3.1 min → .040

3.1 min → .020

3.1 min → .010

3.1 min → .005

3.1 min → .0025

3.1 min → .0013

98.43

1.57

100.00

98.43%

METABOLIZED
AT THIS
POINT

Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: G3566

Date Rcvd: 02-03-97

From: Bret M. Sawyer

FAN FREE Clinic (Ltr sent to Casey W. Kilgus)

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ☒

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97



January 30, 1997

Casey W. Riley, Director
Division of STD/AIDS
Virginia Department of Health
P.O. Box 2448 Rm 112
Richmond, VA 23218

Dear Mr. Riley:

Thank you very much for taking time to read my letter. I am contacting you because of recent events concerning the Central Virginia HIV Care Consortium at VCU. Their actions or inactions seem to be insensitive to the population that the Ryan White Title II funds are suppose to serve.

The first problem with VCU is the fact that issuing a check would take six weeks. As a result, VCU relies on United Way to issue the checks. Although using United Way is quicker than their own system, this system is still too slow to respond to client emergencies which is the Ryan White Emergency Services Fund's intended purpose.

An additional problem with using United Way is that they shut down for three weeks at the end of the year in order to audit their records. Unfortunately, such shut downs do not acknowledge the fact that client emergencies do not simply cease. Again, this system seemed to forget the purpose behind these "emergency funds." Emergencies by their very nature happen regardless of what the Consortium and United Way are doing - and especially around Christmas time when money for most people is tight.

The latest problem with the consortium is that clients still do not have access to these funds. Nobody at the Consortium is taking responsibility for this matter. For the record, I worked at the Peninsula AIDS Foundation for three years, and not once did the Consortium in Norfolk, under the leadership of MaryAnne Moore and Joe Riddick, have this problem. This incongruity leads me to believe that the Central Consortium needs better direction.

What makes this matter worse is that after repeated phone calls to Judy Bradford, Wayne Thacker, Fred Wilson, and Terry Pendleton, and a complaint letter to Judy Bradford, nobody can give me a date as to when emergency funds will be available. I was informed that funds need to be transferred and that this involves HRSA. We have now been without access to emergency funds since January 7th of this year. In combination with United Way's audit, funds for the most part have been unavailable since mid-December.

To be fair to the Consortium, they did extend a 500 dollar credit limit which the Fan Free Clinic could be reimbursed; however, this has caused twice the amount of paperwork for myself, and has very nearly resulted in some clients losing their phone and power services. In addition, ever since this action, the Consortium has arbitrarily changed policies without notifying community case managers. For example, a request was denied because the bill did not indicate it was a turn-off notice. This policy, which is uninformed because the Consortium cannot even respond in time to a turn-off notice, had never been enforced in the last eight months. Even worse, I had never been informed of this policy, nor could this policy be found anywhere in the Ryan White Emergency Services Funds Paperwork the Consortium had provided me back in April of 1996. Furthermore, this 500 dollar credit limit would have normally been gone in one week.

1721 Hanover Avenue ♦ P.O. Box 5669 ♦ Richmond, Virginia 23220 ♦ (804) 358-6343

As a result of the Consortium's actions, I am reaching the conclusion that since they do not work directly with clients, they are out of touch with what needs to be done. They do not realize that when they make mistakes and decisions, they directly impact the community case managers, and more importantly the clients themselves. In order to be fair to the Consortium, as a result of my complaints, I was invited to be on their Emergency Services Fund Board which I joined; however, this action still does not resolve the current crisis, and I still feel quite powerless and skeptical as to any meaningful differences I can make. Your attention to this matter would be most appreciated.

I have enclosed the letter I sent to Judy Bradford in which I had requested a written response. To date, she has not responded. This letter to Judy better pinpoints my exact complaints in reference to their last minute policy changes which I feel are directly related to their lack of funds, and their inability to transfer funds.

Sincerely,

A handwritten signature in black ink, appearing to read "Bret M. Sawyer". The signature is fluid and cursive, with the first name "Bret" being more prominent.

Bret M. Sawyer, Ed.S.
Community Case Manager

cc: Judy Burnett, Executive Director, Ryan White Foundation
Patricia Fleming, Director, Office of National AIDS Policy Coordinator

January 22, 1997

Judy Bradford
901 West Franklin Street
POB 843016
Richmond, VA 23284-3016

Dear Judy:



As a result of some recent events, I have become concerned about the Consortium and its direction. These are my concerns:

(1) The amount of time that transpires from when the request (Ryan White Emergency Services Funds) is received by the Consortium and when the vendor receives payment. At the Consortium in Norfolk (AIDS Resource Center), I was able to get authorization over the phone, and the Peninsula AIDS Foundation was reimbursed by the AIDS Resource Center. I would like this to happen here in Richmond. If these funds are truly for "emergency purposes," then these funds need to be available in time for client emergencies.

(2) I do not understand why a request can only be submitted on Tuesdays. While I recognize that United Way will only send checks out on Fridays, we need a system which is more flexible and responsive to client's needs.

(3) United Way needs to be a better vendor. The audit which occurred at the end of December and early January negatively impacted clients especially since it occurred right around Christmas time. Is it possible that another vendor could be found?

(4) The word, "emergency," needs to be defined. I do not appreciate having request denied for something that was never written in official policy or told to me in person. For example, I was recently denied a request because I did not provide a document which stated that this was a turn-off notice. This refusal of my financial request is despite the fact that I had verified over the phone that the client's phone would be turned off on the 27th of this month. I was told my "word" was insufficient. This "rule" had never been brought to my attention before, and well over 20 financial requests had been accepted despite not having this type of documentation. Please further note that in the emergency services funds paperwork, no mention of this required documentation is present. All policies should be in written form to assure proper compliance and made available to community case managers.

(5) Also, I do not understand why emergency services funds are still not available. In my three years of working with the AIDS Resource Center, this lapse of accessibility has never occurred. I further do not understand why a date as to when these funds will be available cannot be divulged.

Judy, I would greatly appreciate your responding to these concerns, in writing, within seven days. I want to know why these funds are not currently available, and what steps are being taken to address these concerns. I extend this letter to you as a professional courtesy to give you an opportunity to respond before I take further action.

Sincerely,

Bret M. Sawyer, Ed.S.
Community Case Manager

1721 Hanover Avenue ♦ P.O. Box 5669 ♦ Richmond, Virginia 23220 ♦ (804) 358-6343

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G35??

Date Rcvd: 02-12-97

From: Thomas S. Shidaker
Beoward House

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ✓

Assigned To: PF

RCVD: _____ DONE: _____

Recommendations/Instructions:

To Support Staff: _____

Date of Response: 2-14-97

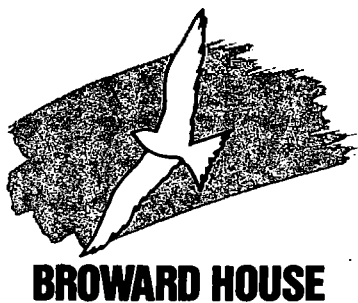
n:\corresli

THE WHITE HOUSE

2/14/97

Dear Tom -

Thanks for writing. I am so pleased and proud of all of you at Broward House. What wonderful growth you are responsible for. The is my last day in the W.H. I'll be moving on but plan to stay involved with HIV. Good luck & best regards, Pat



February 5, 1997

Patricia S. Fleming
Director
Office of National AIDS Policy
Executive Office of the President
750 17th Street, NW, Suite 600
Washington, DC 20503

Dear Patsy,

Thank you so much for sending me the President's Proclamation in commemoration of World AIDS Day. It is framed and proudly displayed in my office.

Since we last saw each other, it seems that Broward House has grown significantly. Our Family Living Center is fully occupied, providing housing for 14 adults and 24 children, with the newest baby born just before Christmas. The entire apartment building has become a family unto itself, with one parent taking care of the children of another during hospitalization, etc. The Junior League continues to provide activities such as puppet shows, ice cream socials and holiday parties. Representatives even donned Santa hats and brought gifts to each and every child. American Express shared the holiday spirit as well, providing all the children with bicycles, toys and clothing at a special party complete with Santa himself. I have enclosed a photo taken of Kevin, age 8 on Santa's knee at the American Express party. He and his mother live at the Family Living Center and wanted you to have this.

Through an award from HOPWA 1995 funds, we are negotiating the purchase of an additional independent living site in southern Broward County where needs are great and services are few. We will keep you apprised of our progress.

Our Chemical Dependency Treatment Program now has 86 clients enrolled in treatment. We are providing these services not only to clients living at our Assisted Living Facility, but to all other HIV-specific housing sites and throughout the community as well.



P.O. Box 350367
Fort Lauderdale, Florida 33335
954-522-4749

I am hopeful that your travels will bring you to South Florida again soon. In the meantime, we send our very best wishes to you.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom Shidaker", with a large, sweeping initial "T".

Thomas J. Shidaker
Chief Executive Officer

TJS:ml

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3564

Date Rcvd: 02-03-97

From: Reverend Carlton W. Veazey
Religious Coalition for Reproductive Choice

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy ✓

Assigned To: _____

RCVD: _____ DONE: _____

Recommendations/Instructions:

NR

To Support Staff: _____

Date of Response: 2-14-97

MEMBER ORGANIZATIONS

UNITED METHODIST CHURCH
GENERAL BOARD OF CHURCH AND SOCIETY
GENERAL BOARD OF GLOBAL MINISTRIES
WOMEN'S DIVISION

PRESBYTERIAN CHURCH (USA)
NATIONAL MINISTRIES DIVISION
WOMEN'S MINISTRIES
WASHINGTON OFFICE

UNITED CHURCH OF CHRIST
BOARD FOR HOMELAND MINISTRIES
COORDINATING CENTER FOR WOMEN
OFFICE FOR CHURCH IN SOCIETY

THE EPISCOPAL CHURCH
WOMEN IN MISSION AND MINISTRY
WOMEN FOR SOCIAL WITNESS

MORAVIAN CHURCH IN AMERICA
NORTHERN PROVINCE
COMMITTEE ON CHURCH AND SOCIETY

CAUCUSES/OTHER ORGANIZATIONS
AMERICAN BAPTIST WITNESS FOR CHOICE
CATHOLICS FOR A FREE CHOICE
CHURCH OF THE BRETHREN WOMEN'S CAUCUS
DISCIPLES FOR CHOICE
EPISCOPAL URBAN CAUCUS
EPISCOPAL WOMEN'S CAUCUS
LUTHERAN WOMEN'S CAUCUS
METHODIST FEDERATION FOR SOCIAL ACTION
PRESBYTERIANS AFFIRMING
REPRODUCTIVE OPTIONS

CONSERVATIVE MOVEMENT
UNITED SYNAGOGUE OF CONSERVATIVE JUDAISM
WOMEN'S LEAGUE FOR CONSERVATIVE JUDAISM

RECONSTRUCTIONIST MOVEMENT
FEDERATION OF RECONSTRUCTIONIST
CONGREGATIONS AND HAVUROTH

REFORM MOVEMENT
UNION OF AMERICAN HEBREW CONGREGATIONS
WOMEN OF REFORM JUDAISM
THE FEDERATION OF TEMPLE SISTERHOODS
NORTH AMERICAN FEDERATION
OF TEMPLE YOUTH
WOMEN'S RABBINIC NETWORK

OTHER ORGANIZATIONS
AMERICAN JEWISH COMMITTEE
AMERICAN JEWISH CONGRESS
B'NAI BRITH WOMEN
HADASSAH WZOA
NA'AMAT USA
NATIONAL COUNCIL OF JEWISH WOMEN
WOMEN'S AMERICAN ORT

UNITARIAN UNIVERSALIST
UNITARIAN UNIVERSALIST ASSOCIATION
UNITARIAN UNIVERSALIST WOMEN'S FEDERATION

YWCA OF THE USA
AMERICAN HUMANIST ASSOCIATION

ETHICAL CULTURE MOVEMENT
AMERICAN ETHICAL UNION
NATIONAL SERVICE CONFERENCE OF
THE AMERICAN ETHICAL UNION



Religious Coalition for Reproductive Choice

1025 VERMONT AVE NW

SUITE 1130

WASHINGTON

DC 20005

202 628 7700

FAX 202 628 7716

January 28, 1997

Patricia S. Fleming
Office of National AIDS Policy
750 17th Street, NW
Washington, DC 20503

Dear Ms. Fleming,

In celebration of the new spirit of bipartisanship and compromise to which the 105th Congress and the Clinton Presidency are publicly committed, the Religious Coalition for Reproductive Choice will hold Faithful Witness for Choice: A National Religious Convocation, on Tuesday, February 25 at 7:00 p.m. at the historic Metropolitan AME Church at 1518 M Street, NW, in Washington, DC.

We come together to stand on the side of reproductive health for all women. Many of us have repeatedly upheld and protected the vital right to choose in the face of censure and condemnation from some religious organizations and leaders. Too often, the voice of religion in these exchanges has lacked compassion and tolerance.

Together with the Pro-Choice Public Education Project, we invite you to join religious and other organizational leaders from diverse faith traditions to bear witness to this new collaborative and cooperative tone for the 105th Congress and for the last Presidency of the Twentieth Century. We convene to meld our voices in support of reproductive choice as people

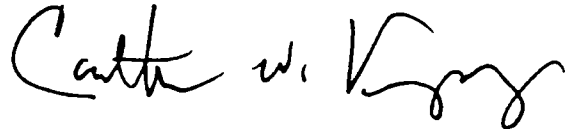
Page Two

of conscience, people of faith, people of commitment. We come together to make public witness, to honor women and men who struggle with difficult choices, to uphold those who risk their lives to provide reproductive health services.

Help establish the voice of forbearance in this debate in the opening days of the 105th Congress. We will reserve a seat for you in the Leadership section. Our goal is to have more than one thousand people in attendance. A large attendance will impress upon Members of Congress and the Administration that people of faith are, indeed, pro-choice. Please help us by sharing the enclosed fliers with your friends, colleagues, congregations, or grassroots networks.

Please call Laurie Shepard, 202-628-7700, extension 204, to RSVP or for further information. We look forward to welcoming you on February 25.

Sincerely,

A handwritten signature in black ink, reading "Carlton W. Veazey". The signature is fluid and cursive, with the first name "Carlton" being the most prominent.

Reverend Carlton W. Veazey
Interim Acting Director

Enc.

Witness for Faithful Choice

**A National
Religious
Convocation**

February 25, 1997

7:00 p.m.

Metropolitan AME Church

1518 M Street NW

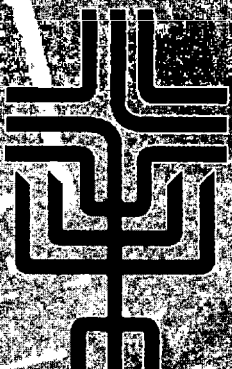
Washington, DC



Keynote Speaker:

The Reverend James Lawson

Holman United Methodist Church, Los Angeles



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**IN CONJUNCTION WITH
THE PRO-CHOICE PUBLIC
EDUCATION PROJECT**

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JUSTICE, JUSTICE YOU SHALL PURSUE!

DEUTERONOMY 16:20

The purpose of the Religious Coalition for Reproductive Choice is to ensure that every woman is free to make decisions about when to have children according to her own conscience and religious beliefs.

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c/o Religious Coalition for Reproductive Choice
1025 Vermont Avenue NW, Suite 1130
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Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: G2318

Date Rcvd: 12-15-95

From: Reggie Clark
ASHA

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy _____

Assigned To: CB - Scheduling - I see no point -
They are telling us nothing
new. If they wanted
to discuss how STD
programs in the US
could be reformed -
that's another story -

RCVD: _____ DONE: _____

Recommendations/Instructions:

To Support Staff: _____

Date of Response: 2-14-97

n:\corresli

Done

December 15, 1995



Ms. Patsy Fleming
Director
Office of National AIDS Policy
750 Seventeenth Street, NW
Suite 600
Washington, DC 20503

*American
Social
Health
Association*

Dear Ms. Fleming:

On behalf of the American Social Health Association (ASHA), I would like to request a meeting with you to discuss the role of sexually transmitted disease (STD) prevention in curbing the spread of HIV/AIDS. As coordinator of the Coalition to Fight Sexually Transmitted Diseases (STD Coalition) and operator of the national AIDS hotline, ASHA has been a leader in the fight against all STDs for the last eighty years.

I would like to discuss the role that pre-existing STDs play in facilitating HIV transmission. Enclosed are documents which offer compelling evidence that STDs increase susceptibility to HIV infection. Of considerable note:

- The results of a recently completed study in Africa which provides compelling evidence that treatment of STDs can lead to a dramatic drop in HIV infection rates. The investigators in this study confirmed that, "simple replicable STD care activities integrated into primary health care services can lead to a considerable reduction of HIV." In fact, improved STD case management resulted in a 42% drop in HIV incidence in the general population in Tanzania. It is important to note that the largest reduction in HIV transmission occurred among women age 15-24. As you know, in this country HIV infection rates are exploding among young women.
- As the enclosed map demonstrates, areas of the nation that experience the highest incidence of STDs, also exhibit the highest rate of HIV infection in women of childbearing age.

311 Massachusetts Avenue, NE
Washington, DC 20002
(202) 543-9129
Fax (202) 543-5327

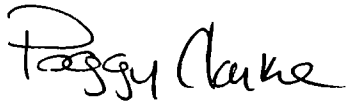
Ms. Fleming
December 15, 1995
Page Two

Twelve million new STD infections occur in the United States every year. When one considers that each of these persons faces an increased risk of acquiring HIV, it is clear that STD prevention and control should be an integral part of the national AIDS program. I would like to explore further how your office could coordinate with HIV and STD advocates to educate Americans about this risk factor.

I would appreciate the opportunity to discuss these issues in person. Ms. Erin Bush of ASHA's Washington office will contact your office next week in order to determine if your schedule would allow for a brief meeting in early January.

Thank you for considering this request.

Sincerely,

A handwritten signature in black ink, appearing to read "Peggy Clarke". The signature is fluid and cursive, with the first name "Peggy" written in a larger, more prominent script than the last name "Clarke".

Peggy Clarke
President

enclosures

Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial

Heiner Grosskurth, Frank Mosha, James Todd, Ezra Mwijarubi, Arnoud Klokke, Kesheni Senkoro, Philippe Mayaud, John Changalucha, Angus Nicoll, Gina ka-Gina, James Newell, Kokugonza Mugeye, David Mabey, Richard Hayes

Summary

A randomised trial was done to evaluate the impact of improved sexually transmitted disease (STD) case management at primary health care level on the incidence of HIV infection in the rural Mwanza region of Tanzania. HIV incidence was compared in six intervention communities and six pair-matched comparison communities. A random cohort of about 1000 adults aged 15–54 years from each community was surveyed at baseline and at follow-up 2 years later. Intervention consisted of establishment of an STD reference clinic, staff training, regular supply of drugs, regular supervisory visits to health facilities, and health education about STDs.

12 537 individuals were recruited. Baseline HIV prevalences were 3.8% and 4.4% in the intervention and comparison communities, respectively. At follow-up, 8845 (71%) of the cohort were seen. Of those initially seronegative, the proportions seroconverting over 2 years were 48 of 4149 (1.2%) in the intervention communities and 82 of 4400 (1.9%) in the comparison communities. HIV incidence was consistently lower in the intervention communities in all six matched pairs. Allowing for the community-randomised design and the effects of confounding factors, the estimated risk ratio was 0.58 (95% CI 0.42–0.79, $p=0.007$). No change in reported sexual behaviour was observed in either group.

We conclude that improved STD treatment reduced HIV incidence by about 40% in this rural population. This is the first randomised trial to demonstrate an impact of a preventive intervention on HIV incidence in a general population.

Lancet 1995; 346: 530–36

Introduction

The cumulative total of adult HIV infections rose to an estimated 18 million by late 1994, and is projected to reach 30 to 40 million by the year 2000.^{1,2} Most new infections are acquired in the developing world and are heterosexually transmitted. Large numbers of infections continue to occur in sub-Saharan Africa, the region most severely affected during the first decade of the epidemic. Recently, the epidemic has begun to spread rapidly in some parts of southern Asia, and the number of new infections there may exceed that in Africa within the next 10 years.³

In the face of this severe and worsening epidemic, AIDS prevention programmes of varying intensity and efficiency have been set up in most affected countries. However, the impact of these programmes is unclear, due largely to lack of well-designed evaluation studies.³

In the absence of an effective cure or vaccine, the main preventive strategy has been health education aimed at achieving a reduction in risky sexual behaviour and, in some countries, the promotion of condom use. Other sexually transmitted diseases (STDs) are highly prevalent in many of the worst affected populations,⁴ and observational studies suggest that the sexual transmission of HIV may be enhanced in the presence of such STDs.^{5,6} For this reason, the WHO has recommended programmes to improve the management of STDs as an additional HIV control tool, and it has been suggested that the treatment of bacterial STDs may be one of the most cost-effective health interventions available in some developing countries.^{7,8} However, no empirical data have been available on the impact of such measures on the incidence of HIV infection, or on their cost-effectiveness as a public-health strategy.

It was against this background that we undertook a community-based randomised intervention trial in a rural area of north-western Tanzania. The objectives of the trial were to establish a programme for the improved diagnosis and treatment of STDs in the general population, and to measure the impact of this intervention on the incidence of HIV infection and on the prevalence and incidence of STDs. The improved STD services were designed to be feasible rather than optimal, were integrated with the Tanzanian primary-health-care system, and were based on syndromic treatment algorithms as recommended by WHO.⁹ We report the impact of the programme on HIV incidence.

Methods

The trial was conducted between November, 1991, and December, 1994, in the Mwanza region of Tanzania, which is situated on the southern shores of Lake Victoria. The study population, and the rationale and design of the trial and of the intervention programme, have been described,¹⁰ but the most important aspects are summarised below.

African Medical and Research Foundation (AMREF), Mwanza, Tanzania (H Grosskurth MD, J Todd PhD, E Mwijarubi, P Mayaud MD, A Nicoll FRCP, G ka-Gina MD, J Newell PhD); London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK (H Grosskurth, J Todd, P Mayaud, A Nicoll, J Newell, Prof D Mabey FRCP, R Hayes MSc); National Institute for Medical Research, Mwanza (F Mosha MD, K Senkoro MSc, J Changalucha MSc); Bugando Medical Centre, Mwanza (A Klokke PhD); Regional Medical Office, Mwanza (E Mwijarubi); and Municipal Health Office, Mwanza (G ka-Gina, K Mugeye MD)
Correspondence to: Mr Richard Hayes

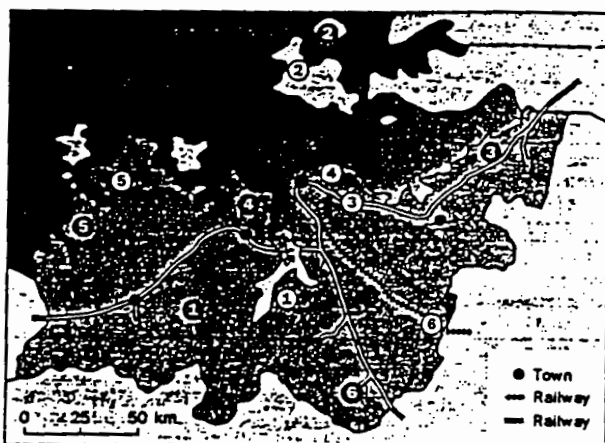


Figure 1: Map of Mwanza region
Numbered circles indicate location of six pairs of study communities;
intervention communities are shown in black circles.

STD intervention programme

The programme had five components. First, establishment of an STD reference clinic and laboratory in Mwanza town to monitor the aetiology of STDs and the effectiveness of the treatment algorithms. Second, training of existing staff from health centres and dispensaries in the intervention areas in the diagnosis and treatment of STDs with syndromic treatment algorithms. The training comprised 1 week of classroom teaching followed by 2 weeks of practical training at the STD reference clinic in Mwanza town. The staff were also trained to provide patients with STDs with health education and to offer free condoms for use during the current STD episode. Third, regular supply of the drugs needed to treat STDs effectively. To ensure continuous availability of drugs, a special delivery system was set up to supplement the supplies provided through the national essential drugs programme. Fourth, regular supervisory visits by a programme officer to each health facility to provide in-service training, and to check drug supplies and patient records. Finally, periodic visits by a team of health educators to the villages served by each health facility to provide information on STDs, focusing on the availability of effective treatment and encouraging prompt attendance for treatment of symptomatic STDs.

Impact evaluation

12 large communities, each consisting of the catchment population of a health centre and its satellite dispensaries, were selected as the elements for randomisation. A previous survey in the region had demonstrated substantial geographical variations in HIV prevalence, with a higher prevalence in roadside settlements than in rural villages,¹³ and a raised prevalence was also observed in villages close to the lake shore. To help ensure comparability of the intervention and comparison communities with respect to baseline HIV and STD prevalences and risk factors for infection, the communities were matched into six pairs according to the following criteria: roadside, lakeshore, island, or rural location; geographical area (paired communities were generally in the same district and less than 50 km apart); and prior STD attendance rates at the health centre, mainly to eliminate those health centres that were barely functioning.

In each matched pair, one community was randomly chosen to receive the STD intervention immediately following the baseline survey, whereas the comparison community received the intervention after the follow-up survey 2 years later. Locations of the study communities are shown in figure 1.

The impact of intervention on the incidence of HIV infection and on the prevalence and incidence of STDs was measured in a random cohort consisting of 1000 adults from each community. Clusters of households were sampled randomly from the population residing within 90 min walking distance of the health centre, by a sampling scheme described previously.¹⁴ All adults

aged 15–54 years in the selected households were eligible for inclusion.

Surveys of the study cohort were conducted at baseline and at follow-up 2 years later. Informed oral consent was obtained from each adult at enrolment, and personal characteristics, circumcision status, and history of STDs were recorded through a confidential interview. A sample of venous blood was taken from all consenting subjects. Men were asked to provide a first-void urine sample, which was tested on the spot with a leucocyte esterase dipstick (LED, Nephur-Test+Leuco, Boehringer-Mannheim). Men with a positive LED test, and those reporting or found on examination to have urethral discharge, were asked to provide a urethral swab. All participants were seen by a clinician, who provided treatment for symptomatic STDs and other illnesses.

Laboratory methods

Serum was separated and tested for HIV antibodies by ELISA assay (Vironostika HIV MIXT Microelisa, Organon, Teknika, Baxtel, Netherlands). All positive samples underwent confirmatory testing with a methodologically independent ELISA (Wellcozyme HIV 1+2 GACELISA, Murex Diagnostics, Dartford, UK) and, in case of discrepant or indeterminate ELISA results, a western blot test (HIV-1 Westernblot, Epitope, Beaverton, Oregon, USA). Western blot results were considered positive if WHO criteria were fulfilled.¹⁵ Indeterminate western blot results were considered negative in the analysis. HIV-2 has yet to be observed in this area, and data on HIV prevalence and incidence can be taken to refer to HIV-1 infection.

Serological tests for syphilis were carried out by the rapid plasma reagin (RPR) test (with VD 25 VDRL Carbon Antigen, Murex, Dartford, UK) and the *Treponema pallidum* haemagglutination test (TPHA, Fujirebio, Tokyo, Japan). TPHA seropositivity was considered to indicate past or current syphilis infection, while positivity on both TPHA and RPR tests was considered indicative of active syphilis. An initial RPR test was done in the field, and subjects with a positive RPR test were treated on the spot for syphilis.

Urethral swabs were tested for *Neisseria gonorrhoea* by gram stain, and for *Chlamydia trachomatis* by an antigen capture enzyme immunoassay (IDEIA Chlamydia, Novo Nordisk Diagnostika, Cambridge, UK). Gonorrhoea was diagnosed when intracellular gram negative diplococci were seen in urethral smears. For logistical reasons, it was not possible to attempt isolation of *N gonorrhoea* in this rural population-based study. Chlamydia infection was diagnosed after a confirmatory blocking assay on all positive samples. Urethritis was defined as *N gonorrhoea*/*C trachomatis* infection and/or the presence of five or more polymorphs per high power field in urethral smears.

Sexual behaviour survey

To determine whether any differences in HIV incidence between intervention and comparison groups may have resulted from differences in sexual behaviour, separate random sampling of one in eight cohort members was done after the baseline and follow-up surveys. The selected individuals were revisited and interviewed concerning sexual attitudes and practices with a detailed questionnaire.

Statistical methods

Since randomisation was applied at the community level, statistical inference needed to take account of between-community variations in HIV incidence. Within each matched pair, the risk ratio (RR) of HIV incidence in the intervention community relative to the comparison community was computed. A point estimate of the overall RR was calculated as the geometric mean of the pair-specific RRs. Statistical significance was assessed with the paired *t* test on the logarithms of the RRs, and corresponding 95% CIs for the RR were obtained. Significance was further evaluated with the non-parametric sign test.

	Men		Women	
	Intervention (n=2881)	Comparison (n=2998)	Intervention (n=3261)	Comparison (n=3397)
HIV positive	3.4	4.1	4.1	4.7
Syphilis (TPHA+)	15	14	17	16
Active syphilis (TPHA+/RPR+)	7.9	7.8	9.5	8.8
NG/CT	2.4	3.2	..	..
Symptomatic NG/CT	0.3	0.5	..	..
Urethritis	10	11	..	..
Symptomatic urethritis	1.0	1.3	..	..
Reported GUS ever	14	16	5.1	6.1
Reported GDS ever	24	31	7.7	8.7

NG/CT=*N gonorrhoea*/C *trachomatis*, GUS=genital ulcer syndrome, GDS=genital discharge syndrome.

Table 1: Baseline prevalence (%) of HIV infection and other STDs by sex, in intervention and comparison communities

To adjust for differences between the intervention and comparison communities that might bias the estimate of impact, a logistic regression model was fitted using data on individuals and including terms for the matched pair, age-group (15-19, 20-24, 25-29, 30-34, 35-44, 45-54 years), sex, travel out of the village during the follow-up period, reported history of STD (ever) at the baseline survey, and male circumcision status. By computing observed and expected numbers of HIV seroconversions in the intervention (O_1 , E_1) and comparison (O_0 , E_0) communities, an adjusted RR was obtained for each pair as $(O_1/E_1)/(O_0/E_0)$. Adjusted significance tests and confidence intervals were calculated as before.

Evaluation of the impact of the intervention on the prevalence of STDs at follow-up was based on the seroprevalence of active syphilis, and on the prevalence of confirmed urethritis and *N gonorrhoea*/C *trachomatis* infection in men. Since many urethral infections were symptomless,¹⁴ additional analyses were done of the prevalence of symptomatic urethritis and *N gonorrhoea*/C *trachomatis* infections in men. Statistical methods were as for HIV incidence.

The number of communities and the size of the cohort were chosen to provide 80% power of detecting a 50% reduction in annual HIV incidence from 1% to 0.5%, taking account of the expected level of between-community variation in incidence rates.¹⁵

Results

Cohort enrolment and baseline comparability

12 537 adults were enrolled at the baseline survey, representing 85% of eligible individuals from the sampled households. Detailed results of the baseline survey have been presented previously.¹⁴ The randomisation and matching procedures were shown to have provided intervention and comparison groups that were generally similar at baseline with respect to HIV prevalence, history and prevalence of STDs, and measured risk factors for HIV infection. However, there was some imbalance in reported history of STDs (ever), travel away from the village, and male circumcision, and so these variables were adjusted for in the impact analysis.

	Intervention	Comparison	Total
Men			
Recruited	2881	2998	5879
Seen at follow-up	2052	2187	4239
Coverage (%)	71	73	72
Women			
Recruited	3261	3397	6658
Seen at follow-up	2234	2372	4606
Coverage (%)	69	70	69
Total			
Recruited	6142	6395	12 537
Seen at follow-up	4286	4559	8845
Coverage (%)	70	71	71
Losses to follow-up	1856	1836	3692
Moved	814 (13%)	924 (14%)	1738 (14%)
Temporary absence	291 (5%)	459 (7%)	750 (6%)
Died	87 (1%)	109 (2%)	196 (2%)
Other	664 (11%)	344 (5%)	1008 (8%)

Table 2: Numbers recruited to cohort, coverage at follow-up survey, and reasons for loss to follow-up in intervention and comparison communities

Baseline prevalences of HIV and STDs are summarised in table 1. Overall HIV prevalences at baseline were 3.8% and 4.4% in the intervention and comparison groups, respectively, while prevalences of active syphilis were 8.7% and 8.3%, respectively. HIV prevalence was higher in the intervention community in three matched pairs, and in the comparison community in the other three pairs.

Implementation of intervention

The intervention programme was successfully established in all six intervention communities. Clinic records showed that 11 632 cases of STDs were treated in the intervention health units during the 2 years of follow-up. Previous data¹⁷ (unpublished observations) have shown that the treatment regimens would be expected to achieve cure in over 90% of cases.

Coverage at follow-up survey

8845 (71%) cohort members were seen again at the follow-up survey 2 years later. 1738 (14%) had moved permanently away, 750 (6%) were temporarily away, 196 (2%) had died, and 1008 (8%) did not participate for other reasons (refusals, inaccessibility due to heavy rains, or reason not recorded). Coverage rates were very similar in the intervention (70%) and comparison (71%) groups (table 2). Reasons for non-participation were broadly similar in the two groups, although losses due to "other" reasons occurred somewhat more frequently in the intervention group.

Impact on HIV incidence

HIV prevalence at baseline, and HIV seroconversions over the 2 years of follow-up, are shown for each community in

	HIV baseline prevalence (%)		HIV seroconversions		Crude RR (95% CI)	Adjusted RR* (95% CI)
	Intervention	Comparison	Intervention	Comparison		
Matched pair/stratum						
1 Rural	3.9	3.0	5/568 (0.9%)	10/702 (1.4%)	0.62	0.59
2 Islands	2.0	1.6	4/766 (0.5%)	7/833 (0.8%)	0.62	0.65
3 Roadside	6.8	8.6	17/650 (2.6%)	20/630 (3.2%)	0.82	0.88
4 Lakeshore	5.4	4.3	13/734 (1.8%)	23/760 (3.0%)	0.59	0.62
5 Lakeshore	2.8	4.7	4/732 (0.5%)	12/782 (1.5%)	0.36	0.35
6 Rural	1.8	4.5	5/699 (0.7%)	10/693 (1.4%)	0.50	0.50
Overall	3.8	4.4	48/4149 (1.2%)	82/4400 (1.9%)	0.57† (0.42-0.76)	0.58† (0.42-0.79)

*Adjusted for age, sex, travel during follow-up period, history of STD (ever) at baseline, and male circumcision. †Geometric mean.

Table 3: HIV incidence over 2 years in intervention and comparison communities, and crude and adjusted risk ratios

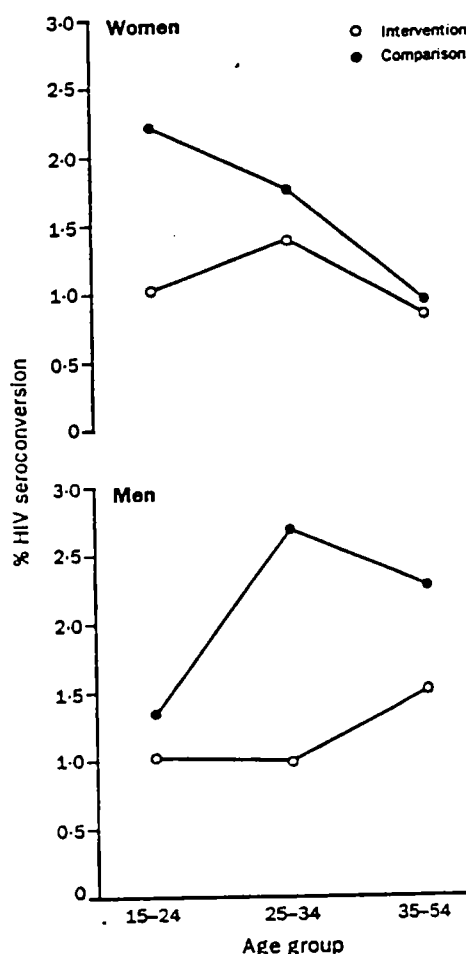


Figure 2: Incidence of HIV infection over 2 years by age and sex in intervention and comparison communities

table 3. HIV results were available at both baseline and follow-up for 8825 (99.8%) of those seen at follow-up. Of these, 276 (3.1%) were HIV positive at baseline, so that HIV incidence calculations were based on 8549 initially seronegative individuals—4149 in the intervention group and 4400 in the comparison group.

Over the 2 years of follow-up there were 48 seroconversions (1.2%) in the intervention group and 82 (1.9%) in the comparison group. HIV incidence varied substantially between matched pairs, but was consistently lower in the intervention community than the comparison community in all six matched pairs (table 3). When the data were analysed to take account of between-community variation, the RR for seroconversion in intervention compared with comparison communities was 0.57 (95% CI 0.42–0.76, $p=0.004$). When the analysis was adjusted for variables showing an imbalance between the two treatment groups at baseline, the RR was virtually unchanged (0.58, 0.42–0.79, $p=0.007$). A non-parametric test gave similar results (two-sided $p=0.03$ for both unadjusted and adjusted analyses).

Seroconversion rates are shown by age and sex in figure 2. HIV incidence in the comparison group was highest in women aged 15–24 years and men aged 25–34 years. In the intervention group, the greatest proportionate reductions in incidence occurred in the same two age/sex groups. However, numbers of seroconversions at each age were small, and the differences in effect between age/sex groups were not statistically significant (test for

Marker	Prevalence		Crude RR* (95% CI)	Adjusted RR*† (95% CI)
	Intervention	Comparison		
Active syphilis	445/4260 (10.4%)	516/4539 (11.4%)	0.90 (0.76–1.06)	0.92 (0.78–1.07)
NG/CT‡	52/2052 (2.5%)	66/2187 (3.0%)	0.68 (0.27–1.68)	0.65 (0.26–1.62)
Symptomatic NG/CT‡	19/2052 (0.9%)	26/2187 (1.2%)	0.58 (0.14–2.51)	0.72 (0.25–2.07)
Urethritis‡	119/2052 (5.8%)	152/2187 (7.0%)	0.84 (0.31–2.26)	0.84 (0.32–2.20)
Symptomatic urethritis‡	32/2052 (1.6%)	54/2187 (2.5%)	0.48 (0.09–2.70)	0.49 (0.09–2.55)

NG/CT=N gonorrhoea/C trachomatis.

*Geometric mean of pair-specific risk ratios. †Adjusted for age, sex, travel during follow-up period, history of STD (ever) at baseline, and male circumcision.

‡Men only.

Table 4: Markers of STD prevalence at follow-up in intervention and comparison communities, and crude and adjusted risk ratios

interaction obtained by logistic regression, ignoring between-community variation, gives $\chi^2=2.69$, 5 df, $p=0.75$).

Impact on STD prevalence

Markers of STD prevalence at follow-up in the intervention and comparison communities are shown in table 4. Prevalence was consistently lower in the intervention group for all markers. However there was substantial between-community variation, and none of the differences were statistically significant when this variability was taken into account. The greatest effect observed was on symptomatic urethritis in men, with prevalences at follow-up of 1.6% in that intervention group and 2.5% in the comparison group, giving an adjusted RR of 0.49 (CI 0.09–2.55, $p=0.32$).

Sexual behaviour

Results from the sexual behaviour surveys at baseline and follow-up are summarised in table 5. At baseline,

	Men		Women	
	Intervention	Comparison	Intervention	Comparison
Baseline				
n	237	281	298	301
Lifetime partners (%)				
0	1	3	3	4
1	7	5	28	26
2–4	18	22	47	53
5–19	44	44	19	16
20+	31	26	3	1
Partners past year (%)				
0	7	10	9	10
1	44	36	78	83
2	22	25	9	6
3–4	18	22	3	1
5+	10	8	1	0
Follow-up				
n	216	268	248	255
Partners past year				
0	5	4	10	10
1	42	46	81	75
2	27	26	7	12
3–4	18	19	2	2
5+	8	6	0	0
Casual partners past 2 years				
0	62	55	89	87
1	14	17	6	7
2	10	11	3	3
3+	14	17	2	3

Table 5: Numbers of sexual partners reported in intervention and comparison communities at baseline and follow-up

reported numbers of lifetime sex partners and of sex partners during the past year were similar in the intervention and comparison groups in both sexes. At follow-up, reported partners during the past year showed no change from baseline, and there was still no material difference between the intervention and comparison groups. Data were also collected at follow-up on reported "casual" partners during the past 2 years, defined as all sex partners other than those described as "regular" or living with the respondent. Similar results were again obtained in the intervention and comparison groups.

At baseline only 2% of men reported sexual contact with bar girls or prostitutes during the past year, and this question was not repeated at follow-up. Information was collected at follow-up on condom use during the follow-up period. Condom use with sex partners other than their spouse was reported by only 2.4% of men (intervention 1.6%, comparison 3.0%) and 2.3% of women (intervention 2.7%, comparison 1.8%). Only three individuals reported regular use of condoms.

Discussion

Rational health policy decisions depend on reliable data on the cost-effectiveness of different health interventions. Because of the urgency of the AIDS epidemic, interventions have had to be made without the benefit of such data. Although a few evaluation studies have been published,¹⁸⁻²⁰ these have been observational in design, and this is the first report of a randomised controlled trial of a preventive intervention against HIV in the general population anywhere in the world.

Although WHO has advocated improved STD treatment as an additional HIV control strategy for some years, the empirical basis for this policy has been slender. While evidence from observational studies is consistent with the hypothesis that STDs act as a biological cofactor for HIV transmission,²⁴ there are substantial difficulties in interpreting such data, and the magnitude of any such effect is unknown.²¹⁻²³ The impact of improved STD treatment depends on the proportion of HIV infections in the general population that are attributable to the cofactor effect of STDs, and on the reduction in STD prevalence that might be achieved by an intervention programme, and neither is easy to predict. By incorporating randomisation within the phased introduction of an STD intervention programme in the Mwanza region of Tanzania, we have been able to obtain reliable data on the impact of this programme on HIV incidence.

We have demonstrated an overall reduction in HIV incidence of about 42% over 2 years of follow-up. The reduction occurred in both sexes, and was observed consistently in all matched pairs of study communities. The observed annual incidence of 0.9% in the comparison group was close to the 1% assumed in the study design, and similar to the incidence observed in the rural population of neighbouring Kagera region.²⁴ Since the intervention was randomised at the community level, it was essential to use statistical methods that took account of between-community variation in incidence. Such analysis demonstrated a highly significant impact, and it is therefore very unlikely that chance accounted for the observed differences. Are there any sources of bias which might account for the findings?

These results might be explained by a lack of comparability between the treatment and comparison communities, such that HIV incidence would have

differed in the absence of intervention. Although matching and randomisation should have minimised this problem, with 12 study communities some differences cannot be ruled out. However, data collected at baseline support the comparability of the two groups and, in particular, baseline prevalences of HIV and syphilis were similar.¹⁴ Where imbalances in risk factors were identified, these were adjusted for in the analysis, with little effect on the impact estimates.

Losses to follow-up are an important source of bias in prospective studies, since those lost may differ in risk from those continuing under follow-up. Of our cohort, 71% were seen at follow-up, or 83% after excluding those who had died or moved away permanently. These coverage rates are within the range generally considered acceptable in population-based studies. Coverage rates were almost identical in the intervention and comparison groups, and reasons for loss to follow-up were broadly similar, although losses due to "other reasons" were somewhat higher in the intervention group. This discrepancy was due mostly to a low coverage rate in one intervention community, which became inaccessible due to onset of the rains, and to field worker error in another intervention community resulting in failure to record reasons for some losses. It seems unlikely that the comparison of the two groups has been influenced substantially by losses to follow-up.

The HIV testing algorithms employed were highly sensitive and specific, but a small number of false positives or negatives cannot be ruled out. Since the HIV testing laboratory was kept blind to the origin of the serum specimens, any such misclassification should not be different between the two study groups, and the effect of misclassification would be modest dilution of the intervention effect.

Further bias may have resulted from "contamination" effects—for example, if individuals from comparison communities travelled to intervention villages to take advantage of the improved services. In our trial, the study communities were carefully chosen with respect to the geography of the region, so that distances between communities were large, and travel between them difficult and time-consuming. To check for this possibility, however, data were collected at the intervention health units on the place of residence of patients treated for STDs. During the 2 years of follow-up, only 59 patients from the comparison communities were recorded at these units, representing only 0.5% of those treated for STDs. The effect of any contamination bias would again be to dilute the effect of the intervention. The estimate of impact may therefore be an underestimate.

We conclude that there is strong evidence that our STD intervention programme has a substantial effect on HIV incidence in this rural population. Might this be explained by changes in risk behaviour in the intervention communities? The main focus of the intervention was on the provision of improved STD treatment services. Periodic visits were made by the project team to the intervention villages to inform the population about STDs, the main emphasis being on the importance of seeking treatment promptly and on publicising the improved treatment services available. These visits were not expected to have a substantial impact on patterns of sexual behaviour. Health education activities of the National AIDS Control Programme continued equally in the intervention and comparison communities during the

follow-up period. Although health workers in intervention units were trained to offer condoms to patients attending with STDs, patient registers indicate that only 0.9% of patients took condoms. To provide empirical data on behavioural change, special surveys of sexual behaviour were conducted at both baseline and follow-up in random samples selected from the study cohort. These data indicated no change in sexual behaviour over the 2-year follow-up period, and no material difference between the intervention and comparison communities. Furthermore, condom use remained at a very low level in both groups. Whereas condoms now seem to be relatively well-accepted in Mwanza town, due partly to the intensive condom promotion activities there, acceptability and use of condoms remain low in rural areas and more intensive interventions will be needed to change this pattern.

In the absence of sexual behaviour change, the most plausible explanation for our results is that the STD treatment programme reduced HIV incidence by shortening the average duration of STDs, thus effectively reducing the probability of HIV transmission. The data on STD prevalences were consistent with this hypothesis, all measured indicators showing a lower prevalence in the intervention group than in the comparison group at follow-up, but none of these effects was statistically significant. Moreover, some indicators showed some imbalance at baseline.

An intervention based on syndromic treatment of self-reporting cases would not be expected to have a substantial effect on the prevalence of symptomless infections. The high frequency of symptomless infections in men in this population was not recognised when the trial was designed,¹⁶ and the sample size was too small to detect a significant effect on symptomatic infections. The most reliable measure of symptomatic infections in our study cohort was the prevalence of confirmed urethritis in men reporting symptoms at the time of our survey, and it is of interest that this indicator showed the greatest reduction in the intervention group compared with the comparison group.

Our data on STDs were limited by logistical constraints on the diagnostic methods that could be employed in a rural field survey, and by the subjective nature of responses on symptomatic infections. Future trials will need to pay careful attention to these difficulties.

The magnitude of the effect on HIV incidence is the clearest evidence to date that a large proportion of HIV infections in this population are attributable to the cofactor effect of STDs, and this may help to explain the rapid heterosexual spread of HIV in many parts of sub-Saharan Africa. The largest impact of intervention was seen in women aged 15–24 and men aged 25–34; these are the age/sex groups in which the highest incidences of HIV were observed in the comparison communities, and STDs might play a particularly important part in facilitating HIV transmission in these groups. If an STD intervention strategy that relied on effective treatment of self-presenting symptomatic cases is able to reduce HIV incidence by almost half, more intensive STD control measures might have a greater effect.

How generalisable are our results to other rural populations in Africa? With an adult HIV prevalence of around 4% and an annual incidence of around 1%, the rural population of Mwanza region is fairly typical of many other parts of eastern and southern Africa.

Although information on the prevalence of STDs in African population is sparse, our data are similar to other published results.^{12,13} Furthermore, the intervention strategy we adopted was chosen for its potential replicability in low-income countries, and was designed to be implemented through routine primary-health-care services. However, ease of implementation will clearly vary according to the structure and functioning of the health services. To ensure a constant supply of the drugs needed for STD treatment, the intervention in Mwanza region incorporated a special delivery system to supplement the supplies provided through the national essential drugs programme. The cost analysis will need to examine likely variations in cost and effectiveness if a less intensive intervention were established—for example, if the programme were to rely on the routine drug supply system, or if supervisions were carried out less frequently.

Many other parts of the developing world, including southern Asia where the HIV epidemic is now spreading rapidly, have high rates of STDs and poor STD treatment services, so our intervention strategy is potentially of much wider applicability. Educational interventions, aimed at modifying risk behaviour, were not evaluated in this trial, but should in our view remain an important priority for national AIDS control programmes. However, our results suggest the importance of complementing these activities with improvements to STD treatment services wherever STDs are highly prevalent. Commentators have emphasised the inadequacy of the resources being directed globally to HIV prevention, in particular in the developing countries most affected by the epidemic. This failure may partly reflect “donor fatigue” and doubts about the impact of control activities. The demonstration that HIV incidence can be almost halved by a modest intervention in one of the world’s most disadvantaged countries should provide a message of hope, and help stimulate renewed efforts to control this epidemic throughout the developing world.

We thank the Principal Secretary, Ministry of Health, the manager of the National AIDS Control Programme, and the Director General of the National Institute for Medical Research, Tanzania, for permission to carry out and publish the results of this study; the Regional Medical Officer, Mwanza, the Director of the National Institute for Medical Research, Mwanza, the Director of the Bugando Medical Centre, Mwanza, the Director General of the African Medical and Research Foundation, and regional, district, ward, and community leaders for their support; and we thank the populations of the study communities for their support and hospitality. We also thank Dr Ties Boerma for assistance with additional data analysis, Prof Peter Smith, and Dr Maria Paalman for helpful comments on earlier versions of the manuscript, and Dr Lieve Fransen for her continuous support. The trial was supported by the European Communities (DG VIII), with additional funds from the UK Overseas Development Administration, the EC Life Sciences and Technologies for Developing Countries programme, the Centre for International Migration and Development, Germany, and the UK Medical Research Council.

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STD control for HIV prevention—it works!

See page 530

Prevention and management of sexually transmitted diseases (STDs) have seldom ranked high on national healthcare priority lists, despite their serious threat to health, especially of women and newborn babies.¹ With the emergence of a new lethal STD, HIV, and the increasing evidence that sexually acquired lesions and inflammation could facilitate HIV transmission, the picture has changed.² STD case-management has increasingly been included in HIV-prevention strategies but its potential impact on the spread of HIV remained controversial. Furthermore, STD control is often thought to be a complex and expensive strategy that drains resources from promotion of condoms and other safer sex behaviours.

In this issue, Grosskurth and colleagues report the results of a well-designed community randomised trial which show a 42% reduction of HIV incidence as a result of improved STD case-management in a rural area of Tanzania. As the researchers note, the magnitude of the effect on HIV incidence observed in this trial is the clearest evidence so far that a large proportion of HIV infections in this population are attributable to the enhancing effect of STDs. Even more important, this study shows that simple replicable STD care activities integrated into primary healthcare services can lead to a considerable reduction of HIV. Although there were earlier reports of a significant decline of HIV incidence as a result of STD case-finding in high-risk women,³ the Mwanza trial shows convincingly for the first time that the concept of STD control for HIV prevention works in the general population. If shortening the duration of self-reported STDs, mainly in males, results in a 42% reduction of HIV incidence, what would have happened if more aggressive strategies had been implemented—eg, addressing symptomless STDs via case-finding among vulnerable groups? One could reasonably expect an even greater effect.

What lessons can we learn from this study? With an apparently low key intervention (including training of healthcare workers in STD syndrome management, making available effective antibiotics for STDs, and promoting healthcare-seeking behaviour) a large effect can be obtained in terms of the proportion of STDs cured by the health services, especially when baseline quality of STD care is poor.⁴ However, the replicability and sustainability of this minimal package should be seen in the context of declining quality of health systems in many developing countries. For example, access to STD drugs is primarily a function of general access to drugs, except if separate distribution systems are established, which was the case in the Mwanza trial.

In the Tanzanian study there was no difference in sexual behaviour and condom use in the intervention and control communities. From a methodological point of view, this observation makes a more convincing case for the role of STDs as cofactors in HIV incidence, but in public health terms this finding is worrisome. Healthcare workers confronted with STD patients should not miss the opportunity to talk about safe sex and promote condoms.⁵ The disappointingly low condom uptake among the trial participants in Mwanza contrasts with

experience in other HIV/STD prevention projects.^{6,7} Promotion of behaviour change during clinic visits, although limited by time constraints, remains one of the most neglected components of STD/HIV prevention activities in developing countries.

One of the most striking findings of this intervention trial was that the largest impact on HIV incidence occurred among the very young women (15–24 years). The potential for STD/HIV reduction is the largest among young women, who are at increased risk for STD and HIV acquisition because of both behavioural and biological mechanisms (immature cervix with large area of ectopy).⁸ Special attention should be given to this highly neglected group of patients, many of whom are adolescents, in terms of comprehensive reproductive health education and delivery of services. Recent interest in integrating STD services in family planning and maternal and child health may work well for older women, but unmarried adolescents are often not welcome or make little use of such facilities.

We still do not know how best to provide accessible and effective STD care for groups such as adolescents or sex workers. The lack of simple technical tools to detect gonococcal and chlamydial infections in women is a first obstacle, and the syndromic approach to case-management works poorly in symptom-free women. With respect to service delivery, waiting for clients to come to the clinic is not enough. Outreach activities, community involvement, and low-threshold services are important components if we want to influence these hard-to-reach populations.

HIV is still spreading fast; the problem is urgent. We have learnt that no single approach will contain the epidemic, and we need all the means that are available, how imperfect they may be. The Mwanza study confirms that improving STD care-management is an important additional HIV prevention strategy. Its potential benefit will clearly depend on the prevalence of STD in the population, and the effectiveness of the STD programme. Rather than focusing our efforts on further quantifying the attributable risk of STD control, we should now put all our energies into determining how best to deliver STD care, especially to highly vulnerable populations.

Marie Laga

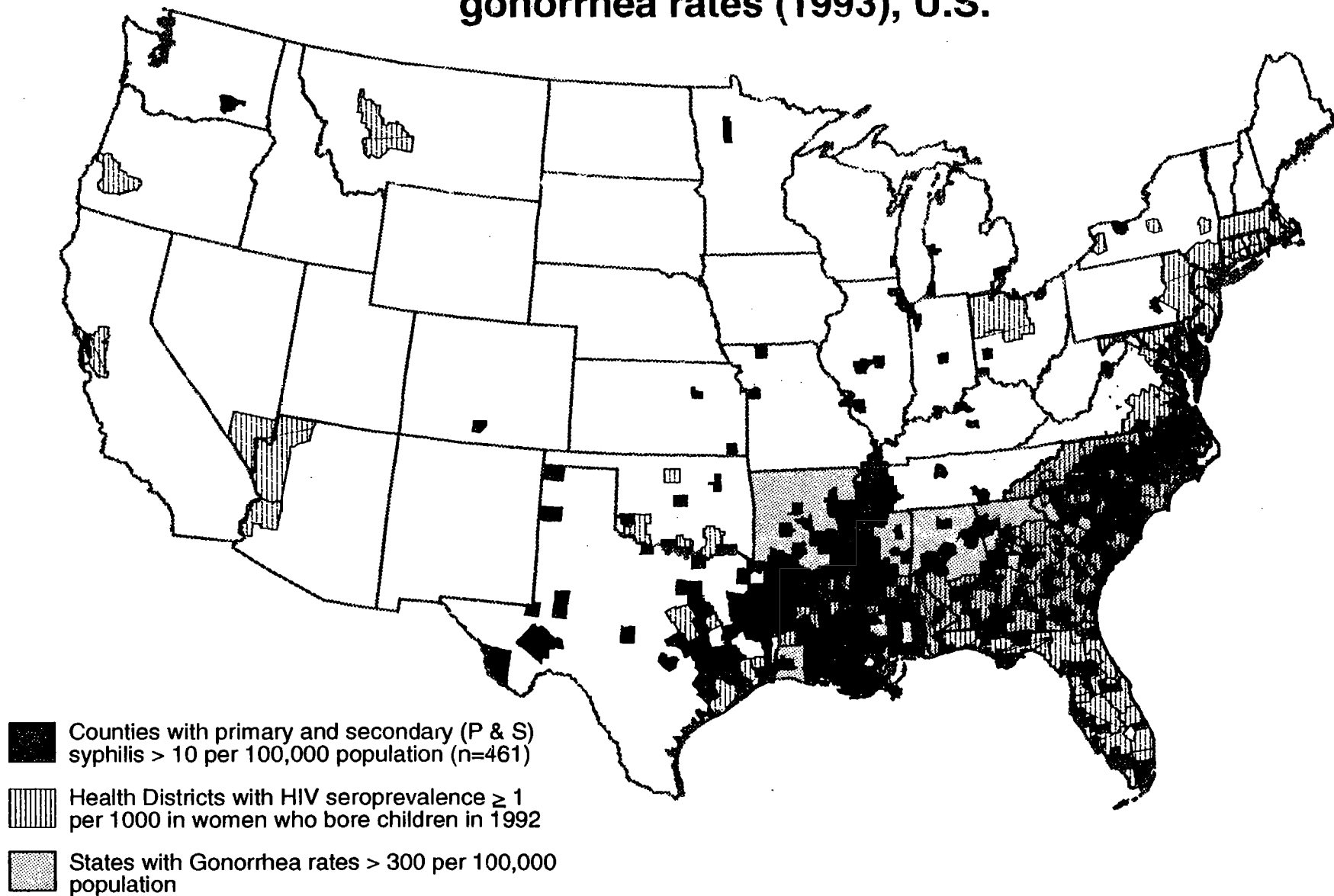
STD/HIV Research and Intervention Unit, Institute of Tropical Medicine, Antwerp, Belgium

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Health Districts with the highest HIV seroprevalence in women who bore children in 1992, counties reporting the highest primary and secondary syphilis rates (1993), and states reporting the highest gonorrhea rates (1993), U.S.



To Carmena

Date _____ Time _____

WHILE YOU WERE OUT

M. Erin Bush

of American Social Health

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TELEPHONED		PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	

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Message _____

What Patsy Schedule is

Feb. 12th or 13th

Monday AM

President

Any

Operator _____



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Erin Bush | 543-9129 |



MEMORANDUM

*American
Social
Health
Association*

January 26, 1996

TO: Carmina Paris
FROM: Erin Bush
SUBJECT: Possible Meeting Time

311 Massachusetts Avenue, NE
Washington, DC 20002
(202) 543-9129
Fax (202) 543-5327

In my continued quest to schedule a meeting between Patsy Fleming and our President, Peggy Clarke, I would like to offer a new meeting time. Peggy Clarke will be flying into Washington very early **Monday, February 12th** and would be honored to have a breakfast meeting with Ms. Fleming at **8 or 8:30 AM**.

Peggy Clarke will be in town for a meeting of the Coalition to Fight Sexually Transmitted Diseases. She would like to discuss some exciting new opportunities for the prevention of HIV transmission. Recent studies have proven that simple treatment and prevention of STDs other than AIDS can lead to a 41% drop in HIV transmission rates.

I will call you at the beginning of next week to determine if Ms. Fleming's schedule will allow for a brief breakfast meeting on the morning of February 12th. I can be reached at (202) 543-7460.

Thank you for all of your help.

*Any Monday
in March -
9-12*

Office of
National AIDS Policy

Correspondence Routing Slip

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Tracking Number: G 1870

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From: Tracie M. Gardner

Thursday

Staff Action:

Reviewed By Jeff: _____ Reviewed By: Patsy _____

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RCVD: _____ DONE: _____

Next trip
~~7/14~~

Recommendations/Instructions:

See G-1507

To Support Staff: _____

Date of Response: 2-14-97

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Federation of Protestant Welfare Agencies, Inc.



281 Park Avenue South • New York, NY 10010 • (212) 777-4800 • FAX (212) 533-8792

May 30, 1995

Ms. Patricia S. Fleming
Director
Office of National AIDS Policy
The White House
Washington, D.C.

Dear Ms. Fleming:

Patsy!

It was a pleasure seeing you last Thursday at the New York AIDS Coalition event. I appreciate your taking time to talk with me about the work that you are doing to call attention to the HIV epidemic and its impact on women and their children. I am writing to invite you to share your perspective and insight with HIV/AIDS and other human service providers of the Federation of Protestant Welfare Agencies (FPWA). We would appreciate your providing FPWA members with an update on the federal response to the HIV epidemic among women and children. We would also appreciate your commenting on the future of HIV/AIDS funding at the national level and the role and responsibilities of community based human service organizations in the fight against AIDS.

As you know, FPWA is a membership organization of more than 260 voluntary health and welfare agencies serving over 1.5 million people of all ages, races and faiths in metropolitan New York. The Federation was founded in 1922 and is a leader in the fight to provide the highest possible level and quality of services to children and families, the elderly and low income New Yorkers. The FPWA has been active in HIV/AIDS related issues since 1986. Since then, the number of our member agencies providing HIV/AIDS related services has grown rapidly in response to the impact of the epidemic on low income women and their children and families.

Please contact me at (212) 777-4800, ext 310 for more information and to confirm a date and time that would be mutually convenient.

I look forward to hearing from you soon.

Sincerely,

Tracie

Tracie M. Gardner
Policy Analyst - HIV/AIDS

cc: Megan McLaughlin, DSW
Executive Director/CEO

Federation of Protestant Welfare Agencies, Inc.

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Fax Transmittal

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MESSAGE:

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ALEXANDER BEAR
Asthma/Allergy

Hi, I'm Alexander Bear and I have asthma and allergies. I have lots of friends like me at La Rabida Children's Hospital in Chicago, Illinois. My friends and I know that having asthma means avoiding "triggers" that can sometimes cause an attack. When we have an attack, it feels like our windpipe is closing and we can't get enough air. It's scary because we can't breathe. Our triggers, such as dust mites, pollution, pollens and molds, smoke and pet dander, usually cause an allergic reaction that starts an attack.

I'm spending the year traveling and I want to see as many interesting places and meet as many exciting people as I can. Please use my journal to record tales of my travels and feel free to attach any souvenirs to help people see where I've been. Then send me off with family or friends who may be traveling, or send me to a special friend across the country. My friends in Chicago will wait eagerly for postcards to help track where I've been!

My friends in the hospital are waiting for me to be back in Chicago for a big homecoming party by July 1996. If you have me in July, please send me back to:

La Rabida Children's Hospital and Research Center

East 65th Street at Lake Michigan

Chicago, IL 60649

Attn: Development Office

Thanks for being a great travel mate!

6/13 Tracy Gardner
4:55 P.M. F PWA

212 777-4800
x 310

Whatever Patsy can do - they
will accommodate. JHOU

TO <u>Patsy</u>		TELEPHONED ☒	PLEASE CALL ☒
DATE <u>6/13</u> TIME <u>3:00</u>		CALLED TO SEE YOU ☐	RETURNED CALL ☐
PHONE CALLS		WILL CALL AGAIN ☐	URGENT ☐
"WHILE OUT" RECORD		MESSAGE <u>Spoke w/ Tracy</u>	
M. <u>Tracy Gardner</u>		<u>6/13/15</u>	
OF <u>ext 310</u>			
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RCVD: _____ DONE: _____

Reviewed by Jeff: _____ Reviewed by Patsy: _____

Recommendations/Instructions:

See G-1870

To Support Staff: _____

Date of Response: 2/14/97

Federation of Protestant Welfare Agencies, Inc.



281 Park Avenue South • New York, NY 10010 • (212) 777-4800 • FAX (212) 533-8792

May 30, 1995

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Director
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The White House
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I look forward to hearing from you soon.

Sincerely,

Tracie M. Gardner
Policy Analyst - HIV/AIDS

cc: Megan McLaughlin, DSW
Executive Director/CEO