Tropical Institute physicians refute CDC coverup report

In May 1986, the Atlanta-based Centers for Disease Control's (CDC) Morbidity and Mortality Weekly Report (MMWR) *threatened to publish a fraudulent report to explain away the overwhelming pattern of "No Identifiable Risk" (NIR) AIDS cases in Belle Glade, Florida. Belle Glade has the highest percentage of AIDS cases, and of NIR cases of AIDS, in the country. The CDC report was not based upon any scientific study, but was nothing more than a continuation of their "opinion" that there could not be such a pattern of cases in Belle Glade because of how they, the CDC, have arbitrarily defined the "only possible" routes of AIDS transmission.*

Dr. Mark Whiteside and Dr. Caroline MacLeod of the Tropical Disease Institute in Miami, who have courageously led a campaign to reveal the true scientific facts about AIDS and collapsed environmental factors in the tropics, produced a stinging rebuttal of the CDC report at the time, in the form of a letter to CDC officials. In response, the CDC withdrew its faulty report from publication. Nonetheless, four months later, in late September, the CDC published its lying draft. Dr. Whiteside therefore released his rebuttal to EIR *on Oct. 7, along with a prefatory statement. Below is Dr. Whiteside's statement of Oct. 7, followed by the full text of the letter:*

It is clear to me that the CDC officials had already reached their conclusions before they ever came to Belle Glade. James Mason stated in a letter to Warren Hamerman, dated Aug. 27, 1985, that "Most of the patients reported from Belle Glade have known risk factors for AIDS, such as homosexuality or intravenous drug use." Harold Jaffe reaffirmed this position and predicted that the hypothesis that "mosquitoes, poverty, or the environment" contribute to AIDS would be "laid to rest." This *MMWR* report reflects an overwhelming bias toward sexual transmission of AIDS, and the conclusions are not warranted by the available data. It is evident to a growing number of scientists and concerned citizens that there is, in fact, a direct relationship between environment and disease in Belle Glade, Fla. It is most unfortunate if this report allows us to neglect the conditions of economic squalor that allow the uncontrolled spread of such diseases as AIDS and tuberculosis.

The Whiteside/MacLeod letter to CDC

We reviewed the May 13, 1986 *MMWR* draft entitled, "Acquired Immunodeficiency Syndrome (AIDS) in western Palm Beach County, Florida." This document is unscientific, and a gross misrepresentation of the pattern of AIDS in the 'glades area. The conclusion that AIDS can be explained in this region by the classic "risk factors" with an increase in (bidirectional) heterosexual transmission is not supported by available data. It is outrageous that such sweeping conclusions are drawn when the studies are incomplete and the possible role of environmental factors have not been examined. This clumsy attempt to blame the AIDS epidemic in the Tropical setting on "sex and dirty needles" with environmental factors neatly sidestepped, is particularly unfortunate when Belle Glade is perhaps the best barometer of the changing pattern of AIDS in south Florida. The following point-by-point critique of this *MMWR* document explains why we believe it should not be published in the present form.

The article addresses western Palm Beach County, but certainly the vast majority of AIDS cases (even those listed with current residence in South Bay or Pahokee) in the Glades area, lived in or had an important link to Belle Glade. What are the facts? Independent surveys (by CDC and the Institute of Tropical Medicine in Miami) document a 9-11% seroprevalence of antibodies to HTLV-III/LAV among a largely heterosexual control population from one of the two central depressed—that is, southwest—neighborhoods of Belle Glade.[1] Over 50% of "official" AIDS, and 60-70% of HTLV-III/LAV antibody positive individuals do not have an identifiable "risk factor."[1,2] Considering that the southwest neighborhoods contain approximately 40% of Belle Glade's 20,000 population, at least 1 in 10 has been "exposed" and 1 in 200 already has AIDS. These rates are indeed comparable to those observed in Central Africa.

The "official" figures cited in the *MMWR* draft do not accurately reflect the true numbers of sick individuals in Belle Glade or the changing pattern of disease in this community, the increasing percentage in the "no identifiable risk" (NIR) category. Lack of diagnostic facilities (for example bronchoscopy-endoscopy) and few autopsies in this isolated, rural community have meant that AIDS is under-reported by a

factor of at least 3 to 1. A tropical disease clinic operated by the Palm Beach County Health Department maintains a list of over 200 persons with AIDS, presumptive AIDS (most of whom are already dead), ARC, and HTLV-III/LAV antibody positive (sick) individuals.

Clinicians, including ourselves, caring for these individuals realize the majority of new cases of AIDS are no identifiable risk (NIR) men and women, born either in the Caribbean or in the Southeastern United States. A physician, who recently visited the Tropical Disease Clinic, asked, "Don't you have any patients who are in one of the usual risk groups?"

On page 1 of the *MMWR* draft, it states that, "An additional four AIDS cases initially placed in this (NIR) category were reclassified as transfusion-associated or heterosexual contacts of intravenous drug users based on further information." CDC officials reclassified these individuals without consulting the primary care physicians, and by using secondhand or undocumented sources of information. A male who (questionably) had sexual contact with a female drug user, was considered to be "at risk" in this study.[1] Finding evidence of sexual contact in a few cases may mean nothing more than shared environmental exposures.

The CDC table of AIDS by patient characteristics and sex would indicate that 20% of AIDS occurred among persons born in Haiti. Our own records indicate that 30% of AIDS now occurs among persons born in the Caribbean.[3] The majority of these individuals do not have identifiable risk factors for AIDS. The CDC, however, continues to overlook the problem of AIDS among Caribbean immigrants to south Florida. The federal investigators do not evaluate AIDS among Haitians in Belle Glade, apparently satisfied by their own limited data suggesting that AIDS is spread by heterosexual means (or "promiscuity") in this group.[4] How, we asked, do they explain that 16% of AIDS in Florida occurs in individuals born in the Caribbean or that the rate of AIDS among Haitians living in Miami is four times the rate of AIDS of Haitians living in New York City?[5]

Newly diagnosed cases of AIDS and ARC increasingly follow the "Tropical pattern" of men and women without the usual pre-existing "risk factors." They represent nearly all age groups, with a growing number of persons from the 50- to 60-year-old age group. Although not yet diagnosed with AIDS, several children with severe Failure to Thrive Syndromes and multiple infections are being followed prospectively in the Tropical Disease Clinic.

Although the age and sex distribution reported in the *MMWR* do not reflect the current trends, the predominance of the adult male cases actually support an environmental exposure (for example, more field work, mechanical injuries, fishing on canals, etc.) and argue against heterosexual transmissions, as female-to-male AIDS is unproven, and has rarely been reported in the United States. The lack of AIDS in children is unconvincing as an argument against environmental spread of AIDS, since we believe AIDS is a disease of repeated exposure over time (enhancement) and one would expect, as seen with insect-borne viruses (for example, yellow fever), a gradually increasing instance of antibodies with age.[6]

It is puzzling why CDC finds it difficult to accept NIR AIDS, since they readily accept hepatitis B (serum hepatitis) as a model for transmission. In the Tropics, hepatitis B is a disease of the general population living in an environmentally poor, overcrowded condition. Several studies implicate insect transmission of hepatitis B in this setting.[7] It is only as the standard of living improves, that hepatitis B becomes a disease of "risk groups" with transmission by parenteral or indirect parenteral means, i.e., shared needles, direct introduction, sexual practice, at least to break some skin and mucosa. It is apparent that investigators from CDC have spent little time reviewing modes of transmission of hepatitis B in the Tropics, or the known modes of transmission of animal retroviruses. Mechanical transmission by large bloodsucking insects is a major means of spread of bovine leukemia virus and equine infectious anemia ("swamp fever") in conditions of crowding and abundant insect populations.[8,9] These retroviruses are rarely sexually transmitted from male to female animal.

This clumsy attempt to blame the AIDS epidemic in the Tropical setting on "sex and dirty needles" with environmental factors neatly sidestepped, is particularly unfortunate when Belle Glade is perhaps the best barometer of the changing pattern of AIDS in south Florida. The rates are comparable to those in Central Africa.

No identifiable risk and female-heterosexual-contact AIDS, as well as infant cases, are concentrated in black and Hispanic (often Puerto Rican) populations living in poor environmental conditions along the Southern and East Coast of the United States.[10] There has been a notable absence of female-heterosexual-contact AIDS in regions of high incidence of homosexual/bisexual men, for example, San Francisco, Calif. and Key West, Fla. All reported cases of AIDS from Belle Glade, Fla. have long-term residence in the slums

of the southwest neighborhood.

We repeat our premise that an untreatable sexually transmitted disease does not confine itself to geographical regions or a single poor neighborhood. There is no mention in this report of the concurrent epidemic of tuberculosis limited to the same poor neighborhoods in Belle Glade.

The reference to the CDC Fort Collins arbovirus survey on p. 40 of the *MMWR* draft, indicates that the Atlanta group has decided not to investigate vector transmission of AIDS, or our hypothesis that repeated exposures to Bunyamwera serogroup arboviruses lead to immunosuppression and activation of retroviruses such as HTLV-III/LAV. This paragraph omits the following critical information: 1) It was only at our urging and direction that antibodies to these arboviruses were tested; 2) Antibodies to arboviruses were measured by plaque reduction neutralization; all antibodies to HTLV-III/LAV were measured by ELISA and Western Blot procedures. It is well known that most patients with AIDS lack neutralizing antibodies to HTLV-III/LAV! 3) The survey showed a remarkably high seroprevalence of antibodies to one of these arboviruses in the HTLV-III/LAV negative control group; and 4) 17% (versus 15% in our own survey) showed antibodies to Maguari, a Bunyamwera serogroup virus endemic to the Caribbean and South America, and not previously reported in the United States.[11]

Our own data using indirect immunofluorescence (IFA), a serologic test comparable to ELISA for HTLV-III, has shown a highly significant association between antibodies to Maguari and AIDS.[12] There was an inverse correlation between neutralizing antibodies to Bunyamwera arboviruses (Tensaw, Maguari) and antibodies to HTLV-III, supporting our hypothesis of sub-neutralizing (but enhancing) concentrations of antibody to the arbovirus in persons with AIDS. The CDC has steadfastly refused to test AIDS patients for arboviruses by other serologic methods, including the IFA technique we have used for several years. It would be a miracle, if the CDC found a link between AIDS and insect vectors, considering their closed-mindedness and refusal to seriously study the subject.

One of the fundamental problems of the ongoing CDC/Florida HRS Cross-Sectional Study of AIDS in Belle Glade is that it assumes HTLV-III/LAV is the only "cause" of AIDS, and it focuses on sexual transmission of AIDS to the virtual exclusion of environmental factors. It has been noted that many people have antibodies to HTLV-III/LAV, but with no evidence of immune dysfunction, and conversely, some AIDS patients have no evidence of HTLV-III/LAV infection. Bi-directional heterosexual contact has not been proven to be the primary mode of transmission of AIDS in tropical regions (for example, Africa, Caribbean); we already know that the majority of NIR AIDS in south Florida are not explained by this mechanism. This report implies that only when CDC interviews patients is the data valid, whereas, in fact, even early (now deceased) NIR cases of AIDS in Belle Glade were independently interviewed by ourselves, public health physicians, and epidemiologists.

There is intense national and international scrutiny of the ongoing studies of AIDS in Belle Glade, and we believe the lessons learned have major public health significance, not only in south Florida, but for other communities worldwide. The *MMWR* is a greatly respected format for dissemination of accurate information. Unfortunately, there is no mechanism for rebuttal.

We never thought it would be necessary to debate with public health officials, the importance of the environment in relation to health and illness. We should have prevention and control of AIDS as our primary goal. If we wait to act until all causes and all modes of transmission of AIDS are proven, then millions will continue to be infected and die from the disease. It will be a sad day for public health in south Florida, if this document is published in the same tone as presented in the draft of May 13, 1986.

(Signed)
Caroline L. MacLeod, M.D., M.P.H., and P.M.
Mark E. Whiteside, M.D.

References

1. Lieb, S., Castro, K., Witham, D., et al., "AIDS in a rural community. Seroepidemiologic Pilot Studies, Belle Glade, Fla." APHA annual meeting, epidemiology exchange, late breakers, Nov. 20, 1985.

2. Whiteside, M. E., Whitham, D., Tavris, D., and MacLeod, C. L., "Outbreaks of No-Identifiable-Risk AIDS in Belle Glade, Fla." International Conference on AIDS, Atlanta, Ga., April 15, 1985.

3. Case Records, Tropical Disease Clinic, Palm Beach County Health Department, Glades Health Center, Belle Glade, Fla.

4. Castro, K. G., Fischel, M. A., Landesman, S. H., et al. "Risk factors for AIDS among Haitians in the United States," International Conference on AIDS, Atlanta, Ga., April 16, 1985.

5. Hardy, A. M., Allen, J. R., Morgan, W. M., Kern, J. W. "The Incidence of AIDS in Selected Populations," *JAMA*, 1985, 253, pp. 215-220.

6. Haddow, A. G., McCallum, D. Report of East African Virus Research Institute, 1962, p. 31.

7. Blumberg, D. S., in *Advances in Hepatitis Research* (Francis V. Chisari, ed.), Masson Publishing, U.S.A. & Co., 1984, pp. 1-8.

8. Brech-Nielson, S., Piper, C. E., Ferrer, J. S. "Natural Mode of Transmission of the Bovine Leukemia Virus, Role of Bloodsucking Insects." *American Journal of Veterinary Research*, 1978, vol. 39, pp. 1089-92.

9. Issel, C. T., Foil, C. D., "Studies on Equine Infectious Anemia Virus Transmission by Insects," *JAVMA*, 1984, vol. 184, pp. 293-97.

10. CDC Surveillance Statistics, AIDS Branch, CDC, Atlanta, Ga., July 1985.

11. Personal communication, Charles Calisher, CDC Vector-Borne Diseases, Fort Collins, Colo., Spencer Lieb, Epidemiologist Florida Department of Health and Rehabilitative Services, Tallahassee, Fla.

12. MacLeod, C. L., Whiteside, M. E., De Medina, M., and Shoup, R. E. "Antibodies to Maguari in Patients with AIDS," presented at American Society of Tropical Medicine Hygiene, Miami, Fla., Nov. 5, 1985.