
The AIDS Pandemic

What scientists really think about AIDS—and the media do not report

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Because of the deliberate attempts of supranational agencies such as the World Health Organization (WHO) and governmental organizations such as the Centers for Disease Control (CDC) in this country to downplay the real story of AIDS, the actual thinking of scientists as expressed in the principal scientific journals has been suppressed.

We recently reviewed the last few years' articles in four of the most well-known journals: *Lancet*, *Nature*, *Science*, and the *New England Journal of Medicine*. In comparing these published reports to newspaper accounts of the research, the general pattern is that the popular mass media have engaged in systematic non-reporting, mis-reporting, and under-reporting of the significance and extent of the research findings.

Furthermore, the evidence is overwhelming in the scientific literature that our nation and other nations should have already imposed traditional public health measures. The policy of "waiting it out" and not acting, which the U.S. government authorities have pursued, is demonstrated to have been a radical and high-risk course which has played "Russian roulette" with the health and safety of the American people.

The accompanying statement from Dr. Myron Essex of the Harvard School of Public Health further draws out the implications of our dangerous situation. The *EIR* Biological Holocaust Task Force is honored to publish the full text by the noted and distinguished scientist, Dr. Essex.

A brief sampling of the most significant of the not-generally-known material from the scientific literature itself is abstracted below:

On the respiratory transmission of AIDS

Case #1. *New England Journal of Medicine*, July 18, 1985 (Vol. 313, No. 3), contained a "Correspondence" on the extraordinary work of a team of French scientists who succeeded in isolating virulent AIDS virus from the pulmonary fluid of a 30-year old Haitian woman. The report was co-signed by the following scientists from the Pasteur Institute, the Groupe Hôpitalier Pitié-Salpêtrière, the Hôpital

Claude Bernard, and the Hôpital Laennec: J.M. Ziza, M.D., F. Brun-Vézinet, M.D., A. Venet, M.D., C.H. Rouzioux, M.D., J. Traversat, M.D., B. Israel-Biét, M.D., F. Barre-Sinoussi, Ph.D., J.-C. Chermann, Ph.D. and P. Godeau, M.D. The French scientists reported that the woman from whom they had isolated the virulent AIDS virus "had no history of blood transfusion, drug abuse, or sexual promiscuity." In a paper published in the last issue of *EIR* magazine (Oct. 25, 1985), Dr. John Seale of England commented on the French finding as follows: "This finding may explain the observation that acquired immune deficiency syndrome (AIDS) affects men and women equally in Haiti and Central Africa. It also raises the ugly possibility that LAV [the name of the AIDS virus in France] may often be transmitted by respiratory aerosols in the tropics."

Case #2: *Lancet* March 9, 1985. "Acute AIDS Retrovirus Infection": In a prospective study of AIDS antibody-negative homosexuals in Sydney, Australia, the authors found that sero-conversion (sero-conversion is the change from the blood sample not showing antibodies to a disease to the state of showing such antibodies) to AIDS-positive was correlated with an acute viral-type illness from two to six weeks prior to the sero-conversion. A prospective study monitors patients as they progress in time, whereas a "retrospective" study reports on data of events which took place before the study started. A prospective study is generally more reliable since it does not rely on haphazard data tabulation in the past nor on unreliable recollections. The illness was characterized by sore throat, muscle aches, weakness, fever, swollen lymph nodes, etc. The timing of the illness being two to six weeks before sero-conversion fits the usual picture of the lag between exposure to a pathogen and the development of immunity response. Since this illness probably represents an acute AIDS virus infection, with respiratory involvement, it is quite likely that an individual in this stage is contagious and could spread the infection via the respiratory aerosol route. Such an epidemic spread, similar in pattern to a flu, cannot be ruled out. This kind of initial reaction to the AIDS

infection may be the rule rather than the exception, but has not been noticed so far because most studies are retrospective, and the patient generally would not be able to remember, nor correlate a relatively mild flu-like syndrome occurring several years before the full-blown AIDS syndrome appears, with the disease. In any event, such flu-like syndromes are so common, that only a prospective study could hope to pick it out and relate it to sero-conversion. This kind of phased reaction to an infection is not unknown; syphilis is similar, presenting acutely with a local genital sore which resolves, followed by a possible skin rash months later which also resolves, only to be followed decades later by severe neurological disease and other manifestations.

On the stability of the AIDS virus

Case #1: *Lancet*, Sept. 28, 1985, contained an extraordinary "Correspondence" from F. Barre-Sinoussi, M.T. Nugeyre, and J.C. Chermann of the Pasteur Institute in France on the "Resistance of AIDS Virus at Room Temperature": There are two parts to this research, one in which the AIDS virus was kept in wet conditions for 2, 4, and 7 days; and another part in which the virus was dried and kept for 4 or 7 days. The article reports that in the wet conditions, no significant decrease in viability of the virus was noted after 7 days, so there is no defined "cutoff" point; the experiment needs to be continued for longer periods of time to see how long the virus can survive in wet conditions. In the dry condition, there was a significant drop-off in survivability at 7 days, but still a significant number of viruses, more than 10%, survived at 7 days. In their letter, the French scientists concluded: "This resistance of LAV [the AIDS virus] at room temperature may explain the appearance of some AIDS cases in non-risk groups. To prevent possible contamination by viral particles in dry or liquid form hygiene should be increased in the general population. Moreover, some more safety precautions should be taken in laboratories and in hospitals and by dentists. . . ." In contrast to the actual report by the French scientists, the press sensationalized the results to the point of ridicule under the format of the sort that "French scientists say AIDS can survive on a doorknob for seven days." This is misleading, since the actual maximum dry survival time was not reached in the study; and the issue of wet conditions, in which the AIDS did not even begin to significantly decline after 7 days, is not even mentioned. It should be noted that the temperature of the wet conditions is room temperature, 20° Centigrade, which could be equivalent to a dirty sewer/drinking water source in a tropical environment. There are also implications for survival of the virus in a respiratory aerosol form, whether still wet as in a cough or sneeze at close range, or in dried aerosol particles which could collect in dust, as in tuberculosis.

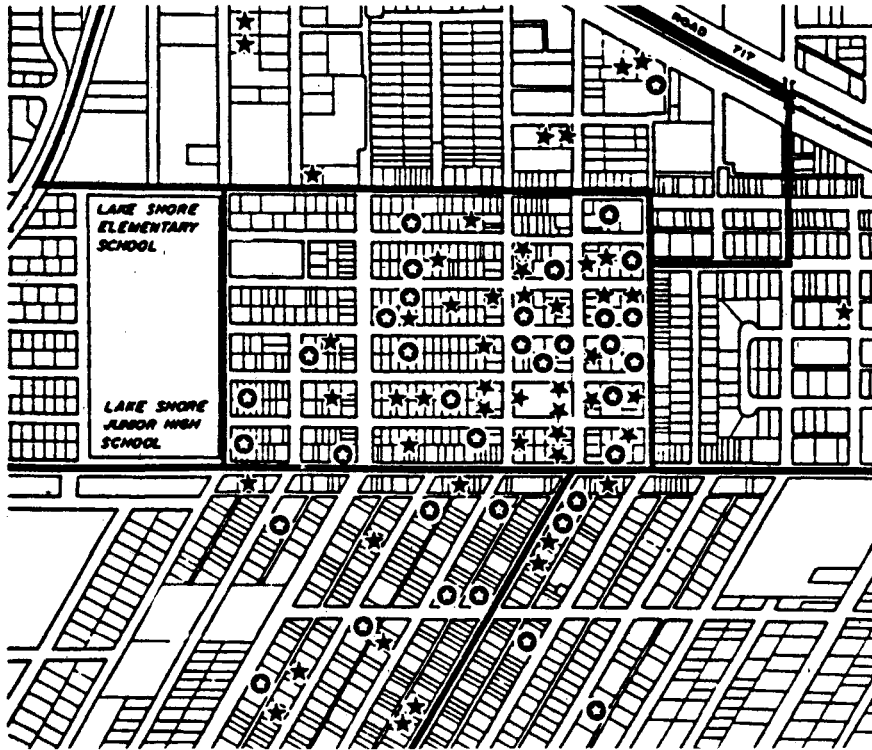
Case #2: *Lancet*, Sept. 7, 1985, contains a "preliminary communication" from six scientists at the National Eye In-

stitute, the National Cancer Institute, and the National Institutes of Health in Bethesda, Maryland on "Isolation of Human T-Lymphotropic Virus Type III from the Tears of a Patient with the Acquired Immune Deficiency Syndrome." AIDS virus was isolated from tears from a patient with AIDS. The authors state: "Repeated contact with the tears of AIDS patients could facilitate transmission of HTLV III." As an aside, the article notes that "The symptom-free patient with ARC [AIDS-related complex, such as swollen lymph nodes, but without the full-blown picture of AIDS] may be more likely than a patient with AIDS to have virus in the tears since the isolation of virus from other fluids is often easier in patients with ARC." This is important, since there are many more patients with ARC than AIDS, and if the virus is more easily isolated from those with ARC, then they probably are more infectious than those with AIDS syndrome. Not only are they more numerous than full-blown AIDS patients, but they may have only minimal symptoms and are therefore less likely to know that they are even sick.

On the possible transmission of AIDS by insects

Case #1: *Lancet*, Sept. 7, 1985, contained a paper signed by 11 leading scientists from the following institutions—the National Cancer Institute in Bethesda, Maryland; the Institute of Tropical Medicine and the University of Antwerp, both in Antwerp, Belgium; the Institute of Cancer Research in Aarhus, Denmark; Biotech, Inc., in Rockville, Maryland; and Katana Hospital, of Fomulac, Zaire. These international scientists report on a study of 250 outpatients in rural Zaire which directly correlates instances of malaria with instances of AIDS in a paper entitled: "ELISA HTLV Retrovirus Antibody Reactivity Associated with Malaria and Immune Complexes in Healthy Africans."

"A survey of 250 outpatients in rural Zaire showed that the prevalence of antibody against HTLV I, HTLV II, and HTLV III, as detected by enzyme-linked immunosorbent assay, correlated strongly with levels against *Plasmodium falciparum* [malaria]." This finding was mentioned by Dr. Mark Whiteside in his *EIR* interview (Sept. 27, 1985, Vol. 12 No. 38). The article enumerates four hypotheses to explain the correlation: Hypothesis A. Another factor, such as age or rural poverty is causing people to have both infections, which, however, are being spread by different means. The authors dismiss the possibility of age as not supported by the age data but can not rule out the factor of rural poverty; Hypothesis B. Both infections, AIDS and malaria, are spread the same way, by insects; here, the authors point out that the virus could be carried outside or possibly within the malaria parasite, and mention that in other parts of Africa, AIDS-positive serum is correlated with other parasites, such as schistosomiasis, tropical splenomegaly, and malaria in Kenya; and as well, HTLV I is correlated with malaria in Ghana, filariasis



A street map of the depressed neighborhood in Belle Glade, Florida which has produced the nation's highest per capita incidence of AIDS—and the correlation of this outbreak with an outbreak of well known disease of overcrowded, unsanitary conditions: tuberculosis.

- Confirmed AIDS (37)
- ★ Active Tuberculosis (50)

in Japan, Chagas disease in Venezuela, and strongyloidiasis in Okinawa. Some of these parasitic diseases have vectors of transmission, and some do not; C. Malaria may influence the host immune response, increasing, say, the antibody response to HTLV-III virus which is already in the body, possibly activating it; this is very close to Whiteside's suggestion of multiple factor interaction; D. The positive serum reaction in Africans may be false-positive, due to cross-reactivity with other infections; note that the test subjects in this study were apparently healthy males; a different picture may emerge if the same study is done with people with full-blown AIDS disease.

On the generalized risk of AIDS

Case #1: *Lancet*, July 14, 1985: a correspondence from five French scientists at the Hôpital de la Pitié reports on "AIDS in an Apparently Risk-Free Woman." This is a case report of a British woman who contracted AIDS two and a half years after one episode of vaginal intercourse with a Haitian as her only possible source of the infection. This kind of case argues against the promiscuous and repeated exposure which the Atlanta Centers for Disease Control describes as needed to get the infection.

Case #2: *Science*, Oct. 26, 1984: A joint paper by sci-

entists from the Pasteur Institute and Hôpital Claude Bernard in Paris, France; the Centers for Disease Control in Atlanta; the Institute of Tropical Medicine in Antwerp; the Mama Yemo Hospital in Kinshasha, Zaire; the Rega Institute at the University of Leuven; and the National Institute of Allergy and Infectious Disease in Bethesda. The authors wrote: ". . . serologic data suggest that LAV [the AIDS virus] was present as early as 1977 in Zaire." The concluding paragraphs, signed by two doctors at the Atlanta CDC itself—J. McCormick and S. Mitchell—as well as the other scientists states: "The observation of LAV seropositivity in heterosexual partners and children of AIDS patients is consistent with earlier observations of heterosexual and *familial* (vertical) transmissions of AIDS in Zairean patients. These epidemiologic features are different from those observed in the United States and Europe and will require further studies for confirmation. Finally, the significance of the higher rate of LAV seropositivity in hospitalized patients without AIDS but with tuberculosis or malaria and the significance of the correlation of seropositivity with lowered T4/T8 ratios and decreased T4 lymphocytes are still unknown. *One possibility is that these patients may have had early clinical manifestations of AIDS, but which did not fulfill our strict definition of AIDS. . . .* [emphasis added]."