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by Robert S. Mendelsohn, MD

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AIDS linked to smallpox vaccine

Have you read anything in your newspaper which links the AIDS epidemic with vaccinations? Have you seen or heard any television or radio reports on the subject? I haven't, and as you know, I've been following the AIDS epidemic very carefully.

Have you heard Dr. Robert Gallo, the U.S. expert who first identified the AIDS virus, talk about AIDS and vaccines? I haven't. But, Dr. Gallo did tell the London Times (May 11, 1987), "The link between the WHO programme [the World Health Organization effort to eradicate smallpox in Third World countries] and the [AIDS] epidemic in Africa is an interesting and important hypothesis. I cannot say that it actually happened, but I have been saying for some years that the use of live vaccine such as that used for smallpox can activate a dormant infection such as HIV."

Has Dr. Gallo been making these speculations "for some years" to only the British press? Or, if he and Surgeon General Koop and the experts from the Centers for Disease Control have mentioned this to U.S. reporters, have their words been drowned in the cacaphony of statements telling people that it's their own fault if they get AIDS?

Government scientists have been quick to point the finger at peoples' lifestyles--"You don't have the right sexual partners," "You don't wear enough condoms," etc. But nowhere on the front pages of U.S. newspapers has there been a hint that the doctors may have played at least as important a role in spreading AIDS as have the people.

Look how quick government doctors are to blame drug addicts for spreading AIDS by sharing needles. But have they told you that, in the recent WHO smallpox vaccination campaign, needles were re-used 40 to 60 times? The main method of "sterilization" was waving the needle across a flame. Doctors are quick to play the game of "blame the victim," but what if it turns out that doctors themselves are responsible for the victims' plight?

WHO information indicates that the AIDS table of Central Africa matches the concentration of smallpox vaccinations, i.e., the greatest spread of HIV infection coincides with the most intense immunization programs. Thus, Zaire, at the top of the AIDS list, had 36,000,000 people immunized with the smallpox vaccine. Next is Zambia, with 19 million, followed by Tanzania with 15 million, Uganda with 11 million, Malawai with 8 million, Ruanda with 3.3 million and Burundi with 3.2 million. Brazil, the only South American country covered by the smallpox eradication campaign, has the highest incidence of AIDS in that part of the world.

This theory--that the AIDS epidemic in Africa may have been triggered by the smallpox immunization program--has sparked intense debate among scientists. You may not have heard about this debate, but an urgent call for evidence to support the idea has been demanded by the World Health Organization. This theory was discussed by WHO officials last autumn. No follow-up data are available from the smallpox eradication campaign because no systematic studies of the complications produced by the mass immunization have been done(!).

According to Professor Oswald Jarrett, an AIDS researcher at the University of Glasgow (Scotland): "We need to know whether the virus was spread from a small to a large group of people through the immunization programme." And Dr. Laurence Gerlis, a clinical AIDS researcher, states, "Previous circumstantial evidence looks more persuasive alongside the latest research that shows AIDS can be stimulated by smallpox vaccination."

Here's what the unnamed WHO advisor who disclosed the problem to the Times had to say: "I thought it was just a coincidence until we studied the latest findings about the reactions which can be caused by vaccinia. Now I believe the smallpox vaccine theory is the explanation to the explosion of AIDS."

This theory also provides an explanation of how AIDS infection is spread more evenly between males and females in Africa than in the West.

Further evidence of the link between AIDS and the smallpox vaccine comes from the Walter Reed Army Medical Center in Washington, D.C., where routine smallpox vaccination of a 19-year-old army recruit was the trigger for the stimulation of dormant HIV virus into full-blown AIDS. This discovery was made by a medical team working with Dr. Robert Redfield at Walter Reed. The recruit developed AIDS two-and-a-half weeks after being immunized against smallpox, and he died shortly thereafter.

While in no way diminishing the role certain lifestyles play in AIDS causation, isn't it high time that we turn the spotlight on the possibility that modern medical miracles--immunizations included--can help cause modern medical plagues?

AIDS and hepatitis B vaccine

The safety of the hepatitis B vaccine (a human blood product) has been questioned in the Journal of the American Medical Association (January 16, 1987). Albert L. Meric of Metairie, Louisiana, disagrees with other researchers who insist that the AIDS virus has been physically removed from the hapatitis vaccine. He points out that just because hepatitis vaccine recipients did not develop antibodies to the AIDS virus does not mean the AIDS virus is not present in the hepatitis vaccine. Or, to use his own words, "It does not rule out the physical presence of AIDS virus antigen in the vaccine." Meric concludes that the presence of AIDS virus in Heptavax-B remains an open question.

If your doctor recommends this vaccine, ask him if he has read this important article.

As a result of your work and that of others, I have decided not to immunize our 18-month-old son against most childhood diseases. My only concern is with the tetanus vaccine. Although I hesitate to give it because of the various immune and chronic disease risks which seem to accompany it, it does seem to be important: If my son receives a deep tissue injury and has not been previously immunized, the treatment includes an injection of tetanus immune globulin, a pooled blood product which carries with it the risk of AIDS and other contagion.

What is your advice? Are such globulin injections really necessary and, if so, in what sorts of injuries?--S.F.

AIDS and tetanus vaccine

I share your suspicion of tetanus immune globulin and all other pooled blood products, including pooled plasma, gamma globulin, the hepatitis vaccine, RhoGAM and certain anti-bee venom extracts. Furthermore, tetanus immune globulin has never been subjected to a scientifically-controlled study. That is, no one has ever taken a bunch of patients injured by rusty nails who never had previous tetanus vaccine, given half the group tetanus immune globulin and the other half a placebo injection and then compared the outcomes.

In the absence of that kind of scientific proof, no one knows whether that immune-globulin is effective in preventing or ameliorating tetanus or has no effect at all. Furthermore, no one knows what kind of damage (in addition to the risk of AIDS) might be caused by tetanus-immune globulin. So, any doctor who wants to use this unproven remedy on a patient ought to tell the patient that he is basing his recommendations not on scientific evidence, but rather on his opinion, belief, hunch, guess, conjecture or theory. So much for tetanus immune globulin.

As for the tetanus vaccine, I'm not surprised that you are holding onto that after giving up on the other vaccines. So thoroughly indoctrinated was I with the fear of rusty nails that it took me a long time to give up tetanus immunizations. But, more than 10 years ago, I began to collect evidence showing that:

1) The tetanus vaccine has been so watered down that its effectiveness approached the vanishing point.

2) Over the past half century, the virulence of tetanus, like plenty of other diseases, had greatly receded. Thus, plenty of people who had never been immunized never got tetanus in spite of plenty of puncture wounds with rusty nails.

3) Since no one has ever done a controlled study on the tetanus vaccine, there is no scientific evidence to support its effectiveness and safety.

4) There is a growing concern among many doctors about a linkage between immunizations, tetanus included, in early life and the development of auto-immune diseases (e.g., multiple sclerosis, Parkinsonism, etc.) in later life.

5) Evidence exists that frequent tetanus booster shots actually may be counterproductive.

Condoms aren't foolproof

Now that the media, at least in part, is accepting ads for condoms, it is important to present the whole truth about condoms. The promoters of "condom education" would do well to begin with the September, 1986 articles in the Journal of the American Medical Association where we learn:

-- There is a 10 percent failure rate per year when condoms are used to prevent pregnancy.

-- In order to properly use a condom, it must be applied early in the sex act, i.e., before pre-ejaculatory fluid appears.

-- The user must make sure that the condom does not fall off or tear.

-- Considerable amounts of lubricant and spermicidal jelly must be used.

-- A San Francisco study has demonstrated that gay men are no more motivated to use condoms than is the general population. Eighty percent knew that the use of a condom could prevent AIDS transmission, but only six percent of this same study actually used condoms.

-- Some studies indicate that all condoms, including those derived from the intestinal membranes of sheep (natural condoms) are effective in preventing the "in vitro" (under laboratory conditions) transmission of the AIDS virus. In these laboratory experiments, the condom was fitted over a plunger of a 12 cc plastic syringe and submerged in a beaker; repeated aspirations and expulsions were carried out.

-- In another series of experiments involving the hapatitis B virus, synthetic condoms did prevent leakage, but natural condoms did not. In this set of experiments, instead of using plastic syringes, a battery-operated mechanical vibrator was used to create agitation of condom contents. The researchers suggest, "Perhaps mechanical vibration alters natural condom permeability...." However, the hepatitis virus continued to leak through the condom even after the vibrator had been turned off. Also, the 8-inch vibrator had a diameter of 3.5 cm as compared with 1.5 cm for the plunger of the 12 cc syringe. Thus, the researchers wisely conclude, "It is conceivable that stretch and/or tension of natural condoms plays an important role in determining viral passage.

-- The researchers recommend further studies before natural condoms can be endorsed as a form of prevention against the transmission of the AIDS virus.

In view of these findings, it seems obvious that, if condom education is to be complete, the ads should clearly spell out whether the condoms are made of latex or of sheep gut. The ads also should give us some clues on how to extrapolate the laboratory findings into human experience.

Blaming the victim

The confusion over AIDS continues to mount, but some eternal truths abide. One of them is the attitude doctors have towards sexually-transmitted diseases. Four decades ago, I learned in medical school that when a doctor takes a patient's history, there were different ways to record patients' responses. Thus, if I asked a patient, "Have you ever had high blood pressure?" and the patient answered, "No," I wrote down "No." In contrast, if I asked the patient, "Have you ever had venereal disease?" and the patient answered, "No," I was taught to write: "Patient denies venereal disease."

Nothing has changed. In the May 22, 1987 Morbidity and Mortality Weekly Report put out by the Centers for Disease Control, the good doctors at that government agency reported on three health care workers who developed HIV (the latest abbreviation for the AIDS virus). These three workers had not been stuck by needles which had been used on infected patients. But what about other risk factors such as drug abuse or homosexual activity?

In the very first sentence, the CDC doctors report that these health care workers "denied" other risk factors. In the case of one woman whose only sexual partner for more than eight years had been her husband, her husband also "denied" risk factors. The health worker herself "denied" ever receiving a blood transfusion, ever using intravenous drugs, or having been stuck by a needle during the past eight years.

Health Care Worker #2 similarly "denied" having any sexual contact during the previous two years, ever using drugs intravenously or ever receiving a transfusion. Health Care Worker #3 "denied" risk factors for HIV infection. She "denied" ever receiving a transfusion, ever using intravenous drugs or having any needle stick injuries in more than two years. The patient whose blood accidentally spilled on Health Care Worker #3 also "denied" risk factors.

By the use of this kind of language, are the good doctors implying that these three health care workers, as well as the patient and the husband of one of the workers, really are guilty but are not telling the truth? Why not simply say that the medical histories contained no evidence of risk factors instead of implying that these people are a bunch of liars?

Let's look at the rest of the language of this report. Working in an Emergency Room, Health Care Worker #1 was applying pressure to the insertion site of an arterial catheter in a patient who was suffering cardiac arrest. The pressure was supposed to stop the bleeding. Did

any of the blood from the patient actually touch the health care worker? The doctors state, "She may have had [italics mine] a small amount of blood on her index finger for about 20 minutes before washing her hand." But then again, she may not have. "Afterwards, she may also have assisted in cleaning the room." But then again, she may not have. She had no open wounds, "but her hands were chapped." But there must have been something wrong with the lady because the doctors report that 15 other employees who assisted in the care of the patient tested negative to AIDS at least four months after the exposure.

Health Care Worker #2, who had blood spattered on her face and in her mouth from an out-patient with a suspected HIV infection, had no open wounds, but she had "facial acne." There must have been something wrong with her too, because a co-worker who was splattered with blood on the face and in the mouth during the same incident was sero-negative for AIDS one year after the incident.

Health Care Worker #3 "does not recall" having any open wounds on her hands. (Are the doctors implying that she really did have open wounds, but has a poor memory?) However, she had "dermatitis on one ear," and "may have touched it." But again, she may not have touched it. She also must have had something wrong with her because a co-worker, who was similarly exposed during the same procedure, remained sero-negative after three months.

After describing these three cases, the good doctors assure us that exposure of skin or mucuous membranes to contaminated blood may "rarely" result in transmission of HIV. However, this assurance is short-lived. The very next sentence reads, "The magnitude of the risk is not known since data on the frequency with which such exposures occur are not available." In other words, doctors have no idea how great the risk is, but they hope it's rare.

There are still more hedging phrases in this paragraph dealing with incidence. These include the expressions "are thought to occur," and "is likely to be." These weasel words simply mean that the good doctors have no idea about the source and incidence of transmission.

But the doctors remain adamantly opposed to testing hospitalized patients for HIV infection. After all, these three exposures did not occur in the hospital itself; two occurred in an "out-patient clinic setting," and the third occurred in the "emergency room."

In conclusion, the doctors recommend strict enforcement of previously published measures to minimize the risk of exposure of health care workers to blood and body fluids of patients. And they add a new warning to anyone whose skin is chapped, abraded or afflicted with dermatitis.

What questions does this raise?

1) When it comes to a history of sexually-transmitted disease, do doctors believe patients' reliability anymore today than they did 40 years ago?

2) What significance do these events in health care settings have for school settings, i.e., a child with AIDS who suffers an injury in the schoolyard which results in blood being spattered on his classmates who might have chapped skin?

3) How do the doctors know that the HIV virus gained entry through chapped skin, acne or ear dermatitis? Isn't it possible--perhaps even more likely--that the AIDS virus entered through the intact skin?

4) Will doctors continue to play the game of blaming the victim? If they can't pin the charge of homosexual activity or drug abuse on the patient, they then will try to blame the patient for having chapped hands. They will test everyone around the patient in an attempt to demonstrate that there is something peculiar about this particular patient which led to his or her contracting AIDS while his co-workers did not.

Just to show to what extremes doctors will go, the CDC officials' editorial note which accompanies these three cases carried this sen-

tence: "Unrecognized or forgotten needle stick exposures to other infected patients cannot be totally excluded." In other words, these health workers probably did get stuck with needles, but their memories were so faulty that they didn't tell the investigators.

5) How come these three cases were not reported as each one was discovered, especially since the exposure occurred during 1986? And why aren't we told where they occurred--what cities, what hospitals, what universities, what medical centers?

I'm sending a copy of this to the CDC, and I will share with you any response I receive.

Q A

Are AIDS pregnancy tests necessary?

Surgeon General Koop is advising women who want to get pregnant to be tested for AIDS. Do you think this is necessary?--M.U.

The Surgeon General's recommendation concerns me because of the checkered history of premarital and pregnancy blood tests which were used for detection of venereal disease long before AIDS appeared on the scene.

Sure, those blood tests for syphilis did have some value because they saved some infants from congenital infections transmitted through their mothers. But screening tests for syphilis, including the routine hospital admission testing of all patients which was carried out well into the 1960s, have been abandoned practically everywhere.

One of the reasons for abandoning these VD blood tests was because of the falling incidence of syphilis. Perhaps even more important was the growing recognition by both doctors and patients of the inaccuracy of those tests.

Tests for syphilis yielded a significant number of false positives. Thus, if a person had infectious mononucleosis, his blood might test positive for syphilis. The same error might occur in patients who had pneumonia, tuberculosis, lupus, pellagra, malaria, infectious hepatitis, rheumatoid arthritis and a variety of other important diseases. Pregnancy itself might show a false positive reaction, as could old age! Many such false positives were not discovered until long after the various blood tests were introduced. Imagine how long it will take before the inaccuracies of the various tests for AIDS are similarly revealed! Thus, those syphilis blood tests often led to a lot of mischief and grief.

Today's AIDS tests are no better than were those syphilis tests of decades ago. They also have a significant rate of false positives and false negatives. Thus, if your blood turns out positive, that doesn't necessarily mean you have AIDS or have even been exposed to AIDS. On the other hand, if the test results turn out negative, that doesn't mean you are free of AIDS infection. Since it doesn't require clairvoyant powers to predict the mischief and confusion, both public and private, that will result from routine premarital and pregnancy AIDS testing, I hope Dr. Koop will share the medical profession's historical record of venereal disease testing with the public so that the same set of mistakes does not get repeated.

Startling information on the subject of AIDS tests comes from the Los Angeles County Medical Association Bulletin (June 15, 1987) which gives us data from Abbott Laboratories, a leading manufacturer of testing material. According to an Abbott product manager, "If you are testing a group in which one-tenth of one percent are infected, 60 of every 100 positive tests will be false." In other words, if you are subjected to an AIDS test and receive a report of "positive," don't hurl yourself from

the nearest window. Chances are better than even that if there is a low incidence of AIDS in your population group, your positive test result is in error.

In the past, we have been assured that such false positive AIDS tests (ELISA) are checked again, using the Western Blot, which is supposedly a more accurate, and more expensive, test. However, the Abbott product manager states, "Interpreting a Western Blot is a subjective procedure requiring considerable skill. Those factors that can lead to a false positive in an ELISA can also lead to a false positive on a Western Blot."

So after you have been tested for AIDS, what do you really know? Maybe your test is a true positive. Maybe it is a false positive. Maybe it is a true negative. Maybe it is a false negative. (Since the immune system of advanced AIDS patients may become so damaged, they can become unable to produce even enough antibodies for the AIDS test to detect.)

You must clearly recognize that the AIDS test is no different than any other testing method. Even the best medical tests have 20 percent error rates. Most medical tests fall far below this standard.

We might just as well go back to reading animal entrails.

What does positive AIDS test indicate?

The Health Department in my home town of Evanston, Illinois, has jumped into the AIDS test controversy with both feet. In a bulletin (May 19, 1987) announcing free AIDS testing, the Department states, "In many ways, the HIV antibody tests is very much like the tuberculin skin test that most of the U.S. population has come to know in that the tuberculin skin test only indicates whether or not the individual has come into contact with the tuberculosis bacillus. In other words, the HIV antibody test will only indicate whether or not the individual has come into contact with the virus associated with AIDS."

Let's hope the Evanston Health Department is correct. After all, look at the tens of millions of Americans who have positive tuberculin skin tests vs. the handful who actually contract TB.

If you go for AIDS testing and if your test turns out to be positive, ask your doctor if he agrees with the Evanston Health Department.

AIDS tests 60% false-positive

The bad news about the AIDS test may be even worse than you and I had thought. This Newsletter already has brought you information right from the FDA Drug Bulletin about the high rates of false positives (around 70 percent) and false negatives (at least five percent) of the AIDS antibody test.

Now, Palmer Jones, Executive Vice President of the New Hampshire Medical Society, in discussing testing of people who apply for marriage licenses points out that in New Hampshire, approximately 22,000 individuals apply for licenses every year (AMA News, May 24, 1987). Of these, 220 would test positive on the first test, but when the follow-up test would be performed, "It is estimated that only two will be true positives with the remaining 218 being false positives."

Can you imagine a medical test with a 99 percent false positive rate? Can you imagine the anxiety, grief, anguish, (broken engagements?) which these 218 healthy, solid, stalwart New Hampshire citizens will suffer while awaiting the follow-up tests?

Maybe "counseling" will help allay the fears of all these false positive reactors. Or maybe we can call in the tooth fairy.

Another View

by Marian Tompson

Writing last year (Volume 10, Number 1) about co-factors commonly found in AIDS patients, I asked the question, "Is anybody looking into immunizations?" If immunizations compromise our immune system the way some scientists suspect they do, it made sense to me to include immunization histories in any study of AIDS sufferers.

Much of my quarrel with epidemiological research in recent years has had to do with the questions that are not being asked, leaving us with incomplete information at best, and totally misleading conclusions at worst. The research cited in the discussion of cervical cancer (Volume 11, Number 6) is a case in point.

The first two and a half pages of that Newsletter are devoted to studies that, in the words of Dr. Mendelsohn, "confirmed the link between cervical cancer and the number of men with whom a woman has sexual intercourse." Quotes supporting this statement abound: "Cervical neoplasia (cancer) behaves like venereal disease in many aspects, being rare in celibates and most common in prostitutes....Women with three or more husbands have higher rates of cervical cancer as do prostitutes." The book, "Presymptomatic Detection and Early Diagnosis," by English physicians Sharp and Keen is cited as including data from several investigators which "leave little doubt that carcinoma of the uterine cervix is related to sexual activity." (Is everyone quoting the same study/studies?)

When Mrs. H.R. wrote to Dr. Mendelsohn objecting to this label of promiscuity for women with cervical cancer (she and her sister, both faithful and happily married women, had been diagnosed as having the disease), she was told, "The burden of proof remains with those who claim that cervical cancer is not related to multiple sexual partners, the Pill, or the IUD."

So what are the questions that still need to be asked? Let's start with checking into birth control used by women with cervical cancer. While I strongly agree with Dr. Mendelsohn that the IUD and the Pill might be predisposing factors, I know of no studies which examine this possible linkage. Could not using birth control be part of the reason why nuns and women whose husbands have had vasectomies are at low risk for the disease?

Recognizing the powerful effect of the mind on the body, we also need more information on the psychological states of women who developed cervical cancer during the years before their cancer became apparent. Had they suffered emotional hurts, particularly blows to their femininity, which they found difficult to deal with? Might such emotional trauma be part of the explanation for the recent study which shows higher risk for cervical cancer among women whose husbands were sexually promiscuous?

And what about nutrition? Even the National Cancer Institute now recognizes the relationship between diet and cancer. Eighty million dollars of NCI's current budget has been earmarked for investigation of the prevention of cancer by nutrition and dietary measures.

If Mrs. H.R. had written to me, I would have agreed with her that statistical correlations are never absolute proof when it comes to the individual, and I would voice my suspicion that much of our currently accepted research reflects the fable of the blind men confronted with the elephant. Each of the blind men mistakenly based his description of the entire beast on that small portion of the animal that he could feel. And I would reassure Mrs. H.R. that despite the tone of his reply, Dr. Mendelsohn continues to work so diligently to alert the public to the "blame the victim" game that I can't imagine he ever would expect any of his readers to accept that kind of accusation, even when it comes from him.

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