THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 4 #3 December, 1982

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This Newsletter is published by the National Coaltion 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 (414/277-76710. Please credit the NCGSTDS when reprinting items from the Newsletter. We're eager to hear from you! All correspondence answered!

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CURRENT ASPECTS OF STDs SYMPOSIUM--III, SEATTLE, AUGUST 4

Current Aspects of Sexually Transmitted Diseases Symposium--III (CASTDS): Critical Gay Health Needs: New Diseases, Persistent Problems and Prophylaxis" will be a full day CME accredited symposium designed to provide practitioners, public health workers and researchers with the most up-to-date information available regarding STD problems in homosexually active men. This year's CASTDS will focus on the areas of AIDS diagnosis and treatment, new developments in the diagnosis and treatment of enteric infections, hepatitis B prophylaxis, and STD control programs. In addition, there will be an evening panel discussion on the subject of AIDS risk reduction recommendations. This panel will feature prominent experts in the areas of forensic medicine, ethics, disease control, behavioral sciences and health education. A casual evening get-together and fundraising dance aboard the popular Steamship Virginia V on a moonlight cruise of the Puget Sound, will precede CASTDS on the evening of August 3.

Individuals interested in presenting short papers in any of the topics listed above should obtain abstract forms from Mark Behar, Chairperson, NCGSTDS, PO Box 239, Milwaukee, WI 53201. Copies of the abstract form and registration information are included in this issue of the Newsletter. Deadline for submitting abstracts is April 11 (notification of program acceptance by May 23); registration deadline is June 15. Registration fees will be $75, with discounts to NCGSTDS members and students/practitioners-in-training who register in advance. CASTDS will be held at the Seattle Sheraton Hotel, and program registrants are encouraged to lodge there; limited housing will be available with private individuals, thanks to the cooperation of members from the Seattle Gay Clinic and North West Physicians for Human Rights.

CASTDS and the steamship cruise are sponsored by the NCGSTDS and are being directed by the following Coalition members: Bob Wood, MD (Seattle; North West Physicians for Human Rights), David Ostrow, MD, PhD (Chicago; CASTDS--I Director, 1979; Howard Brown Memorial Clinic), Bob Bolan, MD (San Francisco; CASTDS--II Director, 1980; Bay Area Physicians for Human Rights), and Mark Behar, PA-C (Milwaukee; Chairperson, NCGSTDS). CASTDS will follow the Fifth International Meeting of the Society of STD Research, August 1-3, and a CDC sponsored STD Clinical Update, July 31, also at the Seattle Sheraton Hotel. For additional information about these CME accredited programs, write: Ms. Susan Kaetz, Program Coordinator, 325 9th Av. (ZA-89), Seattle, WA 98104. SEE ENCLOSURES WITH THIS NEWSLETTER FOR ABSTRACT & REGISTRATION INFORMATION!

Two very popular Seattle attractions, The Seattle Opera Company presenting the "Pacific Northwest Wagner Festival (Der Ring Des Nibelungen)," and the Seafair celebrations, will be occuring in late July-early August. Details forthcoming in future Newsletters.

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FIFTH NATIONAL GAY/LESBIAN HEALTH CONFERENCE IN DENVER

The Fifth National Gay/Lesbian Health Conference will be held in Denver, tenetatively in June, 1983, according to preliminary announcements from the National Gay Health Education Foundation.

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FIFTH NATIONAL GAY/LESBIAN HEALTH CONFERENCE, Continued

The Conference, which will feature workshops on alcoholism & substance abuse, AIDS, and other physical & mental health concerns within the gay/lesbian community, will be cosponsored by the Gay & Lesbian Health Alliance of Denver, the Foundation, and the American Association of Physicians for Human Rights (AAPHR). The official theme of the Conference is "Health Care Pioneering in the 80s." Speakers, workshops, and sessions will focus on the lesbian and gay role in contributing to a new paradigm of health care delivery and philosophy, highlighting lesbian & gay participation in health, including health care delivery, definitions of health, health research, and health politics. The gay contribution to health knowledge will also be addressed. In addition, organizational time will be given to national gay health groups upon request. [The NCGSTDS will host its annual meeting at the Conference.] AAPHR may tentatively host accredited CME medical workshops during the Conference, and a second AIDS Forum is planned. A "Call-for-Papers" and further information about registration, etc., will be forthcoming in January or February, according to Dan Pfeffer, Conference Coordinator. For additional information, contact: Dan Pfeffer (714/494-0293) or Fran Miller (415/653-3724), Conference Coordinators, or the Gay & Lesbian Health Alliance of Denver, P.O. Box 6101, Denver, CO 80206-0101, Attention: Barry Gaspard. Further information in future Newsletters.

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NCGSTDS ACQUIRES NEW TYPEWRITER

Thanks to the kindness of several benefactors, the NCGSTDS was able to purchase a new typewritter, a Smith-Corona Ultrasonic, which will help expedite Coalition business and the publication of the Newsletter. Watch for changes in the format of the Newsletter over the next several months! Thanks again to our friends who made donations for this special purchase!

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ARTICLES OF INTEREST TO GAY STD SERVICE PROVIDERS

Degen, K., & Waitkevicz, H.J. Lesbian health issues. (Little published information exists on lesbian health issues. The following provides such information based on experience in a voluntary clinic run by and for lesbian women.) British Journal of Sexual Medicine, May, 1982, pp. 40-54.

Carlen, Robert. Against free care for sexually transmitted diseases. (A letter to the editor.) New England Journal of Medicine, November 18, 1982, p. 1350. [This one is quite outrageous--it is therefore reprinted below for your review and response!]

AGAINST FREE CARE FOR SEXUALLY TRANSMITTED DISEASES

To the Editor: The response of public-health authorities to serious, treatable, preventable, and prevalent communicable diseases has been to establish free clinics. It is at least possible that free clinics for sexually transmitted diseases actually promote such diseases. I am certain that free care for sexually transmitted diseases harms patients and equally certain that these free clinics have no just claim to public money.

Sexually transmitted diseases are exactly that — sexually transmitted — and they are preventable to an enormous extent by careful practices, especially the use of condoms. Unlike tuberculosis, for example, these maladies pose no threat whatever to the public at large. Since recent papers[1,2] have concluded that the demand for physicians' services is elastic — i.e., price-dependent — we might expect that if patients with sexually transmitted diseases were required to pay for their own care they would arrange to need less of it, just as Americans consumed less oil when its price rose. Many clinic patients know there are effective treatments for all common sexually transmitted infections except herpes, so free care removes one of the few remaining disincentives to getting them, fire and brimstone being out of fashion. Repeat offenders abound.

What harm do we know that free clinics do? Since their entire cost is borne by the public, they foster dependency and irresponsibility. It's shockingly unfair, too, that taxpayers who get sick or injured through no fault of their own must pay for their own care and pay, as well, for those who have irresponsible sex. The latter, in turn, pay not a cent.

A day's work in a clinic for sexually transmitted diseases will convince anyone that among its clients truly innocent victims, such as raped women and molested children, are few and far between. Although such victims excite our compassion they are no more entitled to free care than, say, women who have been mugged rather than raped or children with diabetes or heart disease. Sexually active teen-agers can buy condoms like anyone else and while doing so can help themselves to displayed literature about sexually transmitted diseases and their prevention. If they take no precautions, they or their parents will have to pay their bills — a requirement that should serve as an effective complement to their health-education courses.

ROBERT CARLEN, M.D.
84 Lincoln Ave.
Sayville, NY 11782

1. Lee RH, Hadley J. Physicians' fees and public medical care programs. Health Serv Res. 1981; 16:185-203.
2. Newhouse JP, Manning WG, Morris CN, et al. Some interim results from a controlled trial of cost sharing in health insurance. N Engl J Med. 1981; 305:1501-7.

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SISTERS OF PERPETUAL INDULGENCE REVISING "PLAY FAIR" BROCHURE

by Sister Florence Nightmare, RN, Head Nurse, SPI

San Francisco's popular Sisters of Perpetual Indulgence are preparing a third edition of their "Play Fair" brochure on recommendations to help create a disease-free community. Many of the inaccuracies in the first edition [published in Volume 4:1 of the Newsletter] have been corrected in the second edition, and the Sisters are asking for your feedback so that the third edition will be perfect. They are also planning to target distribution of the pamphlet to the nation's gay STD services & clinics. Please contact Sr. Florence Nightmare, RN, Sisters of Perpetual Indulgence, Box 770, 55 Sutter St., San Francisco, CA 94104 for any comments, suggestions, or feedback.

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NCGSTDS PLANS THIRD EDITION OF "GUIDELINES & RECOMMENDATIONS" BROCHURE

Based on comments from a recent seminar on gay STDs and prophylaxis at the American Public Health Association in Montreal (November 17, 1982), a revised third edition of the "Guidelines & Recommendations for Healthful Gay Sexual Activity" brochure is being prepared. Most of the proposed corrections/additions include highlighting the recent AIDS Forum risk reduction statement [see elsewhere in this Newsletter], and changing the statement about the association of oral-genital and oral-oral contact with hepatitis B. There was some criticism of the frank and explicit language in the brochure, with a recommendation to publish a "nonexplicit" version. Other recommendations included printing a version in French, and a version for both heterosexuals and homosexuals. A "tongue-in-cheek" suggestion for writing a version for the "elective illiterates," i.e., those that can but usually don't read--that version could be totally illustrated with large red circles with diagonal bars indicating high risk activities. Additional suggestions are being solicited. Please send comments to the NCGSTDS by January 28, 1983: PO Box 239, Milwaukee, WI 53201.

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PENNSYLVANIA'S NEWLY REVISED STD BOOKLET FOR GAY MEN

The Pennsylvania Department of Health revised their "Sexually Transmissible Diseases--Information for Gay Men" July, 1982. The booklet was revised by Drs. John Whyte, Dan William, and Walter Lear, discusses the common STDs among homosexually active men and also includes a section on AIDS. The NCGSTDS' G&R brochure is recommended. Please contact the Department of Health for a copy of the booklet [sorry, no address available--consult your public library--Editor].

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WHITMAN-WALKER CLINIC REELECTS OFFICERS

The Washington, DC, Whitman-Walker Clinic Board of Directors held its annual meeting on October 31, 1982, and reelected Jim Graham and Dusty Cunningham as President and Treasurer of the organization for a one year term. Larry Medley was reappointed Clinic Administrator and Rhonda Davis was reappointed Medical Technologist. In addition, new members were added to the 20 member Clinic Board of Directors--they included Dennis DeVol, a volunteer with the gay men's VD program, and Don Wainwright, general manager of Rascals bar. Whitman-Walker Clinic includes five components--the gay men's VD clinic, the gay council on drinking behavior, the lesbian health center, the counseling group, and the gay hotline.

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MONTROSE CLINIC NAMES NEW DIRECTOR

Houston's Montrose Clinic recently announced the appointment of Frank J. Berrier, Jr., MPA, as the new Administrative Director by the Board of Trustees. All future correspondence should be addressed to him directly, at 104 Westheimer, Houston, TX 77006. "Frank's background in health care management will be a real asset to our operation here," stated Dr. Robert B. O'Brien, MD, Chair of the Board of Trustees.

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HEPATITIS TASK FORCE MEETS IN MONTREAL

The Task Force on Vaccination Strategies for Sexually Transmitted Hepatitis B (Task Force) sponsored a symposium held as part of the scientific program of the American Public Health Association's 110th Annual Meeting at Montreal's Sheraton Center Ballroom, November 15, 1982. Approximately 50 persons heard presentations from the following individuals (* indicates Task Force Members): David Ostrow*--Review of the Objectives and Recommendations of the Task Force; Promoting the Use of the Hepatitis B Vaccine in the Gay Community--Mark Behar* [a copy of this report is included in this Newsletter]; Gay Community Clinics' Response to the Hepatitis B Vaccine--Thomas Nylund*; The Public Health Sector's Response to Hepatitis B Vaccine: Strategies and Limitations--Frank Judson*; Rural Homosexually Active Men and Hepatitis B Risk--Roger Gremminger*; Attitudes of Chronic Hepatitis B Patients Towards Risk of Disease Trasmission: A Preliminary Study of Perception of Risk and Its Behavioral Effects--David Ostrow*, Doug Chene, Harley McMillen; Support Strategies for the Chronic Hepatitis B Patient--Armand Cerbone & Harley McMillen; and Public Policy and Economic Aspects of Vaccination Programs--Walter Lear, Discussant. Members of the audience participated in discussion after each individual presentation. The following issues seemed to be the most important by participants:

1) Why has there not been a vigorous demand for the HB vaccine within the gay community, and are the reasons for this different or the same as for other high risk groups?

2) Do we have information on the best ways to motivate individuals at risk for hepatitis B to obtain prophylactic vaccination?

3) Is the lack of aggressive marketing of the vaccine to the gay male population the result of fears within Merck, Sharp, & Dohme of associating the vaccine with gay men, or merely the result of inadequate knowledge and expertise within Merck's marketing division regarding items 1) & 2)?

A more complete report summarizing the individual presentations and discussions held at the Symposium will be prepared for possible publication as either a monograph or a special section of an appropriate medical journal. The Task Force held a dinner meeting later that day which was attended by almost all of the above participants in addition to the following guests: Yehudi Felman (Director, New York City VD Control Bureau); Mark Kane (CDC Hepatitis Laboratories, Phoenix); Jerry Feuer (Boston's Fenway Clinic); Alan Kristal (New York Gay Mens Health Crisis); Ron Sable (Chicago's Howard Brown Memorial Clinic); Ron Vachon (Executive Director, National Gay Health Education Foundation, New York); Nobbie Gilmore (Chairperson, Montreal Gay Physician's Association); Bruce Dull (Task Force Member, President, Prevention, Inc., Atlanta); and Jerry Kelly (San Francisco KS Foundation).

The afternoon symposium was favorably received at the evening meeting, and enthusiasm was expressed about the proposed extensive report that may result from the symposium and subsequent discussions. Additional papers were invited. Discussion then centered around an article in the September 9, 1982 New England Journal of Medicine by Mulley, Silverstein, & Deinstag. It was felt that the risk-benefit analysis for vaccination of high risk groups as presented by Mulley, et al., underestimated the true value of vaccinating large portions of individuals at risk for sexually transmitted hepatitis B (HBV). By omitting such factors as chronic HBV infection and other sequellae, the actual cost-benefit calculations did not adequately reflect the importance of mounting vaccination programs for sexually active gay men. While the authors did indicate that they had omitted such considerations from this article, it was felt that a letter to the editor, or a brief editorial comment, stressing the additional cost-benefit considerations in favor of HBV vaccination programs would be an appropriate and important activity of the Task Force. Drs. Judson, Kane and Ostrow will draft such a letter.

What role could the Task Force play in the development of effective educational and marketing materials for the promotion of prophylactic HBV vaccination among susceptible gay men? The various explanations of why no effective materials in this area had yet been prepared by Merck were discussed. It was generally felt that the lack of effective PR materials reflected more a lack of knowledge of how to promote the vaccine to gay men than any premeditated avoidance of this market by Merck's marketing personnel. A "model educational

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HEPATITIS TASK FORCE, Continued

and promotional packet" will be prepared.

Finally, the topic of whether the Task Force should meet again, was discussed. Although the prospect of additional funding was not likely, Task Force members expressed interest in possibly meeting during the International STD Meeting/Current Aspects of STDs Symposium in Seattle, August 1-4, 1983. The Task Force meeting was adjourned and was immediately followed by a meeting of the AIDS Case Finding Network Steering Committee Meeting (referred to as "STD/AIDS Information Network" in last Newsletter), a report of which is included elsewhere, in the AIDS section of this Newsletter. [Report prepared by David Ostrow.]

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KNOCK OUT HEPATITIS!

San Francisco's Resource Foundation has published an excellent brochure about hepatitis, serological testing, and the vaccine, entitled, "Facts About Hepatitis B." Contact them for further information: The Resource Foundation, 130 Church St., San Francisco, CA 94114, 415/864-0550.

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VD INTERCHANGE LISTS GAY STD PROGRAMS

The CDC's VD Interchange reports on several interesting services & programs of interest to gay STD service providers. On the third Thursday of the month in a local gay bar in Key West, Florida, bartenders hand out friendly reminders to get a VD check-up. The bartenders don nurses' uniforms and will escort patrons to a waiting area where volunteers hand out literature, show films, draw blood, perform cultures, and answer questions on AIDS and traditional STDs. An average of 20-25 clients are screened per session, and several cases of asymptomatic syphilis and gonorrhea have been detected. For more information contact: Margie Potter, ARNP, Monroe County Health Department, Key West, FL 33040 (305/294-1021). All STD services & programs are encouraged to request VD Interchange, an excellent information sharing device. Write to the Centers for Disease Control, Atlanta, GA 30333.

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QUALITY ASSURANCE GUIDELINES FOR STD CLINICS--1982

The CDC's VD Control Division recently released the 1982 edition of the Quality Assurance Guidelines for STD Clinics (QAG). The 70 page manual first provides an outline for clinic structure, management, and medical care. The second part includes the STD Medical Protocols Section with the new therapy guidelines, and serves to guide each clinic in developing its own treatment policies and protocols. The third part, the Appendices Section, contains samples of handouts for patient education, medical records, and protocols currently used by some clinics, which can be adapted to fit each clinic's local environment.

The QAG is a must for every STD service or clinic. Write to the Technical Information Services, Center for Prevention Services, Centers for Disease Control, Atlanta, GA 30333 (404/329-2580) (publication #00-4066). [If the QAG is out of stock at the CDC, you may request a photocopy of the Coalition's copy--send $5 for copying & postage.]

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STD NATIONAL CONFERENCE, MARCH 8-11, 1983, DALLAS

The 1983 STD National Conference, sponsored by the Centers for Disease Control, will provide an opportunity for clinicians, scientists, laboratorians, and other health professionals in the public and private sector to discuss current developments in the field of STDs. The incidence and clinical scope of STDs, as well as improvements in their therapeutic and epidemiological management, will be emphasized. The Conference, which will offer 20 category I CME credits,

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STD NATIONAL CONFERENCE, Continued

will take place March 8-11, 1983, at the Dallas Hyatt Regency. No registration fees will be required. ALL STD SERVICES HAVE A DETAILED BROCHURE & REGISTRATION FORM INCLUDED WITH THIS NEWSLETTER. In order to receive the flier, or to get additional information, contact: Dr. Stephen Margolis, Conference Director, 1983 STD National Conference, Centers for Disease Control, Atlanta, GA 30333 (404/329-3971).

Limited housing may be available through the courtesy of members of the Dallas Gay Alliance (transportation will remain the responsibility of each participant). Details in the next Newsletter.

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STD PREVENTION/TRAINING CLINICS 1983 SCHEDULES ANNOUNCED BY CDC

A cooperative venture among State and local health departments, selected medical schools and the Centers for Disease Control has led to the establishment of nine Sexually Transmitted Diseases (STD) Prevention/Training Clinics. Medical school faculty and clinic personnel have designed instruction and training for nurses, nurse practitioners, physician assistants and physicians who work or will soon begin to work in STD clinics. Medical update seminars are also available to clinicians, public health advisors and private physicians.

Six different courses and seminars, geared to the needs and experiences of the trainees are offered periodically at the STD Prevention/Training Clinics. The courses include:

STD CLINICIAN TRAINING COURSE—COMPREHENSIVE:
(formerly "LEVEL I") An introductory clinical training course, aimed at full-time STD nurses, physicians and physician assistants, 80 hours (2 weeks) long. The course content includes: Introduction to STD, STD Diagnosis and Management, Clinic-Patient Interaction, The Clinic Record, History and Physical Examination, Laboratory, Epidemiology, Therapeutics, Patient/Health Education and Clinic Management. The course format includes formal lectures, class discussion, audiovisual presentations and practical clinical and laboratory experience. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0149

STD CLINICIAN TRAINING COURSE—INTENSIVE: An introductory clinical training course aimed at STD nurses, physicians, physician assistants and other health personnel, 40 hours (1 week) long. The course content is similar to the "Comprehensive" course, but offers limited practical clinical and laboratory experience. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0154

STD PART-TIME CLINICIAN TRAINING COURSE—INTENSIVE: An introductory clinical training course aimed at part-time STD nurses and physician assistants, 24 hours (3 days) long. The course offers a brief overview of STD diagnosis and management, Several hours of practical clinical experience are provided. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0154A

STD CLINICIAN TRAINING COURSE—ADVANCED:
(formerly "Level II") A course designed for experienced clinical personnel in need of advanced training and for graduates of the "Comprehensive" course who have also had 2-4 months of applied clinical experience. The course is 40 hours (1 week) long. Course content includes: Review of STD Diagnosis and Management, Differential Diagnosis, Multiple Infections, Laboratory, Clinic-Patient Interaction and Clinic Management. The course format includes formal lectures, clinical problem-solving workshops and relevant clinical and laboratory experience. Continuing medical education credit is granted for this course (Category I, AMA).
Course Number: 0165

STD UPDATE FOR CLINICIANS: An update seminar for practicing clinicians, 16 hours (2 days) long. The seminar includes clinical problem-solving workshops, formal lectures, consultation time and supervised clinical and laboratory experience. Continuing medical education credit is offered for this seminar (Category I, AMA).
Course Number: 7008-D

STD UPDATE FOR PUBLIC HEALTH ADVISORS: An update seminar for public health advisors, 24 hours (3 days) long. The seminar provides an overview of current developments in STD diagnosis and management.
Course Number: 7008-DPHA

It is recommended that full-time clinicians with no STD experience follow this sequence: STD CLINICIAN TRAINING COURSE—COMPREHENSIVE (0149); 2-4 months of clinical experience at their place of employment; then STD CLINICIAN TRAINING COURSE—ADVANCED (0165).

BALTIMORE: Training Coordinator, Baltimore City STD Training Center, 111 N. Calvert St., Room C-223, Baltimore, MD 21202 (301/396-4448, FTS 922-0989); Intensive: 3/21-25, 4/11-15, 6/20-24, 9/12-16, 10/17-21; Clinician Update: 1/6-7, 2/3-4, 5/19-20, 11/17-18, 12/15-16.

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STD PREVENTION/TRAINING CLINICS, Continued

CHICAGO: Training Coordinator, Municipal Social Hygiene Clinic, 27 E. 26 St., Chicago, IL 60616 (312/225-9598, FTS 353-4312); Comprehensive: 1/17-28, 3/21-4/1, 7/18-29, 10/17-28, 12/5-16; Advanced (emphasis on clinician-patient interaction): 2/14-18, 5/2-6, 6/27-7/1, 8/29-9/2, 10/3-7; Clinician Update: 2/3-4, 4/7-8, 7/7-8, 11/17-18.
CINCINNATI: Training Coordinator, Cincinnati STD Center, 3101 Burnet Av., Cincinnati, OH 45229 (513/352-3143, FTS 684-3240); Comprehensive: 1/31-2/11, 4/25-5/6, 7/25-8/5, 9/12-24, 11/28-12/9; Advanced: 3/21-25, 6/20-24, 10/24-28; Clinician Update: 6/16.
DALLAS: Training Coordinator, Dallas STD Training Center, Dallas Countywide Health Dept., 1936 Amelia Ct., Dallas, TX 75235 (214/920-7984, FTS 729-7888); Comprehensive: 1/10-21, 3/21-4/1, 5/9-20, 7/11-22, 9/12-23, 11/7-18; Advanced (emphasis on clinical management skills): 10/17-21.
DENVER: Training Coordinator, Denver STD Training Center, 605 Bannock St., Denver, CO 80204, (303/893-7446, FTS 327-5640); no courses in 1983.
LOS ANGELES: Training Coordinator, Central Health Center, STD Clinic, Room 238, 241 N. Figueroa St., Los Angeles, CA 90012 (213/974-7551); Comprehensive: 2/21-3/4, 5/9-20, 7/11-22, 10/31-11/11; Intensive: 8/15-19; Clinician Update: 4/29-30, 9/16-17.
NASHVILLE: Training Coordinator, Metropolitan Health Dept., 311 23rd Av., North, Nashville, TN 32703 (615/327-9313 x360, FTS 852-7432); Comprehensive: 1/10-21, 4/11-22; 7/11-22, 9/26-10/7; Part-time Intensive: 1/31-2/2, 6/7-9, 8/22-24, 12/5-7; Advanced: 2/28-3/4, 10/17-21; Clinician Update: 5/1-2; Public Health Advisor Update: 3/24-26, 8/3-5.
SAN JUAN: Training Coordinator, Latin American STD Center, Call Box STD, Caparra Heights Station San Juan, PR 00922 (809/754-8127); Comprehensive: 1/24-2/4, 3/7-18, 6/13-24, 11/7-18; Intensive: 5/9-13, 9/19-23; Advanced: 4/4-8, 10/3-6; Clinician Update: 7/11-12, 12/5-6.
SEATTLE: Training Coordinator, STD Training Program, Mail Stop ZA-89, Harborview Medical Center, 325 Ninth Av., Seattle, WA 98104 (206/223-3430, FTS 399-2762); Comprehensive: 1/3-14, 3/14-25, 5/16-27, 9/12-23; Advanced: 2/7-11, 4/18-22, 6/13-17, 10/17-21, 11/14-18; Clinician Update: 7/31.

Application for course or seminar enrollment should be made directly to the training site. There is no charge for tuition or for educational or laboratory supplies. Travel expenses and per diem are the responsibility of the participant or the participant's agency.

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MMWR REPRINT ON SPECTINOMYCIN-RESISTANT GC

Included with this Newsletter is a reprint of a recent Morbidity & Mortality Weekly Report on Spectinomycin-Resistant Neisseria gonorrhoeae--worldwide (December 3, 1982, Vol. 31:47).

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NATIONAL GAY HEALTH COALITION URGES COMMUNICATION WITH WORLD HEALTH ORGANIZATION

The National Gay Health Coalition (NGHC) at its November 7th meeting, agreed to support a recommendation of the Fourth International Conference of the International Gay Association (IGA) to request that all organizations dealing with gay health care support a resolution to delete homosexuality from the ICD list of diseases of the World Health Organization (WHO). Organizations are being asked to write and pressure their "parent" or "boss" organization to write to WHO and the American delegate to WHO to recommend the change in nomenclature. For example: the NCGSTDS should write to the American VD Association, urging them to write to the AMA to write to WHO and the American delegate to WHO; a local gay clinic or a gay physician/practitioner/nursing group should write to their local & state medical societies & public health departments, urging them to write to the AMA, CDC, and eventually the WHO. Especially important are letters from deans of medical schools, and others of important professional status. mainstream health organizations. Address letters to WHO, and the American delegate to WHO: Dr. Robert Isreal, Director, National Center for Health Statistics, 3700 East-West Highway, Hyattsville, MD 20782.

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1982 STD TREATMENT GUIDELINES

Enclosed with this Newsletter is the MMWR supplement (Vol. 31:2S, Aug. 20, 1982) on STD Treatment Guidelines for STD Services ONLY. If you'd like a copy, send 50¢ postage to the NCGSTDS. (Sorry, due to the additional expense of postage, we were unable to send one to everyone!)

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PROMOTION OF THE HEPATITIS B VACCINE IN THE GAY COMMUNITY--A SURVEY

by Mark Behar, PA-C

[The following report was presented as part of a symposium on "Vaccination Strategies for Sexually Transmitted Hepatitis B" at the American Public Health Association's 110th Annual Convention in Montreal. A summary of the entire symposium, with recommendations of the Ad Hoc Task Force on Vaccination Strategies for Sexually Transmitted Hepatitis B Infection, is presented elsewhere in this Newsletter. The survey was conducted from September-November, 1982, and may now be outdated. Address comments to the author.]

The question of how to (or not to) promote the use of the hepatitis B vaccine in the gay community first requires an understanding of what resources are presently available in the American gya community. In order to acquire this information, a telephone survey of all known gay STD services in the United States was accomplished in order to determine the availability of, and interest in HBV screening and vaccination by those local communitites. Although the vaccine has been available since July, only 16 services from 24 American communities surveyed are offering hepatitis screening and/or vaccination programs. However, almost all of the services are providing educational materials or programs about the disease. In spite of these educational efforts, community response to the vaccine can be summarized in one word: underwhelming. Let's quickly review the highlights from each community, in alphabetical order.

1) The Anchorage Dept. of Health is the priamary provider of gay STD services and has a very good relationship with the gay community. Screening is provided by private practitioners and the vaccine will be made available for free or very low cost in 1983. An extensive PR campaign directed to all area citizens is planned, and will include placing posters in gay bars and the gay community center. Up to now, there have been essentially no inquiries about the vaccine from members of the gay community. 2) Ann Arbor's Lesbian & Gay STD Clinic works closely with the University of Michigan Student Health Service. Screening is free for students; nonstudents are charged for the serologies. Although all patients are uniformly charged $125 for the vaccine, it may be covered by some third party payers. A special slide-tape audio-visual presentation is in preparation for lay heterosexual & gay audiences about gay health, however, in spite of patients being told about the availability of the vaccine, the response is still poor. 3) The Atlanta Gay Center's Physical Health Committee is only offering referrals to private physicians for hepatitis screening and vaccination. There are no immediate plans for expansion into that area. 4) Baltimore's Gay Community Center Clinic offers hepatitis screening through an agreement with the state laboratory. The vaccine is available through the clinic at about $100, plus a $5contribution for each visit. There has been little community response in spite of publicity about hepatitis and the vaccine in the gay media. Vaccination & screening is also available at area medical centers--John Hopkins & the University of Maryland, however they seem to be reluctant to push for screening, possibly due to fear of legal issues surrounding the serendipitous identification of HBV carriers--such as workman's compensation. 5) Berkeley's Gay Mens Health Collective has no vaccination program, but cooperates with The Resource Foundation in San Francisco, who provides screening services for free. There are patient education materials, however. 6) Boston's Fenway Clinic has seen only about 20 people for screening, in spite of advertising in the gay & straight media and talks to the Gay & Lesbian Youth Group. Cost for the first visit screening, is about $75, which includes educational materials, screening serologies, and if the person is found to be a chonic carrier, liver panels. The vaccine costs a flat $150 for the 3 shots. A benefit for generating funds for those unable to afford the vaccine is in progress. No one will be refused the vaccine due to inability to pay, at least as of yet. The Harvard Community Health Plan, a large HMO in Boston, gives the vaccine to its members for free. Fenway is submitting claims to Blue Cross-Blue Shield for reimbursement, without positive results yet. 7) Chicago's Howard Brown Memorial Clinic offers a full range of HBV services. The 8 month program includes 5 visits: the first visit pretest costs $40; the second and third visits are for the 1st and 2nd vaccine doses, and cost $75 at each visit; the 4th visit offers the 3rd dose, and the 5th visit a month later for a post-test for antibody to identify non-responders. Standard STD screening is included without additional charges. Payment cannot be deferred or postponed, and a very limited number of vaccines are available at reduced cost, thanks to community donations made to the Hepatitis Research Fund. 8) The Denver Lesbian/

(Continued)

PROMOTION OF THE HBV VACCINE, Continued

Gay Health Alliance refers all inquiries to the Denver Metro VD Clinic, who offers screening and vaccination at cost. 9) Detroit's Palmer Clinic has had only a few people inquire about screening and vaccination. Screening is being offered for $15 plus whatever the lab directly charges the patient. This $15 fee may be exchanged for volunteer services to the Clinic. Third party reimbursement is made through the MD's name. The Clinic is planning to solicit other gay community organizations for developing a hepatitis "war chest" to help pay for the testing & Vaccination. The Clinic is also providing thorough educational services to gay community groups, high schools, gay youth organizations, and the gay media. Brochures are available, and patients are seen by a VD counselor to deal with additional concerns or questions about hepatitis. 10) Houston's Montrose Clinic has just begun screening and vaccination--screening costs $45, and the entire screening-vaccination post-test program costs $190. There is limited advertising in the gay media. The largest concern expressed by members of the community is that of vaccine safety regarding the possibility of transmitting whatever unknown agent may be responsible for AIDS. Dallas, which is several hundred miles north of Houston, is just organizing gay health services and there are no hepatitis programs available yet. 11) Key West, Florida's Monroe County Health Department is presently developing plans for hepatitis screening and vaccination for 1983. In spite of good gay media support, advertising, and patient education literature on the disease, surveys taken in area bars have revealed only a "fair" response. 12) Los Angeles' Clinic--Gay & Lesbian Community Services Center offers screening for $60 and the vaccine at cost. Only about 21 people have been enrolled since the end of July, in spite of extensive advertising in the gay community--not even Clinic staff is interested. The response frequently centers around the cost factor. Some local MDs are advising their patients to wait 6-12 months to see if vaccine recipients will get AIDS. Funding is extremely tight in the community, and "slush fund" money for those unable to afford the vaccine is not available. Some 3rd party reimbursement is available. 13) Madison's Blue Bus Clinic works closely with the University of Wisconsin Hospital & the Student Health Service, similar to Ann Arbor. County residents and UW students will receive free STD screening, which includes hepatitis testing, and a slight discount for the vaccine compared with nonresidents/nonstudents: $104 vs. $113.50. Nonresidents/nonstudents must also pay a $20 screening fee. Post-testing screening for antibody costs $20 for everybody. The Wisconsin Bureau of Laboratories charges only $15 for the entire STD and HBV screening. One of the popular gay bars in Madison sponsors a hepatitis sweepstakes one day each month. Everyone receiving routine STD screening there will be entered into the sweepstakes--after every 115 people tested, the first person meeting the medical criteria for vaccination wins a free vaccine, to be administered at Blue Bus. Some insurance plans have covered the vaccine. 14) Milwaukee's Brady East STD Clinic is presently the only program offering a sliding scale payment system for screening & vaccination. This was made possible through the the generosity of one of the Clinic's volunteer directors, who prepaid for 30 doses of vaccine. Patients with incomes of up to $8000 will pay $50 over 4 visits--$20 for screening (incidentally through the same Wisconsin Bureau of Laboratories, which offers an STD & HBV screening panel for $15) and $10 for each of the next 3 visits; incomes from $8-12000 will pay a total of $100 in 4 equal payments; incomes of $12-20000 will pay a total of $150, with the initial visit costing $30, and the remainder ($120) paid in the remaining 3 visits; incomes of $20-40000 will pay $180 in 4 equal payments; and income levels exceeding $40000 are charged $180 plus a donation, also in 4 equal payments. Post-testing is optional for an extra $20. Out of the approximately 25 individuals so far enrolled, only about 10 were serosusceptible & therefore eligible for the vaccine. Unfortunately, but expectedly, the higher income enrollees were also those who were found to be antibody positive. Collections are about breaking even, and it is too early to evaluate the program's success. Due to the absence of a viable gay press in Milwaukee, informational sheets were posted in bars to help generate interest in the program. 15) Minneapolis' Lesbian & Gay Community Services Center only refers inquiries to private physicians as there are no gay STD services in the area. Hennepin County's Red Door Clinic, which sees many gay patients and provides otherwise excellent services, does not offer screening or vaccination for hepatitis. 16) New York City has two gay STD programs: The Gay Men's Health Project offers only screening services in cooperation with the New York Blood Center. Referral is made to private physicians or other clinics as needed. The Project

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PROMOTION OF THE HBV VACCINE, Continued

receives $1 for each blood drawn, and receives a "finders fee" if the blood is judged suitable for research or plasmapharesis. There are no local programs for encouraging the young, economically depressed, sexually active gay man. St. Marks Clinic offers screening, vaccination, and the post-test for a flat fee of $150. Patient's assume responsibility for keeping the vaccine at their own home. There is no 3rd party reimbursement. There are no other advertising campaigns or posters for promotion of the vaccine. 17) Philadelphia Community Health Alternatives offers only referrals for screening and vaccination. As of now, due to the severe funding situation, there are no plans for expanding into these areas. 18) Pittsburgh's Free Clinic provides patient education materials on hepatitis but does no screening or vaccination at this time. They refer all inquiries to private physicians. As there is some community interest in this program, services may be expanded to accomodate patients in the future. 19) Sacramento's Hepatitis B Project essentially coordinates community education & hepatitis services that are available for individuals. Screening will soon be available, however referrals are made to private physicians who will provide the vaccine at cost plus nominal administration fees. A volunteer MD serves as an advocate to get 3rd party payment, and was recently responsible for convincing Kaiser-Permanente HMO to provide the vaccine for members. A major 30 minute VHS video presentation covering 5 gay health areas--AIDS/KS/PCP, hepatitis, herpes, syphilis, and gonorrhea, is under production for national distribution. 20) San Francisco's Resource Foundation has screened over 8000 individuals since August, 1981, through its network of private doctors, plasma services, and labs. About 10% of these were antigen positive. Patients are referred to private physicians for vaccination and an optional post-test screening. In addition to screening, the Foundation has programs in counseling and general education with outreach to members of the Asian, gay, and medical/professional communities. A limited community vaccination program is pending, especially directed to the target population (young, economically depressed, sexually active gay men)--funds are needed however, and are hard to come by in a city where there are numerous fundraising events for worthy (and some unworthy) projects. A research program is also pending, and interested researchers (from anywhere in the country) are encouraged to contact the Foundation with a proposal. The Foundaton is preparing a bilingual pamphlet in Chinese and English on hepatitis B, and a hepatitis hotline with trained volunteers is available, and receives lots of inquiries, especially after a good wave of publicity in the gay media. 21) The Seattle Gay Clinic offers hepatits screening for a flat $18 and plans to begin a vaccination program soon. Inadequate storage space for the vaccine poses a significant problem and therefore the Clinic plans to begin slowly--first by offering the vaccine to Clinic staff and patients, and eventually expanding into the community with extensive advertising in 1983. There are no plans to finance the vaccine for those unable to pay the approximate $100 fee. There is only very limited support from 3rd party payers--only employees of Group Health Cooperative of Puget Sound, a large local HMO, are able to get vaccinated. In addition to the Clinic and private physicians, the Seattle Public Health Clinic will offer the vaccine. 22) Tucson's Gay Health Project refers patients to a local plasma center for screeening. Those that are serosusceptible are referred to the private sector for the vaccine. 23) Tulsa Oklahomans for Human Rights have indicated that everyone, including medical personnel, believe that since the incidence of hepatitis B is essentially nonexistant in their area, that the vaccine is not needed. 24) Washington, DC's Whitman Walker Gay Men's VD Clinic has no immediate plans for developing a vaccination program, however testing is done at cost. Susceptible patients are referred to local physicians.

In reviewing these 24 communities, we've seen many similar and different strategies for managing hepatitis screening, vaccination, and education. Several areas of need are apparent.

1) A serious and thorough assessment of interest, motivation, and need of the gay communities in these (and other) cities can help determine why the response to the vaccine is so unimpressive. Is it the expense? Or the lengthy period required for administering the 3 dose vaccine? Is hepatitis B just being eclipsed & overshadowed by AIDS? Are gay men uninterested in their own health? Or inadequately informed about the dangers of hepatitis and the value of vaccination?

2) Advertising and effective marketing is needed, to convince the target groups of the importance and need for vaccination. Not advertising directed to medical health professionals,

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CORRESPONDENCE BETWEEN THE GAY PUBLIC HEALTH WORKERS & THE AMERICAN HOSPITAL ASSOCIATION

[The following letter was written by Jonathan Goldman of the Gay Public Health Workers Caucus of the American Public Health Association, to Michael Guerin, Director of Policy Development of the American Hospital Association, and is reprinted at the request of the GPHW. It is self explanatory.]

"The Steering Committee of the Caucus of Gay Public Health Workers has directed me to contact you about an issue of concern to us that we feel the AHA can have positive impact on. Simply, gay and lesbian hospital patients are often discriminated against by hospital administration/ personnel at the consumer level.

"In 1975, the APHA passed a resolution calling for non-discrimination of gays and lesbians in the area of health services employment and to educate heatlh workers about sexism. We would like to see your organization enact by whatever process applicable, a similar statement. Specifically, we see a resolution calling on your members to include the term "sexual preference/orientation" in patients' Bill of Rights antidiscriminatory clause. Also, a resolution calling on your members to be less reluctant on giving out information about a patient's status to non-family members. As you are aware, the traditional nuclear family unit is not as traditional in 1982 as it was in 1952. There are many adults choosing to cohabitate with same or opposite sex partners without marrying. Should these "significant others" be denied information about a loved one because of lack of familial ties? This can often be more difficult on gay/lesbian couples were there an estrangement from family because of the manner in which the individual has chosen to lead his/her life.

"...We hope that your organization will enjoy the opportunity to undertake the effort to rectify these issues and thus ultimately improve health services for all...." [8/20/82]

"Thank you for submitting your letter and supporting materials concerning hospital discrimination against gay and lesbian hospital patients. As I indicated in our phone discussion, it was my intention to submit your recommendations to our councils for their consideration at their next meetings in March of 1983.

"I have, of course, reviewed the material you submitted. I would like to suggest that, for the most productive deliberation on both the employment issue and the release of patient information issue, the councils could benefit from some indication of the extent to which you feel these problems exist. Do you, for example, have any data on the extent to which hospital employment has been denied because of sexual preference, or about the instance of formal or informal hospital policies which result in discrimination. Similarly, do you have data about the extent to which, "significant others" are denied patient information? I realize such data may not be readily available, but I believe whatever data you can submit will help our people reach some conclusions about the need for the remedial action you suggest." [9/14/82]

[Please send documents and other evidence of antigay/lesbian discrimination in hospital employment, or evidence documenting the extent to which "significant others" are denied patient information or visitation to: Frances Hanckel, Coordinator, Gay Public Health Workers, 2601 Madison Av., #807, Baltimore, MD 21217, or call 301/383-1356.]

NEXT ISSUE OF NEWSLETTER

The March, 1983 issue of the Newsletter will tentatively be available in late February-early March; deadline for submitting articles is February 11. New approaches in design are being investigated. In spite of the expected changes, we still rely upon your notifying us of important news of interest to gay health providers!

NCGSTDS MEMBERSHIP LIST REVISED

Due to space limitations and word processor problems, the NCGSTDS membership list that was promised for this issue of the Newsletter, will instead be included with the next issue. Sorry for any inconveniences! Please advise of any changes immediately to be included.

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LESBIAN & GAY COUNSELING CENTERS SURVEYED

Seventy-two gay & lesbian agencies in 27 cities from around the country were surveyed by psychologist Joe Norton, in the Spring of 1982. For a copy of this 19 page report, contact Dr. Joe Norton, PhD, 10 Eberle Rd., Latham, NY 12110. A self-addressed, legal sized stamped envelope (71¢ first class postage) with $1 for photocopy expenses would be appreciated.

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NEWS ABOUT NONOXYNOL-9

Schmidt Labs has received FDA marketing approval for a new product, Ramses Extra, a conventional latex condom with a spermicidal lubricant (nonoxynol-9), according to Bill Moran, company president. The product should be available in drug stores soon. Dr. Hershel Jick of the Boston Collaborative Drug Surveillance Program said that sexually active women who used spermicides (such as nonoxynol-9) ran ¼ to 1/8 the risk of developing gonorrhea compared to women using oral contraceptives or those surgically sterilized. Research among prostitutes is underway testing a lubricant containing nonoxynol-9 as an effective prophylaxis against gonorrhea & other STDs.

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NCGSTDS SEMI-ANNUAL MEETING REPORT

The semi-annual meeting of the NCGSTDS was held Wednesday, November 17, in conjunction with the 110th Annual Meeting & Convention of the American Public Health Association in Montreal in the hospitality suite of the Gay Public Health Workers at the Mont Royal Hotel. This constitutes an abbreviated report of business transacted at that meeting. (All figures below are for July 1-November 12, 1982, unless specified otherwise.) Membership: 49 new members in all categories this year, bringing the total up to 133. There are no plans for promoting a membership drive in the foreseeable future. Finances: Total income for the first 3½ months of this year was approximately $3881 ($1700, membership fees; $1524, Guidelines brochure; the remainder in donations); expenses amounted to approximately $2585 ($1103 for publication of the Guidelines brochure & postage; $160 in long distance telephone expenses; $900 for publication & mailing of two issues of the Newsletter; the remainder in miscellaneous expenses such as postage for answering almost 500 pieces of correspondence, membership in organizations such as the American VD Association, the Progressive Health Network, etc.). A preliminary cost analysis was made comparing traditional long distance charges vs SPRINT satellite services; savings were considerable--the average charge per long distance call in 1981-82 was $2.83, compared with $2.04 in 1982-83. The comparison will be continued through June. A proposal to use a recent appeal for donations that yielded over $500 for a new typewritter to aid in Coalition business was approved. [A Smith-Corona Ultrasonic electronic typewritter was purchased.] Letter of acknowledgement & thanks were mailed to all benefactors. G&Rs: Over 13,500 copies of the revised 2nd edition have been distributed since July 1. There have been numerous requests to reprint the brochure from city health departments, free clinics, et al. The issue of reprint rights was discussed, and a suggestion to have a one time charge for such reprint rights was made, as well as the difficulty of implementing this and other such policies. It was also suggested to offer the responsibility of printing & distributing the brochure to one gay STD service, to help lighten the work load on the Chairperson. Any service so interested is encouraged to contact the NCGSTDS. Several suggestions were offered for a 3rd edition of the brochure: 1) a boxed section on AIDS with the risk reduction statement highlighted; 2) correcting the statement about oral-genital and oral-oral contact and its association with with hepatitis B (it is); 3) insert "For bulk ordering [rather than "reprint"] information, contact...." Other issues: writing a "straight" or "gender/sexual orientation neutral" version, perhaps in conjunction with Planned Parenthood, the Montreal Health Press (publisher of the VD Handbook), or the VD National Hotline (or its parent American Social Health Association); a French translation edition; and an edition for the "elective illiterates," those individuals that can but usually don't read. Considerable discussion was devoted to the issue of whether the limited energies & resources of the gay community (or the NCGSTDS) should be used to help develop heterosexual STD materials. It was also mentioned that some gay STD service providers may be grossly prejudiced against those who declare their sexual orientation to be bisexual. Additional comments from NCGSTDS members are encouraged.

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NCGSTDS MEETING, Continued

NHGC/NGHEF: Walter Lear gave a lengthy report on the National Gay Health Coalition (NGHC) & the National Gay Health Education Foundation (NGHEF). At a recent business meeting of the NGHC, the topic of alcoholism and substance abuse in the gay community was addressed as a significant and neglected issue. It will get featured attention at the next National Lesbian /Gay Health Conference in Denver. Each affiliate of the NGHC should include it as an agenda item. [Each gay STD service certainly should incorporate some education, awareness, and/or referral services on alcoholism & substance abuse for clients. We need to be reminded that propensity for developing STDs are related to such things as alcohol or other substance abuse that alter decision-making abilities and the sensorium to dull pain & emotions.] A set of written guidelines for screening of individuals for alcoholism and other substance abuse/ dependence will be developed & circulated, primarily with the help of our colleagues in the gay alcoholism professionals group. Everyone who has contact with gay people should be equipped to identify or screen such individuals. Most people in psychotherapy don't like to handle alcoholic/drug abuse problems and aren't competant to handle such persons. Appropriate referrals by such psychotherapists is a reflection on their care, concern, and competance. Also recognized was that there is almost no data about alcoholism & drug addiction in the gay & lesbian community. Epidemiological studies will be encouraged. The major studies already accomplished (e.g., Young & Jay, Weinberg) don't include any questions on alcoholism. A national resource directory & bibliography are available through: Dana Finnegan & Emily McNally, National Association of Gay Alcoholism Professionals, PO Box 376, Oakland, NJ 07436. Also discussed at the NGHC, was the issue of racism, and that the National Lesbian/Gay Health Conference should give a conscious & sophisticated attention to the issue of racism. Finally, the International Gay Association (IGA) meeting was discussed. The NGHC and the United States were represented at that meeting by Michael Weltman and Walter Lear. (The next meeting of IGA members of the Americas will be held in Toronto, May 7-8; next IGA international meeting will be in the second week of July in Vienna.) The major issue in the health workshop was the campaign to delete homosexuality from the International Classification of Diseases (ICD-9-CM) of the World Health Organization (WHO). It was agreed to solicit as many letters as possible from as many influential organizations & people as possible to the WHO and the American delegate to WHO (e.g., a physician associated with a medical school should write a letter to both the county & state medical societies & to the medical school department chairman & dean; who would respectively write to the AMA and the American Association of Medical Schools, who would write to WHO, etc.) It was announced that an independent group, the Progressive Health Network, was established by Dan Pfeffer and Ron Vachon undertake gay health political action activities that was earlier thought to be a task of the NGHC (blessings were given). The next meeting of the NGHC will be April 24 in Philadelphia. Walter continued his report on the recent meetings of the NGHEF. Since IGA designated 1984 as the "International Year of the Lesbian & Gay," the National Lesbian/Gay Health Conference in 1984 may be considered as the First International Gay Health Conference (in NY or SF?). The Fourth Conference will be in Denver, June, 1983 [details elsewhere]. The National Gay Health Directory, a publication of the Foundation, will cost $5 and should be out shortly [the Newsletter will feature an article on the Directory with ordering information when it becomes available]. The issue of fundraising occupied considerable discussion, and the Foundation Board invited Ron Vachon to be the part-time Executive Director. AIDS was not discussed due to the lack of time at the Foundation's meeting. Joe Norton was selected as the official liaison person between the NGHC and the NGHEF and will help provide written reports & communiques. The NCGSTDS was advised to resubmit a letter to the NGHEF requesting "liaison services to raise funds on a tax-deductible basis" [a.k.a. "laundering]. After Walter's report, there was one suggestion for the Foundation to investigate issueing of "gay savings bonds" to help finance projects and the salary of the Executive Director.

Other agenda items were brought up at the NCGSTDS meeting. AIDS: The NCGSTDS was designated as the official interim national communication devise by the National AIDS Forum. A discussion comparing the NGTF's new Crisisline with the VD National Hotline [see elsewhere] began. The issue of accountability of the VD National Hotline was brought up--if they receive federal funding for the Hotline, should they continue to promote & devote considerable resources to herpes, when considerably more dangerous disease entities, such as hepatitis, PID, AIDS, are economically and socially more devastating? NCGSTDS members were encouraged to call

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NCGSTDS MEETING, Continued

both hotlines [see elsewhere in Newsletter for those numbers] to determine how they handle your inquirie. It was also suggested that the two national hotlines along with other local hotlines (e.g., New York's Gay Men's Health Crisis) work together in developing a written training manual for dealing with AIDS (rather than telephone crisis management) for hotline workers, with the assistance of the NGHEF and the National AIDS Forum Design Team. CASTDS: The CASTDS and a fundraising dance aboard a steamship on a cruise were discussed in detail [reports elsewhere in Newsletter].

It was decided that the next NCGSTDS meeting will be held in conjunction with the Fourth National Lesbian/Gay Health Conference in Denver. The meeting was adjourned.

[NCGSTDS members are invited to comment on or inquire about the meeting. Agenda items for the next meeting in June are being solicited. Please address to: NCGSTDS, P.O. Box 239, Milwaukee, WI 53201.]

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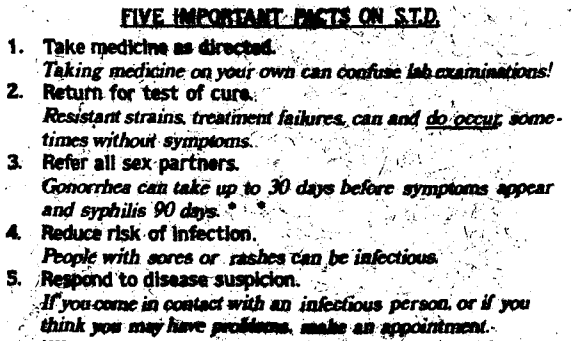
GAY STD SERVICES BEGINNING IN DALLAS
by Jerry Diggin

Dallas' first VD clinic with regular hours outside of the City Health Department will soon be operating with the help of ambitious & energetic volunteers from the gay community. Initially, the clinic will be open on Monday & Wednesday evenings and Saturdays for screening, and eventually expanding into treatment services. The City and County Health Departments will be training volunteers, and will help with supplies and funding. A sliding scale fee will also help generate operating funds for supplies, insurance, equipment, and educational materials. Already available is a wallet sized card describing where to go for diagnosis and treatment on one panel, and "5 Important Facts on STDs" on the facing panel (see right). The card is freely available from area bars and bathhouses.



FIVE IMPORTANT FACTS ON S.T.D.

1. Take medicine as directed.
   Taking medicine on your own can confuse lab examinations!
2. Return for test of cure.
   Resistant strains, treatment failures, can and do occur, sometimes without symptoms.
3. Refer all sex partners.
   Gonorrhea can take up to 30 days before symptoms appear and syphilis 90 days. **
4. Reduce risk of infection.
   People with sores or rashes can be infectious.
5. Respond to disease suspicion.
   If you come in contact with an infectious person, or if you think you may have problems, make an appointment.

*We recommend a screening at least every 30 days.

Because the services are brand new, any advice about operating a new clinic would be greatly appreciated from NCGSTDS members. Please write or phone: Jerry Diggin, Post Office Box 2361, Dallas, TX 75221 (214/641-1677 home, 214/980-4126 work.)

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NEWS ABOUT HERPES: NEW VACCINE & MISGUIDED MEDIA ATTENTION

ABC-TV News announced the development of a new vaccine for the prevention of herpes by researchers at the University of Chicago. Such a vaccine is not a cure, and since 80-90% of all adults have antibodies to herpes simplex (and thus prior exposure), the vaccine would be of little benefit to anyone except the newborn. Details were not available, and VD National Hotline could not be reached for comment. In a related development, a Washington Post-ABC News public opinion poll interviewed a "random selection of 1505 adults over the age of 18 by telephone over a six day period" and found (among other things) that almost half believed genital herpes was more serious than syphilis, 23% thought it less serious, and 11% thought them equal in severity. Three fourths of those questioned thought that "a herpes test should be mandatory before marriage;" 22% of young unmarried people said they altered their sexual behavior "to avoid the risk of contracting herpes," as opposed to almost 14% who said they were "not concerned enough" to make any changes.

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AIDS INFORMATION IN THE NEWSLETTER

The NCGSTDS Newsletter has been designated as "the official interim national communication device" for desseminating information about AIDS by the participants of the AIDS Forum, National Gay Leadership Conference, Dallas, TX, August 13-15, 1982. Information about the Acquired Immune Deficiency Syndrome (AIDS) will be relegated to this special section in the back of each issue.

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EDITORIAL: AIDS RISK REDUCTION GUIDELINES--PROCESS & PROBLEMS

by Robert K. Bolan, MD, and David G. Ostrow, MD, PhD
reprinted from Homosexual Health Report (HHR), volume 1:3, with permission

It is not likely that the AIDS mystery will soon yield its secrets; nor is it likely that once understood, it will be easily controlled or stopped. Evidence mounts for an infectious agent as the initiator of immune suppression and its consequences. If true, this agent or agents must be transmissable sexually, through blood products and contaminated needles to fit the epidemiological picture seen to date. Transmission of these agent(s) to unwitting sexual partners and blood product recipients is a public health concern meriting risk reduction precautions. The obvious problems with the task of writing such precautionary recommendations are that no well controlled clinical study has yet been done to identify certain individual risks; the natural history of AIDS is not fully understood; and no agent has been definitively identified. But we are rapidly approaching a time when public statements must be made even if they are guided by less than complete information.

A particularly difficult area is that of blood donation policy. Since no serum marker is yet available for the screening of recipient blood for AIDS agent(s), there is a rising cry to prohibit gay men from donating blood. Although such a solution is simple-minded, impossible to enforce, and would not completely eliminate the AIDS problem, attempts to implement such a policy would undoubtedly fan dangerous and homophobic flames. The choices at present seem limited. As an interim solution, one of two variants on the same theme could be considered. One option would be to screen potential blood donors with questions drawn from current epidemiological data covering the chief apparent risks but excluding specific sexual activities and orientation: numbers of different partners and history of previous STDs. Coupled with these questions would be testing for specific STD markers, such as fluorescent treponemal antibody (FTA) and antibody to hepatitis B core and/or surface antigen (anti-HBc/anti-HBs) in addition to the VDRL and hepatitis B surface antigen (HBsAg) tests already being performed. Another option would be to utilize the same questions but rather than asking them directly, prominently advertise or display them and rely on the altruism of those who donate blood to exclude themselves if appropriate.

No less difficult than the blood donor issue will be the issue of general AIDS risk reduction recommendations. Such recommendations must address several different groups: those who are well and attempting to stay well, those who are possibly immunocompromised and trying to cut their losses, and those who are gravely ill, struggling to survive. There are tremendous problems in trying to meet the needs of all these groups. First, we must agree on risk factors. In our discussions, we must consider contributions of mental health and personal integration (life satisfaction, stress management), life habits (diet, exercise, sleep, drugs), and sexual activities (place, type, frequency, anonymity, number of different partners). Second, once we have agreed on a preliminary set of risk factors, we must develop prospective mechanisms for measuring the practicality and impact of specific precautions. Third, and perhaps most important, since AIDS precautions will undoubtedly entail exhortations to change behavior--decrease some activities and stop others--the recommendations must be devised and delivered in as sex-positive and effective a manner as possible.

In general, development and promulgation of AIDS risk reduction recommendations must anticipate their psychosexual health effects of those very recommendations on the intended audience. Until the natural history of AIDS is better appreciated or an agent(s) identified and their transmission understood, recommendations will serve to further divide that community into

[Continued]

EDITORIAL: AIDS RISK REDUCTION, Continued

somewhat arbitrary "safe," "possibly contaminated," and "definitely contaminated" groups. Further, community reception of AIDS recommendations will be mixed no matter how carefully crafted their development and delivery. Medical science's pronouncements are being met with significant skepticsm and even mistrust, particularly among gay men. Some of the mistrust seems to be rooted in our uncertainty about homosexual health problems, differring medical opinions about their etiology/epidemiology, and the proximity of these factors in personal and social time to repression of homosexual expression. Thus, admonitions against specific sexual activities must be carefully weighed against potentially negative personal and community consequences.

Tom Smith, MD, writing in the October, 1982 Newsletter of the NCGSTDS [Volume 4:2], stated that health recommendations that merely present either/or dictates (i.e., "don't do X") may provoke guilt and failure responses and that a more effective approach would suggest how to make positive gradations in behavioral change. Dr. Smith predicts that we will be more effective if we "also replace negative, passive-victim, defeatist attitudes with more positive and rational thoughts and imagery," and "promote attitudes that emphasize the humanism in gay male bonding and encounters--even brief ones." In contrast to that viewpoint is that recently expressed by Michael Caillen and Richard Berkowitz, tow New York City AIDS patients, who, writing in the November 8th New York Native, "declare war on promiscuity: ...If going to the baths is really Russian roulette, then the advice must be to throw the gun away, not merely to play less often."

By following these principles as we work to develop AIDS recommendations, we can turn this nightmare into a tool for positive social change. Of course, when exhorting behavioral changes for the public good, each individual's sense of responsibility is critical. This sense of responsibility must be cultivated through emphasis that the cultural diversity of the gay subculture, clearly evidenced by listings of gay groups in existence (see HHR, volume 1:4) proves that there is a community. And through these groups, which importantly influence their members, we can show that the gay community is a social context of which we can be proud. By emphasizing the positive aspects of the gay community, the sense of personal responsibility or caring can be fostered, which further builds on a sex-positive gya ethos.

Lastly, as a counterpoint, we wish to strongly caution that we not treat the gay male community like eggshell art. These are tough times and tough questions must be asked, tough decisions made. To question the healthiness of specific forms of sexual expression is not homophobic. Also, let us not be hamstrug by our scietific method--it is slow and cannot accurately detect trends until much time and data have accrued; let us not be lind to common sense and let us say what is obvious, even if controversial. Current Aspects of STDs Symposium--III (CASTDS) will convene in Seattle, August 4, 1983. One of our tasks will be to continue the process of drafting AIDS risk reduction recommendations. We will draw upon broad resources within the scientific community, we'll enlist invaluable aid from prominent sexologists, ethicists, religious and business leaders. For now the dialogue must continue.

[The NCGSTDS invites dialogue! Please address responses to the NCGSTDS, PO Box 239, Milwaukee, WI 53201.]

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NEWSWEEK REPORTS ON AIDS

The December 27, 1982 issue of Newsweek reports on the latest victims of AIDS, infants. Since this group is "socially acceptable" (unlike gay men, Haitians, and drug addicts, who may not be considered to be "socially acceptable"), it is thought that there may be greater media exposure and attention to this "lethal mystery story." In any event, hotlines around the country may begin experiencing increased inquiries from panic-stricken people: blood donors and recipients, gay people, and others.

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UPDATED LISTING OF AIDS FOUNDATIONS & ORGANIZATIONS

In order for you to be well informed and prepared to care for your patients, we urge you to become a part of the growing communication network of national AIDS foundations & organizations--request to be on their mailing lists and please contribute generously! Following is an updated listing, alphabetized by city (exclusive hotlines or newsletters providing limited services are excluded):

Atlanta:	AID-Atlanta, P.O. Box 52785, Atlanta, GA 30305 404/872-0600, 876-2354
Boston:	Mayor's Task Force on AIDS, c/o Brian McNaught, Mayor's Gay Liaison, City Hall, Boston, MA 617/424-5916 (AIDS at Boston City Hospital); 267-7573 (Fenway Community Health Center); 426-9371 (Lesbian & Gay Hotline)
Chicago:	AIDS Action Project, Howard Brown Memorial Clinic, 2676 N. Halsted, Chicago, IL 60614, 312/871-5777
Denver:	AIDS Committee, Gay & Lesbian Health Alliance, PO Box 6106, 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
New York:	Gay Men's Health Crisis, Box 274, 132 West 24th Street, New York, NY 10011, 212/685-4952
Philadelphia:	AIDS Task Force, Philadelphia Community Health Alternatives, PO Box 7259, Philadelphia, PA 19101, 215/232-8055
San Francisco:	Kaposi's Sarcoma Clinic, UCSF, 110 East Court, Petaluma, CA 94952, 415/666-1407 Kaposi's Sarcoma Research & Education Foundation, 470 Castro St., #207, Box 3360, San Francisco, CA 94114, 415/864-4376

Remember, we need to work together! Please share your information & resources with the above groups and the NCGSTDS, PO Box 239, Milwaukee, WI 53201.

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GUIDELINES FOR INDIVIDUALS FOR REDUCTION OF RISK FOR DEVELOPING AIDS

The following statement was unanimously adopted by the National AIDS Forum, August 16, 1982, Dallas, TX, and is reprinted here for your review (see Volume 4:1 of Newsletter for entire text of the Risk Reduction Committee). [Thanks to the Progressive Health Network's Newsletter, Volume 1:1 for the typeset copy.]

Acquired Immune Deficiency Syndrome (AIDS) is a new and poorly understood medical condition involving an impairment of the body's immune defense system. It constitutes a serious health problem at present particularly among some homosexually active men. This severe dysfunction of the body's ability to fight certain diseases is associated with the appearance of opportunistic infections, such as *Pneumocystis carinii* pneumonia, and rare cancers, such as Kaposi's sarcoma.

All of the various proposed causes of this condition are theories at this time and there are as yet no definitive explanations.

While the goal of this statement is to make recommendations towards reduction of risk for AIDS acquisition, there is insufficient information for the formulation of specific recommendations at this time. Therefore, *this is a preliminary set of guidelines,* the aim of which is to limit the spread of AIDS as much as possible during the interim period until more conclusive evidence regarding the cause(s) and prevention of AIDS are available. These guidelines are issued with the expectation that they will be continuously updated as further information becomes available.

These recommendations are made in the context that the most likely explanation of the AIDS phenomenon will involve infectious process(es). There is a rapidly growing body of information about probable risk factors. The most prominent of these appear to be intravenous drug use and frequent sexual encounters with many partners especially partners who themselves have large numbers of different sexual partners. This pattern of risk factors is similar to that seen for Hepatitis B transmission; in homosexually active men Hepatitis B virus is transmitted primarily through sexual contact.

The following recommendations are made to sexually active individuals who are concerned about their risk of developing AIDS:

1. Although we do not know all the ways AIDS can be acquired, an individual's chances of developing AIDS increase with the number of DIFFERENT sexual partners. The frequency of sex does not appear to be relevant. It is the NUMBER of DIFFERENT partners that increases the risk of disease.
2. Individuals suspecting that they may be developing AIDS should seek counsel from a knowledgeable health professional.

Adopted unanimously by the National Forum on AID, August 16, 1982, Dallas, Texas.

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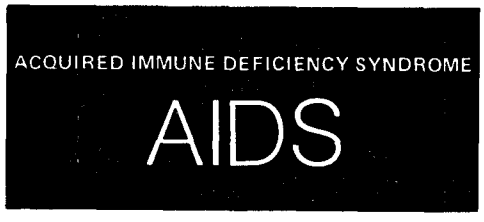
PHILADELPHIA AIDS TASK FORCE
by Nick Ifft, MD

The primary objectives of the Philadelphia AIDS Task Force of the Philadelphia Community Health Alternatives (PCHA) have been to educate both the gay community and area health care providers about AIDS, and to establish liaison with major treatment centers to develop a referral network. As part of efforts to educate the health care community we have sponsored or participated in a number of local conferences on AIDS, and have written a newsletter for physicians which the city health department publishes and distributes to all providers on its mailing lists. This newsletter is currently available on request from both the city health department and the AIDS Task Force, and we send with it a copy of the Kaposi's sarcoma Foundation of San Francisco pamphlet containing color photographs of Kaposi's lesions. Educational efforts directed to the community have included providing speakers for community groups, broadcasts on the local gay radio program, regular articles and ads in the gay press, and posters containing brief cards (see right) about AIDS, as well as wide personal distribution of these pocket-size cards at bars, baths, and other gathering places. The use of the card format was suggested by Dr. Larry Gross, co-chair of the Task Force, and participant in the First AIDS Forum in Dallas (August, 1982). The pocket-size card format was found to be an extremely effective way of reaching the community. In addition, an AIDS hotline service was established, staffed mostly by lay volunteers, who have regular training sessions, including role-playing techniques, and who take calls in their homes via call-forwarding. The hotline offers information on AIDS, referrals to local MDs familiar with AIDS, referrals to support services for AIDS patients, and AIDS information for physicians for doctors and other health providers. Callers are mailed a copy of the "AIDS: Questions & Answers" pamphlet or advised of locations where the pamphlet can be obtained. The Task Force also maintains regular contact with the medical writers of the Philadelphia daily newspapers to offer information on AIDS, and is currently preparing public service announcements for a number of local radio and television stations. Psycho-social support services for AIDS patients and their significant others are provided by a committee of the Task Force, led by a locally well known psychiatrist. Letters concerning the availablity of these services and the name of the physician to contact have been sent to appropriate people at major area hospitals (generally infectious disease and oncology departments); support services are available on both individual and group bases. We've found that publicizing the support services in this manner has been a very effective way of introducing the Task Force to these people, and of gaining information about existing AIDS patients and treatment resources. We are currently examining a number of local research proposals for which our cooperation and/or participation have been requested. Meetings with the state health department for requesting their assistance in encouraging case reporting and distribution of AIDS information to MDs throughout the state are underway. The Task Force has problems, too. Chief among them is the lack of accurate reporting of AIDS cases in the Philadelphia area. While the city health department has attempted more active surveillance at our request, the results have been so far somewhat disappointing, and we do not yet have an accurate case count in this area. Part of this is due



(215) 232-8055

For information or referral

HOURS: 7-11 PM Mon.- Wed.- Fri.

This material has been prepared by the AIDS Task Force of Philadelphia Community Health Alternatives (PCHA) and Philadelphia Health Professionals for Human Rights (PHPHR). PCHA operates a gay men's VD clinic which can be reached at the number above. PHPHR is the local gay and lesbian physicians and dentists organization. The AIDS Task Force is a volunteer organization which provides AIDS information and education for the community and health professionals, support services for AIDS patients, and promotes AIDS research. Tax deductible contributions to support this work may be made to: "PCHA" - AIDS Fund, PO Box 7259, Phila. PA 19101.

We would like to thank Dr. Lawrence Mass of the New York Gay Men's Health Crisis for his help in the preparation of this information.

What is AIDS? Acquired Immune Deficiency Syndrome (AIDS) is a breakdown in the body's ability to fight disease. It has been referred to as "gay plague" or "gay cancer"; this is wrong. It is neither a plague or cancer, nor are all victims gay. However, a skin cancer, Kaposi's Sarcoma, or severe infections such as Pneumocystis pneumonia may be signs of AIDS.

What are the symptoms?

- Swollen glands (lymph nodes) in the neck, armpit or groin that have been present for several months.
- Purplish bumps or spots, like small bruises, that don't go away. They may be on the skin or inside the mouth, nose or anus.
- Weight loss of more than 10 lbs in 2 months for no known reason.
- Severe tiredness, not related to exercise, tension or drug use.
- Fevers or night sweats lasting for several days to weeks.
- Dry cough (not from smoking) that has lasted more than three weeks.
- Persistant diarrhea.

What to do? If you have any of these symptoms, see your doctor at once or call (215) 232-8055 for the name of a doctor familiar with AIDS. Additional AIDS information is also available at this number. All calls are confidential.

How can I reduce my risk for AIDS? While the cause of AIDS remains unknown, current thinking is that a communicable agent such as a virus is probably involved. Reducing the number of different sex partners should reduce risk of AIDS as well as other sexually transmitted diseases. It is the number of different partners, not the frequency of sexual activity that is related to increased risk. Injecting or "shooting" street drugs is also associated with increased risk of AIDS.

(Continued)

PHILADELPHIA AIDS, Continued

to the usual problems with case reporting, and part due to the fact that the city collects information only on patients who are residents of Philadelphia proper. Our estimate, based on information from major area hospitals, and with which the city agrees, is that there have been about 30 cases so far, with a larger number of patients with probable prodromal symptoms such as generalized lymphadenopathy. And then there is the question of money. While the city health department paid for the publication and distribution of the newsletter to physicians and the printing of the "Questions & Answers" pamphlet, all other activities were financed by private donations, mostly from members of the AIDS Task Force itself. A series of fund-raising events were held at a number of local bars, which raised substantial money, and similar events are planned for the future. In addition, we have been the fortunate recipients of many hours of invaluable volunteer time from many individuals in the community. For additional informaiton, contact Nick Ifft, MD, Secretary, Philadelphia Health Professionals for Human Rights (215/561-5330, evenings) or the Philadelphia AIDS Task Force, c/o PCHA, PO Box 7259, Philadelphia, PA 19101.

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GAY MEN AS BLOOD DONORS?

by Ron Vachon, PA, Executive Director, National Gay Health Education Foundation, Inc.

The New York City AIDS Network, an informal group of individuals and organizations involved in the AIDS issue has asked me to communicate with you about a serious new development in the ongoing AIDS epic. Hopefully this will be the beginning of regular communications from the NGHEF to you. The December 10 issue of MMWR [reprinted with this Newsletter] reports new data on hemophiliacs and a case study of a child with an AIDS-like syndrome. There are now at least 10 hemophilia patients with AIDS--1 in 1000 hemophiliacs in this country, furthering the concept that AIDS is spread through blood products. The child was an Rh incompatible neonate transfused at birth with the blood of 19 different donors, one of whom was diagnosed as having AIDS 8 months after giving blood. Although he denied being gay, since his death, that denial was questioned. This has led many scientists to once again raise the question: "Should gay men with multiple sex partners be allowed to donate or sell blood?

With the participation of the National Gay Health Education Foundation, the National Gay Task Force, the American Association of Physicians for Human Rights, and the New York City Gay Men's Health Crisis, the NYC AIDS Network is seeking your input into the following ideas to potentially put a lid on this problem:

1) Assuming that the gay health and political communities will be approached to help stop gay men from giving or selling blood, all of us must be prepared to kill this "gay blood = bad blood" issue. In particular, most of the press is likely to misrepresent the real issues. "Killer gay disease spreads to kids," was the headline of the New York Post news item of December 11, 1982. 2) Realizing that screening for "gayness" before someone gives blood is not only an invasion of privacy, but also unreliable (and outrageous), we propose that all blood for distribution be screened for hepatitis B core antibody (HBcAb) for the following reasons: a) hepatitis B has been identified as having characteristics similar to AIDS; b) approximately 85% of all AIDS victims are HBcAb positive; and c) 5-6% of donors at the New York City Blood Center are HBcAb positive.

The Public Health Service's Committee on Opportunistic Infections in Patients with Hemophilia, first convened in August to discuss the first cases of AIDS in hemophiliacs, has been recalled for a meeting on January 4 in Atlanta to reconsider the issue in this new light. We will continue to have credible input on this panel, but defusing the "gay blood = bad blood" idea is not going to be an easy task. We urge you to share your thoughts with us and to spread the word in your community. We hope that in this way, not only will our response as a community be a well considered one, but also that the AIDS networking begun in Dallas at the AIDS Forum (August, 1982) will continue to grow and give us strength. Please communicate with either myself, Ron Vachon, 506 W. 42nd St., #E3, NY, NY 10036 (212/563-6313) or Dr. Roger Enlow, MD, 60 E. 12th St., #2J, NY, NY 10003 (212/420-0226).

[POST SCRIPT: An additional suggestion was offered by Dr. Dan William, MD, of New York.

(Continued)

GAY MEN AS BLOOD DONORS? Continued

The suggestion is for the above groups, possibly lead by AAPHR and its affiliates, to take an offensive, and recommend that all sexually active blood donors (regardless of sexual orientation) having greater than a certain number of different sexual partners over the preceding year, voluntarily refrain from donating blood until further laboratory diagnostic advances or other discoveries are made. The "certain number" of different sexual partners would be determined by reviewing the cases in the case-control CDC and New York University AIDS studies and determining the mean number of sexual partners over the last year preceding clinical onset of illness of those cases, taking 2 standard deviations from that mean, and using the lower number as the cut-off point. This method assumes that most homosexually active men altruistically donate, rather than sell their blood, and would therefore altruistically refrain from donating. Please share your feelings and thoughts about this proposal with Ron or Roger. --The Editor.]

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GAY CIRCUS AIDS BENEFIT IN NEW YORK

What is being called "the biggest gay social event of all time" is planned for April 30: New York's Gay Men's Health Crisis has reserved more than 17,500 tickets for a performance of the Ringling Bros. and Barnum & Bailey Circus in Madison Square Gardens. The project hopes to raise more than $150,000 to fund research into AIDS and to provide support services for AIDS patients and loved ones. The circus night will be part of an "Aid fir AIDS Week" in New York, featuring a wide range of social activities. Tickets for the circus cost $25, $15, and $10; special classes of benefactors paying $500, $250, or $100 will be invited to pre-circus entertainment. All tickets are tax-deductible. Checks may be made payable to GMHC-Circus and sent to GMHC, 132 W. 24th St., Box 274, New York, NY 10011. For Mastercharge and VISA orders of for further information, call 212/807-7517. Orders received by February 1 will be filled by March 1.

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NGTF TOLL-FREE CRISISLINE DEALS WITH AIDS

The National Gay Task Force has through the generous assistance of local organizations like Chelsea Gay Association, opened its toll-free Crisisline, a national telephone number which will be used to compile nationwide statistices on homophobic violence, and to provide callers with access to local hotlines and support services. The Crisisline will also give callers information about groups, projects, and hotlines in their local communities, and in some instances will provide limited referral information about AIDS hotlines, services, and clinics. Kevin Berrill, Violence Project Coordinator, said at the October 6 opening of the Crisisline, "Antigay violence in America is increasing. Until now, there has been no way to show the dramatic rise as a national figure. NGTF is using its resources and its recognizability factor in the gay/lesbian community to provide a national hotline to put the overall picture of homophobic violence into focus." The NGTF Crisisline is open weekdays from noon to 6 pm EST, and is staffed by volunteers who have undergone rigorous "hotline training." The toll-free number is 800/221-7044; in New York State, call 212/807-6016. [See associated article, comparing the NGTF Crisisline with the VD National Hotline, elsewhere in this Newsletter.]

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AIDS SCREENING PROTOCOL AND RESOURCE & REFERRAL LIST DEVELOPED IN SAN FRANCISCO

by Jeff Richards, President-Elect, National Gay Health Education Foundation

A uniquely well-integrated model for community mental and physical health services was developed by Pat Norman, Coordinator, Gay & Lesbian Health Services, City & County of San Francisco, 101 Grove St., San Francisco, CA 94102 (415/558-2541). "AIDS: Screening Protocol and Resource & Referral Lists" contains information for use by health care providers in deciding the proper referral process and protocol for people with symptoms of AIDS. Write Pat for additional information.

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COMPARISON BETWEEN VD NATIONAL HOTLINE & NGTF CRISISLINE, DECEMBER, 1982

[The following comparison between the VD National Hotline and the National Gay Task Force's Crisisline may help evaluate national hotline services for inquiries about AIDS. Local hotlines, although they may receive calls from around the country (eg, New York's Gay Men's Health Crisis) were not considered (criteria: national 800 toll-free number). Additional information or comments are invited; Address to the NCGSTDS, POB 239, Milwaukee, WI 53201.]

	VD National Hotline	National Gay Task Force Crisisline
Agency	American Social Health Association 260 Sheridan Av. Palo Alto, CA 94306 Bea Mandel, Director 800/227-8922 (different in CA?) hours: M-F, 8-8pm, PST (tape message when closed)	National Gay Task Force 80 Fifth Av., #1601 New York, NY 10011 Kevin Berrill, Director 800/221-7044 (212/807-6016 in NY, AK, HI) hours: M-F, 12-6pm, EST (tape message when closed)
Primary Purposes	VD Information & Referrals Computer information retrieval for referral (no data collection yet) with 3 files: private, public, & crisis files.	Crisis, Anti-gay violence, & Referrals Referral directory & card file by state.
Funding	Federal funding through November, 1983 (renewed year by year). Funding fairly certain, but gov't may change at any time (politically influenced)	Funding through NGTF and Fund for Human Dignity. Future is uncertain--need is there, but money is questionable.
Staff Training	15-20 hours total--medical & telephone counseling. Training occurs monthly. Willing to work with other hotlines on programming or staff development	15-20 hours total in 6 sessions for all volunteers: about 4 hours on AIDS; 2-3 hours on counseling skills & talking with patients; remainder on crisis management, violence, etc. Willing to work with other hotlines on programming or staff development; another training session planned for January, 1983
# Volunteers	65	9
Date of Origin	October, 1979; inherited from "Operation Venus," which is now a local hotline in Pennsylvanis	October 6, 1982
# of Lines	Four 800 (toll-free) lines	Two 800 (toll-free) lines One New York State line
# Calls per Day & Makeup	About 400 (12 hour day) 60-75% currently on herpes	About 50-60 (6 hour day) 50% currently on AIDS
Problems, Concerns, Comments, Etc.	Difficult to get through--busy or no answer; heavy volume of calls on herpes due to media-generated scare; any major media event (herpes, AIDS, etc.) impacts the Hotline & makes it difficult to get through welcomes help from other hotlines	Never saught consultation with representatives of National Gay Health Education Foundation, NCGSTDS, Gay Public Health Workers, National Gay Health Coalition, etc. in developing services--however, better late than never; willing to work with other groups but has limited resources.

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AIDS CASE FINDING NETWORK STEERING COMMITTEE MEETING

The meeting of the AIDS Case Finding Network Steering Committee (previously referred to as the AIDS/STD Information Network in this Newsletter) was held November 15, 1982, in conjunction with the Ad Hoc Task Force for Vaccination Strategies for Sexually Transmitted Hepatitis B Infection (Task Force) at the APHA Meetings in Montreal (see elsewhere in Newsletter for a report of that group). Those present and their affiliations: David Ostrow, MD, PhD (Howard Brown Memorial Clinic, Chicago); Mark Behar, PA-C (NCGSTDS, Milwaukee); Frank Judson, MD (Metro VD Clinic, Denver); Yehudi Felman, MD (New York City VD Control Bureau); Alan Kristal (New York Gay Men's Health Crisis); Jerry Feuer, PA-C (Fenway Clinic, Boston); Nobbie Gilmore, MD (Montreal Gay Physician's Organization); Walter Lear, MD (Institute of Social Medicine & Community Health, & National Gay Health Education Foundation, Philadelphia); Thom Nylund (The Clinic--Gay & Lesbian Community Services Center, Los Angeles); Roger Gremminger, MD (Brady East STD Clinic, Milwaukee); Bruce Dull, MD (Prevention, Inc., Atlanta); Mark Kane, MD (CDC Hepatitis Laboratories, Phoenix); Armand Cerbone & Ron Sable, MD (Howard Brown Memorial Clinic, Chicago); Ron Vachon, PA (National Gay Health Education Foundation, New York); and Jerry Kelly (KS Research & Education Foundation, San Francisco).

Dr. Ostrow reviewed the information given to him by Dr. James Curran (CDC's AIDS Task Force) about the Network's most recent communication with the CDC AIDS Task Force regarding the national casefinding network. Dr. Curran's recommendations follow: A) We should keep questions of hepatitis and general STD information collecting separate from the primary goal of the Network, which is to perform active surveillance of AIDS and pre-AIDS cases. B) CDC considers our efforts an integral part of the establishment of a National Surveillance Program (NSP) for AIDS and pre-AIDS cases; CDC also appreciates our input to the formulation of a NSP but as yet has identified no funding for the NSP. C) As an interim measure, the CDC AIDS Task Force is planning to appoint a Scientific Advisory Committee (SAC) to which one or more members of our Network Steering Committee would be appointed. D) Funding priorities of the CDC in regards to AIDS surveillance are as follows: 1) Funds have been allocated for establishment of active surveillance programs in New York City and San Francisco. 2) If CDC does receive specific AIDS funding in fiscal year 1983 significantly in excess of the $2 million which it has already budgeted, they will request proposals from groups such as ourselves for establishment of components of a NSP. 3) In absence of specific funding for networks such as we have proposed, Dr. Curran will support our attempts to obtain state and local health department support and involvement in our efforts, and will attempt to increase communication between our Network and other interested persons active in AIDS surveillance. E) Given the current overall situation, Drs. Curran and Ostrow feel that our Network Steering Committee can serve a primary purpose as a cluster of interested investigators facilitating collaborative planning and communication functions.

A consensus was reached on the four major goals and purposes of the Network. A) The primary goal of the Network will be to establish an active surveillance system for AIDS and prd-AIDS cases in participating cities other than New York and San Francisco. B) The preliminary reporting form will only include information necessary for identification of AIDS/pre-AIDS cases both to maximize reporting compliance and to avoid problems of confidentiality and consent problems involved in the collection of epidemiological information. However, the reporting system will have a built in mechanism established at the local level for more intensive epidemiological investigations if and when such studies are added to the Network's activities. C) As a collaborative investigative group, however, Steering Committee members are encouraged to share with other members through the Network Chairperson (David Ostrow) reporting forms that they are developing that go beyond the Network's Case Identification form. This would allow the Network Steering Committee to facilitate groups in development of uniform instruments for AIDS/pre-AIDS information gathering. D) The Network case identification form should be as simple as possible and designed so accurate information could be collected without the use of trained interviewers since resources for such interviewers may not be available in most participating cities.

Additional discussion ensued regarding the validity of various questionnaires being used to

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AIDS CASE FINDING NETWORK, Continued

collect epidemiological information and type of questions which should be included in such instruments. It was felt that the CDC instrument needed considerable expansion and validity testing. In particular, it was recommended that more extensive interviewing regarding travel, and sites of sexual activity correlated with types of sexual activity performed in those cities and sites should be added. As mentioned above, it was felt that the Network's activities in developing a standardized epidemiological questionnaire must be viewed as separate and distinct from our primary case-finding questionnaire and purpose.

There was some discussion of various investigations being proposed to the National Institutes of Health (NIH) by individual Network participants and the posssible role of our Network relative to the probable establishment of multi-centered cooperative research programs on AIDS (National Cancer Institute [NCI], National Institutes of Allergic & Infectious Disease [NIAID]). Suggestions for our Network's unique contribution to such research programs are: A) Emphasis on the concept of our Network as an information-sharing group thus facilitating communication between a multi-centered cooperative network, CDC AIDS Task Force, and our individual members; B) Ability of our Network's pre-AIDS surveillance system to develop clearer definitions of AIDS prodromal syndromes and recommended diagnostic and serologic work-ups for potential pre-AIDS patients; C) To function as a clearinghouse for both information gathering instruments and educational materials regarding AIDS; and D) To assist individual Network components in the development of educational materials aimed at increasing individual practitioner's knowledge regarding AIDS, diagnosis and treatment of AIDS patients and standardized collection of case reporting information. Along these lines, Dr. Ostrow and appropriate CDC personnel will be planning a workshop on AIDS case finding procedures to be held at the National STD Conference in Dallas, TX, March 8-11, 1983 [details elsewhere in this Newsletter].

At the conclusion of the meeting, the discussion turned to the overriding concern of how the Network and its component individuals could effectively achieve any of its primary or secondary goals, given the very limited resources currently available. It was strongly encouraged that each Network participant develop a set of priorities consistent with the above Network priorities and to identify resource needs at each priority level. If and when a formal application for funding of the Network is made to CDC, NCI, NIAID, or any other agency, a hierarchal listing of Network forms, functions and funding requirements will be essential to successful funding efforts.

A suggested (revised) AIDS Report Form is reproduced here in condensed form. The following information is collected: reporter's name, date of report, patient's ID number, information source, patient's date of birth, age, race, sex, sexual orientation, & mother's maiden name, and person to contact for further information. All relevant diagnoses are checked & recorded for date of onset, presumed diagnosis, biopsy/culture proven, and date if so proven for the following diseases: Kaposi's sarcoma, lymphoma (type?), other malignancy (type?), pneumocystis carinii pneumonia, disseminated herpes, disseminated CMV, other opportunistic infection (type?), thrush (site?), and bleeding disorder (type?). Date of onset of the following relevant symptoms are also recorded: unexplained lymphadenopathy (sites?), fever of unknown origin, unexplained weight loss greater than 25 lbs. or 10% ideal body weight, night sweats, extreme malaise, lymphopenia (total WBC? % lymphs?), rash or purplish spots (sites?), unexplained cough, and immunological workup (specify where workup done and test results).

This report was prepared by David Ostrow [with slight modifications by Editor]. If you'd like more information about the Network, or would like to provide input, please contact: David Ostrow, MD, PhD, 155 N. Harbor Dr., #5103, Chicago, IL 60601.

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EXCELLENT ARTICLE ABOUT AIDS IN NURSING JOURNAL

Allen, J., & Mellin, G. The new epidemic: Immune deficiency, opportunistic infections, and Kaposi's sarcoma. American Journal of Nursing, November, 1982, pp. 1718-22.

This illustrated article provides an excellent update about AIDS for allied health professionals, with references, and specific information for educating patients. Highly recommended!

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VD NATIONAL HOTLINE SEEKS PHYSICIAN REFERRALS

The VD National Hotline is seeking names of private physicians who would be willing to accept referrals from the Hotline, on a fee-for-services basis, particularly for the gay caller. They are especially interested in clinicians skilled in working with AIDS inquiries. Please contact Bea Mandel, Director, VD National Hotline, 260 Sheridan Av., Palo Alto, CA 94306, or call 415/321-5134.

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THE SHANTI PROJECT & PSYCHOSOCIAL NEEDS OF AIDS PATIENTS

The Shanti Project, founded in 1974 by Dr. Charles Garfield, provides volunteer counseling services in the San Francisco Bay Area to persons with life-threatening illnesses, their loved ones, and the bereaved. Counseling is provided wherever it is needed--in the home, hospital, or other care facility. For additional information, contact: The Shanti Project, 890 Hayes St., San Francisco, CA 94117, 415/849-4980 (M-F, 10am-5pm PST). Shanti recently distributed a working paper on the "psychosocial needs of AIDS patients," which is reprinted here for your review.

WHEN DIAGNOSED: 1) Accurate, accessible information on disease history, latest findings, possible treatment. Reason: Diagnosed patients want as much as much information as they can get on what this means for them. While it is true that much of the material on AIDS is discouraging, it will only be a matter of time before they secure it. Recommendation: Provide hospitals with packets of information on AIDS which would be given to patients upon diagnosis. Note: the content of this packet should be explained first and a phone number of a community group skilled in working with the psychosocial needs of persons with life-threatening illness included.

IN THE HOSPITAL: 1) Need for supportive, informed, non-condescending respect from hospital personnel. Reason: Patients diagnosed with a potentially life-threatening illness are in a very vulnerable and compromised place, they don't need the added burden of dealing with staff prejudices and fear. Recommendation: Nurses and other hospital employees should be offered ongoing inservice classes on the needs of AIDS patients. Perhaps speakers from the gay/lesbian community can be included in these workshops to respond to the myths that abound. 2) Patients should have the right to request another hospital worker if homophobia is encountered. Reason: In this vulnerable situation support is essential, the patient should not have the added job of raising consciousness. Recommendation: Hospital personnel should be asked by their supervisors if working with AIDS patients is comfortable for them, and if it is not (and the supervisor & employee can't work through it), the patient shoulc be assigned a new worker. 3) Patients should be provided with precise, comprehensive explanations of tests and treatments. Reason: Many patients have felt ripped off by having violent reactions to tests and treatments that they were not psychologically prepared for. Recommendation: Persons from the community or part of a community group be advocates for AIDS patients on bettering communication between physician and patient. 4) Full visitation rights for lovers and friends, particularly in the intensive care units. Reason: These units are frequently limited to immediate family members, and friends and lovers are unduly hassled or even denied access. Recommendation: Local political groups could investigate how various ICUs handle this situation and if necessary, create political pressure to have these rules changed. 5) When possible, to have gay/lesbian staff identify themselves as gay/lesbian. Reason: If the AIDS patient is either gay/lesbian, there is nothing as comforting as knowing that your caregiver understands you in a way that few can. Recommendation: Healthcare givers should be made aware of how important this is to their patients whenever possible.

IN THE COMMUNITY: 1) Patients should have the option to have access with other AIDS patients. Reason: When you are scared, it is often very helpful to talk with someone who is experiencing similar emotions. There is also a power created in patients bonding that can greatly assist them in asserting their rights. Recommendation: Persons diagnosed should be asked if they would like to speak with other individuals with these illnesses, and if so, consenting

[Continued]

SHANTI, Continued

patient's phone numbers should be shared. Trained facilitators in the community with expertise in working with life-threatening illnesses can lead patient support groups. 2) Support services for lovers, friends, and family members are necessary. Reason: With so much focus on the patient, it is easy to forget the needs of those close to them. Recommendation: Trained facilitators in the community with expertise in working with life-threatening illnesses and its effect on loved ones can lead support groups. 3) Appropriate help with legal aid and insurance issues. Reason: Tests to diagnose, and treatment for these diseases are costly. Many do not have adequate insurance, and this concern creates high levels of stress at a time when it is important to be stress free. Recommendation: A referral list can be devised and given to patient (with packet on AIDS) at time of diagnosis. Perhaps local legal aid group would help in preparation of a current and responsive referral list. 4) Accurate reporting as to the diversity of who AIDS patients are. Reason: There are so many misconceptions as to the assumed lifestyle of these individuals. These are degrading to persons who like ourselves, are diverse in the amount of their sexual contacts, drug use, and health precautions. Recommendations: Whenever possible, to have the press interview these persons with such illnesses, particularly those who will shatter existing stereotypes, e.g., low drug users, persons in primarily monogamous relationships, non-gays, and women. 5) Persons with AIDS need to be treated as human beings, not "lepers." Reason: Because of the concern over these diseases being in some way sexually transmittable, many people recoil upon finding out that someone they know has AIDS. While this fear has to be dealt with, it is very isolating for someone who has a heightened need for emotional support. Recommendation: As people unafflicted with AIDS try to find sensitive, supportive friends to begin processing your fears, take comfort in knowing that no healthcare professional working with these patients have contracted the illness. Be honest with your friends who may have AIDS, but realize that they need you more than ever.

COMMUNITY NEEDS: 1) Accurate, current information about warning signs, risk factors, and prevention. Reason: There is growing concern in the community about what all this means for me. Current information will allay this fear, assist in early diagnosis, and possibly aid in prevention. Recommendation: The community should work together in getting this information out. Newspapers should donate regular free space. Places where people gather should have well displayed information. 2) Immediate referral access for medical evaluation and attention. Reason: It is taking too long; when someone finds a spot or symptom they get scared, they need to be seen soon. Recommendation: More cooperation between Physicians for Human Rights and crisis line centers. A core of people selected to organize a more siensitive and immediate referral system. 3) Community forums that will be held regularly to educate and provide current information. Reason: To lessen misconceptions and community panic. Recommendation: These forums should include knowledgeable medical persons, AIDS patients, and plenty of time to answer audience questions. 4) Educate community crisis line staff to the high fear level around these illnesses, and have appropriate referrals for them. Reason: This is a new phenomenon and one in which people working with the public have to be sensitive to the implications of. Recommendation: Qualified persons chosen to meet with crisis line supervisors and give classes around this issue. 5) Provide community support groups for persons dealing with fears of contracting AIDS and/or making lifestyle changes to prevent disease onset. Reason: If this syndrome increases and the causitive factor remains unknown, community fear will most likely increase. These groups would help keep this fear managable. Recommendation: Qualified persons chosen to facilitate such groups--perhaps to contract with city for funding. 6) Support groups for persons working directly with patients: doctors, nurses, counslors, etc. Reason: Fear level and personal grief level will be higher among this population, and having the most experience in working with these individuals they need to take extra caution in preventing burnout. Recommendation: Qualified persons chosen to facilitate such groups.

[The Shanti Project and the NCGSTDS invites your input and comments.]

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VIDEO PROJECT ON AIDS

The Sacramento Hepatitis B Project will soon begin addressing AIDS in addition to hepatitis. One of the first projects that will be accomplished is a vidotape presentation on AIDS, expected to be completed June 1, 1983. For more information, contact Ken Brock, MSW, Coordinator, Hepatitis B Project, PO Box 140486, Sacramento, CA 95816 (916/453-8995).

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SEATTLE GAY COMMUNITY FORUM & BENEFIT FOR AIDS

Hunter Handsfield, MD, Doug Aklmon, PhD, Ann Collier, MD, Tom Marsella, MD, and Tim Burak were featured speakers and discussants at a recent open forum on AIDS called, "Keeping Our Gay Community Healthy." AIDS' impact on gay cultural mores (e.g., sexual repression, anonymous sex) and development of healthy alternatives were discussed, as well as physical and psychological aspects of the syndrome. The workshop helped to initiate an ongoing effort to help resolve the potential crisis in our health, and to work with those who are now suffering its serious personal effects. Money was raised for the Seattle Gay Clinic and the Seattle Counseling Service, for AIDS programming and services.

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MMWR REPRINTS IN NEWSLETTER

Several reprints from recent Morbidity & Mortality Weekly Reports (MMWR) from the CDC are included in the back of this Newsletter, and should bring you up to date on the AIDS crisis.

Nov. 5, 1982. AIDS: Precautions for Clinical & Laboratory Staffs
Nov. 12: Cryptosporidiosis: Assessment of chemotherapy of males with AIDS
Dec. 10: Update on AIDS among patients with hemophilia A
Dec. 10: Possible transfusion-associated AIDS--California
Dec. 17: Unexplained immunodeficiency & opportunistic infections in infants

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NEWS FROM AAPHR: AIDS DISCUSSED IN BOSTON; FEBRUARY MEETING IN HONOLULU
by Lary Abramson

Gay and Lesbian Physicians of New England (GALPONE) wined, dined, and "shined" for the October meeting of the American Association of Physicians for Human Rights (AAPHR) in Boston. The two day meeting and symposium on the "state of the art" in AIDS, KS, and the hepatitis B vaccine was made especially enjoyable by several cocktail parties hosted by the hospitable members of GALPONE.

Five scientific points were stressed throughout the meeting: 1) A firm diagnosis of AIDS requires the presence of a clinical illness (weight loss, fever, or an opportunistic infection) plus a persistant decrease in the absolute number of helper T-cells. This mandates a total lymphocyte count and evidence of a helper/suppressor ratio of less than 1.0. It must be noted that at any given time, 80% of controls have a reversed H/S ratio due to various internal and/or external environmental factors such as viremia. Thus "routine," "one-shot" determination of H/S ratios is useless in making a positive and correct diagnosis of AIDS. 2) The "generalized lymph node syndrome:" Five of 50 cases investigated in New York by Roger Enlow, MD, developed KS in less than 18 months. None of the San Francisco cases investigated by Don Abrams, MD, developed KS during a 2½ year follow-up period. Drs. Enlow and Abrams are currently collaborating in an effort to resolve the reason(s?) for this discrepancy. The present theory is that the "incubating pool" has existed for a longer period of time in NYC. 3) Opportunistic infections: The mortality rate in those cases which were diagnosed prior to June 1, 1981, has now reached 75%. 4) Hepatitis B vaccine: It is the opinion of all researchers that there is no reason to fear dissemination of AIDS or KS from the vaccine. The vaccine is made from the surface antigen and not the virus itself. The three-step inactivation process eliminates all known viruses, including the slow viruses. 5) The "gay plague"

(continued)

NEWS FROM AAPHR, Continued

concept is to be deplored and discouraged. The suggestion that these diseases are other than sexually transmitted is causing severe anxiety in gay men, particularly in those without ready access to the more detailed information increasingly available in the gay press. It must be understood that they are virtually certainly STD's having multiple causes, and that the same preventive measures will be found effective in curbing their transmission as are effective in reducing the risk of acquiring such old stand-bys as N. gonorrhea.

AAPHR's role is seen to be that of coordinating the national effort to define the ultimate etiology(ies) of AIDS, and to discover effective means of treating them. These and other issues will be highlights of the mid-winter meeting of the general board and members, scheduled for Honolulu, Hawaii, February 13-21, 1983. This meeting will include an educational program and update on AIDS as well as provide a "retreat atmosphere" for the Board and members to plan the directions of the organization and focus for issues confronting gay and lesbian health care. AAPHR's Administrative Assistant, Doug Carner, is pursuing travel arrangements to provide a "package deal" in order to keep costs down. For further information, contact: Doug Carner, AAPHR, P.O. Box 14366, San Francisco, CA 94114 (415/673-3189).

The NCGSTDS is attempting to compile a list of all physician/practitioner for human rights groups in North America. When addresses & phones are compiled, they will be published in the Newsletter. Already such groups exist in the following cities: San Francisco, San Diego, Philadelphia, Boston, Seattle, Dayton, Toronto, Montreal, New York, Washington, DC, Milwaukee, and Minneapolis. If you have any information about groups in these or other cities, please write to the NCGSTDS, POB 239, Milwaukee, WI 53201. Thanks!

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SCREENING FOR RISK OF AIDS

NCGSTDS members Frank Greenberg and Roger Enlow submitted the following letter to the editor of the New England Journal of Medicine (Volume 307:24, December 9, 1982, pp. 1521-22):

SCREENING FOR RISK OF ACQUIRED IMMUNE-DEFICIENCY SYNDROME

To the Editor: Acquired immune-deficiency syndrome (AIDS) is a disorder that has recently been noted among homosexual men, Haitians, and persons with hemophilia.[1-3] It is characterized by unusual malignant conditions, such as Kaposi's sarcoma, non-Hodgkin's lymphoma, and Burkitt's lymphoma, as well as by increased frequency and severity of opportunistic infections that require a cell-mediated immune response. The immunologic defects include altered ratios of certain T-cell subsets, with diminished numbers of helper-inducer T cells and apparently normal numbers of suppressor-cytotoxic T cells in the peripheral blood.[4,5] These phenotypic abnormalities have been recognized largely by monoclonal antibodies that detect certain cell-surface markers, which in turn have been associated with particular functional activities. Indeed, those functional activities are based on what may well be a limited insight into the full capacity of a particular phenotype for cellular immune function.

The commercial availability of these monoclonal reagents, together with the urgency of identifying persons who may be affected by AIDS, has prompted a number of laboratories throughout the country to offer T-cell phenotyping. It is implied that this is a known, standardized evaluation of the immune system and its functional state, capable of predicting the risk of AIDS and its complications. Such commercialized screening is inappropriate at this time.

The criteria for screening tests have been frequently discussed and should be heeded.[5-7] The test should be accurate, reliable, and reproducible, and its specificity and sensitivity should be known for accurate interpretation. As in various forms of genetic screening, the results need to be conveyed to the person being screened with careful, appropriate counseling so that the person may understand the results and their implications. Screening can only identify persons who may be at higher risk of disease, and further testing is necessary either to confirm that risk or to diagnose disease.

Data on T-cell phenotyping and function testing and their predictive value for AIDS are still being evaluated. Further research is urgently needed before the test should be used for clinical screening. The opportunism involved in providing premature, incomplete, and perhaps misleading solutions to this extraordinary and complicated problem must be discouraged, particularly when the social, psychological, and political implications may be at least as far-ranging as the medical aspects.

FRANK GREENBERG, M.D.
Houston, TX 77030 Texas Children's Hospital

ROGER W. ENLOW, M.D.
New York, NY 10003 The Hospital for Joint Disease

1. Update on Kaposi's sarcoma and opportunistic infections in previously healthy persons — United States. Morbid Mortal Weekly Rep. 1982; 31:294, 300-1.
2. Opportunistic infections and Kaposi's sarcoma among Haitians in the United States. Morbid Mortal Weekly Rep. 1982; 31:353-4, 360-1.
3. *Pneumocystis carinii* pneumonia among persons with hemophilia A. Morbid Mortal Weekly Rep. 1982; 31:365-7.
4. Fauci AS. The syndrome of Kaposi's sarcoma and opportunistic infections: an epidemiologically restricted disorder of immunoregulation. Ann Intern Med. 1982; 96:777-9.
5. Enlow RW, Mathur U, Mildvan D, et al. An acquired immune deficiency syndrome (AIDS) complicated by lymphadenopathy and Kaposi's sarcoma in a group of gay men — a prospective study. Lancet. (in press).
6. Wilson JMG, Junger G. Principles and practice of screening for disease. Geneva: World Health Organization, 1968. Public Health Papers no. 34.
7. Committee for the Study of Inborn Errors of Metabolism. Genetic screening: procedural guidance and recommendation. Washington, D.C.: National Research Council, 1975.
8. Galen RS, Gambino SR. Beyond normality: the predictive value and efficiency of medical diagnoses. New York: John Wiley, 1975.

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REPORT ON ACTIVITIES IN NYC REGARDING AIDS

by Jack N. Doren, PhD, New York AIDS Network

[The following detailed series of reports on activities in New York City regarding AIDS was compiled by Jack Doren for the New York AIDS Network and the NCGSTDS Newsletter. His reports will be a regular feature in the AIDS section of the Newsletter.]

The following is a report on activities in NYC regarding AIDS. It follows guidelines set in Dallas at the First AIDS Forum for dissemination of local information nationally to facilitate communication exchange between local areas and to know what each is doing and how each is meeting this health challenge. This list of activities and groups is not complete, but supplements will follow in subsequent Newsletters.

N.Y.C. Surveillance of AIDS & Related Diseases From May-Nov. 17, 1982

Following the month is the number of reported cases/number of diagnosed cases (this reflects the number of cases determined by date of primary diagnosis--i.e., first chronological diagnosis; does not include updates of subsequent diagnosis). May, 1982--29 reported/23 diagnosed; June--41/37; July--40/25; August--44/25; September--33/33; October--41/31; and November (through 11/17)--30/8.

Through November 17, 1982, there were 157 male and 1 female cases of Kaposi's sarcoma; 167 male and 17 female cases of pneumocystis carinii pneumonia; and 77 male and 6 female cases of other opportunistic infections without KS or PCP. There were 401 total men and 24 women cases.

Sixty-nine percent of the male cases were homosexual (275); 17% of the men were heterosexual (69); 9% were bisexual (36); and 5% had unknown sexual orientation (21); in contrast, none of the women cases were lesbian or bisexual; 92% of the women were heterosexual (22); and 8% of the women had an unknown sexual orientation (2).

N.Y. AIDS Network

Roger Enlow, Coordinator
Dept. of Rheumatology
Hospital for Joint Diseases/Orthopedic Institute
301 East 17 Street
New York, NY 10003
(212) 598-6516

Having begun several months ago, initially meeting at NGTF and presently at St. Marks Clinic, the Network meets every Thursday morning at 8. It is composed of representatives and heads of the various gay health or health related organizations in NYC, including the Gay Men's Health Crisis, Committee on Gay Concerns of the New York State Psychological Association, New York Physicians for Human Rights, American Association of Physicians for Human Rights, Association of Gay Psychologists (National), New York Association of Gay & Lesbian Psychologists, National Gay Task Force, St. Mark's Clinic, Gay Men's Health Project, and also community representation including the Gay Synagogue, and also AIDS Network committees, including the Scientific Review Committee, and also the NYC Dept. of Health.

The purposes include:

1. to provide a forum for communication amongst various aspects of the gay health community in NYC, so as to coordinate efforts, etc.;
2. to provide a forum for communication between the gay health community and the Dept. of Health of NY, and through the latter, other branches of city and federal government;
3. to provide a mechanism for collectively and effectively responding to AIDS related emergencies (i.e., the current blood issue);
4. to create, as needed, committees to provide services as needed, such as the Scientific Review Committee.

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NYC AIDS REPORT, Continued

Scientific Review Committee of the NY AIDS Network

Alan R. Kristal, Chair
316 West 75 Street, #4C
New York, NY 10023
(212) 580-2562

Formed in Oct., '82, members include a clinical immunologist, a research immunologist, a primary care physician, a clinical psychologist, psychiatric epidemiologist, and an epidemiologist. The group was formed in response to the inadequate research on the social and behavioral aspects relevant to AIDS among gay men. The group functions as an interface between the existing medical research establishment and the gay community. There are presently three main functions:

1. assist in the development of research protocols, specifically measurement of gay sexual and social behavior;
2. interpretation of results from research on gay sexual and social behavior;
3. interpretation of scientific data for the gay community and foundation of scientifically valid public health recommendations.

Initial activities include:

1. worked with Irving Selikoff on a major prospective epidemiologic study;
2. worked with CDC on the active surveillance program for AIDS - NYC;
3. preparing letters for New England Jnl. of Medicine, and the American Jnl. of Public Health;
4. has established ongoing functional relationship with NYC Dept. of Health.

The overall function of the SRC is to maintain input with the presence of professionally qualified gay men in AIDS research.

New York City Dept. of Health

David Sencer, Commissioner
c/o Jim Monroe
125 Worth Street, Rm. 328
New York, NY 10013
(212) 566-3630

The Dept. of Health:

1. conducts a surveillance, compiled monthly, of AIDS and related diseases in NYC; *(see section on "NYC Surveillance")*
2. has received a $100,000 contract from the federal govt. for next year, so now additional staff can be hired, along with backup services in laboratories in the area of clinical immunology;
3. functions as convenor and host for Clinical Research Investigators Meeting *(see section thusly labeled)*, a monthly meeting of researchers in this area;
4. is represented on the national committee that is dealing with blood products;
5. is working with federal Social Security Administration's regional office re the criteria that would make AIDS patients eligible for such - helping them to become aware of problems in identifying qualifications for disability, and their non-familiarity with the terms we are dealing with;
6. Seeing if city space can be found for counseling, etc., including GMHC and St. Mark's Clinic needs. Space has been offered, but found to be inadequate by GMHC; DOH has agreed to speak to appropriate city officials to clarify space needed;
7. has agreed to develop a catalogue of services and resources available in NYC to AIDS persons; and
8. invited heads of depts. of pediatrics to a meeting on AIDS, held on 15 Dec., to apprise them of AIDS and familiarize them with the syndrome. This was in part so that the diagnosis of AIDS is not inappropriately used as a catch-all term for children who are ill.

Further, David Sencer once a month, and Jim Monroe weekly, attend the NYC AIDS Network meetings, updating the group on DOH's activities to date, and providing the latest NYC surveillance statistics. (Continued)

NYC AIDS REPORT, Continued

Intergovernmental Committee on AIDS and Related Problems

David Sencer, NYC Commissioner of Health, chair
c/o Jim Monroe

125 Worth St., Rm. 328
New York, NY 10013
(212) 566-3630

Meetings are held on the second Tuesday of each month at the Dept. of Health Commissioner's office. The first meeting of this committee was held on 14 December 1982, and is composed of high level officers of the DOH, the Dept. of Mental Health, the Health Resources Administration (HRA), Manhattan Borough President's Office, Health & Hospitals Corp, and the gay community represented by NYC AIDS Network & Gay Men's Health Crisis.

One week prior to each meeting, members will be contacted by phone by Jim Monroe of the DOH/CDC on which issues should be addressed on the agenda. The December 14 meeting was designed to set up procedural operations of the committee. In addition to several of the points listed under the *New York City Dept. of Health* section, which were decided at this meeting, HRA has assigned a specific contact person to expedite claims for assistance by AIDS persons. This person, a Mr. Alocca, is assigned to work with GMHC.

Clinical Research Investigators Meeting

David Sencer, NYC Commissioner of Health, chair
c/o Jim Monroe

125 Worth St., Rm. 328
New York, NY 10013
(212) 566-3630

Meeting once a month on the last Wednesday of each month, this meeting consists of 50 - 100 researchers in the area of AIDS and related diseases. These meetings, hosted by the NYC Dept. of Health, are designed as arenas for communication among these researchers, and include presentation of the latest CDC surveillance statistics.

Gay Men's Health Crisis, Inc.

Mel Rosen, Executive Director

Box 274
132 West 24th Street
New York, NY 10011
(212) 807-6655 (executive offices)
(212) 685-4952 (hotline)

Having begun about a year and a half ago, this is a NYC organization created specifically to deal with AIDS and the opportunistic infections associated with it. In these efforts, GMHC functions in the following areas: 1. Education - to disseminate information to the gay community, and to function as a resource regarding information on AIDS to the general public. This is accomplished through:

a. Newsletter (free, the second edition of which is expected to be available in early Jan., '83) for, but not limited to, the gay community;
b. Brochure (free) - "What You Should Know About our Health Emergency" - single page flyer with basic AIDS symptoms, and recommendations;
c. Lectures for health professionals
d. Open Forums - lectures for the gay community by health professionals.

2. Patient & Individual Services
a. Hotline - available 24 hrs/day (with message machine when when not personally staffed).

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NYC AIDS REPORT, Continued

b. Crisis Intervention - approximately 45 crisis intervention counselors who are laypersons trained by physicians and psychologists. Upon diagnosis, the physician gives the individual the phone # for GMHC, and someone gets back to them within 12 hours. The CIC remains assigned to the patient until referral to a group.
c. Groups - There are 3 types of groups: (1) AIDS group
(2) KS group
(3) "Significant other" group.

There is no fee for any group, and all are led by psychologists, psychiatrists, and social workers.
d. Buddy System - This includes hospital attendance service, and subsequent cooking, cleaning, and general "taking care of you" services.
e. Financial Aide Dept. - Have contacts in the welfare dept. who will "zip you into the welfare system".

3. Funding - including that for research, and for various AIDS-related efforts by gay professional/political community.
4. Political Lobbying

Next major fundraising event: Ringling Brothers Barnum & Bailey Circus at Madison Square Garden. All 17,597 tickets have been bought out by GMHC for Sat., April 30, 1983. For tickets, write to GMHC with check or MC or Visa # & exp. date, or call (212) 807-7517.

Committee on Gay Concerns of the New York State Psychological Association

Hal Kooden, Chair

154 8th Avenue, #2
New York, NY 10011
(212) 243-3582

Having been created in the Fall, '82, meetings of this 6-person committee occur monthly at the NYSPA offices. Also attending is the Exec. Dir. of NYSPA and the Chair of its Legal/Legislative Committee.

A main function of CGC to to try to develop a conduit for psychologists to become involved in AIDS issues and needs, by:
1. bringing psychologists into the situation, and
2. developing a means for psychologists to get involved in the gay community without having to come out publicly.

Specifically, activities and goals include:
1. trying to get psychologists to donate time in supervision, training, and therapy for AIDS people or people working with AIDS people;
2. has invited the psychologist on the Scientific Review Committee of NY AIDS Network (Elliot Rutter) to come to the next meeting as liaison to see how they can work together;
3. has invited head of clinical services for Gay Men's Health Crisis (Ken Wien) to attend next meeting to see how CGC and be of use in linking more psychologists directly into the GMHC psychological support system;
4. Hal Kooden has been appointed to the Intergovernmental Committee on AIDS;
5. to have input in MYSPA's newsletter regarding AIDS to let people know of community resources;
6. contacting various named researchers in the field of sexuality in efforts to obtain funding and research.

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NYC AIDS REPORT, Continued

National Gay Health Education Foundation, Inc.

Ron Vachon, Exec. Director — 506 West 42 Street, #5E
Paul Paroski, Chairperson, Bd. of Directors — New York, NY 10036 (212) 563-6313

The NGHEF presently has two main functions regarding AIDS:

1. organizing and cosponsoring the 2nd National AIDS Forum. This will occur during the weekend of June 8 - 12, 1983 in Denver, and will be part of the 5th National Gay Health Conference;
2. The 3rd edition of the National Gay Health Directory will include a separate AIDS Resources section, which will include the major referral institutions (not pvt. health care individuals) for AIDS and individuals at institutions, categorized according to state and city. These facilities are either taking referrals or provide referrals to such for AIDS. Expected publishing date is January, '83. (Copies can be ordered through NGHEF, POB 834, Linden Hill, NY 11354, with checks for $5.00/copy and $1.35/order for handling and postage made out to NGHEF or "The Health Fund".) Copies will be available at the National Gay Health Conference in June.

National Gay Task Force

(included because of its NYC base and its active involvement in the NY AIDS Network)

Ginny Apuzzo, Executive Director — 80 Fifth Avenue
John Boring — New York, NY 10011
Kevin Berrill — (212) 741-5800

NGTF is taking an active role in coordinating political aspects of AIDS. When needed, they will make connection with the gay professional health community, getting their input regarding specific issues, and connect that where appropriate, such as the political machinery, media, etc. Included in their plans is making contact with the various mayoral liaisons to the gay communities across the country, making them aware of the current issues and status regarding AIDS that they will have to be dealing with, and to thereby coordinate a political response. This will begin after 1 Jan.

AIDS Hotline (NY State, Alaska, Hawaii--212/807-6016; All Other States--800/221-7044)

Initiated on 6 Oct., '82, 550 calls have been received through 9 Dec. (3 in October, 248 in November, and 299 in the first 9 days of December). Calls have been from 38 states, 1/3 have been from women. NATURE OF CALLS:

- 47% - want information only
- 28% - reported having symptoms
- 7% - from health workers, including physicians & nurses attending AIDS persons, requesting information
- 9% - from friends or relatives of gay men who have AIDS or who have questions regarding such
- 9% - unclassified (because of the volume of recent calls)

NATURE OF RESPONSE

- 100% - given practical information
- 24% - referral to local AIDS projects
- 12% - if more information was needed but no local AIDS project existed, info. was provided on how to find a local board certified non-homophobic medical provider.
- 25% - sent GMHC Newsletter (approx. 1500 copies, obtained through the Fund for Human Dignity), or their names put on GMHC mailing list.

GMHC has been providing on the last few Wed's. 2-3 volunteers to helf staff the hotline. NGTF also keeps a national directory listing 30 medical facilities (not pvt. physicians) that deal with AIDS.

Also, NGTF is represented at NY AIDS Network meetings by Ginny Apuzzo, John Boring, and by Kevin Berrill, who attends each week.

(Continued)

NYC AIDS REPORT, Continued

Report on an Invitational Briefing by William Foege, Director, Centers for Disease Control, Atlanta
Monday, 6 December 1982
Washington, D.C.
Arranged through American Public Health Association by Tim Westmoreland and Laurence Deyton for significant interest groups, congressional aides, and lobbyists.

(report prepared by Jack N. Doren for the N.Y. AIDS Network)

"We think this is a new problem. If it existed before, it must have existed at such a low level that it really wasn't detectable and therefore was not a public health problem. We are talking about an epidemic of an immune deficiency that inhibits proper response to a number of diseases."

"We now have 788 known cases in less than 18 months with about 300 deaths." The death rate has been approximately 40% - far higher than [that from toxic shock or the] first Legionnaires' outbreak.
That 40% is probably a minimum figure. This will continue to get higher - for cases diagnosed in 1981 or before , the death rate is already in excess of 60%. "In fact, we do not know of any people who have had a reversal in the basic immunologic defect. We don't know of anyone who has ever had this immunologic defect that has then [regained immunologic competence]." One goes "from one infection to the next, and when people get over that infection they are still vulnerable to the next problem."

Dr. Feoge then reviewed past theories - drugs, sperm - then stating that subsequent data have tended to support the theory of a transmissible agent/ virus and weaken other theories. There are 4 basic groups afflicted with AIDS:

1. Gay men
2. IV drug users (which would support both the infectious agent and/or drug usage theories)
3. Haitians (which would be compatible with the transmissible agent theory, but not at all with drug usage)
4. Hemophiliacs (1 case of AIDS/1000 hemophiliacs, "which is an extremely high rate".)

95% out of all cases we know of fall under those 4 categories.

The other 5%:

1. children of Haitians or children of IV drug users. There are 15-20 such cases. The difficulty is in defining whether these are AIDS cases or not.
2. heterosexual contacts of AIDS cases. "This is not exclusively a homosexual problem." 2-3 such cases.
3. 3 cases of AIDS where there were not other known risk factors but these 3 people in the past did receive blood transfusions.
   One of the 3 is a 20 month old child who received blood from a male donor who "was healthy at the time the blood was donated. He (the donor) did not develop AIDS symptoms until 8 months after he had donated the blood. That would all tend to strengthen the theory that the virus is not present necessarily at the time people get sick, but it is present some months before they get sick, which is part of the explanation of why it's so hard for us to isolate a virus. By the time we know whom to study, the virus is already gone." The donor has subsequently died.

(Continued)

NYC AIDS REPORT, Continued

NATIONAL SURVEILLANCE -- As of 1 December 1982 -- Domestic cases

Number of cases: 788
Number of deaths: 295 (The first death that we can determine from AIDS - Dec '7
"There are in addition some 13 other countries that have reported AIDS cases. That number will certainly go up" as other countries develop surveillance systems.

Most cases are 25 - 49 years old, and are previously healthy people. 95% are male. About 75% are homosexual or bisexual. ½ are in New York State, with about 20% in California, "but we're gradually getting more and more cases in other areas, particularly with the hemophiliac cases...Over 30 states have reported AIDS cases."
During the last 6 months of 1981 - 1 case/day was reported.
During the last 6 months of 1982 - in excess of 2 cases/day is being reported

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"The theory that seems to fit the facts best is that this is a transmissible agent, that it's probably a virus, that it has epidemiology very similar to hepatitis B. Is it a new virus or an old virus that has changed? I think that there are some interesting facts that have come up in the last year that might shed some light on this. It might be a new virus. ... But it could also be an old virus that has been changed in character, not necessarily by mutation, but in the last year we have had an outbreak of something that has been called a delta agent - an outbreak of hepatitis in S. America that was much more severe than usual and resulted in a high mortality rate. ...Delta agent is a subviral particle that can do nothing on its own even if it gets into a cell. The only way it can achieve immortality is to be fortunate enough to link on to a hepatitis B virus, and with that virus go into a cell and it changes hepatitis B virus, and the hepatitis B virus changes the workings of the cell. So people with delta agent won't get sick; people with hepatitis B get hepatitis B; people with both delta agent and hepatitis B end up with a severe hepatitis and a high mortality. It may be that AIDS is a common virus with something like this being linked onto it. We don't know."

Procedures for Diagnosing AIDS - knowledge from research

Presently, complex immunologic studies are needed for diagnosis. However, "we can characterize some chemical changes in lymph nodes of people with AIDS that is not found in any other disease that we know of. There are also some antibody/antigen complexes being discovered, and I think that's the first step to finding the trail that the virus leaves behind and a way of identifying people who may have had contact with the virus in the past. So I'm encouraged that we're coming closer to being able to identify some of the people who have the disease without doing the complex immunologic studies."

Statement of CDC commitment

NIH estimates that they spent over $3 million on AIDS last year. CDC spent in excess of $2 million. "All I can do is reassure you that whether or not we get money specifically tagged for AIDS, we will continue to regard this as a serious epidemic that we will do our best to try to come up with a cause and then a solution. We hope within the next few weeks in the MMWR to put together some interim guidelines on our best estimates of what people could do to reduce their risk. That's going to be hard to put out because we'll be saying things like reduce your sexual contacts and see if there are barriers that can be put up, such as the use of condoms, but we'll do our best to come out with what seems to make sense at the present time."

(Continued)

NYC AIDS REPORT, Continued

QUESTION & ANSWER PERIOD (partial listing)

Q: "Do you always find AIDS to be fatal?"

A: "We do not know of anyone that's had a reversal in the basic problem, and I would be careful not to say that it's always fatal because I don't know that that's true, and I think that there's always a possibility we'll come up with better treatment mechanisms."

"I think that this is the most complex epidemic that we've ever dealt with, and it's a serious epidemic. It involves young people. It prolongs devastating illness with no good therapeutic possibilities now, and we simply have to see it as a frontrunner."

Roger Enlow, M.D.: "Speaking as a clinical investigator and research immunologist, there have been very few events in modern history, medical history in particular, that would measure up to its complexity, or the value long range in terms of understanding our fundamental selves, immunologically, and our relationship to our environment."

Q: "Is it possible to prevent the highest [risk] groups from giving blood?"

A: "I think it will depend on whether the 3 cases we are investigating now, that we could really tie these to bloodgiving. For instance, the child that apparantly has AIDS, where receiving platelets from a donor who subsequently developed AIDS - that man evidently gave another unit of blood. If we're able to demonstrate a second case someplace that could have resulted from either of those 2 donations - I think that strengthens the case of a virus spread through blood-products to the point where you have to state this is real. Or if we are able to demonstrate this in the other 2 cases. If that happens, then I don't know of any way to screen donors, and I think instead what we would do is end up looking at what are the risks of donation and appeal to people in high risk groups not to donate blood until we have a way of screening. At some point I would guess just as with hepatitis we will have a screening technique to look at the unit of blood, not for screening the individual. That would really simplify this. But until that time, if we become definitely convinced that this is a blood-borne agent, then I think that what we would do is appeal to certain groups."

Review of Legislation for Appropriation of Funding for AIDS - presented by Tim Westmoreland, Ass't. Counsel, Subcomm. on Health & the Environment, House of Representatives. Congressman Waxman, Chair.

"Last April our subcommittee held an oversight hearing on AIDS and what is known about it now and we talked about the money that was needed to investigate AIDS adequately. The NIH program has to be reauthorized this year and our committee also[used] fairly strong[language] asking NIH to investigate what every research scientist that I've talked to has said is the next Nobel prize for cancer."

"In the supplimental which Mr. Reagan vetoed but which was eventually everridden, the Senate had added $500,000 to CDC's appropriation to allow it to do extra AIDS investigation, and that was agreed to by the House. And now this time the House appropriations bill past last Wednesday has an amendment in it adding 2.6 million to CDC's appropriations to do preventive health services, especially AIDS. The Senate is working on that appropriations bill now. ...We're being deluged with major medical institutions who are interested in appropriations..."

* * * * (END)

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Spectinomycin-Resistant *Neisseria gonorrhoeae* — Worldwide

Until recently, only eight isolates of spectinomycin-resistant *Neisseria gonorrhoeae* had been reported worldwide; four were penicillinase-producing *N. gonorrhoeae* (PPNG), and four were non-PPNG (*1*). During the last 4 months, however, six additional isolates of spectinomycin-resistant gonococci have been identified and reported. Available details on these cases highlight the potential magnitude of the problem.

Non-PPNG case: A 21-year-old U.S. airman stationed at Osan Air Force Base, Republic of Korea, was seen at the Osan hospital clinic July 20, 1982, with a 3-day history of purulent urethral discharge that began 3 days after sexual exposure to a prostitute. A Gram stain was consistent with gonorrhea, and he was treated with spectinomycin 2 g intramuscularly (IM). Cultures of the discharge grew beta-lactamase-negative *N. gonorrhoeae* susceptible to penicillin and spectinomycin.

On July 27, the patient returned for a scheduled test of cure. He remained symptomatic with purulent urethral discharge on examination, and the gram-stain smear was again consistent with gonorrhea. He was given 4 g of spectinomycin IM. Cultures of the urethral exudate grew beta-lactamase negative *N. gonorrhoeae* susceptible to penicillin but resistant to spectinomycin.

Symptoms persisted until July 30, when the patient was hospitalized for further evaluation and definitive therapy. A gram-stain smear was still consistent with gonorrhea. Urethral cultures were positive for *N. gonorrhoeae* susceptible to penicillin but resistant to spectinomycin. He was given 4.8 million units of procaine penicillin IM and 1 g of probenecid orally. His symptoms resolved, and cultures of post-treatment urethral specimens were negative.

PPNG cases: Since a September 17 report (*1*), five additional cases of infection with PPNG resistant to spectinomycin have been reported. A spectinomycin-resistant PPNG isolate was obtained in Detroit from a 25-year-old male whose last sexual exposure was to a 30-year-old female in London between July 23 and August 7, 1982. A pretreatment isolate on September 8 was beta-lactamase negative and susceptible to penicillin and spectinomycin. Treatment with tetracycline, followed by ampicillin and probenecid, did not cure the infection. Subsequent urethral cultures grew beta-lactamase-positive, spectinomycin-resistant *N. gonorrhoeae*. The patient was successfully treated with cefotaxime 1 g IM.

Two cases were reported from London in males aged 30 years and 23 years (*2*); Asian-type plasmids were found in both. Two other cases have recently been reported to the Venereal Disease Reference Laboratory in London (*3*).

Reported by AJ Patefield, MD, USAF Hospital, Osan, Korea; WG Westbrook III, MD, USAF Hospital, Yokata, Japan; NA Johnston, Venereal Diseases Reference Laboratory, London; Sexually Transmitted Diseases Laboratory Program, Center for Infectious Diseases, Venereal Diseases Div, Center for Prevention Svcs, CDC.

Editorial Note: Although still uncommon, seven apparently unrelated spectinomycin-resistant gonococcal infections have been identified since summer of 1982. Fourteen cases of spectinomycin-resistant gonorrhea (nine PPNG and five non-PPNG) have been noted worldwide since the first report in 1973 (*4*). Although the increase may reflect only improved surveillance, there is no evidence that surveillance has recently changed in London, where most of the cases have occurred.

The emergence of spectinomycin resistance could be the result of selection associated with increased use of spectinomycin worldwide. However, induction of resistance is another possibility. Pre-treatment isolates were susceptible to spectinomycin, but post-treatment isolates were resistant, emphasizing that resistance may emerge in a single treatment period.

Health care personnel should be aware that not all patients treated with spectinomycin will be cured of gonorrhea. Post-treatment cultures should be an integral part of patient management. All PPNG isolates and isolates from patients with positive cultures after spectinomycin therapy should be tested for spectinomycin susceptibility using a provisional disc-diffusion method (*4*). Patients should be treated with cefoxitin 2 g IM in a single injection plus

Neisseria gonorrhoeae — Continued

probenecid 1 g orally, or cefotaxime 1 g IM in a single injection (*5*).

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Acquired Immune Deficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs

The etiology of the underlying immune deficiencies seen in AIDS cases is unknown. One hypothesis consistent with current observations is that a transmissible agent may be involved. If so, transmission of the agent would appear most commonly to require intimate, direct contact involving mucosal surfaces, such as sexual contact among homosexual males, or through parenteral spread, such as occurs among intravenous drug abusers and possibly hemophilia patients using Factor VIII products. Airborne spread and interpersonal spread through casual contact do not seem likely. These patterns resemble the distribution of disease and modes of spread of hepatitis B virus, and hepatitis B virus infections occur very frequently among AIDS cases.

There is presently no evidence of AIDS transmission to hospital personnel from contact with affected patients or clinical specimens. Because of concern about a possible transmissible agent, however, interim suggestions are appropriate to guide patient-care and laboratory personnel, including those whose work involves experimental animals. At present, it appears prudent for hospital personnel to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis B virus infection, in which blood and body fluids likely to have been contaminated with blood are considered infective. Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin and mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS. The following precautions do not specifically address outpatient care, dental care, surgery, necropsy, or hemodialysis of AIDS patients. In general, procedures appropriate for patients known to be infected with hepatitis B virus are advised, and blood and organs of AIDS patients should not be donated.

The precautions that follow are advised for persons and specimens from persons with: opportunistic infections that are not associated with underlying immunosuppressive disease or therapy; Kaposi's sarcoma (patients under 60 years of age); chronic generalized lymphadenopathy, unexplained weight loss and/or prolonged unexplained fever in persons who belong to groups with apparently increased risks of AIDS (homosexual males, intravenous drug abusers, Haitian entrants, hemophiliacs); and possible AIDS (hospitalized for evaluation). Hospitals and laboratories should adapt the following suggested precautions to their individual circumstances; these recommendations are not meant to restrict hospitals from implementing additional precautions.

A. The following precautions are advised in providing care to AIDS patients:

1. Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material and to avoid contact of open skin lesions with material from AIDS patients.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / PUBLIC HEALTH SERVICE

Acquired Immune Deficiency Syndrome – Continued

2. Gloves should be worn when handling blood specimens, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.
3. Gowns should be worn when clothing may be soiled with body fluids, blood, secretions, or excretions.
4. Hands should be washed after removing gowns and gloves and before leaving the rooms of known or suspected AIDS patients. Hands should also be washed thoroughly and immediately if they become contaminated with blood.
5. Blood and other specimens should be labeled prominently with a special warning, such as "Blood Precautions" or "AIDS Precautions." If the outside of the specimen container is visibly contaminated with blood, it should be cleaned with a disinfectant (such as a 1:10 dilution of 5.25% sodium hypochlorite [household bleach] with water). All blood specimens should be placed in a second container, such as an impervious bag, for transport. The container or bag should be examined carefully for leaks or cracks.
6. Blood spills should be cleaned up promptly with a disinfectant solution, such as sodium hypochlorite (see above).
7. Articles soiled with blood should be placed in an impervious bag prominently labeled "AIDS Precautions" or "Blood Precautions" before being sent for reprocessing or disposal. Alternatively, such contaminated items may be placed in plastic bags of a particular color designated solely for disposal of infectious wastes by the hospital. Disposable items should be incinerated or disposed of in accord with the hospital's policies for disposal of infectious wastes. Reusable items should be reprocessed in accord with hospital policies for hepatitis B virus-contaminated items. Lensed instruments should be sterilized after use on AIDS patients.
8. Needles should not be bent after use, but should be promptly placed in a puncture-resistant container used solely for such disposal. Needles should not be reinserted into their original sheaths before being discarded into the container, since this is a common cause of needle injury.
9. Disposable syringes and needles are preferred. Only needle-locking syringes or one-piece needle-syringe units should be used to aspirate fluids from patients, so that collected fluid can be safely discharged through the needle, if desired. If reusable syringes are employed, they should be decontaminated before reprocessing.
10. A private room is indicated for patients who are too ill to use good hygiene, such as those with profuse diarrhea, fecal incontinence, or altered behavior secondary to central nervous system infections.

Precautions appropriate for particular infections that concurrently occur in AIDS patients should be added to the above, if needed.

B. The following precautions are advised for persons performing laboratory tests or studies on clinical specimens or other potentially infectious materials (such as inoculated tissue cultures, embryonated eggs, animal tissues, etc.) from known or suspected AIDS cases:

1. Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting should not be allowed.
2. Needles and syringes should be handled as stipulated in Section A (above).
3. Laboratory coats, gowns, or uniforms should be worn while working with potentially infectious materials and should be discarded appropriately before leaving the laboratory.
4. Gloves should be worn to avoid skin contact with blood, specimens containing blood, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.

Acquired Immune Deficiency Syndrome — Continued

5. All procedures and manipulations of potentially infectious material should be performed carefully to minimize the creation of droplets and aerosols.
6. Biological safety cabinets (Class I or II) and other primary containment devices (e.g., centrifuge safety cups) are advised whenever procedures are conducted that have a high potential for creating aerosols or infectious droplets. These include centrifuging, blending, sonicating, vigorous mixing, and harvesting infected tissues from animals or embryonated eggs. Fluorescent activated cell sorters generate droplets that could potentially result in infectious aerosols. Translucent plastic shielding between the droplet-collecting area and the equipment operator should be used to reduce the presently uncertain magnitude of this risk. Primary containment devices are also used in handling materials that might contain concentrated infectious agents or organisms in greater quantities than expected in clinical specimens.
7. Laboratory work surfaces should be decontaminated with a disinfectant, such as sodium hypochlorite solution (see A5 above), following any spill of potentially infectious material and at the completion of work activities.
8. All potentially contaminated materials used in laboratory tests should be decontaminated, preferably by autoclaving, before disposal or reprocessing.
9. All personnel should wash their hands following completion of laboratory activities, removal of protective clothing, and before leaving the laboratory.

C. The following additional precautions are advised for studies involving experimental animals inoculated with tissues or other potentially infectious materials from individuals with known or suspected AIDS.

1. Laboratory coats, gowns, or uniforms should be worn by personnel entering rooms housing inoculated animals. Certain nonhuman primates, such as chimpanzees, are prone to throw excreta and to spit at attendants; personnel attending inoculated animals should wear molded surgical masks and goggles or other equipment sufficient to prevent potentially infective droplets from reaching the mucosal surfaces of their mouths, nares, and eyes. In addition, when handled, other animals may disturb excreta in their bedding. Therefore, the above precautions should be taken when handling them.
2. Personnel should wear gloves for all activities involving direct contact with experimental animals and their bedding and cages. Such manipulations should be performed carefully to minimize the creation of aerosols and droplets.
3. Necropsy of experimental animals should be conducted by personnel wearing gowns and gloves. If procedures generating aerosols are performed, masks and goggles should be worn.
4. Extraordinary care must be taken to avoid accidental sticks or cuts with sharp instruments contaminated with body fluids or tissues of experimental animals inoculated with material from AIDS patients.
5. Animal cages should be decontaminated, preferably by autoclaving, before they are cleaned and washed.
6. Only needle-locking syringes or one-piece needle-syringe units should be used to inject potentially infectious fluids into experimental animals.

The above precautions are intended to apply to both clinical and research laboratories. Biological safety cabinets and other safety equipment may not be generally available in clinical laboratories. Assistance should be sought from a microbiology laboratory, as needed, to assure containment facilities are adequate to permit laboratory tests to be conducted safely.

Reported by Hospital Infections Program, Div of Viral Diseases, Div of Host Factors, Div of Hepatitis and Viral Enteritis, AIDS Activity, Center for Infectious Diseases, Office of Biosafety, CDC; Div of Safety, National Institutes of Health.

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Cryptosporidiosis: Assessment of Chemotherapy of Males with Acquired Immune Deficiency Syndrome (AIDS)

Since December 1979, 21 males with severe, protracted diarrhea caused by the parasite, *Cryptosporidium*, have been reported to CDC by physicians in Boston, Los Angeles, Newark, New York, Philadelphia, and San Fransisco. All 21 have acquired immune deficiency syndrome (AIDS); 20 are homosexual; and one is a heterosexual Haitian. Their ages range from 23 to 62 years with a mean of 35.7 years. Most had other opportunistic infections or Kaposi's sarcoma in addition to cryptosporidiosis. Eleven had *Pneumocystis carinii* pneumonia (PCP); nine had Candida esophagitis; two had a disseminated *Mycobacterium avium-intracellulare* infection; one had a disseminated cytomegalovirus infection; and two had Kaposi's sarcoma. T-lymphocyte helper-to-suppressor ratios were decreased (< 0.9) in all 18 patients on whom this test was performed. Fourteen patients have died.

The illness attributed to *Cryptosporidium* was characterized by chronic, profuse, watery diarrhea. The mean duration of diarrhea was 4 months, often continuing until the patient's death. Bowel movement frequency ranged from six to 25 per day. The estimated maximum volume of stool during illness ranged from 1 to 17 liters per day with a mean of 3.6 liters per day. Diagnosis of cryptosporidiosis was made by histologic examination of small bowel biopsies (13 patients) or large bowel biopsies (four patients), or by stool examination using a sucrose concentration technique (16 patients) (*1*). More than one type of diagnostic method was positive for several patients.

Table 1 shows the drugs given to the 21 patients while they had diarrhea attributed to *Cryptosporidium*. Only two patients (9.5%) have had sustained resolution of their diarrhea with negative follow-up stool examinations. The first was being treated with prednisone (60 mg daily) for chronic active hepatitis at the time his diarrhea began. When cryptosporidiosis was diagnosed, he was started on diloxanide furoate (500 mg three times daily for 10 days), and the prednisone was tapered over 2 weeks and then stopped. Two weeks later, his diarrhea was improving; in another 2 weeks, his diarrhea had completely resolved. He has had no diarrhea for 8 months. Follow-up stool examinations 2 weeks and 6 weeks after discontinuation of diloxanide furoate were negative for *Cryptosporidium*.

The second patient, who also had a clinical and parasitologic response, subsequently died of PCP. In early February 1982, 6 months before his death, he had onset of watery diarrhea, and a small bowel biopsy showed *Cryptosporidium*. Treatment with furazolidone (100 mg four times a day) was initiated on May 5, and within 6 days, the patient had gained 1.1 kilograms (2.4 pounds); parenteral nutrition was discontinued, although he continued to produce a liter of watery stool each day. Ten days after treatment was started, his stools became formed for the first time in 4 months, but *Cryptosporidium* oocysts were still present. Furazolidone was increased to 150 mg four times daily. Twenty days after therapy was started (10

Cryptosporidiosis – Continued

days after the higher dose of furazolidone was begun), the patient had one bowel movement a day, but his stool was still positive for *Cryptosporidium* and remained positive despite continued use of furazolidone at 150 mg four times daily for a total of 2 months. At that time, two stool examinations failed to detect oocysts, and the furazolidone was stopped. One week later, the patient developed PCP; despite treatment with trimethoprim-sulfamethoxazole, he died 2 weeks later on July 22. An autopsy was not permitted.

After various treatment regimens, seven patients have had partial or transitory decreases in their diarrhea. Two received no anti-parasitic drugs. A third patient temporarily improved after treatment with furazolidone (100 mg orally four times a day for 7 days), although 2 weeks elapsed between the end of treatment with furazolidone and the onset of clinical improvement. The patient's diarrhea abated, but follow-up stool examinations remained positive for *Cryptosporidium*. Three months after furazolidone therapy, he again developed diarrhea, and his stools were positive for *Cryptosporidium*. Two patients had less diarrhea when given tetracycline. The first received tetracycline 500 mg orally four times a day for 4 months. His diarrhea decreased from 12 watery stools to three loose stools per day, but stool examination after 4 months of therapy still showed *Cryptosporidium*. The second patient, given the same treatment, also had a reduction in the number of stools. When the drug was discontinued, his diarrhea again increased.

TABLE 1. Drugs used to treat males with cryptosporidiosis and AIDS

Drug*	Dose and route of administration†	Number of patients	Unchanged n	Unchanged (%)	Improved§ n	Improved§ (%)	Cured¶ n	Cured¶ (%)
No treatment	—	2	0	(0.0)	2	(100.0)	0	(0.0)
Trimethoprim/ sulfamethoxazole	25 mg/kg QID of sulfamethoxazole	7	7	(100.0)	0	(0.0)	0	(0.0)
Trimethoprim/ sulfamethoxazole	800 mg PO BID of sulfamethoxazole	4	4	(100.0)	0	(0.0)	0	(0.0)
Furazolidone	100 mg PO QID	6	4	(66.7)	1	(16.7)	1	(16.7)
Furazolidone	300 mg PO QID	1	1	(100.0)	0	(0.0)	0	(0.0)
Metronidazole	750 mg PO TID	5	4	(80.0)	1	(20.0)	0	(0.0)
Metronidazole	750 mg IV TID	1	0	(0.0)	1	(100.0)	0	(0.0)
Pyrimethamine/ sulfa	25 mg PO per day of pyrimethamine	4	4	(100.0)	0	(0.0)	0	(0.0)
Diloxanide furoate	500 mg PO TID	3	2	(66.7)	0	(0.0)	1**	(33.3)
Quinacrine	100 mg PO TID	3	3	(100.0)	0	(0.0)	0	(0.0)
Diiodohydroxyquin	650 mg PO TID	2	2	(100.0)	0	(0.0)	0	(0.0)
Tetracycline	500 mg PO QID	3	1	(33.3)	2	(66.6)	0	(0.0)
Doxycycline	100 mg PO per day	2	2	(100.0)	0	(0.0)	0	(0.0)
Pentamidine	4 mg/kg IM per day	2	2	(100.0)	0	(0.0)	0	(0.0)
Chloroquine/ primaquine	500 mg PO per day of chloroquine	1	1	(100.0)	0	(0.0)	0	(0.0)

*Some patients received more than one drug.
†BID = twice daily; TID = three times daily; QID = four times daily; PO = orally; IV = intravenously
§Decrease in number of stools by at least 50%.
¶Absence of diarrhea for more than 2 weeks and stool examination negative for *Cryptosporidium*.
**Improvement temporally related to stopping prednisone.

Cryptosporidiosis – Continued

Two patients' diarrhea stopped following treatment with opiates and metronidazole, given orally in one case and intravenously in the other. Neither patient had diarrhea after a few days of treatment, but both died within 1 week, and autopsies were not allowed. The first patient died from suspected peritonitis; the second died with disseminated Kaposi's sarcoma and pneumonia.

The remaining 12 patients have had continuous, severe diarrhea. In addition to the drugs listed in Table 1, bovine-transfer factor has been given to one patient and intravenous gamma globulin to two patients; neither was effective. At present, 14 (66.7%) of the 21 individuals have died, and six are alive with persistent diarrhea. In no instance was cryptosporidiosis thought to be the direct cause of death, but the associated severe malnutrition was often considered a contributing factor.

Shortly before cryptosporidiosis was recognized in AIDS patients, investigators at the U.S Department of Agriculture National Animal Disease Center (NADC) began testing drugs for efficacy against *Cryptosporidium* in animals; results of these initial studies were published in February, 1982 (*2*). More recently, five additional drugs have been evaluated at the NADC. Calves or pigs up to 14 days old without infection were given the drugs orally twice daily. One day after the drugs were started, each animal received a single oral inoculation of *Cryptosporidium*. The following drugs (with doses in mg/kg/day) were tested: amprolium (10.7), difluoromethylornithine (1250) plus bleomycin (6 IM), diloxanide furoate (125.0), dimetridazole (19.0), ipronidazole (23.8), lasalocid (0.7), metronidazole (23.8), monensin (4.8), oxytetracycline (50.0), pentamidine (10.0), quinacrine (11.9), salinomycin (6.0), sulfaquinoxaline (200.0), sulfadimidine (119.0), and trimethoprim (4.8) plus sulfadiazine (23.8). Although small numbers of animals were tested in each treatment group, no drugs prevented fecal shedding of oocysts or reduced the number of *Cryptosporidium* seen on intestinal biopsies.

Reported by J Goldfarb, MD, H Tanowitz, MD, Albert Einstein College of Medicine, Bronx, R Grossman, MD, Medical Arts Center Hospital, C Bonanno, MD, D Kaufman, MD, P Ma, PhD, St. Vincent's Medical Center, R Soave, MD, New York Hospital-Cornell Medical Center, D Armstrong, MD, J Gold, MD, Memorial Sloan-Kettering Cancer Center, S Dikman, MD, M Finkel, MD, H Sacks, MD, Mt. Sinai Medical Center, R Press, MD, New York University Medical Center, D William, MD, St. Luke's-Roosevelt Hospital, S Friedman, MD, New York City Dept of Health, R Rothenberg, MD, State Epidemiolgist, New York State Dept of Health; S Brown, MD, United Hospitals, Newark, WE Parkin, DVM, State Epidemiologist, New Jersey State Dept of Health; EJ Bergquist, MD, Thomas Jefferson University Hospital, Philadelphia, CW Hays, MD, State Epidemiologist, Pennsylvania State Dept of Health; P Forgacs, MD, Lahey Clinic Medical Center, Burlington, L Weinstein, MD, Brigham and Women's Hospital, Boston, NJ Fiumara, MD, State Epidemiologist, Massachusetts State Dept of Public Health; D Busch, MD, San Francisco, M Derezin, MD, M Gottlieb, MD, J Matthew, MD, W Weinstein, MD, UCLA Center for Health Sciences, J Chin, MD, State Epidemiologist, California Dept of Health Svcs; H Moon, PhD, National Animal Disease Center, Ames, Iowa; AIDS Activity, Div of Parasitic Diseases, Center for Infectious Diseases, CDC.

Editorial Note: *Cryptosporidium* is a protozoan parasite; it is a well recognized cause of diarrhea in animals, especially calves, but has only rarely been associated with diarrhea in humans (*3*). Individuals with normal immune function who have developed cryptosporidiosis have

Cryptosporidiosis – Continued

self-limited diarrhea lasting 1-2 weeks, but immunosuppressed individuals have developed chronic diarrhea. An effective drug to treat cryptosporidiosis has not been identified, and the above reports are equally discouraging. Of seven patients who are still living, only one has no diarrhea at present. His recovery coincided with treatment with diloxanide furoate and discontinuation of prednisone. It seems unlikely that diloxanide furoate was responsible for his recovery, since three other patients who received the drug did not respond, and the drug was ineffective in experimentally infected pigs given nearly six times the recommended human dose. It is similarly difficult to be certain that improvement reported in other patients was due to the drugs they received because only a few patients receiving a drug responded, responses were brief, and the same or similar drugs were ineffective in preventing infection in experimental animals. The difficulty in interpreting isolated responses is underscored by the two patients who improved before any specific therapy began.

Since none of the drugs reported above appears clearly efficacious, additional tests of other anti-parasitic drugs in animals are needed. Until an effective drug for cryptosporidiosis is identified or the underlying immune deficiency in patients with AIDS becomes correctable, management of diarrhea due to cryptosporidiosis will continue to focus on supportive care.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Update on Acquired Immune Deficiency Syndrome (AIDS) among Patients with Hemophilia A

In July 1982, three heterosexual hemophilia A patients, who had developed *Pneumocystis carinii* pneumonia and other opportunistic infections, were reported (*1*). Each had in vitro evidence of lymphopenia and two patients who were specifically tested had evidence of T-lymphocyte abnormalities. All three have since died. In the intervening 4 months, four additional heterosexual hemophilia A patients have developed one or more opportunistic infections accompanied by in-vitro evidence of cellular immune deficiency; these four AIDS cases and one highly suspect case are presented below. Data from inquiries about the patients' sexual activities, drug usage, travel, and residence provide no suggestion that disease could have been acquired through contact with each other, with homosexuals, with illicit drug abusers, or with Haitian immigrants—groups at increased risk for AIDS compared with the general U.S. population. All these patients have received Factor VIII concentrates, and all but one have also received other blood components.

Case 1: A 55-year-old severe hemophiliac from Alabama developed anorexia and progressive weight loss beginning in September 1981. He had developed adult-onset diabetes mellitus in 1973, which had required insulin therapy since 1978. He had had acute hepatitis (type unknown) in 1975. In March 1982, he was hospitalized for herpes zoster and a 17-kg weight loss. Hepatosplenomegaly was noted. The absolute lymphocyte count was 450/mm^3. Liver enzymes were elevated; antibodies to hepatitis B core and surface antigens were present. A liver biopsy showed changes consistent with persistent hepatitis. Evaluation for an occult malignancy was negative. The zoster resolved following 5 days of adenosine arabinoside therapy.

In early June, he was readmitted with fever and respiratory symptoms. Chest x-ray showed bibasilar infiltrates. No causative organism was identified, but clinical improvement occurred coincident with administration of broad spectrum antibiotics. Laboratory studies as an outpatient documented transient thrombocytopenia (63,000/mm^3) and persistent inversion of his T-helper/T-suppressor ratio (T_H/T_S =0.2). He was readmitted for the third time in early September with fever, chills and nonproductive cough. His cumulative weight loss was now 47 kg. Chest x-ray demonstrated bilateral pneumonia, and open lung biopsy showed infection with *P. carinii*. He responded to sulfamethoxazole/trimethoprim (SMZ/TMP). His T-cell defects persist.

Case 2: A 10-year-old severe hemophiliac from Pennsylvania had been treated with Factor VIII concentrate on a home care program. He had never required blood transfusion. He had been remarkably healthy until September 1982 when he experienced intermittent episodes of fever and vomiting. Approximately 2 weeks later, he also developed persistent anorexia, fatigue, sore throat, and nonproductive cough. On October 20, he was admitted to a hospital with a temperature of 38.4 C (101.2 F) and a respiratory rate of 60/min. Physical examination revealed cervical adenopathy but no splenomegaly. The absolute number of circulating lymphocytes was low (580/mm^3) and the T-helper/T-suppressor ratio was markedly reduced (T_H/T_S = 0.1). His platelet count was 171,000/mm^3. Serum levels of IgG, IgA, and IgM were markedly elevated. Chest x-rays showed bilateral pneumonia and an open lung biopsy revealed massive infiltration with *P. carinii* and *Cryptococcus neoformans*. Intravenous SMZ/TMP and amphotericin B have led to marked clinical improvement, but the T-cell abnormalities persist.

Case 3: A 49-year-old patient from Ohio with mild hemophilia had been treated relatively infrequently with Factor VIII concentrate. During the summer of 1982, he noted dysphagia and a weight loss of approximately 7 kg. In October, he was treated for cellulitis of the right hand. Two weeks later, he was observed by a close relative to be dyspneic. He was admitted in November with progressive dyspnea and diaphoresis. Chest x-rays suggested diffuse pneumonitis. His WBC count was 11,000/mm^3 with 9% lymphocytes (absolute lymphocyte number 990/mm^3). The T_H/T_S ratio was 0.25. Open lung biopsy revealed *P. carinii*. The patient was treated with SMZ/TMP for 6 days with no improvement, and pentamidine isethionate was added. Virus cultures of sputum and chest tube drainage revealed herpes simplex virus. He died on November 22.

Case 4: A 52-year-old severe hemophiliac from Missouri was admitted to a hospital in April 1982 with fever, lymphadenopathy, and abdominal pain. Persistently low numbers of circulating lymphocytes were noted (480/mm^3). Granulomata were seen on histopathologic examination of a bone marrow aspirate. Cultures were positive for *Histoplasma capsulatum*. The patient improved after therapy with amphotericin B. During the following summer and early fall, he developed fever, increased weight loss, and difficulty thinking. On readmission in early November, he had esophageal candidiasis. Laboratory tests showed profound leukopenia and lymphopenia. A brain scan showed a left frontal mass, which was found to be an organizing hematoma at the time of craniotomy. A chest x-ray showed "fluffy" pulmonary

infiltrates. Therapy with SMZ/TMP was begun. Exploratory laparotomy revealed no malignancy. A splenectomy was performed. Biopsies of liver, spleen, and lymph node tissues were negative for *H capsulatum* granulomata. The lymphoid tissue including the spleen showed an absence of lymphocytes. His total WBC declined to 400/mm^3 and the T_H/T_S cell ratio was 0.1. He died shortly thereafter.

Suspect Case: Described below is an additional highly suspect case that does not meet the strict criteria defining AIDS. A 7-year-old severe hemophiliac from Los Angeles had mild mediastinal adenopathy on chest x-ray in September 1981. In March 1982, he developed a spontaneous subdural hematoma requiring surgical evacuation. In July, he developed parotitis. In August, he developed pharyngitis and an associated anterior and posterior cervical adenopathy, which has not resolved. In late September, he developed herpes zoster over the right thigh and buttock, and oral candidiasis . Chest x-rays revealed an increase of the mediastinal adenopathy and the appearance of new perihilar infiltrates. In late October, enlargement of the cervical nodes led to a lymph node biopsy. Architectural features of the node were grossly altered, with depletion of lymphocytes. Heterophile tests were negative. IgG, IgA, and IgM levels were all elevated. He has a marked reduction in T-helper cells and a T_H/T_S ratio equal to 0.4. Recent progressive adenoid enlargement has caused significant upper airway obstruction and resultant sleep apnea.

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Editorial Note: These additional cases of AIDS among hemophilia A patients share several features with the three previously reported cases. All but one are severe hemophiliacs, requiring large amounts of Factor VIII concentrate. None had experienced prior opportunistic infections. All have been profoundly lymphopenic (< 1000 lymphocytes/mm^3) and have had irreversible deficiencies in T-lymphocytes. Clinical improvement of opportunistic infections with medical therapy has been short lived. Two of the five have died.

In most instances, these patients have been the first AIDS cases in their cities, states, or regions. They have had no known common medications, occupations, habits, types of pets, or any uniform antecedent history of personal or family illnesses with immunological relevance.

Although complete information is not available on brands and lot numbers for the Factor VIII concentrate used by these additional five patients during the past few years, efforts to collect and compare these data with information obtained from the earlier three cases are under way. No common lot number has been found among the lots of Factor VIII given to the five patients from whom such information is currently available.

These additional cases provide important perspectives on AIDS in U.S. hemophiliacs. Two of the patients described here are 10 years of age or less, and children with hemophilia must now be considered at risk for the disease. In addition, the number of cases continues to increase, and the illness may pose a significant risk for patients with hemophilia.

The National Hemophilia Foundation and CDC are now conducting a national survey of hemophilia treatment centers to estimate the prevalence of AIDS-associated diseases during the past 5 years and to provide active surveillance of AIDS among patients with hemophilia.

Physicians are encouraged to continue to report AIDS-suspect diseases among hemophilia patients to the CDC through local and state health departments.

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Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS) — California

CDC has received a report of a 20-month old infant from the San Francisco area who developed unexplained cellular immunodeficiency and opportunistic infection. This occurred after multiple transfusions, including a transfusion of platelets derived from the blood of a male subsequently found to have the acquired immune deficiency syndrome (AIDS).

The infant, a white male, was delivered by caesarian section on March 3, 1981. The estimated duration of pregnancy was 33 weeks; and the infant weighed 2850 g. The mother was known to have developed Rh sensitization during her first pregnancy, and amniocentesis done during this, her second, pregnancy showed the fetus had erythroblastosis fetalis. The infant had asphyxia at birth and required endotracheal intubation. Because of hyperbilirubinemia, six double-volume exchange transfusions were given over a 4-day period. During the 1-month hospitalization following birth, the infant received blood products, including whole blood, packed red blood cells, and platelets from 19 donors. All blood products were irradiated.

After discharge in April 1981, the infant appeared well, although hepatosplenomegaly was noted at age 4 months. At 7 months, he was hospitalized for treatment of severe otitis media. Oral candidiasis developed following antibiotic therapy and persisted. At 9 months of age, he developed anorexia, vomiting, and then jaundice. Transaminase levels were elevated, and serologic tests for hepatitis A and B viruses and cytomegalovirus were negative; non-A non-B hepatitis was diagnosed.

At 14 months of age, the infant developed neutropenia and an autoimmune hemolytic anemia and thrombocytopenia. Immunologic studies showed elevated serum concentrations of IgG, IgA, and IgM, decreased numbers of T-lymphocytes, and impaired T-cell function in vitro. Following these studies, he was begun on systemic corticosteroid therapy for his hematologic disease. Three months later, a bone marrow sample, taken before steroid therapy began, was positive for *Mycobacterium avium-intracellulare*. Cultures of urine and gastric aspirate, taken while the infant received steroids, also grew *M. avium-intracellulare*. The infant is now receiving chemotherapy for his mycobacterial infection. He continues to have thrombocytopenia.

The parents and brother of the infant are in good health. The parents are heterosexual non-Haitians and do not have a history of intravenous drug abuse. The infant had no known personal contact with an AIDS patient.

Investigation of the blood products received by the infant during his first month of life has revealed that one of the 19 donors was subsequently reported to have AIDS. The donor, a 48-year-old white male resident of San Francisco, was in apparently good health when he donated blood on March 10, 1981. Platelets derived from this blood were given to the infant on March 11. Eight months later, the donor complained of fatigue and decreased appetite. On examination, he had right axillary lymphadenopathy, and cotton-wool spots were seen in the retina of the left eye. During the next month, December 1981, he developed fever and severe tachypnea and was hospitalized with biopsy-proven *Pneumocystis carinii* pneumonia.

Although he improved on antimicrobial therapy and was discharged after a 1-month hospitalization, immunologic studies done in March 1982 showed severe cellular immune dysfunction typical of AIDS. In April 1982, he developed fever and oral candidiasis, and began to lose weight. A second hospitalization, beginning in June 1982, was complicated by *Salmonella* sepsis, perianal herpes simplex virus infection, encephalitis of unknown etiology, and disseminated cytomegalovirus infection. He died in August 1982.

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Editorial Note: The etiology of AIDS remains unknown, but its reported occurrence among homosexual men, intravenous drug abusers, and persons with hemophilia A (*1*) suggests it may be caused by an infectious agent transmitted sexually or through exposure to blood or blood products. If the infant's illness described in this report is AIDS, its occurrence following receipt of blood products from a known AIDS case adds support to the infectious-agent hypothesis.

Several features of the infant's illness resemble those seen among adults with AIDS. Hypergammaglobulinemia with T-cell depletion and dysfunction are not typical of any of the well-characterized congenital immunodeficiency syndromes (*2*), but are similar to abnormalities described in AIDS (*3*). Disseminated *M. avium-intracellulare* infection, seen in this infant, is a reported manifestation of AIDS (*4*). Autoimmune thrombocytopenia, also seen in this infant, has been described among several homosexual men with immune dysfunction typical of AIDS (*5*). Nonetheless, since there is no definitive laboratory test for AIDS, any interpretation of this infant's illness must be made with caution.

If the platelet transfusion contained an etiologic agent for AIDS, one must assume that the agent can be present in the blood of a donor before onset of symptomatic illness and that the incubation period for such illness can be relatively long. This model for AIDS transmission is consistent with findings described in an investigation of a cluster of sexually related AIDS cases among homosexual men in southern California (*6*).

Of the 788 definite AIDS cases among adults reported thus far to CDC, 42 (5.3%) belong to no known risk group (i.e., they are not known to be homosexually active men, intravenous drug abusers, Haitians, or hemophiliacs). Two cases received blood products within 2 years of the onset of their illnesses and are currently under investigation.

This report and continuing reports of AIDS among persons with hemophilia A (*7*) raise serious questions about the possible transmission of AIDS through blood and blood products. The Assistant Secretary for Health is convening an advisory committee to address these questions.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Unexplained Immunodeficiency and Opportunistic Infections in Infants — New York, New Jersey, California

CDC has received reports of four infants (under 2 years of age) with unexplained cellular immunodeficiency and opportunistic infections.

Case 1: The infant, a black/hispanic male weighing 5 lb 14 oz, was born in December 1980 following a 36-38-week pregnancy. Pregnancy had been complicated by bleeding in the fourth month and by preeclampsia in the ninth month. The infant was well until 3 months of age, when oral candidiasis was noted. At 4 months, hepatosplenomegaly was observed, and at 7 months, he had staphylococcal impetigo. Growth, which had been slow, stopped at 9 months. Head circumference, which had been below the third percentile, also stopped increasing. At 9 months, serum levels of IgG and IgA were normal; IgM was high-normal. T-cell studies were normal, except for impaired in-vitro responses to *Candida* antigen and alloantigen.

At 17 months of age, the infant had progressive pulmonary infiltrates, as well as continuing oral candidiasis, and was hospitalized. *Mycobacterium avium-intracellulare* was cultured from sputum and bone marrow samples. A CAT scan of the head revealed bilateral calcifications of the basal ganglia and subcortical regions of the frontal lobes. Repeat immunologic studies done at age 20 months showed lymphopenia, decreased numbers of T-lymphocytes, and severely impaired T-cell function in vitro; immunoglobulin determinations are pending. The infant remains alive and is receiving therapy for his mycobacterial infection.

The infant's mother, a 29-year-old resident of New York City, gave a history of intravenous drug abuse. Although she was in apparently good health at the time of the infant's birth, she developed fever, dyspnea, and oral candidiasis in October 1981. One month later, she was hospitalized and died of biopsy-proven *Pneumocystis carinii* pneumonia (PCP). She had been lymphopenic during the hospitalization; further immunologic studies were not done. At autopsy, no underlying cause for immune deficiency was found.

Case 2: The infant, a Haitian male weighing 6 lb 11 oz, was born in January 1981 following full-term pregnancy. The immediate postpartum period was complicated by respiratory distress. Diarrhea developed at 2 weeks of age and persisted. His physical development was retarded. At 5 months, he was hospitalized because of fever and diarrhea. On examination, he had hepatosplenomegaly, lymphadenopathy, and otitis media. While on antibiotics, he developed pulmonary infiltrates. An open lung biopsy revealed *Pneumocystis carinii, Cryptococcus*

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neoformans, and cytomegalovirus. Serum IgG, IgA, and IgM concentrations were elevated. The percentage of T-lymphocytes was decreased, but T-cell response to mitogens was normal. The infant died of respiratory insufficiency at 7½ months of age. At autopsy, the thymus, spleen, and lymph nodes showed lymphocyte depletion. His parents were residents of Brooklyn, New York; their health status is unknown.

Case 3: The infant, a Haitian male weighing 8 lb, was born in November 1981 following a normal, full-term pregnancy. He was apparently healthy until 5 months of age, when he was hospitalized with fever and respiratory distress. On examination, he had hepatosplenomegaly. A chest x-ray showed bilateral pulmonary infiltrates. Despite antibiotic therapy, the infant's condition deteriorated, and an open lung biopsy revealed PCP. Immunologic studies showed elevated serum concentrations of IgG, IgA and IgM, decreased percentage of T-lymphocytes, and impaired T-cell function in vitro. The infant died in May 1982. At autopsy, no cardiovascular anomalies were seen; the thymus was hypoplastic, but all lobes were present. His parents were residents of Newark, New Jersey; their health status is unknown.

Case 4: The infant, a white female weighing 5 lb, was born in April 1982 following a normal 35-week pregnancy. She was well until 2 months of age, when oral and vaginal *Candida* infections were noted. She responded to antifungal therapy, but at 5 months, candidiasis recurred, and she had hepatosplenomegaly. Immunologic evaluation showed that serum IgG, IgA, and IgM levels, normal at 2 months, were now elevated. The percentage of T-lymphocytes was decreased, and lymphocyte response to alloantigen was impaired. At 6 months of age, the infant was hospitalized because of fever and cough. Open lung biopsy revealed PCP. Despite appropriate antibiotic therapy, she died in November 1982.

The infant's mother, a 29-year-old resident of San Francisco, is a prostitute and intravenous drug abuser with a history of oral candidiasis and mild lymphopenia. She has had two other female children by different fathers. These half-sisters also have unexplained cellular immunodeficiency; one died of PCP. The children had not lived together.

None of the four infants described in the case reports was known to have received blood or blood products before onset of illness.

Other cases with opportunistic infections: Six additional young children with opportunistic infections (five with PCP, one with *M. avium-intracellulare*) and unusual cellular immunodeficiencies are under investigation. Three are male. All six children have died. One was a half-sister of the infant in Case 4.

Other cases without opportunistic infections: Physicians from New York City, New Jersey, and California have reported another 12 young children with immunodeficiencies similar to those seen in cases 1-4 but without life-threatening opportunistic infections. One is the other half-sister of the infant in Case 4. All the children are living; their ages range from 1 to 4 years. Eight are male. Clinical features seen in these 12 infants include: failure to thrive (83%), oral candidiasis (50%), hepatosplenomegaly (92%), generalized lymphadenopathy (92%), and chronic pneumonitis without a demonstrable infection (83%). Of the nine mothers for whom information is available, seven are reported to be intravenous drug abusers. None is Haitian.

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Immunodeficiency in Infants – Continued

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Editorial Note: The nature of the immune dysfunction described in the four case reports is unclear. The infants lacked the congenital anomalies associated with Di George's syndrome. The immunologic features of high-normal or elevated immunoglobulin levels and T-lymphocyte depletion are not typical of any of the well-defined congenital immunodeficiency syndromes. They have, however, been described in a few children with variants of Nezelof's syndrome, a rare, poorly characterized illness of unknown etiology (*1,2*). The occurrence of immune deficiency in the infant in case 4 and in her half-sisters raises the possibility of an inherited disorder. However, inheritance would have to have occurred in a dominant manner, an inheritance pattern not previously described for immunodeficiency resembling that seen in these half-sisters.

It is possible that these infants had the acquired immune deficiency syndrome (AIDS). Although the mother of the infant in case 1 was not studied immunologically, her death from PCP was probably secondary to AIDS. The mothers of the other three infants were Haitian or intravenous drug abusers, groups at increased risk for AIDS (*3*). The immunologic features described in the case reports resemble those seen both in adults with AIDS (*4*) and in a child reported to have developed immunodeficiency following receipt of blood products from a patient with AIDS (*5*). Case 2 had essentially normal T-cell responses to mitogens in vitro. This finding is atypical for AIDS, but it has been seen in a few adult AIDS cases (*6*).

Although the etiology of AIDS remains unknown, a series of epidemiologic observations suggests it is caused by an infectious agent (*3,5,7-9*). If the infants described in the four case reports had AIDS, exposure to the putative "AIDS agent" must have occurred very early. Cases 2-4 were less than 6 months old when they had serious opportunistic infections. Case 1 had oral candidiasis beginning at 3 months of age, although *M. avium-intracellulare* infection was not documented until 17 months. Transmission of an "AIDS agent" from mother to child, either in utero or shortly after birth, could account for the early onset of immunodeficiency in these infants.

The relationship between the illnesses seen in the reported cases with severe opportunistic infection and the 12 infants without such infections is unclear at present. The immune dysfuction seen in the children and the sociodemographic profiles of the mothers appear similar in both groups. Prospective study of the 12 children is necessary to define the natural history of their illnesses and the possible relationship of their illnesses to AIDS.

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