WHO conference offers 'control strategies' for defeat by AIDS

by Our Special Correspondent in Stockholm

"We have gone backwards," said an African epidemiologist participating in the 4th International AIDS Conference sponsored by the World Health Organization (WHO). "While the epidemic has increased since last year's conference, we no longer entertain hopes for a vaccine, and treatments don't work." His views were shared by most developing nations represented here.

In contrast, a member of the press corps was enthusiastic about the "feeling" he got from the WHO chiefs' "control strategies": "This morning's plenary was really something, we went from detailed molecular biology on to panels on sex and death. It really felt like we were all together. Tomorrow's world will be a better world, whoever survives, it will be a better world for the survivors."

I am not sure this Israeli citizen understood the terrible implication of what he was saying, but what I can assert, after three days in Stockholm, is that this man had very well assimilated the message of the chief WHO propagandists.

The figures on AIDS

WHO's AIDS director Jonathan Mann announced 96,433 cases of AIDS officially worldwide and "200,000 estimated," with up to "25% in the 20 to 40 age group seropositive in some urban centers and up to 90% seropositivity in some prostitute groups." Most African, Caribbean, and Latin American panelists' posters indicated that wherever the infection was two years ago, it has been growing exponentially.

What is of significance, however, is the *increased virulence of other diseases in association with the presence of HIV.*

G. Slutkin (Global Program on AIDS and Tuberculosis Unit, Geneva WHO) presented the "effect of AIDS on TB." Today, 3 million people a year die of tuberculosis and 10 million have the disease. In developing countries, between 30% and 60% of the populations are infected. Tests done from 1985-87 on HIV seroprevalence in TB patients give very worrisome results. To cite a few figures: in Burundi, 54% of TB patients have HIV antibodies; in Uganda, 45%; and in New York City, 44.7%.

Dr. Pedro Cahn, of the Hospital Fernandes of Argentina, a country with little HIV so far, presented clinical cases of TB/AIDS: There were 15,987 cases of TB in 1986, and an epidemic of Chagas disease. While AIDS/Chagas is not yet found in Argentina, TB/AIDS is there. Haiti also has that problem. Overall, TB is considered number two in the list of the most frequent opportunistic infections associated with AIDS in Africa and tropical or semitropical countries generally. The point was made that Eastern cities of the United States have had a marked increase of TB (demonstrated by Slutkin). TB in HIV-infected patients often resists antibiotic therapy and is incurable. So far, only extrapulmonary TB is included in the definition of AIDS by the WHO.

Severe cerebral malaria has been found in Angolan HIV-positive men, in a study done by a team from Budapest.

A French team with S. Matheron of Hospital Claude Bernard, Paris, and well-known professor J.P. Coulaud, presented findings of visceral leishmaniasis associated with HIV. Since visceral leishmaniasis is endemic in the Maghreb countries and Spain, "the two diseases go hand in hand," Professor Coulaud told this writer. Mantheron argued for the inclusion of that disease in the WHO definition.

Another team argued for close monitoring of periodontal lesions that have an extraordinarily fast evolution from a normal 20 years to a few weeks, and are to be watched for as a sign of AIDS.

In short: There is a rise in virulence of all types of diseases associated with AIDS. Not a day goes by without some developing-country expert arguing that the WHO definition is too limited, inept, and that terminally ill "AIDS" patients can have a wide variety of clinical manifestations.

The neurology problem

Several participants, including Dr. Howlett of Tanzania, denounced the idea that the disease can be different in Europe or the U.S. and in Africa. The definition of AIDS for Africa, the "WHO Bangui definition" is a special category which, for example, excludes neurological findings. No less an authority than Dr. Georges, director of the Pasteur Institut in Bangui, a pioneer in AIDS clinical research in Central Africa, had to argue with the "definition." Out of 93 African AIDS patients, 16% had neurological symptoms (3 dementias, 1

hallucinatory psychosis, etc.), Georges said, "WHO considers neurological symptoms as 'minor signs,' but they can be primary"; the central nervous system is characteristically affected in AIDS, he said.

Dr. Howlett, a feisty Irishman who has done clinical work in Tanzania for five years, came in with an impressive neurological study of some 200 patients. His study, which will first be presented to the public in September at the meeting on AIDS in Harare (Zimbabwe), demonstrates that what appear to be subcortical lesions of the brain due to HIV can be clinically diagnosed with simple reflex tests. He argued (in private) that it is the first time in the history of modern medicine that a disease is defined according to secondary clinical manifestations (opportunistic diseases), as opposed to the identification of the "primary complex," effect on the central nervous system, which is the priority for research. Any breakthrough on AIDS, he thought, will come from scientists working on the side, not the "globalist" types.

Dr. Renee Malouf, a neurologist from Harlem Medical Hospital, New York, wholeheartedly agreed with Howlett: She presented studies evaluating 190 adult inpatients with either AIDS or ARC (AIDS-Related Complex), and found that 91% had neurological symptoms. Among them, she said, were two people who were admitted for severe "homicidal" psychosis into psychiatric wards.

Both researchers thought that the autopsy findings, known throughout Europe and the U.S.A., which show neurological damage in 90% of cases, could be diagnosed clinically before, and that lack of thorough neurological clinical testing was responsible for the low (10-15%) percentage of clinical neurological manifestations. Researcher R. Price, of Sloan-Kettering Memorial Cancer Center, New York, showed pallidonigral degeneration in AIDS and put forth the hypothesis that macrophages of the brain could be presenting antigen obtained from neuronal contamination.

Transmission

Four studies proved that saliva could be used equally well as blood serum to test for AIDS. Dr. Goldstein from Epitope, Inc., Portland, Oregon, said: "Saliva is an ideal body fluid for the detection of specific antibody in individuals exposed to HIV. Saliva would be a safer body fluid for testing, since it eliminates the need for needles." While he did not make the jump to say that saliva could be contaminating, another researcher from Canada, Dr. Pekovic, said, "Salivary HIV is infective as demonstrated in vitro."

Such studies demonstrate that the "condom" campaign expresses a disregard for sound medical epidemiology. Also, most clinicians agreed as to the cofactors of transmission which put into doubt the efficiency of the condom: herpes lesions; periodontal lesions; many patients are bleeding and suceptible of accidentally contaminating their partners, whether or not wearing a condom. Another study demonstrated HIV in urine.

'Control strategy'

WHO's "control strategy" was made clear in a variety of ways. The control affects the freedom of developing countries more than the freedom of the sexually promiscuous or the freedom of HIV to travel. St. John, WHO's Pan American coordinator, in the panel called "Control Strategy" said, in essence, that there could be no further dollars for individual countries' AIDS control policies *until such time* as WHO had evaluated the correctness of the approach, and that a nation was not to be allowed to make its own evaluation, as he said some had asked and were turned down.

However, when a Swedish journalist proposed that hospital construction be financed by WHO in poor countries, Dr. Mann intervened with a lengthy tirade on how "It is easy to tell them what to do," and he was not about to do that.

It was in the plenary session, for the benefit of the full 7,000 attendees, that John Gagnon, of Princeton University, U.S.A., lamented the lack of thorough scientific studies on the sexual behavior of populations both in the advanced and developing sectors.

No discrimination, no restrictions of any sort on the infected drug abuser, or the infected prostitute, was the leitmotif of the plenary sessions. While Walter Redfield of Walter Reed Hospital in Washington, D.C. proposed free distribution of heroin, the neurologist from Harlem Hospital expressed fear: The policy of distributing free needles will increase drug addiction, she said. Already 90% of drug users are infected in the New York ghetto. Besides, the policy of so-called education of addicts on AIDS is just increasing consumption of the new cocaine derivative, "crack," because no needles are involved. The crack victims come in with paralysis, when they don't come in as corpses! But "control" involves primarily money.

A West African official explained, in the corridors, how the World Bank had lent $1 million for health surveillance; when the country could not pay back the debt in time, the program ended, but the debt is still there. Now a new WHO mission is planned for which the country will have to get another loan.

Testing

A clinician from the Caribbean islands said, "An infected prostitute, a drug addict is like someone throwing bombs in my view. I have been called a sheriff for seeking to keep medical records of all the infected. I think we have records for every patient usually, why not for AIDS? Why do we have to ask for informed consent before testing? What does informed consent mean? Do we give lessons in cancerology, biology, etc. before ordering any regular medical tests? So I have been called a sheriff, what is wrong with being a sheriff?"

In the next issue: More findings on neurology: animal retroviruses; the immunological problems in finding a cure.