THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 4 #2 October, 1982

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This Newsletter is published by the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). Although efforts will be made to present accurate, factual information, the NCGSTDS, as a volunteer, nonprofit organization, or its officers, members, friends, or agents, cannot assume liability for articles published or advice rendered. The Newsletter provides a forum for communication among the nation's gay STD Services & providers, and encourages literary contributions, letters, reviews, etc. The Editor/Chairperson reserves the right to edit, as needed, unless specific requests to the contrary are received. Articles for the Newsletter, or inquiries about membership in the Coalition may be addressed to Mark P. Behar, PA-C, Chairperson, NCGSTDS, P.O. Box 239, Milwaukee, WI 53201-0239 (414/277-7671). Please credit the NCGSTDS when reprinting items from the Newsletter. We're eager to hear from you! All correspondence answered.

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NCGSTDS MEETING IN MONTREAL, NOVEMBER 17

The semiannual meeting of the NCGSTDS will be held Wednesday, November 17, 9am-noon at the Hospitality Suite of the Gay Public Health Workers, Mont Royal Hotel, 1455 Peel Street, Montreal (514/842-7777). Topics to be discussed include: Current Aspects of STDs Symposium --III (CASTDS), AIDS Update, Guidelines & Recommendations for Healthful Gay Sexual Activity --proposed 3rd edition, and the 5th National Lesbian/Gay Health Conference in Los Angeles, among other issues. Reports from member services will again be featured. See related articles in this Newsletter.

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GAY ACTIVITIES AT NOVEMBER APHA MEETING

Several exciting presentations in areas of gay health are planned at the American Public Health Association's (APHA) meetings in Montreal this November 14-18. The following tentative schedule of activities was prepared by the Caucus of Gay Public Health Workers, who are co-sponsoring most of the activities. Please consult the GPHW Hospitality Suite (Hotel Mont Royal) or the exhibit booth in the exhibition hall for last minute changes.

Sunday, 11/14,	3-5pm	GPHW Planning Session for Convention (Hospitality Suite)
	5pm	GPHW Wine & Cheese Open House (Hospitality Suite-HS)
	Noon-5pm	GPHW exhibit booth open (Place Bonaventure Exhibit Hall--EH)
Monday, 11/15,	2-5pm	Vaccination Strategies for Sexually Transmitted Hepatitis B (Sheraton Center Ballroom Center) Presentors: Dave Ostrow, Mark Behar, Tom Nylund, Frank Judson, Roger Gremminger, Harley McMillen, and Walter Lear.
	6-7pm	Caucuses of the APHA Social Hour (cash bar) (Sheraton Ctr Hotel mtg rooms 4 & 5)
	7-10pm	Joint Dinner Meeting of the Hepatitis B Task Force and the AIDS Gay STD Info. Network Steering Committee at the Parc Regent Hotel. For Reservations: Call Ms. Laura Coates/ Dr. David Ostrow, 312/871-5777 by Nov. 12!
Tuesday, 11/16	2-3:30pm	Lesbian & Gay Aging--Realities & Challenges (Hyatt Regency, Regency Ballroom B)
	3:30-5pm	Alternative Parenting (see program for place)
Wed., 11/17	9am-noon	NCGSTDS Business Meeting (Hospitality Suite, Mont Royal)
	Noon-2pm	GPHW Annual Meeting & Election of Officers, Luncheon (to be ann.)
	4-5:30pm	STDs in the Gay Male Community--AIDS, Guidelines & Recommendations for Healthful Gay Sexual Activity (Meridien Hotel, picardie A)
	6:30-11pm	Annual GPHW Fundraising Dinner (to be announced)
Thurs., 11/18	10-noon	GPHW Planning Session for Coming Year (Hospitality Suite)

NOTE!

NOTE: Monday, Tuesday, & Wednesday, the GPHW Hospitality Suite will be open from 1-6pm; the exhibit hall, from 9am-4pm. For other times, contact the GPHW.

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ANOTHER HERPES "CURE"

According to the United Press International, a cottonseed oil extract being tested in China as a male contraceptive also has a "killing effect" on genital herpes and gonorrhea, researchers say. "Gossypol," as the extract is called, has been effective against the sexually transmitted diseases in test tube research in Finland and is being tested on two groups of people by University of Helsinki scientists. Sheldon Segal, director of population sciences studies at the Rockefeller Foundation, said that the Foundation had "well over a million dollars" invested in gossypol studies.

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PENICILLINASE-PRODUCING NEISSERIA GONORRHOEAE--A RETROSPECTIVE

The August 12, 1982 issue of The New England Journal of Medicine (Volume 307:7) published a brief editorial comment by Dr. William M. McCormack, MD, entitled "Penicillinase-producing Neisseria gonorrhoeae--a retrospective." Although when first discovered over 5 years ago it was feared that its prevalence may approach that of the garden variety of gonorrhea, due to an aggressive epidemiological and other public health measures those fears have not yet materialized. Yet. Fewer than 400 cases were documented in the United States each year from 1976-79. But in 1980, 1099 cases were reported; 2734 cases in 1981; and an alarming 1323 cases in the first four months of 1982. Most of the cases have appeared among two groups--prostitutes and the urban poor; homosexually active men, which also have a high prevalence of gonococcal infection, have accounted for a very few number of cases. The relative lack of sexual contact between the homosexual and heterosexual communitites may account for this phenomena; alternatively, PPNG may be at a biologic disadvantage in homosexually active men, if the organisms are less able than other gonococci to infect rectal mucosa.

The treatment of choice for PPNG infections is intramuscular spectinomycin hydrochloride (2.0 g dose) in uncomplicated anogenital infections. Pharyngeal infections, at least in men, respond somewhat less well to spectinomycin, and may be treated with trimethoprim-sulfamethoxazole (9 tablets, each containing 80 mg TMP- 400 mg SMZ as a single oral dose for 5 days). Resistance to spectinomycin is not yet common. Gonococci resistant to spectinomycin are also rare. If spectinomycin resistance does develop in PPNG, other effective (albeit expensive) antimicrobials (eg, cefoxitin, cefotaxime) can be used.

If the prevalence of PPNG increases to a substancial minority (maybe 5%?) of all gonococcal infections, penicillins may cease to be the drugs of choice. Although this hasn't happened in the U.S., bitter experience with other resistant microorganisms suggests that despite continued aggressive intervention by public health authorities, PPNG may ultimately prevail. (Ed. Note: See article for details!)

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HEPATITIS B VACCINE SERVICES SURVEY

Gay STD services around the country are now being surveyed by telephone to learn about their hepatitis B testing and vaccination services. A report will tentatively be published in the next issue of the Newsletter, detailing the results of the survey.

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APOLOGY FOR LATE PUBLICATION OF NEWSLETTER

This issue of the Newsletter, like the last one (and maybe the next!), is late in its arrival to you due to the great volume of material and inquiries received, rewriting material, and most importantly (and time-consuming) typing articles into Newsletter format. Typing has become a serious problem due to the non-availability of an appropriate typewriter. Money is now being collected for the purchase of such a typewritter. Contributions are being accepted! Again, sorry for any inconveniences! --The Editor

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MILWAUKEE'S BRADY EAST STD CLINIC

from press release

Milwaukee's gay clinic for the sexually transmitted diseases formally moved into its new and permanent home at 1240 East Brady Street in the heart of the city's gay community on the east side, July 31. Previously known as the Gay Peoples Union VD Clinic and the Farwell STD Clinic for its past affiliation or location, it was renamed the Brady East STD Clinic (BEST for short) and ends a series of temporary homes which the clini has used since its inception eight years ago, in 1974.

After a long period of attempted building fundraisers and aborted searches for a new facility, the clinic's medical director, Dr. Roger A. Gremminger, MD, purchased a building which was converted to medical use and is now being leased back to BEST. Rental space is also available to other gay organizations in the community. During the clinic's existance, it has undergone several internal changes. Beginning with an informal volunteer structure that provided only tri-site gonorrhea and syphilis testing, it has progressed to a full service STD clinic, recognized by Wisconsin public health officials, and governed by a board of directors and several clinic directors. In addition to the traditional STDs, services also include a hepatitis B vaccination program, and community education. Clinic staff continues to be entirely volunteer and includes three physicians, a physician assistant, several nurses, nurse practitioner and nursing students, and many lay people who are trained in testing techniques.

To help celebrate its new home and its eigth anniversary, BEST hosted a wine and cheese reception and open house for the public on September 25th. BEST Week also was kicked off on that day, and emphasized the importance of routine testing. Several testing dates during BEST Week offered the additional incentive of "BEST Friend" buttons and tickets which were redeemable for free drinks at local bars.

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AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS (AAPHR)

The American Association of Physicians for Human Rights (AAPHR) is an organization of physicians and medical students dedicated to the elimination of discrimination on the basis of sexual or affectional orientation in the health profession, and to the delivery of supportive, unprejudiced, and well-informed medical care for gay and lesbian patients. AAPHR is committed to the achievement of these purposes through the coordination and promotion of efforts: 1) to educate physicians in the special needs of homosexual men and women; 2) to educate the gay and non-gay public about the health needs of gay people; 3) to maintain a liaison with medical schools, training programs, and professional organizations regarding the needs of the gay patient and professional; 4) to offer support to gay and lesbian physicians to reach their full potential in their personal and professional lives; 5) to encourage research into the health needs of the gay & lesbian community; 6) to cooperate with other North American groups and individuals who support the above purposes; and 7) to foster communication among the membership and local gay and lesbian physicians' groups. For more information, write to: AAPHR, PO Box 14366, San Francisco, CA 94114, or call 415/673-3189. A future issue of this Newsletter will list all of the local Physicians for Human Rights groups (this information is still being collected).

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MONTREAL HEALTH PRESS WINS GRANT

The Montreal Health Press, publisher of the widely acclaimed VD Handbook, has just received approval from the Canadian government for a grant close to $45,000 to publish the new edition of the book in English and French. The Coalition will notify its members when the handbook is available.

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BALTIMORE GAY COMMUNITY CENTER CLINIC ANNOUNCES CHANGES

by Rudy Forti, Clinic Administrator

The Baltimore Gay Community Center VD Clinic recently moved into its permanent new home on the third floor of the Baltimore Gay Community Center, 241-43 W. Chase Street, 3rd Floor, Baltimore, MD 21201 (301/837-2050). Dr. Ron Pototsky has assumed the role of medical director, succeeding Dr. Bernard Branson, who openned up a private practice. Dr. Pototsky was one of the Clinic's two founding physicians.

Since moving into the new facilities in mid-August, the Clinic has added a Saturday morning session, in addition to the previously openned Tuesday and Thursday evenings. A hepatitis B screening and vaccination program is beginning shortly. More news in future Newsletters.

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REPRINTS IN THIS NEWSLETTER

At the end of this Newsletter, several important articles are attached for your review.

"Preliminary report of the task force on vaccination strategies fro sexually transmitted hepatitis B infection," by Ostrow, et al., Sexually Transmitted Diseases (Volume 9:3, July-September, 1982).

"Persistant, generalized lymphadenopathy among homosexual males," MMWR, Volume 31:19, May 21, 1982.

"Hepatitis B virus vaccine safety: report of an inter-agency group," MMWR, Vol. 31:34, Sept. 3, 1982.

"Spectinomycin resistant beta-lactamase-producing Neisseria gonorrhoeae--England," Vol. 31:36, Sept. 17, 1982, MMWR.

"Update on AIDS--United States," Vol. 31:37, Sept. 24, 1982, MMWR.

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NEW CDC STD TREATMENT GUIDELINES PUBLISHED

The NCGSTDS has requested several hundred copies of the CDC's newly published "STD Treatment Guidelines 1982" in the MMWR supplement (Volume 31:2S, August 20, 1982) for inclusion with this Newsletter but unfortunately, the 30 plus page booklet has not yet been reprinted. Write to the CDC VD Control Division, Atlanta, GA 30333 for your free copy. The Coalition will try to obtain additional copies for inclusion in the next Newsletter.

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CURRENT ASPECTS OF STD SYMPOSIUM--III UPDATE & CALL FOR PAPERS

"Current Aspects of STDs Symposium--III: Critical Gay Health Needs: New Diseases, Persistant Problems and Prophylaxis," (CASTDS) will be a one day CME program addressing clinical aspects of Acquired Immune Deficiency Syndrome (AIDS), enteric diseases, hepatitis B prevention and STD prophylaxis in homosexually active men. Sponsored by the NCGSTDS, CASTDS will be held in conjunction with the 5th International Meeting of the International Society for STD Research, August 1-3, 1983 in Seattle. A Clinical Update on STDs will take place on July 31. Information about these three events were mailed to about 7000 individuals worldwide; advertisements will also appear in 3 STD journals.

CASTDS is scheduled for Thursday, August 4, 8:30-4:30pm at the Seattle Sheraton. Abstract forms & information are available from the NCGSTDS, POB 239, Milwaukee, WI 53201. Persons interested in being CASTDS workshop leaders/speakers/participants should contact one of the following people immediately: AIDS, enteric diseases--R. Bolan, MD, 667 Lakeview Av., San Francisco, CA 94112; Hepatitis B prevention, STD prophylaxis--D. Ostrow, MD, PhD, 155 N. Harbor Dr., #5103, Chicago, IL 60601; Other topics--M. Behar, PA-C, POB 239, Milwaukee, WI 53201. General registration forms and additional information, lodging, etc. will be forthcoming. Write to the NCGSTDS for details or wait for the December Newsletter.

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TULSA OKLAHOMANS FOR HUMAN RIGHTS REPORTS ON NEW GC KIT

Oklahomans for Human Rights (OHR) of Tulsa reports that the Food & Drug Administration has approved marketing a home testing kit for gonorrhea in men. The kit was developed by International Research Distributors, Inc., who say the test is 95% accurate. It will sell for $14.95 and will be available through magazine advertisements and at pharmacies. Each kit contains testing equipment, instructions, a mailing box, and a confidential identification number. The user completes the test, mails it back to the company, and then gets the results by calling a toll-free number. The manufacturers say they hope it will promote earlier detection of gonorrhea (!!!).

The OHR bimonthly VD Clinic is free and is cosponsored by OHR and the Tulsa City-County Health Department.

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HEPATITIS SEROLOGIC TESTING

Is diagnostic serologic testing for hepatitis confusing? The August, 1982 issue of Laboratory Management features an article, "Serologic testing for hepatitis," by Jules Dienstag, MD (address for requesting reprints: Dr. J. Dienstag, GI Unit, Massachusetts General Hospital, Boston, MA 02114; send self addressed, stamped envelope). An algorithm is presented that clearly suggests the recommended tests for the different markers. Highly recommended review!

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NEW HERPES DRUG

The September 1, 1982 Medical World News reports about an experiemental drug that prevents as well as heals herpes lesions. According to Dr. Kendall O. Smith, a microbiology professor at the University of Texas--San Antonio, the new compound, BIOLF-62, may top existing drugs' ability to control venereal and oral herpes lesions. Synthesized by McGill University chemist Kelvin Ogilvie, the new agent is similar to acyclovir (Zovirax), but is almost 10 times more soluble in water. Consequently, higher concentrations of BIOLF-62 penetrate to deeper tissues where the virus multiplies.

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MEMBERSHIP LIST BEING REVISED

The next issue of the NCGSTDS Newsletter will have the revised nonconfidential membership list included to help facilitate communications between Coalition members. Please notify the NCGSTDS immediately if you have any address corrections: NCGSTDS, PO Box 239, Milwaukee, WI 53201.

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PRELIMINARY REPORT OF THE HEPATITIS TASK FORCE

The "Preliminary Report of the Task Force on Vaccination Strategies for Sexually Transmitted Hepatitis B Infection" as reprinted from Sexually Transmitted Diseases (Journal of the American VD Association; volume 9:3, July-September, 1982), is included with this Newsletter for your review. The recommendations of the Advisory Committee for Immunization Practices (ACIP) on the HBV vaccine was published in the Morbidity & Mortality Weekly Report (volume 31:24, June 25, 1982) and also in the Annals of Internal Medicine (volume 97:3, September, 1982, pp. 379-83) and was included with the last Newsletter (volume 4:1, August, 1982).

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COMPUTERS FOR THE GAY COMMUNITY
from press release

Are you a lesbian or gay man who is interested in telecommunications or computers? Are you interested in their uses for yourself, for your business or career, for your organization, or for the lesbian and gay community as a whole? Then you should know about the Telecommunications Information Project (TIP) of the Gay Press Association (GPA). Among the things that those of us who are now part of TIP are interested in are: the GPA Wire Service, computerized conferencing, home computers, the use of computers by lesbian and gay organizations, gay information banks, public access to technology and information, privacy issues, sharing information and resources, keeping our communication systems compatable and avoiding duplication, forming "old girls and boys" networks of lesbian and gay telecommunication & computer professionals, and having fun with various technologies. We welcome people with these and other related interests to join us.

Although we are enthusiastic about the use of telecommunication and computer technology by the gay community, we can also see possible future abuses by anti-gay forces that would make the New Right's use of computerized mailing lists pale in comparison. We want TIP to act as an early warning system for the lesbian and gay community. TIP originally formed as a result of discussions among some of the people working to set up the GPA's Wire Service (which enables gay publications to share stories and information by computer-to-computer communication). The Wire Service is an important step and we find that each of us has important knowledge and information to share. We want to expand our network of interested individuals to include you and others.

A survey was constructed to guage the interest of the community. Please write for a copy of the survey: Send a self addressed, stamped legal size envelope to: GPA/TIP, P.O. Box A, New York, NY 10011. We plan to keep up with new telecommunication developments and to provide information to those who want it. We will put out a newsletter and promote the formation of study groups and committees. Although the TIP is part of the GPA, money to pay for activities must come from other sources as the GPA needs to concentrate its resources on building the Wire Service. Donations are greatfully accepted and needed!

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THE GP REPORTER: A NEWSPAPER FOR NEWSPAPER EDITORS
from press release

A new trade paper reporting on the growing field of gay journalism distributed its first issue to attendees at the Gay Press Association convention in Denver over the Memorial Day weekend. The paper, The GP Reporter, is intended to be useful to all persons, gay or otherwise, who deal with gay related matters in editorial, advertising or public relations contexts. Free sample copies of the bimonthly are available on request from The GP Reporter, PO Box 193, N.D. Station, Staten Island, NY 10306-0193 (212/981-5713). Exchange subscriptions with gay feminist, or alternate media are encouraged. Organizations dealing with media-related issues are invited to place The GP Reporter on their mailing lists.

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HAWORTH PRESS PUBLISHES ALCOHOLISM & HOMOSEXUALITY
from press release

New York's Haworth Press recently announced the publication of Alcoholism & Homosexuality (hardcover, 117 pages, $20), a collection of reports providing a comprehensive overview of the clinical problems and treatment options for gay men and women with problems of alcoholism. New approaches that are being implemented in services for this group of men and women are analyzed, and programs and treatment protocols that have had reasonable measures of success are described. The volume was edited by Thomas O. Ziebold, PhD, Training Consultant, and John Mongeon, Training Projects Coordinator, University Research Corp., Washington, DC.

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GAY NON-PROFIT ORGANIZATIONS CAN HAVE POLITICAL CLOUT!
by Ron Vachon, PA, Lesbian & Gay Progressive Health Network

Non-profit, tax-exempt organizations supported by tax-deductable voluntary contributions are free to engage in many kinds of public affairs/public policy activities, but not in others. Many of the member organizations of the NCGSTDS, fearful of what the IRS would do to their 501(c)(3) status, avoid anything that smacks of political action. The fact is, though, that there are many actions that such organizations can take to effect public affairs/public policy. The following do's and don'ts may help to clarify this issue. Planned Parenthood, on organization that has had a lot of impact on public affairs/public policy, has put this information together. I am grateful to Planned Parenthood of New York City, for sharing this information and allowing me to "translate" into gay terms.

Staff or volunteers representing your organization:

MAY educate candidates for elective office about the organization and its issues. This includes distribution of informational materials to candidates and educational visits with candidates.

MAY educate the public about the organization and its issues.

MAY help draft party planks and candidate position papers on issues of concern to us.

MAY give or lend your mailing lists to candidates, as long as the lists are equally available to all.

MAY conduct voter registration programs, on a non-partisan basis and not in physical conjunction with issue-oriented activities.

MAY publish and/or distribute legislator's voting records on gay issues, during legislative sessions or throughout the year, to inform the public of legislators' actions on specific bills and issues.

MAY refer, on request, to other organizations that can provide the public with more information about candidates' positions or that conduct other types of activities.

MAY publish and/or distribute the results of a primary election, if the information is unbiased and does not include candidates' positions or votes on gay issues.

MAY publish and/or distribute the results of a general election, including information about the winner's position or voting record.

MAY participate in--actively supporting or opposing--ballot initiatives or referenda on issues of concern to us. (These are classified as "legislative activities.")

MAY NOT endorse candidates for elective office nor urge the defeat of any candidate or party.

MAY NOT give financial support to candidates. (The purchase of tickets to fundraising cocktail parties, dinners, and similar events constitutes financial support as much as an outright contribution does.)

MAY NOT participate in election campaigns.

MAY NOT publish and/or distribute candidate questionnaires.

MAY NOT publish and/or distribute statements characterizing candidates positions on gay issues.

MAY NOT publish and/or distribute legislators' voting records during campaigns for election or re-election, unless doing so is a continuation of routine year-round public education activities.

MAY NOT participate publicly in a forum (such as a community meeting, a news conference, or a media program) where candidates for elective office present their views to the public.

SPECIAL NOTE: You may join coalitions in which some members are politically active, as long as the coalition itself does not engage in political activity. It might be wise when joining a coalition that the limitation on political activity be stipulated in writing. Individual volunteers and staff are, of course, free to endorse, work for, and/or make contributions to candidates on their own time, as long as it is made clear that they are not acting in their capacity as the organization's volunteers or staff. This means no use of stationery, office facilities, funds, or staff time. Some groups go so far as to have a map of Congressional Districts posted prominantly, identifying the names of state & US Congresspeople and giving their voting records on issues of concern to that organization. No one has ever gotten into trouble with the IRS in so doing! ***** ***** ***** ***** ***** *****

NCGSTDS ANNUAL MEETING: MINUTES
from notes and cassette tapes

The Annual Meeting of the NCGSTDS was called to order by Chairperson Mark Behar, June 4th, at 1:30 pm at the Fourth National Lesbian/Gay Health Conference (FNLGHC), University of Houston, Houston, TX. After a brief history of the Coalition by Mark, and a welcome to Houston by Frank Greenberg of the Montrose Clinic, members & guests were introduced, the latest Newsletter & Guidelines & Recommendations for Healthful Gay Sexual Activity brochure (G&R) were distributed. John Palmer was appointed time-keeper, and John Whyte and (second person's name unfortunately not recorded) were appointed note-takers. Services represented: New York's Gay Community Health & St. Marks Clinic (Ron Vachon); Los Angeles' The Clinic--Gay & Lesbian Community Services Center (Tom Nylund); New York's St. Marks Clinic & Gay Mens Health Project (John Palmer); Chicago's Howard Brown Memorial Clinic (Tom Klein); Denver's Gay & Lesbian Health Alliance (Barry Gaspard); Minneapolis' Gay & Lesbian Community Services Center (Morris Floyd); Tucson's Gay Health Project (Al Obermaier); Philadelphia's Gay Community Health Alternative (Dave Waldron); and Milwaukee's Farwell STD Clinic (Mark Behar). Others in attendance included: Jeff Richards, Bill Sabella, Kirk K.; Dave Waldron, John Whyte, Chris Mathews, and others unidentified. Houston's Montrose Clinic was represented by Frank Greenberg, who served as a gracious host. Ann Arbor's Gay VD Clinic was also represented by Jim Stablaer.

Reports from member services & guests were solicited. Highlights in brevity: Montrose Clinic (Frank Greenberg): Seeing about 350 patients a week, far surpassing earlier expectations; due to the everpresent financial difficulties, a graduated fee scale in place of donations are being initiated. St. Marks (Ron Vachon): Starting a Lymphadenopathy Screening Program (LASP, not lisp) for AIDS patients with swollen glands for greater than 2 months. Gay Community Health (Ron): screening for the common STDs at the Nautilus Gym, but no treatment yet. Los Angeles (Tom Nylund): 3 support groups for chronic diseases forming--hepatitis B, herpes, and AIDS/KS; recently began study of aymptomatic prevalence screening for amebiasis & giardiasis; last year, 378 cases of syphilis and 3800 cases of gonorrhea were treated; building renovations will be completed soon and will include an enterics lab; although a sliding scale fee is charged for most services, certain services are free--e.g., asymptomatic screening--it's our way of paying people to stay healthy--when health breaks down and we have to repair it, they have to pay us. Philadelphia (Dave Waldron): recently gained tax exemption status however lost several significant grants; trying to find funding sources. San Francisco (Jeff Richards): Although there are no formal gay STD services in town, there are a wide range of services offered. SF City/County has a general VD clinic UCSF seeing the AIDS/KS patients; BAPHR is providing community education; most of the STD care is by private MDs. Minneapolis (John Whyte, Morris Floyd): Red Door Clinic is the city's VD clinic, and although it has a large gay clientele it deals only with the traditional VDs; Red Door has several gay staff as well, and there is a screening program in the baths. John writes a gay mens health column in the local gay paper; The Lesbian/Gay Community Services Center is essentially a mental health facility but does promote wellness; plans underway to offer emotional support to a recently diagnosed AIDS patient; hands out Coalition's G&Rs; although many are referred to Red Door, most won't go there. San Diego (Chris Mathews): STD & AIDS referral list by the San Diego Physicians for Human Rights group; UCSD has started a gay clinic (fee for service). New York (John Palmer): The Gay Mens Health Project is a screening facility only and sees maybe 500 people a week; filing for tax exempt status. Chicago (Tom Klein): HBMC has 3 full time employees; involved with hepatitis B and herpes interferon cream study; limited money available for those unable to afford HBV vaccine. Ann Arbor (Jim Stablaer): Mainstream medical care in community is good; open once weekly; full services offered. Denver (Barry Gaspard): good STD clinic operated by Frank Judson, however no gay clinic yet; one of the 4 bath houses in town will be training their employees in VD testing; had a successful second annual SAFE week for screening & PR during gay pride week; Tucson (Al Obermaier): clinic ran into many problems with mainstream & municipal offered medical care providers; now they only refer over the phone; several gay doctors still associated; involved with training University of Arizona health service MDs.

Membership report: 71 paid members in 6 available membership categories.
Financial report: (see "NCGSTDS Financial Report, 1979-82" following these minutes)

(Continued)

NCGSTDS MINUTES, Continued

In an attempt to hold long distance telephone calls down, a suggestion was made to subscribe to one of the satellite services (MCI, SPRINT) on a trial basis. This was approved for a trial period. A report will be presented either at the next meeting in November or in a winter Newsletter, comparing telephone expenses before and after the new service.
A new dues proposal for members was brought up, discussed, and approved. Services membership will go up to $30 (from $20); practitioners was changed to physicians in practice, and went up to $30 (from $25); individuals went up to $15 (from $10); subscribers went up to $10 (from $8). It was agreed that the Coalition needs to investigate other funding sources so as to run the organization as a full time agency. A proposal to establish a committee to investigate this idea was made, and a name & address sheet circulated. It was also suggested that the Coalition evaluate its goals & objectives & scope.
Discussions about the G&Rs were deferred to the workshop to be held later in the Conference. It is available for reproduction by services or by bulk ordering. Current Aspects of STDs Symposium III (CASTDS) was proposed to be held in conjunction with the Fifth International STD Research Meeting in Seattle, next summer. Proposal to hold meeting in San Francisco cosponsored with BAPHR; proposal to cosponsor with AAPHR; first proposal to hold CASTDS in conjunction with Seattle meeting was approved. Chris Mathews will report to Mark Behar about AAPHR/BAPHR liaison. Incorporation & 501(c)(3) tax exempt status proposals were again brought up, however due to the lack of time, money, and energy, these issues were tabled. The preliminary report of the ad hoc task force for vaccination strategies for sexually transmitted hepatitis B infection is included with this Newsletter. Discussions were deferred to the Conference workshop on that topic. Acquired Immune deficiency syndrome (AIDS), Kaposi's sarcoma, and related opportunistic infections were then briefly discussed; an MD Anderson cosponsored presentation on AIDS was one of the features of the Conference, so most discussions again were deferred to that time.
Homosexual Health Reports was mentioned in the agenda to let everyone know of its existance and purpose: to serve as a more immediate clinical and scientific forum for communicating important medical information about gay health since the time lag for most journals is astonishingly long.

The National Gay Health Education Foundation was asked to move on with activating Foundation activities & functions, and to communicate with other gay health organizations about such activities. It was suggested that the NCGSTDS approach the Foundation for seeking CME approval for future National Lesbian/Gay Health Conferences so as to encourage more participation by professionals (CME or its equivalent can help justify time off from work, can be used for tax deduction purposes, etc.). The question was raised about whether the Conference was supposed to be for consumers or providers or both. It was recommended that the Foundation consider these issues and report to affiliate gay health organizations. Networking was the topic of the next discussion. Several services have access to (or own their own) computer terminals--Chicago & Boston, for example. Al Obermaier will survey the needs of the services with regards to computers (see last Newsletter; results are now being compiled).
A proposal to join the Lesbian & Gay Progressive Health Network was made and approved. The Network is designed to promote networking among gay health organizations on politically related issues. The next NCGSTDS meeting was approved for Montreal, at the American Public Health Association's Annual Meeting, however there was considerable discussion about the alleged homophobic atmosphere in that community. It was suggested that we contact Montreal officials about the "antigay" environment, as well as local gay organizations. In the last agenda item of the meeting, Mark Behar was reelected as Chairperson. A tour of the Montrose Clinic was scheduled for the next day, with cordial invitations extended to all. The meeting was adjourned. (The financial report follows on the next page.)

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ARE CHILDREN OF LESBIANS DIFFERENT?

Although not related to STDs, we thought we'd mention an article on a subject rarely researched. "Children of Lesbians...How Different Are They?" appeared in the October, 1982 issue of Sexual Medicine Today (Vol. 6:10, p. 28), a supplement to Medical Tribune (10/13/82). Send a self-addressed, stamped envelope to the NCGSTDS, POB 239, Milwaukee, WI 53201 for a copy.

NCGSTDS FINANCIAL REPORT, 1979-82

The following report was submitted and approved at the annual business meeting of the NCGSTDS in Houston, TX, June, 1982 at the Fourth National Lesbian & Gay Health Conference.

Income Source	1979-1980	1980-1981	1981-1982
Membership	$420.00	$635.00	$1311.00
STD Services	240.00	320.00	355.00
All Others	180.00	315.00	956.00
Donations	101.00	10.00	150.00
G&Rs	0	0	55.00
Contracts/Ads	0	0	1200.00
Merck, Sharp, & Dohme			1000.00
Haworth Press			200.00
CASTDS	0	1518.71	0
Journal of Homosexuality	0	154.00	0
Interest on Sav. Acct.	0	0	66.22
Airfare Reimbursements	0	0	543.76
Misc.	5.00	10.50	3.00
Total Income	526.00	2328.21	3329.48
Expenses			
Newsletter	$181.45	$341.07	$1151.61
Printing	79.71	163.26	658.85
Postage	81.45	174.31	392.31
Supplies	20.29	3.50	45.45
Typewritter Rental	0	0	55.00
Office Supplies	50.97	37.94	26.41
Stationary	24.09	11.49	15.10
Misc.	26.88	26.45	11.31
Meetings & Refreshments	13.80	0	61.73
Supplies	1.00		7.78
Cassette Tapes	12.80		36.40
Refreshments	0		17.55
Postage, excluding Newsletter	44.24	109.76	150.90
Printing, excl. Newsletter	19.80	7.65	56.01
Copyright	0	10.00	10.00
Long Distance Telephone	61.91	89.16	359.53
PO Box	0	0	24.00
Educational	0	47.95	95.00
Subsc. or membership in other groups		36.00	95.00
Misc.		11.95	0
Transportation	0	57.15	727.70
Guidelines & Recs. brochure	0	0	209.46
Typesetting			125.00
Printing			84.46
Misc.	0	50.00	5.12
Total Expenses	372.17	750.68	2877.47
Total Income	$526.00	$2328.21	$3329.48
Total Expenses	372.17	750.68	2877.47
Net	153.83	1577.53	452.01

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FIRST CANADIAN CONFERENCE ON STD

The first Canadian Conference on STDs will be sponsored by the Canadian Public Health Association, Toronto, November 22-23. For further information, call 613/725-3769. It will be preceeding the annual meeting of the Canadian Assn. of Clinical Microbiology & Infectious Disease.

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AIDS SECTION IN NCGSTDS NEWSLETTER

Beginning with this Newsletter, most of the information about Acquired Immune Deficiency Syndrome (AIDS) will be relegated to a special section in the back of each issue. Exceptions to this "policy" will be specially marked, and will occur only due to space considerations. The NCGSTDS Newsletter has been designated as the official interim national communication devise for desseminating information about AIDS by the participants of the AIDS Forum, National Gay Leadership Conference, Dallas, TX August 13-15, 1982.

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CANCER TREATMENT REPORTS OFFERS UPDATE ON AIDS

The June, 1982 issue of Cancer Treatment Reports (Vol. 66:6, pp. 1391-95) has an article by Arthur S. Levine from the National Cancer Institute: "The epidemic of acquired immune dysfunction in homosexual men and its sequelae--opportunistic infections, Kaposi's sarcoma, and other malignancies: an update and interpretation."

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M.D. ANDERSON FORMS RESEARCH CONSORTIUM

by Michael Wilson (excerpted)

A Consortium for AIDS Research and Epidemiological Studies (CARES) has been formed by the Department of Cancer Prevention, University of Texas System Cancer Center, M.D. Anderson Hospital & Tumor Institute, in Houston. The objectives of CARES would be to design or at least agree upon a core of data which can be collected nationally on AIDS patients and controls, develop and/or modify existing data collection instruments (such as questionnaires regarding clinical history & lifestyle), develop and agree upon certain standard, universal clinical laboratory and immunological laboratory data, develop guidelines for longitudinal followup of patients and prodromal patients, establish a convenient and workable central reporting mechanism, and make the data available for analysis to the various researchers involved. Each of the five major metropolitan areas identified as high risk for AIDS--New York, Philadelphia, Houston, San Francisco, & Los Angeles, will be visited for the purpose of presenting the project and collecting input. A national effort toward expansion of the gay health & lifestyle data base would be of extreme importance epidemiologically and statistically. Such a data base would include such factors as medical history, drugs & medications, nutrition, sexual history/activity/disease, psychological factors, and demographic data, and would be used to compare with clinical and immunological findings. The unique things about CARES are the types of control groups used, the followup of both AIDS and prodromal patients, the inclusion of data collection in areas which are new theories within the past few months (including such things as parasitic infestation, nutritional status, sperm exposure, as well as the traditional areas of gay lifestyle--recreational drugs, sexual activities). It will also collect information on patients' and controls' psychological/social attitudes regarding the AIDS phenomenon. Patients and the community at large seem to be having some definite emotional/psychological/social changes taking place in the gay communities of this country which we intend to collect data on. For more information, contact: Michael Wilson, Coordinator of Public Health Education and Research, Department of Cancer Prevention, M.D. Anderson Hospital, 6723 Bertner Av., Houston, TX 77030, 713/792-3020.

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STD/AIDS INFORMATION NETWORK FORMING

by David Ostrow, MD, PhD

The CDC's AIDS Task Force has expressed interest in a proposal for an STD?AIDS Information Network and a prospective study of the possible associations between various infectious disease syndromes and AIDS. It is based on the assumption that whatever the etiological agent(s) causing AIDS, the differing incidence rates in various locales will be related to the prevalence of clinical syndromes caused by those agent(s). Accordingly, areas with differing incidence rates for AIDS can be thought of as being at various points along a time

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STD/AIDS INFORMATION NETWORK, Continued

line beginning with the introduction of the particular infectious agent(s) into that community, saturation of the groups at highest risk, and eventual spread of the agent(s) into the wider community. Thus, a prospective study of STDs in the gay male community and the occurance of AIDS can be telescoped into a relatively short period of time, say 2-3 years by careful monitoring of both types of statistics in a number of cities with varying AIDS incidence rates.

The essential requirements within a city would be the existance of both a clinic serving a large gay male population representative of the homosexually active population of that city, and able to determine accurate incidence rates for the various infectious agents prevalent in that community. In addition, community wide active surveillance for all cases of AIDS, pre-AIDS, and other prodromal syndromes would be undertaken.

Elements that may have to be added to each participating city and its component organization would be:

1) Community outreach to identify prodromal syndromes and other unusual infectious or neoplastic diseases which may otherwise not be seen in the clinic setting;
2) Development of standardized information collecting and varification systems with appropriate confidentiality safeguards;
3) Development of collaborative ties between each STD clinic and the appropriate laboratories for the confirmation of specific infectious agents which may be involved in the etiology of AIDS (eg, CMV, EBV, HAV, HBV, NANB hepatitis, etc.); and
4) Development of either individual city computerized record keeping systems for the above information or the designation of a central and/or regional data collection system for the tabulation and analysis of this data.

Many of the essential features of the proposed network already exist in at least four cities (Los Angeles, San Francisco, Denver, & Chicago) as a result of the recently completed CDC sponsored hepatitis B incidence & vaccine efficacy studies. These as well as other cities will be chosen for participation on the basis of both differing rates of AIDS and the existance of the appropriate organization for collecting STD & AIDS data as above. (Note: New York City is already being closely scrutinized by CDC personnel.)

CDC AIDS Coordinator Dr. James Curran is very interested in the Network and indicated that it was "...very consistent with our overall goal of expanded AIDS surveillance. It is very desirable that procedures and case definitions be standardized to assure comparability and that clinics serving the gay community be involved in this process." Although no specific funding avenues were yet identified, the CDC is very interested in helping to establish the Network.

The definition of possible prodromal syndromes ("pre-AIDS") is of prime concern to the Network. A "Chinese menu" approach was proposed: information would be solicited and recorded on a symptom, symptom cluster, and historical information basis. Various pre-AIDS and AIDS clusters would be preliminarily defined. However, a major goal of the information gathering/data analysis network would be to define clusters based on the actual data collected.

The following individuals are presently working on the Network: Dr. Hunter Handsfield (Seattle), Dr. Frank Judson (Denver), Drs. Bill McCormack and Dan William (New York), Dr. Ken Mayer (Boston), Dr. David Ostrow (Chicago), Dr. Bernard Branson (Baltimore), Drs. Irv Braff, Selma Dritz, & Marcus Conan (San Francisco), and Mr. Mark Behar (Milwaukee & the NCGSTDS). Other individuals, organizations, or cities interested in joining this Network are urged to contact: David Ostrow, MD, PhD, 155 N. Harbor Drive, #5103, Chicago, IL 60601, 312/565-2109 home or 312/943-6600 x424 work. There will be a dinner meeting of STD/AIDS information Network and the HBV Task Force at the APHA in Montreal, Monday evening, November 15, 1982 at the Parc Regent Hotel. Reservations are needed! Call Dave at the above numbers or his assistant, Ms. Laura Coates, 312/871-5777, at Howard Brown Memorial Clinic!

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CRYPTOSPORIDIOSIS NOW BEING SEEN IN IMMUNE-DEFICIENT GAY MEN
excerpts from Medical News & International Report (volume 6:11, 9/20/82)

Cryptosporidiosis, a protozoan parasite that causes diarrhea in calves, lambs, & horses, has joined the ranks of opportunistic infections afflicting immunodeficient gay men. Cryptosporidium in humans has hitherto been rare and generally self-limiting, but has recently been diagnosed in immune-deficient gay men in San Francisco and New York (and several animal handlers in Alabama, free of immune deficiencies, according to the MMWR, May 21, 1982, Volume 31:19, pp. 252-54). Cryptosporidiosis can be difficult to confirm, according to Dr. David Altman, clinical professor of medicine at the Univeristy of California at San Francisco. "One case was of a gay man with pneumocystis who died of fulminant diarrhea. Several weeks after his death, we came upon a second case, and it was only then that the organism was found in the intestinal tract of the first patient. The second patient was treated with trimethoprim-sulfamethoxazole (Bactrim, Septra) and although he later died of Kaposi's sarcoma, there was no evidence of continuing cryptosporidiosis at the time of death." Attempts to recover the organism from stools have so far been unreliable, and currently the definitive test is through intestinal biopsy and electron microscopy. However, according to Dr. William L. Current, PhD, associate professor of zoology-entomology, all diagnoses may be based on the presence of cryptosporidium oocysts in stool specimens with a modification of the standard flotation technique. The parasite doesn't deeply penetrate the tissues but multiplies in the epithelial surfaces of the small intestitine and causes stunting of the villi and mucosa. A toxin secreted by the organism is apparently the cause of extensive diarrhea, moderate to severe abdominal cramps, malabsorption, and severe weight loss. In healthy persons, it runs its course in about two weeks.

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CRYPTOSPORIDIOSIS--ALL CHEMOTHERAPY ESSENTIALLY INEFFECTIVE

The NCGSTDS received advanced notice of an article scheduled for publicaiton in the November 1, 1982 issue (plus or minus 2 weeks) of the Morbidity & Mortality Weekly Report about the ineffectiveness of all chemotherapy (including TMP-SMZ) for cryptosporidiosis in AIDS patients. A reprint will be published in the next issue of the Newsletter.

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AID ATLANTA GROUP FORMED
by Zell Malcolm, Jr., PA-C

On September 16, the first organizational meeting of the new non-profit organization, AID-Atlanta (AIDA) was held. Just like the Gay Men's Health Crisis in New York, the group will initially deal with teaching, referral, and clinic set-ups, and is closely associated with the Atlanta Business and Professional Guild and the Midtown Business Men's Association, as well as other gay community groups. AIDA will be publishing a newsletter, setting up educational programs both for lay and medical people, devising referral lists, and holding fundraisers (a Halloween party called "The Bride of Frankenstein" will donate $1 for each ticket sold). While Atlanta has been largely spared thus far, AIDA is taking action to see that members of the gay community are aware of AIDS and know what to do if and when the problem develops as it has in New York and California. For more information, write to: AID-Atlanta, PO Box 52785, Atlanta, GA 30305.

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WHITMAN-WALKER CLINIC
by Jim Graham, Clinic President

Washington, DC's Whitman-Walker Gay Men's VD Clinic has been involved in discussions with physicians at Georgetown Medical School's Lombardi Cancer Center and Howard University Medical School, concerning a possible research project involving AIDS. Researchers decided that as of now, there was too little incidence of the problem in this area to justify a screening project at the Clinic. I am convinced that there are things to be done here in that regard, but happily we return to the basic reality that this community has been spared this onslaught to date.

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SEXUAL PSYCHOSOCIAL APPROACHES TO THE AIDS EPIDEMIC AMONG GAY MEN

by Tom M. Smith, MD, San Francisco Medical Center

The new AIDS epidemic has spread concern and panic within and without the gay male community. Many of the psychosocial issues that msut be addressed now are the same issues that have received moderate attention because of the increasing incidence of STDs among gay men. By utilizing the effective crisis intervention model found in the mental health field, the energy generated bu the panic and anxiety over the Kaposi's outbreak can be channelled into the creation of healthier and more satisfactory lifestyles. Psychosocial functioning is always changing within groups; however, change in the near future withinthe gay male subculture may come too rapidly, with results that are either positive or negative on the whole. Caution in planning is very important in order to minimize homophobia both in straight and gay societies, and to enhance gay male bonding and the newly developing gay male subculture.

Several factors quickly come to mind that will facilitate the goals of 1)reduced mortality & morbidity caused by AIDS and STDs; and 2) increased wellness and personal satisfaction among gay men:

AWARENESS: Personal and group awareness of the signs, symptoms, treatment, preventative measures and wellness factors of AIDS & STDs.

INFORMATION: Clear, consistent (as much as possible) ethical information provided in appropriate measure and at appropriate times.

RESPONSIBILITY: Personal and group responsibility taking for social, sexual, medical, psychological, and spiritual behaviors in regards to AIDS and STDs.

CHANGE: Planned, constructive changes on the level of the individual, the gay male subculture, general society and environments.

INTEGRITY: Maintenance of personal and group integrity and pride. Maintenance of personal and sexual freedom. Don't throw out the baby with the bath water.

AVOIDANCE OF HOMOPHOBIA: Avoid homophobic responses from both the general society and within the lesbian/gay male subcultures. To question gay male behavior does not necessarily imply homophobia; however suggestions and implied suggestions for change of gay male behavior should be screened for possible homophobic elements.

INDIVIDUAL DIFFERENCES: Respect of the great variety of gay men and their diversity (ethnic, age, sexual practices, etc.) should enter into plans for psychosocial changes in gay men.

I. PERSONAL RESPONSIBILITY TAKING: Much of the needed change will probably have to take place on the personal level, especially in regards to prevention and wellness efforts. However, caution must be taken to not overburdon the individual with total responsibility. Group, society, and environmental planning levels of responsibility taking can facilitate personal constructive change. Many individuals operate with "skills deficits:" they do not have the appropriate information or methods to take more personal responsibility. Many gay men are misinformed about many aspects of various illnesses. Many gay men do not know what steps to take in order to change behavior. Most guidelines about STD and AIDS imply: "Don't do something (don't rim strangers, swallow cum, etc.)." The person is left with a frustrating either/or dictate that may provoke guilt and failure responses. Suggestions about gradations of behavior (small steps towards positive change) are needed. While trying to show respect for personal sexual freedom, AIDS guidelines usually present what appear to be the clearest "facts" and then leave decision making and choice of behavior to the individual. This method is more humane than the issuing of public health and legal mandates; however, the individual needs more assistance, more information, and more forums in order to make appropriate decisions and to take appropriate actions.

A. Changing Personal Attitudes:

1) Adopt an attitude of increasing personal responsibility in regard to health, hygiene, and sexual ecology. The individual could be advised to plan ahead about health and sexual issues: "What changes would you like to see in your sexual relationship and acts in the next 6 months?"

2) Replace negative, passive-victim, defeatest attitudes with more positive, rational thoughts and imagery. The field of psycho-immunology, though only budding, has

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SEXUAL PSYCHOSOCIAL APPROACHES TO AIDS, Continued

practical techniques that probably increase immunity and counteract frequently seen symptoms such as low self-esteem and depression (which often result from oppression and from substance abuse).

3) Promote attitudes that emphasize the humanism in gay male bonding and in gay male encounters, even brief ones.

4) View gay male sexuality as basically a positive aspect of human functioning, similar to breathing or eating. Respect the many facets and varieties of gay male sexual behavior, most of which have been in existence for centuries and within many cultures.

5) Excessive guilt is automatic, obsessive thinking that serves little purpose other than that of causing self-flagellation and augmenting of masochistic responses to being gay. Excessive guilt leads to depression and poor health. The "excessive guilt model" of self-control can be replaced with a "learning model" whereby the individual rationally plans more optimal behavior in the future.

B. Changing Personal Behaviors:

1) One slogan of the AIDS prevention campaign is "Get Out of the Fast Lane." Implied is a change of lifestyle: more sleep, more relaxation, less drugs, fewer sexual partners and less of some sexual acts. Even though these "risk factors" may be prematurely drawn from limited studies, few people would argue with a wellness approach. Actually, simultaneous with the increased availability and social acceptance of a wide variety of sexual encounters that have facilitated the spread of STDs, the gay male community had made rapid advances in the pursuit of wellness, social activities, and spirituality. The latter needs to be emphasized and capitalized upon.

2) Individuals could profit by knowing more about how sexual behaviors change. Will power works for some people some of the time, however will power can be part of a guilt-failure system. Change of sexual behavior usually has to start with an honoring of basic needs within the individual (eg, need for physical contact, need for oral or anal stimulation, etc.). The change may be gradual (occurring over a period of weeks or months) and less dramatic than was hoped for initially. For example, an individual may decide ot quit rimming, but continues to do so occasionally with irresistible strangers. After several months, he may notice that rimming is even less frequent. Gratification achieved through fantasy rather than through physical activity is another method used to decrease the occurance of "high risk" sexual acts (eg, the individual can imagine that he is rimming while actually licking the umbilicus or armpits, etc.).

3) Alcohol and drug abuse are known and documented causes of immunosuppression. Methods for bringing about cessation and changes in alcohol and drug abuse behaviors are also known and are effective. Both drug use and sexual activity occur in altered states of consciousness. These altered consciousness events are less easily controlled by the usual "normal" states of consciousness types of self-control mechanisms. Factors relatin g to altered conciousness behavior should be part of sexuality planning. Even though sexuality and drug abuse have commonalities, these two types of behavior should not be confused. For example, drug abuse is pathological; multiple sex partners may very well not be pathological, but rather life enhancing in some situations. Treatment of drug abuse is usually cessation of the activity. Change of sexuality usually means fine tuning to increased intimacy, sharing and satisfaction.

4) Somehow, possibly through the influence of films, good hygiene has lost its priority status in some gay male sexual encounters. Cleanliness needs to be eroticized and returned to favor.

5) The role of stress in AIDS and STDs, which is prevalent in the gay male community, needs further examination.

6) Now that gay men are on the quota system, of necessity, quantity will have to

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SEXUAL PSYCHOSOCIAL APPROACHES TO AIDS, Continued

be replaced with quality. Gay male conding needs to be emphasized.
7) The role of sex among gay men, as health promoting, needs to be emphasized.

II. GROUP RESPONSIBILITY TAKING: Fashion, peer pressure and personal testimony in groups have a great effect upon individual behavior. The gay subcultures, including gay health care providers, have various mechanisms for communicaiton and decision making. We need to take responsibility for our actions as a group especially in this area of sexuality, wellness, and socialization. As mentioned above, group action, especially in the form of influencing sexual and social customs, can aid the individual gay man in taking more personal responsibility. For example, one voice will not increase the number of socail alternatives to bars and baths, group effort will.

A. Group Activities:
1) Groups can examine a whole host of issues (virology, immunology, oncology, legal mechanism, social patterns, etc.) that may be too technical and too perplexing for the individual.
2) Gay men need to offer input and leadership in discussing these issues and in carrying out plans of action. These issues are not just abstractions; the gay male subculture lifestyle is being challenged and changed. Gay male sensitivity, self-knowledge and intuition are needed.
3) Newly formed and currently ongoing gay male social, therapy, political, spiritual, business and recreational groups can address these psychosocial issues. Group efforts need to take place on the community, state and national levels; different communities have different needs.
4) Apparently changes in communal sexual practices are being made to reduce the incidence of STD transmission. Honor code bath houses, small exclusive circles of sexual buddies, interpersonal sexual contracts, and personalizing sexual encounters have all been proposed and attempted to some degree. More innovative communal sexual alternatives are needed.
5) An ethics ad hoc committee should monitor the ongoing activities, planning and media presentations of the STD/AIDS prevention campaign.
6) Both the general society and the gay media need input, clear information, and monitoring. Many gay men can only be reached via the general media. The influence of the gay porno industries should be utilized to aid in the wellness effort. For example, porn flicks could show hygenic sexual practices, could model how to decline sexual invitations for certain sexual practices, could eroticize the use of condoms, etc.
7) Group effort is needed to raise funds for STD/AIDS research, treatment, and prevention efforts.

III. ENVIRONMENTAL CHANGE: Environmental change is a necessary part of individual behavior change (good freeway design and safe vehicles may have more effect upon reducing highway mortality than improvements in personal driving skills, etc.). Gay milieu environment change will carry a large cost factor. Even though gay businesses have been organizing, gay businesses (bars, baths, etc.) apparently are no more responsive to public concern than straight businesses. Group action, cooperation, public support and guidance is needed in environmental planning.

A. Alternatives to bars and baths (that are also fun and "in") are greatly needed. Gay businesses will need guidelines concerning what changes in existing facilities or new facilities will promote wellness.

B. Closing gay male "sex clubs" in large cities will probably lead to 1) frustration, 2) further feelings of oppression, and 3) increased utilization of more public (and more dangerous) sexual settings (parks, rest rooms, etc.). If gay men do not take

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SEXUAL PSYCHOSOCIAL APPROACHES TO AIDS, Continued

responsibility for positive change in these environments, then they will be closed from without.

IV. LEGISLATION: Lawrence Mass, MD, has emphasized the "potentially affirmative impact of destigmatization: "...The passage of civil rights legislation for gay people will begin to be seen as a critical cofactor in the prevention of STD, which probably includes AIDS."

V. INFORMATION: As mentioned above, clear, consistant (when possible) and ethical information, devoid of homophobia, is needed. Information about STD/AIDS prevention should be manageable to both the gay and straight societies. Information should be available about and for the many diverse gay male subcultures.

A. Information concerning changes in long established (basic) sexual behavior (fellatio, kissing, anal intercourse, multiple partners, douching, etc.) should be carefully screened prior to media release. The overall benefits of the behavior (psychological, physical, social) should be carefully weighed against the negative consequences. Some sexual behavior should be considered "innocent until proven guilty beyond any reasonable doubt." Conjecture and a few studies are not enough to advise cessation of some activities. For example, the current advice "don't swallow cum," though based on limited studies, could negatively affect over 95% of gay men.

B. Individuals should be allowed to ventilate their own "wild ideas and theories" without reactions of negative labelling ("that notion is paranoid"). Science works on the generation of notions that are then examined for veracity.

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TIPS ON TALKING TO YOUR LEGISLATORS

Your legislators in Congress want to meet you, because they think it may help them get re-elected. You want to meet them because it may help win their votes on legislation that concerns you. When you meet a legislator face-to-face, you have the chance to get your view across directly.

1) Get an appointment. Call the legislator's nearest field office and ask for an appoint ment next time the legislator is in town. When you're in Washington, DC, for business or pleasure, go and see you legislator there.

2) Don't be awed by the legislator or by the impression he or she gives of omniscience. You probably know more than the legislator does about your issue, because the legislator is a "jack-of-all-trades." Act confident, even if you don't feel it.

3) When you first meet the legislator, show that you're a friendly person by compliment-something he or she has done. It's just a pleasantry, but it gets you off on the right foot.

4) Show that you're serious about your issue. Know your facts and make your pitch concisely in five minutes or less. Start by telling the legislator what you're asking him or her to do, then give your arguments. Stress how the issue affects you and others in your community.

5) Be a good listener. Let the legislator ask questions as you go along, and answer them with hard facts and with understanding. You don't have to agree with the legislator's views but you should show that you're willing to hear them.

6) Don't let the legislator evade the issue. If he or she changes the subject, tactfully bring it up again and ask how he or she plans to vote on your issue.

7) Don't assume the legislator is against your cause just because he or she asks a lot of hostile sounding questions. If he or she is going to back your position, he or she will need to know how to answer your opponents' arguments. Use the questions as an opportunity to tell more about the issue.

8) If the legislator is on your side, make him or her feel good about it so that he or she will be willing to work harder for your goals. Make sure he or she knows how much

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TIPS ON TALKING TO YOUR LEGISLATORS, Continued

the issue means to people back home.

9) Press for a commitment, unless the legislator is clearly opposed to your views. Ask whether he or she will vote for your amendment, whether he or she will cosponsor your bill, or whatever it is you want. You're entitled to know what he or she plans to do about the issue.

10) If you can't get to see the legislator in person, go and see a member of his staff instead. You can't press a staffer for a commitment, but you can do your best to persuade the staffer and show how serious you are about the issue, so he or she will give a good report of your concern to the Congressman.

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CONSOLIDATED LIST OF RECOMMENDATIONS FROM THE AIDS FORUM AT THE DALLAS LEADERSHIP CONFERENCE

Following is a list of recommendations from the five workshops (Resource Coordination, Risk Reduction, Psycho-Social Issues, Media, and Political Action) of the AIDS Forum, held at the Dallas Gay Leadership Conference, August 13-15, 1982. Details of the Forum, with detailed reports of each of the workshops, were printed in the last Newsletter (Volume 4:1, August, 1982).

A. Needs of Patients:
   1) List of competant providers for screening & counseling, primary care and tertiary (sophisticated) care
   2) Information and referral service, to help existing gay hotlines become competant on AIDS, and to help establish new special services.
   3) Volunteers for assistance with welfare needs of AIDS patients; "buddies" are needed to accompany patients/possible patients on their visits to hospitals and doctor's offices.
   4) Support groups for AIDS patients
   5) Other assistance to AIDS patients for dealing iwth spiritual and philosophical needs.
   6) Helath alternative activity/social groups

B. Needs of Health Care Providers:
   1) Education and training of I & R service staff and counselors
   2) Education of medical care providers, with emphasis on the most recent information, giving patient a written summary of findings and recommendations, and developing a special need for high quality doctor-patient relationships
   3) Support groups for AIDS medical care providers

C. Needs of Gay Community:
   1) Education of high risk persons, to promote guidelines for individuals, and to promote guidelines for the information campaign for the public at risk.
   2) Technical assistance ot local communities which intend to develop services for AIDS patients, such as packets of literature, telephone consultations, or on the spot consultations.
   3) Develop coalitions of organizations which are advocates/representatives of the groups at high risk, and are opponents of the Family Protection Act and other right wing attacks on minorities, women, and working people.
   4) Information exchange to include a telephone tree to disseminate promptly, emergency news; local organizations are to send all materials to all other local organizations; national directory of AIDS related services with priority to information and referral services; and a newsletter.

D. Needs of All Concerned:
   1) Promotion of positive use of the AIDS crisis with emphasis on the proposals made by Charlotte Brunch in her address to the Opening Plenary Session of the Forum. To wit:

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CONSOLIDATED LIST OF AIDS FORUM RECOMMENDATIONS, Continued

"Understanding ourselves as family can help us in organizing both short and long term responses to the AIDS crisis....1) We must help those in greatest need--patients, friends, lovers--with support services and assistance in getting the social service resources that the government should be providing them. 2) We must educate our community with all the information that we have about this problem and we must educate the straight world in order to prevent anti-gay uses of this issue. 3) We must mobilize support for and assist in the medical research, perhaps as Stanley (Matek, president of the American Public Health Association, and another Plenary Session speaker) suggests by political organizing around the need for government money to support this work.

"In addition to these organizing tasks, we must deal with the fears in our own community that have been generated by this disease. This involves us not only in community educaiton around the medical matters..., but also in looking at a whole range of issues in our community that this crisis brings into focus: 1) questions of disease and death; 2) questions of aging and security and love; 3) questions of stress, drugs, and life styles; 4) questions of lingering guilt, self-hatred, and fear from within as well as from the violence and hatred against us in the society....

"We need all the intelligence, care, honesty, and cooperation within the lesbian and gay community that we can muster in order to respond to this issue well and in its broadest challenges. And if we do this, we have a unique opportunity to set a model for how a community copes with such a difficult and deadly problem as AIDS. And we have the opportunity to demonstrate to the world who and what we can be as a community. But perhaps, most important, we can expand our capacities as a community in crisis and show ourselves that we are indeed a family that cares for its own."

Record of Action Decisions

1) It was the consensus to endorse a proposed political action campaign (letter writing, lobbying) to affect the Congressional budget process with the goal of insuring adequate funding of the National Institutes of Health and Centers for Disease Control for addressing AIDS. A meeting was convened in Washington, DC to plan for lobbying efforts in conjunction with Gay Rights National Lobby, National Gay Task Force, other established gay/lesbian organizations, and other natural allies. An appropriate linkage to CDC will be maintained. Resource persons: Bruce Voeller, Roger Enlow.
2) Bopper Deyton, Tom Nylund, Cleve Jones, and two additional persons agreed to take responsibility for implementing the political action recommendations and monitoring correspondence.
3) It was agreed to "generify" concerns about AIDS to emphasize its effect on groups other than gay men.
4) Official nomenclature is: Acquired Immune Deficiency Syndrome (AIDS, or AID Syndrome).
5) Preparation of the final report of the AIDS Forum was the reponsibility of Roger Pickett, Roger Enlow, Morris Floyd, and Jeremy Landau.
6) It was agreed to develop, an information exchange mechanism to enable systematic, timely exchange of information on AIDS among local groups and between national and local groups. The Design Team responsible for creating, funding, and implementing a proposal are: Mark Behar (NCGSTDS, Milwaukee); Bopper Deyton (Washington, DC); Barry Gaspard (Denver); Chris Mathews (San Diego); Jeff Richards (San Francisco); Helen Schietinger (San Francisco); Ron Vachon (New York); and Michael Wilson (Houston).
7) It was agreed that another forum on AIDS should be held in conjunction with the National Lesbian/Gay Health Conference, summer, 1983 at the latest (tentatively in Los Angeles).
8) An interim committee on AIDS Risk Reduction was appointed; they include the following:

(CONTINUED)

CONSOLIDATED LIST OF AIDS FORUM RECOMMENDATIONS, Continued

Co-chairs: David Ostrow (Chicago) and Jeff Richards (San Francisco); other members are: Mark Behar (Milwaukee); Lawrence Mass, Roger Enlow, Ron Vachon, & Bill Siroty (New York); and Tom Smith, Jim Geary, & Robert Bolan (San Francisco). This committee will:

a) prepare statements of the AIDS Forum risk reduction guidelines targeted to specific groups, such as patients and health care providers.
b) Monitor new developments which may impinge on the guidelines and insure that they are consistant with general STD risk reduction guidelines.
c) Work cooperatively with the Design Team to assure integration of these tasks into the national resource and information network.

9) Information on events in Congress relevant to the AIDS can be obtained from the office of Congressmember Henry Waxman, 202/225-4952.

10) It was agreed to promulgate the revised AIDS Risk Reduction statement.

11) Interim information exchange arrangements:

a) high priority: Gay Mens Health Crisis will establish a telephone tree, which will include addresses
b) Organizations will circulate written material among those on the telephone tree
c) National Gay Health Education Foundation and the American Association for Social Health will publish AIDS related services in their directories.
d) NCGSTDS will publish information on the AIDS pending the establishment of the national resource and information network. Bill Wilson of New York will prepare the material and get it to Mark Behar of the NCGSTDS for publication.

12) It was agreed that a press release aimed at the gay/lesbian press should be prepared to accompany the release of the proceedings of the Forum.

13) It was agreed that provision of technical assistance to local groups is a high priority. Physicians involoved in the Forum will work on a plan and report to the upcoming American Association of Physicians for Human Rights (AAPHR) meeting in Boston. Paul Popham of New York will write up the learnings gained by the Gay Mens Health Crisis.

14) It was agreed that provision of support groups for AIDS patients should be a priority.

15) Special thanks were expressed to: Terry Fonville and the National Gay Task Force for the work involved in calling and coordinating the Forum; James Curran for his presence and co-operation; Walter Lear for chairing the Plenary Session; and the Dallas Gay Alliance and the Grenelefe Hotel for their support and assistance.

* * * * *

AIDS FOUNDATIONS & ORGANIZATIONS

The last issue of the Newsletter (Volume 4:1, August, 1982) had information about several of the nation's AIDS organizations, with newsletters or other information included for your review. In order to be well informed & prepared to care for your patients, we urge you to become part of the Network--request to be on their mailing lists, and please! contribute generously! Following is an updated listing, alphabetized by city:

Atlanta: AID-Atlanta, PO Box 52785, Atlanta, GA 30305 (temporary phone 404/876- 2354)

Boston: Mayor's Task Force on AIDS, c/o Brian McNaught, Mayor's Gay Liaison, City Hall, Boston, MA (no zipcode) 617/424-5916 (AIDS at Boston City Hospital); 617/267-7573 (Fenway Comm. Health Ctr.); 617/426-9371 (Lesbian & Gay Hotline)

Chicago: AIDS Action Project, c/o Howard Brown Memorial Clinic, 2676 N. Halsted, Chicago, IL 60614 312/871-5777

Denver: AIDS Committee, c/o Gay & Lesbian Health Alliance of Denver, PO Box 6101, Denver, CO 80206-0101 303/831-6268 (temporary)

Houston: Kaposi's Sarcoma Committee of Houston, PO Box 1155, 3317 Montrose, Houston, TX 77006 713/666-8251 (Mike Wilson)

New York: Gay Men's Health Crisis, Box 274, 132 West 24th Street, New York, NY 10011 212/685-4952

San Francisco: Kaposi's Sarcoma Clinic, UCSF, c/o 110 East Court, Petaluma, CA 94952 415/666-1407; KS Research & Educational Foundation, 470 Castro St., #207, Box 3360, San Francisco, CA 94114 415/864-4376.

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AIDS NEWS FROM BOSTON'S FENWAY

by Ken Mayer, MD

AIDS is certainly the scourge of the day. There have been about 8 documented cases of Kaposi's sarcoma or Pneumocystis cariini pneumonia in Massachusetts, 7 in Boston (3 in straight men, 1 in an IV drug abuser, the rest gay men). There are many individuals being followed at the Fenway who we consider high risk--e.g., chronic nodes, fever, and "Kaposi's neurosis," what I call the fear of AIDS, which unfortunately continuing to freak out the community. There is a Mayor's Task Force on AIDS, with which the clinic is active, and which primarily serves as a clearinghouse of information between city, state, federal (CDC), and gay community workers. We are finishing up an epidemiological study at the clinic on the prevalence of immunosuppression in generally healthy gay men, having screened about 700 people, with a comprehensive questionnaire and lymphocyte subpopulation studies. We have been developing a working relationship with the Sidney Farber Cancer Center at Harvard to follow the immunolgic and virologic status of the "high risk" men that we are seeing. We are also considering various outreach programs to keep the community informed, without feeding into the prevalent mass hysteria. Specifically, educational seminars and weekly AIDS drop-in sessions are planned, to be staffed by both medical and mental health workers. It is truly a worrisome problem.

* * * *

SCIENCE REVIEWS AIDS MYSTERY

Science, the prestigious weekly journal of the American scientific community, has an excellent review of AIDS in the August 13, 1982 issue (volume 217, pp. 618-21), under the "Research News" section, entitled, "New disease baffles medical community; 'AIDS' is a serious public health hazard, but may also provide insights into the workings of the immune system and the origin of cancer." Highly recommended in easy to understand language, the article's only drawback is that it is without references.

* * *

DISCOVER DISCOVERS AIDS

The September, 1982 issue of the popular scientific magazine, Discover (Volume 3:9) published a good review of the AIDS entitled, "Epidemic--a grave disease first found in homosexual men is spreading" (author, Jerry E. Bishop).

* * * *

AMYL NITRITE MAY STILL BE A FACTOR IN AIDS

Although most researchers are concentrating on the possible infectitious etiological agent of AIDS, investigators are pursuing other hypotheses as well. Dr. Karl Jorgensen, MD, from the University of Aarhus in Denmark reports about the liklihood of amyl nitrite in the causation of KS in the September 30, 1982 New England Journal of Medicine (volume 307:14, p. 893-94). His letter to the editor focuses on the chemistry of the volatile nitrites and their carcinogenic properties. Although the author's conclusions are not convincing, poppers should still be used with caution and moderation (if at all), for their role in immune suppression or carcinogenesis is still embroiled in controversy and debate.

* * * * *

CHICAGO AIDS ACTION PROJECT

The following outline describes the Chicago AIDS Action Project of the Howard Brown Memorial Clinic. It is reproduced with only slight changes for space considerations (originally 7 pages).

The AIDS Action Project consists of five components: 1) Community Education; 2) Clearinghouse 3) Clinical Screening; 4) Patient Support Services; and 5) Research. Each component is briefly outlined below with an indication of some of the tasks required to accomplish specific activities.

(Continued)

CHICAGO AIDS, CONT.

I. Community Education

A. Target group(s)-- The Chicago metropolitan and northern Indiana gay community, local health care professionals, and the gay and non-gay media.

B. Objectives

1. To inform target groups about: a) the nature and extent of the AIDS problem, especially as it affects the Chicago area; b) the steps recommended/available to prevent, detect, and treat AIDS-related conditions; and c) the types of AIDS services available at HBMC, Gay Horizons, and elsewhere.

2. To motivate target groups to: a) take potentially appropriate preventive actions; b) seek screening, diagnostic, treatment and support services as necessary; and c) support HBMC and Gay Horizons through fund giving, volunteer or other assistance, case reporting and patient referrals.

C. Description--Major elements of the community education program include:

1. Development of an educational pamphlet for distribution at HBMC, Gay Horizons and elsewhere in the community (e.g., bath houses, bars, mobile van locations, special meetings). The pamphlet will be designed to asnwer the following questions: What is AIDS?; Who is at risk?; What are AIDS symptoms?; What can be done to lower an individual's risk?; What AIDS services are available?; How can individuals help the AIDS Action Program?

2. Establishment of a speaker's bureau which will provide speakers to interested organizations and groups as well as conduct special forums and symposia. In addition to providing information, speaker's activities will be used to enlist the medical, volunteer, or financial support of the gay and lesbian community and local health care professionals.

3. Promotion of articles, news reports, and public service announcements which emphasize accurate, up-to-date, "non-judgemental" and balanced information about AIDS and AIDS services.

D. Tasks

1. Educational pamphlet. To include: revision on current educational pamphlet; review of revised pamphlet by those knowledgeable about AIDS conditions and services; pretesting of pamphlet on a sample of clinic users; modification of pamphlet based on review and pre-test; and distribution of pamphlet at HBMC, Gay Horizons (a local gay services agency), and in the community.

(CONTINUED)

CHICAGO AIDS, CONT.

2. Speakers Bureau. To include: Identification of credible and effective volunteer speakers; orientation for volunteer speakers; publication of availability of speakers through media, hotlines, etc.; and establishment of a method (e.g., speaker's report) to record new information, volunteer and financial support obtained as a result of speaker's activities.
3. Articles, News Reports. To include: Preparation and distribution of a "press release" informing local media about objectives and activities of AIDS Action Project; and preparation (on a periodic basis) of special articles/reports for publication in local gay paper (Gaylife) and elsewhere.

II. Clearinghouse

A. Target group(s)-- The Chicago metropolitan and northern Indiana gay community; local health care professionals and facilities.

B. Objectives

1. To collect and monitor information about AIDS medical cases.
2. To answer community inquiries concerning the AIDS problem, available services, and types of assistance community members can provide to the AIDS Action Project.
3. To refer individuals to screening, diagnostic, treatment, and support services as appropriate.

C. Description--Major clearinghouse activities include:

1. Establishment of an ongoing system at HBMC for reporting and monitoring of AIDS medical cases. HBMC will obtain information about AIDS cases through its existing relationships with area medical centers and community physicians as well as through new activities (e.g., AIDS Hotline, special outreach to individual medical practitioners and facilities). HBMC will develop confidential procedures to maintain individual case data and periodically report (in the aggregate) on the prevelence/natural history of AIDS cases in the community.
2. Implementation of an AIDS Telephone Hotline ("AIDS Information") to answer community inquiries, refer individuals to needed services, collect possible case information, and respond to special requests from the medical community.

D. Tasks

1. Case Finding System

a. Establishment of uniform reporting procedures to be used with area medical centers and community physicians.
b. Development of special efforts for case finding to reach practitioners serving the gay community (e.g., mailings to individual physicians and facilities).

(CONTINUED)

CHICAGO AIDS, CONT.

c. Development of a uniform format for reporting and publication of case monitoring results to the community.

2. AIDS Telephone Hotline

a. Development and implementation of a training program for volunteer Hotline personnel.
b. Preparation of a set of guidelines for use by Hotline staff. Guidelines would include answers to commonly asked questions, procedures for referrals, etc.
c. Development of forms needed to record information given and received from Hotline activities.

III. Clinical Screening

A. Target group(s) - Individuals reporting one or more AIDS symptoms and/or those expressing acute anxiety about their personal health and AIDS.

B. Objectives

1. To offer a program for the pre-diagnostic examination of suspected AIDS cases.

2. To expand existing cooperative referral sources with Northwestern University Medical Center for diagnostic follow-up.

C. Description - HBMC will routinely offer clinical screening services for suspected AIDS cases and refer symptomatic individuals to Northwestern Medical Center for diagnostic follow-up when appropriate. A physician assistant will be employed to conduct this program. The pre-diagnostic AIDS evaluation will consist of:

1. Taking of a detailed patient history including (but not limited to) history of chronic, recurrent or multiple STD's, a sexual activity profile; and assessment of recreational/intravenous drug use.

2. Assessment of AIDS symptoms through physical examination and patient reports. (Assessment will include lymph node examination).

3. Routine blood tests (white blood cell and lymphocyte counts) which may serve as possible indicators of immune deficiency.

4. Referrals, as appropriate, to established facility for diagnostic services.

5. Patient education based on outcome of pre-diagnostic evaluation.

(CONTINUED)

CHICAGO AIDS, CONT.

For those referred: Education will emphasize that a referral for diagnosis does not mean one is immune deficient or has an AIDS-related condition;education will emphasize that only a full diagnostic work-up, by an established referral center, can determine the presence or absence of AIDS. Referred individuals will also be provided with written information about referral source and required next steps.

For those not referred: Education will emphasize reasons why the individual was not referred. Sexually active individuals will be advised to get a thorough physical examination (especially including lymph node examination) at least once a year and complerte STD testing a minimum of twice a year. Sexually active individuals may also be advised to consider modifying their life style. (e.g., limiting the frequency of sexual encounters with different ((especially anonymous)) partners.)

D. Tasks

1. Hiring and training of a physician assistant.

2. Development of patient hx/examination forms for use in AIDS evaluation.

3. Preparation of education referral cards to be given to referred and non-referred individuals at conclusion of examination.

4. Establishment of a mechanism for follow-up with referred individuals. Mechanism would determine whether referred individuals sought and obtained diagnostic services and outcome of diagnostic testing.

5. Agreement with referral sources on cooperative reporting procedures with HBMC and referral of diagnosed patients to support services sponsored by Gay Horizons

IV. Patient Support Services

A. Target group(s) - those individuals diagnosed as having acquired immune deficiencies and/or AIDS-related conditions; family, friends and loved ones of AIDS patients.

B. Objective

1. To provide a coordinated program of counselingandsocial support services for target group members.

C. Description - services will be provided in conjunction with Gay Horizons. They will include (but not necessarily be limited to):

(CONTINUED)

CHICAGO AIDS, CONT.

1. Individual and group counseling of AIDS patients, family members, friends, and loved ones to assist them to "work through" the stages of illness and cope with the medical and social - psychological implications of AIDS. Different groups might be established based on types of patients, stages of illness, etc. Common issues addressed by patients in therapy may include: internalized guilt and homophobia related to illness; coping with specific treatment modalities; and resulting lifestyle adjustment.

2. Establishment of a "buddy system" for AIDS patients. Under this system, volunteers would be trained to assess patient needs during home or hospital visits and provide support services. For example, patients might need help obtaining welfare/social service benefits, help with domestic chores, or shopping, or assistance traveling to and from treatment. In addition, a "buddy system" has the potential to be an important source of emotional support for patients.

D. Tasks

1. Identification of specific patient needs to be addressed in individual and group counseling.

2. Development and implementation of a training program for staff at Gay Horizons.

3. Identification of social support needs and available community resources for AIDS patients.

4. Establishment of linkages with social service and welfare agencies, as necessary.

5. Development and implementation of a training program for volunteer "buddies."

V. Research

A. Integrate ongoing clinic research, education, and outreach into AIDS Action Project.

1. Reference NUMS-HBMC collaborative AIDS Initiative grant proposal to National Cancer Institute.

2. Expand Hepatitis B Vaccination Program to include blood profiling, immunological surveillance and AIDS risk counselling for participants.

3. Develop research program to assay individual's perception of AIDS risk and evaluation of effectiveness of various approaches to motivate reduced-risk behavior.

4. Function as coordinating center and support the organization of nationwide gay STD/AIDS information network.

★ ★ ★

Preliminary Report of the Task Force on Vaccination Strategies for Sexually Transmitted Hepatitis B Infection

SEXUAL TRANSMISSION may account for 40% of all new hepatitis B virus (HBV) infections in the United States. Homosexually active men are at extremely high risk of contracting HBV infection. Approximately 20% of cases of HBV disease reported during 1981 in the Sentinel County Study conducted by the Centers for Disease Control (Atlanta, Ga.) were in homosexually active men. Furthermore, prospective studies in sexually transmitted disease (STD) clinics in several cities in the United States have reported that the annual incidence of infection in seronegative, homosexually active men is 20–40%. The estimated annual direct medical and work-loss cost of HBV infections in homosexually active men in the United States is at least $70 million.

Because of the high rate of sexual transmission of HBV and the incidence (~6%) of chronic carriage of HBV among this group, the homosexually active male population represents a core group of major epidemiologic importance. Therefore, immunization of these men with hepatitis B vaccine as soon as possible is a high priority, because reduction of the prevalence of infection among this core group would reduce the overall incidence of hepatitis B infection in the United States.

The availability of the hepatitis B vaccine recently licensed in the United States (Merck, Heptavax B) could greatly reduce morbidity due to sexually transmitted HBV infection. However, the high cost of the vaccine and sociocultural barriers to utilization of health care can decrease the impact of the hepatitis B vaccine in the homosexually active male population. To promote the effective use of the hepatitis B vaccine, a task force was organized to make recommendations for the vaccination of persons at risk for sexually transmitted HBV infection. The task force met on March 25–26, 1982. The following is a preliminary report of the task force.

The Task Force meeting was supported by donations to the Howard Brown Memorial Clinic Hepatitis Research Fund. Ms. Joan Davenport and Ms. Laura Coats provided secretarial support.

Reprint requests: Dr. David G. Ostrow, Howard Brown Memorial Clinic, 2676 North Halsted Street, Chicago, Illinois 60614.

* Susceptibility to HBV disease of all contacts of persons with HBV infection should be determined serologically prior to administration of vaccine and/or HBIG.

Public Health Considerations

Recommendations

Homosexually active men. All susceptible* homosexually active men should be vaccinated regardless of current or past sexual habits, age, or duration of homosexual activity. The interval between serologic testing and vaccination should be as short as possible to ensure effective utilization of the vaccine.

Susceptible heterosexual contacts of persons with acute HBV infection. The susceptibility of heterosexual contacts of persons infected with HBV needs to be determined before postexposure prophylaxis is given. Alternatives are hepatitis B immune globulin (HBIG), HBV vaccine, or both. Simultaneous administration of HBIG and HBV vaccine does not alter the immune response to the latter. Current studies comparing these approaches may permit more definitive recommendations in the future. As of now, none can be made.

Susceptible heterosexual contacts to HBV carriers. Susceptible contacts should receive HBV vaccine.

Prostitutes. The risks and prevalence of HBV infection among prostitutes have not been determined in the United States. However, HBV vaccination of susceptible prostitutes is recommended.

Homosexually Active Women. There is no evidence for increased risk of sexually transmitted HBV infection among homosexually active women. Routine vaccination of this group is not recommended.

Male Prisoners. These men may be at higher risk of sexually transmitted HBV infection. They should be examined for susceptibility to HBV infection. Susceptible male prisoners should be immunized.

Strategies

Identification and education of high-risk groups. Because the risk begins as soon as homosexual activity starts, the major effort must be to inform adolescents of the risks of HBV transmission and the availability of serologic tests and vaccine. Specifically, all school health education programs should communicate to their students the high risks of HBV infection that will be experienced by homosexually active males. In addition, college and community organizations of homosexually

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active persons and public health departments and clinics should make special efforts to identify high-risk individuals and encourage them to seek serologic testing. Publicity and educational programs should include a full variety of approaches, such as special publications, leaflets, posters, and the gay media. Methods may be developed cooperatively with plasma collection centers and the vaccine manufacturer.

Homosexually active men residing outside major metropolitan areas may be at high risk but particularly difficult to test and vaccinate. Educational materials identifying testing and vaccination sites should be available at local gathering places for homosexually active men in rural areas. Other information should be published in newspapers, magazines, and newsletters directed at homosexually active men residing in rural areas, and these items should recommend that homosexually active men call a toll-free national or local STD hotline for directions to nearby testing and vaccination centers.

Tests for susceptibility to HBV. Because the above recommendations depend on knowledge of susceptibility to HBV, strategies must be developed for serologic testing. Health-care providers should make available the recommended serologic tests (to be determined by the Advisory Committee on Immunization Practices (ACIP) to the populations for whom vaccine is recommended. Innovative strategies to help cover the costs of serologic testing in the public sector may include third-party payment, donations, and cooperative agreements with plasma service centers.

Vaccine administrations. The high cost of HBV vaccine and the requirement for multiple, widely spaced doses will present formidable obstacles to successful vaccination of some high-risk individuals, especially those who are young and of limited financial resources. At public health-care facilities, efforts should be made to obtain, through existing federal, state, and local immunization programs, the funding for HBV vaccination of high-risk individuals of limited income. Health maintenance organizations, third-party health-care providers, and insurers should make vaccine available to high-risk clients because the cost-benefit factors are favorable.

Community Clinic Considerations

Statement of Problem

Free and community clinics and health groups will have financial difficulty in providing serologic testing and vaccine to low-income individuals. Ironically, these clinics serve as the primary health-care provider to many susceptible homosexually active men.

Recommendations

Serologic testing and HBV vaccine should be provided by such clinics on a sliding-scale basis, and sources of funding should be developed so that these services can be provided at reduced rates to low-income patients.

Strategies

Facilities. Any clinic or STD testing site serving homosexually active men should be encouraged to develop an HBV vaccination program. In cities where such facilities do not exist, there may be other organizations or groups concerned with the health of homosexual patients that might collaborate with private physicians and the public sector to organize vaccination programs.

Programs. Because of their demonstrated effectiveness in serving a sector of the homosexually active population not reached by other health-care providers, community clinics could have a unique role in implementing a successful HBV vaccination program. The program offered by community clinics should include not only serologic testing and vaccination, but also emphasis on public education and outreach activities.

Funding. Public monies for HBV vaccination programs should be made available to community clinics. Clinics may wish to require that patients buy the entire three-dose series at the first visit and may reserve the vial in the clinic dispensary for subsequent visits. Any payment plan should also include the cost of serologic testing. Cooperative arrangements between plasma collection agencies and community clinics can provide serologic testing and limited supplies of vaccine for low-income individuals participating in vaccination programs with sliding-scale payment options.

Private Sector Recommendations

Physicians in private practice who already serve homosexually active men should establish programs for serologic testing and vaccination of their patients. All physicians should be encouraged to identify and vaccinate susceptible individuals at high risk, including homosexual men and sexual contacts of persons who are HBV carriers. Physicians preferring not to develop their own vaccination programs should refer susceptible high-risk individuals to colleagues or to public health or community clinics offering such programs.

Groups offering HBV immunization programs should try to inform private practitioners about those programs.

Evaluation of Vaccination Strategies

An essential component of any immunization program for high-risk groups is evaluation of the effect of

the vaccine in that group. Specific questions may be addressed, and the results may permit more effective use of the vaccine in the future. (*1*) What proportion of the high-risk group received the vaccine? (*2*) Among those who did not receive the vaccine, what were the reasons for nonvaccination? (*3*) Did vaccination decrease the incidence of HBV infection in the high-risk group? (*4*) What proportion of the population at high risk must be vaccinated in order to decrease the incidence of HBV infection in that high-risk group to specified levels? To zero? (*5*) What is the cost-benefit ratio for vaccinating the high-risk group? (*6*) What is the risk and nature of untoward effects?

At a minimum, surveillance of the numbers of cases of HBV and numbers of persons vaccinated should be maintained for all metropolitan areas, with special emphasis given to reporting by clinics and physicians serving homosexually active men. Postmarketing surveillance of untoward effects is also essential. Special efforts must be made to set up monitoring systems that are not only precise but consistent.

A simple surveillance system that might be especially useful in following trends of HBV incidence in homosexually active men would be to screen both patients with syphilis and their contacts for HBV. The trends of both serologic tests might be a crude measure of the effectiveness of the immunization program.

On a more sophisticated level, a computer model might be developed to simulate the disease process and the effect of immunization programs. If the surveillance in several cities with different levels of vaccination agrees with the levels predicted by the model, then this model might be used as an inexpensive, rapid method to predict trends of HBV infection with other levels of vaccination.

Future Research Needs

Many questions remain about the epidemiology of sexually transmitted HBV infection, chronic liver disease, and the use of HBV vaccine. Although homosexually active men are clearly at high risk for this infection, the risk for heterosexually active individuals, prostitutes, and prisoners is not well-established.

Of urban homosexually active men, 3–6% are carriers of HBV, and the long-term outcome for these carriers is unknown. How many will develop chronic active hepatitis, cirrhosis, and liver failure or primary hepatocellular carcinoma? Is the prognosis for homosexually active men who are carriers different from that for other carrier populations? In a number of major metropolitan communities, chronic carriers are given advice concerning infectivity to sexual partners and ways of reducing the potential risk for sexually transmitted HBV. Research aimed at evaluating the effects of various counselling and educational approaches to sexual behavior and even to transmission of disease is of potentially great value for both HBV and other STD with chronic carrier states.

The treatment of chronic carriers is controversial. The value of corticosteroids for therapy of chronic HBV infection is now being questioned, and a role for antiviral agents (adenine arabinoside; Ara-A), immunotherapy (interferon), or HBV vaccine has yet to be established. Further questions remain about use of the vaccine. How long will the vaccine protect and when will booster doses be needed? Can the dose be reduced to <20 μg per injection without loss of efficacy? Will vaccination after exposure be effective? Are there as yet undetermined side effects of the HBV vaccine? A small percentage of vaccine recipients fail to develop an antibody response. Why do they not respond and will they benefit from repeated vaccination? Can we predict nonresponsiveness to the vaccine from genetic and/or immunologic testing prior to its administration? Finally, it will be important to determine how effectively HBV vaccine reaches groups at high risk of sexually transmitted HBV and whether the incidence of disease is reduced.

Ad hoc Task Force on Vaccination Strategies for Sexually Transmitted Hepatitis B

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May 21 1982 / Vol. 31 / No. 19

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports
249 Persistent, Generalized Lymphadenopathy among Homosexual Males

Epidemiologic Notes and Reports

Persistent, Generalized Lymphadenopathy among Homosexual Males

Since October 1981, cases of persistent, generalized lymphadenopathy—not attributable to previously identified causes—among homosexual males have been reported to CDC by physicians in several major metropolitan areas in the United States. These reports were prompted by an awareness generated by ongoing CDC and state investigations of other emerging health problems among homosexual males (*1*).

In February and March 1982, records were reviewed for 57 homosexual men with lymphadenopathy seen at medical centers in Atlanta, New York City, and San Francisco. The cases reviewed met the following criteria: 1) lymphadenopathy of at least 3 months' duration, involving 2 or more extra-inguinal sites, and confirmed on physical examination by the patient's physician; 2) absence of any current illness or drug use known to cause lymphadenopathy; and 3) presence of reactive hyperplasia in a lymph node, if a biopsy was performed.

The 57 patients had a mean age of 33 years and the following characteristics: all were male; 81% were white, 15% black, and 4% Hispanic; 83% were single, 6% married, and 11% divorced; 86% were homosexual, 14% bisexual. The median duration of lymphadenopathy was 11 months. Ninety-five percent of patients had at least 3 node chains involved (usually cervical, axillary, and inguinal). Forty-three patients had had lymph node biopsies showing reactive hyperplasia. Approximately 70% of the patients had some constitutional symptoms including fatigue, 70%; fever, 49%; night sweats, 44%; and weight loss of ≥5 pounds, 28%. Hepatomegaly and/or splenomegaly was noted among 26% of patients.

Recorded medical histories for the 57 patients suggested that the use of drugs such as nitrite inhalants, marijuana, hallucinogens, and cocaine was common. Many of these patients have a history of sexually transmitted infections (gonorrhea 58%, syphilis 47%, and amebiasis 42%). Of 30 patients skin-tested for delayed hypersensitivity response, 8 were found to be anergic on the basis of at least 2 antigens other than purified protein derivative (PPD).

Immunologic evaluation performed at CDC for 8 of the above patients demonstrated abnormal T-lymphocyte helper-to-suppressor ratios (<0.9) for 2 patients. Since this review, immunologic evaluations at CDC of 13 additional homosexual males with lymphadenopathy from Atlanta and San Francisco revealed 6 with ratios of <0.9. The normal range of T-lymphocyte helper-to-suppressor ratios established in the CDC laboratory for healthy heterosexual patients is 0.9-3.5 (mean of 2.3). The normal range is being established for apparently healthy homosexual males.

Since the initiation of this study, 1 patient with lymphadenopathy has developed Kaposi's sarcoma.

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Editorial Note: The report above documents the occurrence of cases of unexplained, persistent, generalized lymphadenopathy among homosexual males. There are many known causes of generalized lymphadenopathy including viral infections (e.g., hepatitis B, infectious mononucleosis, cytomegalovirus infection, rubella), tuberculosis, disseminated *Mycobacterium avium-intracellulare*, syphilis, other bacterial and fungal infections, toxoplasmosis, connective tissue disorders, hypersensitivity drug reactions, heroin use, and neoplastic diseases (including leukemia and lymphoma) (*2*). Causes for the persistent lymphadenopathy among patients discussed above were sought but could not be identified.

This unexplained syndrome is of concern because of current reports of Kaposi's sarcoma (KS) and opportunistic infections (OI) that primarily involve homosexual males (*1,3*). Epidemiologic characteristics (age, racial composition, city of residence) of the homosexual patients with lymphadenopathy discussed here are similar to those of the homosexual KS/OI patients. Thirty-two (44%) of 73 Kaposi's sarcoma patients and 14 (23%) of 61 *Pneumocystis carinii* pneumonia patients reported to CDC in the period mid-June 1981-January 1982 had a history of lymphadenopathy before diagnosis (*3*). *Mycobacterium avium-intracellulare* (an opportunistic agent) has been isolated from the lymph nodes of a homosexual patient (*4*). Moreover, the findings of anergy and depressed T-lymphocyte helper-to-suppressor ratios in some of the patients with lymphadenopathy suggest cellular immune dysfunction. Patients with KS/OI have had severe abnormalities of cellular immunity (*5,6*). The relationship between immunologic findings for patients with lymphadenopathy and patients with KS/OI remains to be determined.

Although these cases have been identified and defined on the basis of the presence of lymphadenopathy, this finding may be merely a manifestation of an underlying immunologic or other disorder that needs to be characterized further. Virologic and immunologic studies of many of these patients are currently under way. An analysis of trends in incidence for lymphadenopathy over the past several years is being conducted to determine whether this syndrome is new and whether homosexual males are particularly affected. Results of these studies and follow-up of these patients are necessary before the clinical and epidemiologic significance of persistent, generalized lymphadenopathy among homosexual males can be determined. Homosexual male patients with unexplained, persistent, generalized lymphadenopathy should be followed for periodic review.

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MORBIDITY AND MORTALITY WEEKLY REPORT

465 Hepatitis B Virus Vaccine Safety: Report of an Inter-Agency Group

Current Trends

Hepatitis B Virus Vaccine Safety: Report of an Inter-Agency Group

On June 25, 1982, the Immunization Practices Advisory Committee (ACIP) recommended using inactivated hepatitis B virus (HBV) vaccine for individuals who are at high risk for HBV infection because of their geographic origins, life styles, or exposures to HBV at home or work (*1*). The recommendations included statements on vaccine efficacy and safety. However, requests for additional information on safety continue to be received, primarily because of the plasma origins of the antigen used to prepare the vaccine. In response to these requests, the Inter-Agency Group to Monitor Vaccine Development, Production, and Usage, with representatives from the Centers for Disease Control (CDC), Food and Drug Administration (FDA), and National Institutes of Health (NIH), has further reviewed the available data. Its conclusions on vaccine production and safety evaluation follow.

HBV vaccine licensed in the United States is prepared from human plasma containing hepatitis surface antigen (HBsAg) (*2*). Hypothetical side effects from the vaccine include reactions to blood substances or to infectious agents present in donor plasma. In trials involving approximately 1900 persons, reactions among vaccine recipients were compared with reactions among placebo recipients, and only minor immediate complaints, primarily of soreness at the injection site, were observed (*3,4*). Infectious agents that might be present in donor plasma are most likely to be viruses. Virus transmission by blood or blood products requires the virus to circulate in plasma or in cellular elements such as leukocytes. The chance of virus transmission increases with the duration of the viremic state. HBV is the only well-characterized extra-cellular human virus with a prolonged carrier state. Other agents, presumably viruses, which remain unidentified despite their common association with post-transfusion hepatitis, are responsible for non-A/non-B hepatitis.

Beginning in 1978, a disease or group of diseases was recognized, manifested by Kaposi's sarcoma and opportunistic infections, associated with a specific defect in cell-mediated immunity. This group of clinical entities, along with its specific immune deficiency, is now called acquired immune deficiency syndrome (AIDS). The epidemiology of AIDS suggests an unidentified and uncharacterized blood-borne agent as a possible cause of the underlying immunologic defect (*5-7*). Because AIDS occurs

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among populations that are sources of HBV-positive plasma, this syndrome should be considered in regard to the inherent safety of HBV vaccine.

Vaccine plasma donors are screened, and only healthy individuals (HBsAg positive) are selected. The plasmapheresis centers are licensed and inspected by the FDA. A physician gives each donor a complete physical examination, which includes a history and suitable laboratory tests. At the time of each donation, the donor's hemoglobin, hematocrit, and serum protein levels must be within normal limits. HBsAg-positive donors' levels of serum aminotransferase activity are permitted to exceed those limits set for otherwise healthy donors, but they must be stable.

The process for producing each lot of licensed HBV vaccine is designed to remove or inactivate infectious HBV and other viruses from the desired immunogen, the 22 nm HBsAg particle. The process relies on both biophysical elimination of infectious particles and treatments which inactivate viruses (pepsin at pH 2, 8M urea, and formalin). The elimination of infectious virus by biophysical purification depends on the density and flotational property of HBsAg in contrast with those of infectious virus particles. The double ultracentrifugation process (isopyknic and rate zonal) has been proven effective in removing 10^4 infectious doses of HBV/ml, as measured by chimpanzee inoculation (*8*). Pepsin treatment alone (1 μg/ml, pH 2.0, 37 C for 18 hours) inactivates 10^5 or more infectious doses of HBV/ml, as measured by chimpanzee inoculation, and has been shown to inactivate viruses in the rhabdovirus, poxvirus, togavirus, reovirus, herpesvirus and coronavirus groups (*9,10*). Urea treatment alone (8M, 37 C for four hours) inactivates 10^5 or more infectious doses of HBV/ml and has been shown to inactivate viruses in the rhabdovirus, myxovirus, poxvirus, togavirus, reovirus, picornavirus, herpesvirus, and coronavirus groups (*9*). Slow viruses, characterized by the viruses of kuru and Creutzfeld-Jakob disease, are inactivated by 6M urea, a lesser concentration than that routinely applied to the HBV vaccine (*11*). Formalin alone inactivates HBV (*9*), as well as many other virus groups, including parvoviruses (*12*), retroviruses (*13,14*) and the delta agent (*15*).

Each lot of HBV vaccine is tested for sterility, innocuousness in animals, and pyrogenicity and is free of detectable viruses, as shown by inoculation into both human and monkey cell-culture systems. Additionally, 22 doses of each vaccine lot are inoculated intravenously into four chimpanzees.

United States licensed vaccine (produced by Merck, Sharp, and Dohme) has been given to over 19,000 persons, 6,000 of whom received vaccine between October 1975 and December 1981 and 13,000 of whom received it in 1982. The vaccine has been demonstrated to protect recipients from HBV infection (*3,4*), and no evidence of hepatitis has been observed as a result of HBV vaccination. Also, studies by CDC, FDA, and others of aminotransferase levels in chimpanzees and humans confirm that HBV vaccine does not transmit the non-A/non-B agent(s).

In three vaccine-placebo trials (two among homosexual men between 1978 and 1980 [*3,4*] and one among hospital employees in 1981), 549, 714, and 664 persons, respectively, received vaccine, and equal numbers received placebo. Follow-up surveillance of participants in these studies was 24, 15, and 18 months, respectively, after the first dose of vaccine with no cases of AIDS being reported. In

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addition to the vaccine/placebo trials, 17,602 persons (including 8,941 health-care workers and 5,985 healthy adults, children, and infants from non-high-risk group settings) have received Merck HBV vaccine in various study settings. Periods of follow-up of these vaccine recipients have ranged from a few months to over 7 years. However, lots used in early studies may have been produced before the occurrence of AIDS. Some of the groups from which HBV vaccine is prepared or for which it is recommended are also at high risk for AIDS; therefore reports of AIDS among donors and vaccinees at some future time may be expected on the basis of chance alone.

To summarize, these findings support the ACIP statement on hepatitis vaccine: 1) immediate side effects are minimal after receipt of HBV vaccine; 2) no long-term reactions have been reported; 3) the purification and inactivation process is known to inactivate representatives of all known groups of animal viruses; 4) each lot is safety tested in primates; 5) no known cases of hepatitis B or non-A/non-B hepatitis have been transmitted by the vaccine and no known occurrence of AIDS has been associated with the vaccine.

Reported by the Inter-Agency Group to Monitor Vaccine Development, Production, and Usage, represented by the Centers for Disease Control, Food and Drug Administration, and National Institutes of Health.

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MORBIDITY AND MORTALITY WEEKLY REPORT

495 Spectinomycin-Resistant B-Lactamase-Producing *Neisseria gonorrhoeae* — England

International Notes

Spectinomycin-Resistant β-Lactamase-Producing *Neisseria gonorrhoeae*— England

Spectinomycin-resistant β-lactamase-producing strains of *Neisseria gonorrhoeae* have been isolated from a female, aged 23 years, and a male, aged 29 years, after treatment failure (ampicillin/probenecid followed by spectinomycin), although original isolates were found to be sensitive by disc tests. Both patients acquired the infection in London but are not known to be connected. The consort of the first case was traced and treated without development of spectinomycin resistance. Plasmid analysis of the strains showed that both carried Asian type plasmids

Reported by Communicable Disease Report (London). 1982;32:31.

Editorial Note: Spectinomycin has been the recommended therapy for persons who have penicillinase producing *N. gonorrhoeae* (PPNG) infections and for those who have failed to respond to gonorrhea treatment (*1*). The first of two cases of spectinomycin-resistant PPNG identified in 1981 was reported to CDC by the United States Air Force in California in April 1981 (*2*). The Air Force conducted an intensive investigation overseas for additional cases related to this initial case; none was identified. The second case was identified in London in November 1981 (*3*). The 1981 cases and the two recent cases reported above have not been epidemiologically connected.

Spectinomycin-resistant gonococci are uncommon; the total number of reported cases is now eight, four with PPNG and four with non-PPNG. CDC continues to advise that all gonococcal isolates be tested for penicillinase production and that PPNG isolates be tested for spectinomycin resistance (*4*). Procedures for a provisional disc-diffusion technique are available (*5*). All spectinomycin-resistant gonococcal isolates should be forwarded to CDC through state health department laboratories; surveillance is essential to describe the distribution and trends of spectinomycin-resistant PPNG. For such cases, the recommended alternative therapies are: cefoxitin 2g intramuscularly (IM) plus probenecid 1g orally or cefotaxime 1g IM (*2*).

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MORBIDITY AND MORTALITY WEEKLY REPORT

507 Update on Acquired Immune Deficiency Syndrome (AIDS) — United States

Current Trends

Update on Acquired Immune Deficiency Syndrome (AIDS) — United States

Between June 1, 1981, and September 15, 1982, CDC received reports of 593 cases of acquired immune deficiency syndrome (AIDS).* Death occurred in 243 cases (41%).

Analysis of reported AIDS cases shows that 51% had *Pneumocystis carinii* pneumonia (PCP) without Kaposi's sarcoma (KS) (with or without other "opportunistic" infections [OOI] predictive of cellular immunodeficiency); 30% had KS without PCP (with or without OOI); 7% had both PCP and KS (with or without OOI); and 12% had OOI with neither PCP nor KS. The overall mortality rate for cases of PCP without KS (47%) was more than twice that for cases of KS without PCP (21%), while the rate for cases of both PCP and KS (68%) was more than three times as great. The mortality rate for OOI with neither KS nor PCP was 48%.

The incidence of AIDS by date of diagnosis (assuming an almost constant population at risk) has roughly doubled every half-year since the second half of 1979 (Table 1). An average of one to two cases are now diagnosed every day. Although the overall case-mortality rate for the current total of 593 is 41%, the rate exceeds 60% for cases diagnosed over a year ago.

Almost 80% of reported AIDS cases in the United States were concentrated in six metropolitan areas, predominantly on the east and west coasts of the country (Table 2). This distribution was not simply a reflection of population size in those areas; for example, the number of cases per million population reported from June 1, 1981, to September 15, 1982, in New York City and San Francisco was roughly 10 times greater than that of the entire country. The 593 cases were reported among residents of 27 states and the District of Columbia, and CDC has received additional reports of 41 cases from 10 foreign countries.

Approximately 75% of AIDS cases occured among homosexual or bisexual males (Table 3), among whom the reported prevalence of intravenous drug abuse was 12%. Among the 20% of known heterosexual cases (males and females), the prevalence of intravenous drug abuse was about 60%. Haitians residing in the United States constituted 6.1% of all cases (*2*), and 50% of the cases in which both homosexual activity and intravenous drug abuse were denied. Among the 14 AIDS cases involving males under 60 years old who were not homosexuals, intravenous drug abusers, or Haitians, two (14%) had hemophilia A.† (*3*)

Reported AIDS cases may be separated into groups based on these risk factors: homosexual or bisexual males—75%, intravenous drug abusers with no history of male homosexual activity—13%, Haitians with neither a history of homosexuality nor a history of intravenous drug abuse—6%, persons with hemophilia A who were not Haitians, homosexuals, or intravenous drug abusers—0.3%, and persons in none of the other groups—5%.

Reported by the Task Force on Acquired Immune Deficiency Syndrome, CDC

*Formerly referred to as Kaposi's sarcoma and opportunistic infections in previously healthy persons. (*1*)

†A third hemophiliac with pneumocystosis exceeded the 60-year age limit of the AIDS case definition.

Editorial Note: CDC defines a case of AIDS as a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease. Such diseases include KS, PCP, and serious OOI.§ Diagnoses are considered to fit the case definition only if based on sufficiently reliable methods (generally histology or culture). However, this case definition may not include the full spectrum of AIDS manifestations, which may range from absence of symptoms (despite laboratory evidence of immune deficiency) to non-specific symptoms (e.g., fever, weight loss, generalized, persistent lymphadenopathy) (*4*) to specific diseases that are insufficiently predictive of cellular immunodeficiency to be included in incidence monitoring (e.g., tuberculosis, oral candidiasis, herpes zoster) to malignant neoplasms that cause, as well as result from, immunodeficiency¶ (*5*). Conversely, some patients who are considered AIDS cases on the basis of diseases only moderately predictive of cellular immunodeficiency may not actually be immunodeficient and may not be part of the current epidemic. Absence of a reliable, inexpensive, widely available test for AIDS, however, may make the working case definition the best currently available for incidence monitoring.

Two points in this update deserve emphasis. First, the eventual case-mortality rate of AIDS, a few years after diagnosis, may be far greater than the 41% overall case-mortality rate noted above. Second, the reported incidence of AIDS has continued to increase rapidly. Only a small percentage of cases have none of the identified risk factors (male homosexuality, intravenous drug abuse, Haitian origin, and perhaps hemophilia A). To avoid a reporting bias, physicians should report cases regardless of the absence of these factors.

Physicians aware of patients fitting the case definition for AIDS are requested to report such cases to CDC through their local or state health departments.

TABLE 1. Reported cases and case-mortality rates of AIDS, by half-year of diagnosis,* 1979-1982, (as of September 15, 1982) — United States

Half-year of diagnosis		Cases	Deaths	Case-mortality rate (%)
1979	1st half	1	1	100
	2nd half	6	5	83
1980	1st half	17	13	76
	2nd half	26	22	85
1981	1st half	66	46	70
	2nd half	141	79	56
1982	1st half	249	67	27

*Excluding 4 cases with unknown dates of diagnosis

§These infections include pneumonia, meningitis, or encephalitis due to one or more of the following: aspergillosis, candidiasis, cryptococcosis, cytomegalovirus, nocardiosis, strongyloidosis, toxoplasmosis, zygomycosis, or atypical mycobacteriosis (species other than tuberculosis or lepra); esophagitis due to candidiasis, cytomegalovirus, or herpes simplex virus; progressive multifocal leukoencephalopathy; chronic enterocolitis (more than 4 weeks) due to cryptosporidiosis; or unusually extensive mucocutaneous herpes simplex of more than 5 weeks duration.

¶CDC encourages reports of any cancer among persons with AIDS and of selected rare lymphomas (Burkitt's or diffuse, undifferentiated non-Hodgkins lymphoma) among persons with a risk factor for AIDS. This differs from the request for reports of AIDS cases regardless of the absence of risk factors.

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Immune Deficiency Syndrome — Continued

TABLE 2. AIDS cases per million population,* by standard metropolitan statistical area (SMSA) of residence, reported from June 1, 1981 to September 15, 1982 — United States

SMSA of residence	Cases	Percentage of total	Cases per million population
New York, N.Y.	288	48.6	31.6
San Francisco, Calif.	78	13.2	24.0
Miami, Fla.	31	5.2	19.1
Newark, N.J.	15	2.5	7.6
Houston, Texas	15	2.5	5.2
Los Angeles, Calif.	37	6.2	4.9
Elsewhere (irrespective of SMSA)	129	21.8	0.6
Total	593	100.0	2.6

*From the 1980 Census

TABLE 3. Cases of AIDS, by sexual orientation and intravenous drug abuse, reported from June 1, 1981, to September 15, 1982 — United States

Sex	Sexual orientation	Cases	Percentage distribution by sexual orientation	Intravenous drug abuse*			Percentage using IV drugs†
				Yes	No	Unknown	
Male	Homosexual or bisexual	445	75.0	42	300	103	12.3
	Heterosexual	84	14.2	49	33	2	59.8
	Unknown	30	5.1	11	11	8	50.0
Female	Heterosexual	34	5.7	20	12	2	62.5
Total		593	100.0	122	356	115	25.5

*Regardless of when the last such activity occurred.
†Excluding cases with unknown history of IV drug abuse.

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(End of Volume 4 #2, October, 1982, NCGSTDS Newsletter; Next issue scheduled for late December, early January--send literary contributions to the NCGSTDS by December 10th!)