THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

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

GPA GAY PRESS ASSOCIATION

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CASTDS--III: TO BE, OR NOT TO BE?!

In spite of the considerable preparation that has already gone into the Current Aspects of STD Symposium--III (CASTDS) by Mark Behar, Bob Bolan, David Ostrow, Bob Wood, and Josh Joshua, there is growing doubt as to whether the Symposium will actually take place in Seattle, August 4, 1983 (see enclosure). Two major signs cast the doubt. Although publicity for CASTDS began with the promotional literature and advertisements from the Fifth International Meeting of the International Society for STD Research (FIMIS; which preceeds CASTDS on August 1-3), and the August, 1982 NCGSTDS Newsletter, there has been little response by either potential program participants (no abstracts or written proposals for talks have been submitted; only 5 individuals have expressed verbal interest), or registrants (few inquiries, one registration). Secondly, the 5th National Lesbian/Gay Health Conference cosponsored by the National Gay Health Education Foundation (NGHEF), American Association of Physicians for Human Rights (AAPHR), and the Gay & Lesbian Health Alliance of Denver, coincidentally preceeds CASTDS by 2 months in Denver. AAPHR plans to offer an almost identical program, offering CME quality clinical and research presentations on AIDS, hepatitis B, enteric diseases, STD prophylaxis, and risk reduction. In addition, the second National AIDS Forum will take place. The 5NLGHC may offer a more attractive "bill of fare" for considerable less expense ($50 vs. $225--FIMIS costs $150, CASTDS, $75) for the same amount of time (4 days) than FIMIS & CASTDS. It also offers a valuable opportunity for gay health workers to network, share ideas and enhanse feelings for a national gay/lesbian community. On the other hand, FIMIS/CASTDS offers the rare opportunity to develop communication, information exchange, & support for gay health issues from scientists & researchers internationally.

We must briefly review the goals & objectives of CASTDS before offering any alternatives. 1) CASTDS was designed to share much needed clinical & scientific information about STDs among gay men in association with an international meeting of STD researchers. What an excellent way to raise the consciousness of health workers from around the world and introduce them to the concepts of quality gay health care available in the United States? 2) CASTDS was designed to enhanse the already growing communication network among gay health workers and between scientists, clinicians & the gay community. 3) CASTDS and the "Cruise the Puget Sound Aboard the Virginia V Steamship" was designed to raise much needed funds for Coalition activities (e.g., the Newsletter is costing over $500 per issue in publication & mailing expenses, and cannot be covered by the cost of membership alone). A security deposit of $350 was already made for the cruiseship.

Exactly what options are available? 1) Continue with CASTDS, even though it will follow the 5NLGHC. Poor attendence and a small number of presentors may adversely affect program quality and future CASTDS/NCGSTDS credibility. 2) Cancel or postpone CASTDS in deference to the 5NLGHC. This too will affect the credibility of CASTDS/NCGSTDS. 3) Request that the 5NLGHC be canceled or postponed in deference to CASTDS. It should be remembered that long before a decision was made to definitely hold the 5NLGHC, and long before Denver was chosen

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CASTDS--III: TO BE, OR NOT TO BE?! Continued

as the site, CASTDS was announced, advertised, and in planning. 4) Cancel CASTDS but keep the fundraising cruise aboard the Virginia V Steamship, and encourage a gay presence at FIMIS. This will require a commitment to attend FIMIS and almost mandates official NCGSTDS representation in Seattle. [According to gay participants at the Dallas National STD Conference sponsored by the CDC, March 8-11, an official gay presence was sorely missed.] 5) Any of the above, plus: investigate affiliation with AAPHR or NGHEF for cosponsorship of a CASTDS in 1984 or 1985. 6) All or none of the above, or any other suggestion that you may have.

It is crucial that a decision about whether or not to hold CASTDS be made within 2 weeks of your receipt of this Newsletter. Address your comments to the NCGSTDS, POB 239, Milwaukee, WI 53201, or call 414/277-7671 evenings (central time zone). The decision will be made after reviewing your comments with Bob, David, Bob & Josh. Coalition membership will be notified of the decision shortly thereafter, in a special mailing. The NCGSTDS still plans on participating in and officially meeting during the 5NLGHC in Denver.

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FIFTH NATIONAL LESBIAN/GAY HEALTH CONFERENCE IN DENVER, JUNE 9-12: INFO & CALL

Between 300-600 registrants from across the continent are expected to converge in Denver for the Fifth National Lesbian/Gay Health Conference (FNLGHC), June 9-12, 1983, at the Executive Tower Inn. The theme of the conference is "Health Pioneering in the 80's" and will offer over 40 workshops and seminars addressing all aspects of lesbian and gay health. Special interest topics to be presented include sexually transmitted disease services, alcoholism services, holistic health and lesbian/feminist health issues. The Conference will include the Second National Forum on AIDS, as well as organizational time for several national gay and lesbian health groups. The NCGSTDS will be holding its annual meeting at the Conference Conference (details in the next issue of the Newsletter).

Highlighting the Conference will be several guest speakers addressing a variety of health issues. These speakers include Virginia Apuzzo, Executive Director of the National Gay Task Force, and Karen Clark, Minneapolis legislator, who will speak on "Health as a Political Issue." In Addition, Bernice Goodman will discuss "Confronting Racism, Sexism & Homophobia," and Jerome Perlinski will speak on "Gays and the New Age."

The Second National AIDS Forum will take place in conjunction with the Conference on June 9-10 (Thursday & Friday). The Forum will bring together AIDS care providers and decision makers and will focus on the medical, psychological, social and political aspects of AIDS.
Healthworkers interested in presenting papers, workshops, or panel presentations must submit a 1 page narrative abstract and/or topical outline by March 31 to the NGHEF/FNLGHC (address below). Presentors will be notified of acceptance by April 30th. The Conference defines paper as, a prepared formal presentation followed by discussion from the floor, lasting up to 1½ hours; workshop may be from 1½-3 hours discussion of a topic area with active audience participation encouraged; panel as a topic presented from several points of view, with the speaker's comments planned to be brief to encourage dialogue between panel members and members of the audience, lasting 1½ hours.

General admission to the Conference is $50 with special discounts to students, senior citizens, and those who stay at the Executive Tower Inn. A flier is enclosed with this Newsletter with additional information. You may also contact Dan Pfeffer (714/494-0293) or Fran Miller (415/653-3724), or write: NGHEF/FNLGHC, 5938 Chabot, Oakland, CA 94618 for additional information. The Conference is cosponsored by the National Gay Health Education Foundation, the American Association of Physicians for Human Rights, and the Gay & Lesbian Health Alliance of Denver.

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NCGSTDS HOLDS ANNUAL MEETING IN DENVER

The NCGSTDS plans to hold its annual meeting during the Fifth National Lesbian/Gay Health Conference in Denver, tentatively on Sunday, June 12th. Agenda items must be submitted by May 16th, to the NCGSTDS, PO Box 239, Milwaukee, WI 53201. The following topics will be discussed: CASTDS--III, Guidelines & Recommendations for Healthful Gay Sexual Activity, the November meeting at APHA in Dallas, AIDS, and perhaps most important, updates from representatives of the nation's gay STD services, among others. Although the meeting will be recorded on 120 minute cassettes, your attendence will insure the proper functioning of the Coalition. Plan on attending! RSVP cards & details about the meeting will be provided in the next issue of the Newsletter.

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GUIDELINE'S BROCHURE BEING USED AS EVIDENCE IN CLUB BATH CASE

A different type of noteriety is being gained for the popular "Guidelines & Recommendations for Healthful Gay Sexual Activity" brochure. In spite of the gay rights laws in both Wisconsin and Milwaukee, police harassment of the local Club Bath Chain affiliate persists. Paul DeMarco, CBC Manager, is being charged with "leasing a building for lewdness," and the G&R brochure is being used as evidence that "lewdness is encouraged." "We will continue to have the brochure for our clientele," Paul affirmed. The Club Milwaukee was the first in the country to offer the brochure to customers, and post risk reduction signs in prominent places at the facility.

SEATTLE GAY CLINIC NEWS * * *

Seattle Gay Clinic (SGC) is truely one of the nation's model gay clinics. Over 100 dedicated, highly motivated & creative volunteers provide a wide range of patient services. And great news for NCGSTDS members--SGC publishes an outstanding, informative, and visually appealing newsletter that reports on activities of the Clinic for staff & friends. Following are some recent activities:

*The Board of Directors held a one day long retreat to discuss the short, medium, & long range plans for the Clinic.

*A Chinese auction was held as a Clinic fundraiser. A Chinese auction is like any other auction in which goods & services are sold to the highest bidder. However, ALL bids are collected, regardless of the final winning bid. A panel of three judges will assemble and compile an auction list of items for bid (which may be either new or certified antique or collectible value) which will be available to bidders (& biddies!).

*SGC staff physician Wayne Dodge moderated a telephone discussion on AIDS over KTNT radio. Featured were internationally known Dr. Hunter Handsfield of Seattle's Harborview Clinic, Larry Kramer of New York's Gay Men's Health Crisis, and a KS patient from San Francisco. Other media presentations saught to inform rather than to alarm: KRAB radio's coverage of the Clinic's AIDS Forum; channel 9 TVs segment on AIDS with interviews of SGC volunteers, and channel 7 TVs recent filming of a group that plans to launch a fundraising prject to finance viral research & diagnostic services for uninsured AIDS patients.
For additional information, contact Tom Speer, SGC Vice-President, PO Box 20066, Seattle, WA 98102 (206/329-8390).

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AUTHOR SEEKS INFORMATION ABOUT STD PROPHYLAXIS

Chicago author Dr. Lonny Myers, MD, is seeking specific information about STD prophylaxis for his soon-to-be-published book on STDs. The issue of post-coital disinfection using products such as the popular World War I & II product, Sanitube: over 300 articles about its effectiveness in the military have been published; the CDC has consistently avoided addressing the issue. [Several years ago, the NCGSTDS attempted to get the FDA to evaluate Sanitube on the basis of its claim as a VD prophylactic; they stated that the FDA has an obligation to review the product, however, "...it has not been determined how and when this review will be accomplished...."] References about vaginal spermicides (specifically nonoxynol 9) causing proctitis are needed. Clinical & anecdotal experiences about using antibiotics as prophylaxis against syphilis and gonorrhea (daily use, or pre-exposure use) are also needed. Please contact the author for additional information or to provide assistance: Lonny Myers, MD, 100 East Ohio St., Suite 230, Chicago, IL 60611, 312/337-3341.

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NGHEF APPOINTS RON VACHON AS EXECUTIVE DIRECTOR

by Paul Paroski, MD, President, B.O.D.

In the past, the National Gay Health Education Foundation (NGHEF), as most of our agencies, has relied on volunteer efforts. Unfortunately, this has created a situation where the agency's activities have occasionally taken a secondary role to the volunteer's mainstream commitments. In light of this, the Foundation has taken an important step forward in developing a strong unified network oflesbian/gay agencies by creating the position of Executive Director.

We are happy to announce that we have appointed Ron Vachon, PA, to this position. Ron has been involved with the gay/lesbian health care movement for many years. He has been active with the National Gay Health Coalition, the Lesbian & Gay Physician Assistant Caucus, the Gay Public Health Workers Caucus, and the National Coalition of Gay STD Services, among others. Ron represents a new phase of professionalism in the Foundation, and soon we will hope to see the establishment of an office with support staff. During this crucial time of growth, we will continue to look forward to your enthusiastic support. All future correspondence to the NGHEF may be addressed to Ron Vachon, Executive Director, NGHEF, PO Box 834, Linden Hill, NY 11354, or to Ron directly, 506 W. 42nd St. #E5, NYC, NY 10036 (212/563-6313).

[The NCGSTDS congratulates Ron on his new appointment, and looks forward to the Foundation's continued commitment of service to the nation's volunteer gay health organizations! --Ed.]

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GAYELLOW PAGES SEEKS INFORMATION

Gayellow Pages, the USA and Canadian directory of accomodations, AA groups, bars, baths, bookstores, businesses, counselors, dentists, doctors, lawyers, publications, organizations, religious groups, services, switchboards, therapists, travel agents, STD clinics, etc., for gay men & women, is seeking information from your group. If your clinic or organization isn't already listed (or needs updating) in the national or regional editions, please write for a free listing or for ordering information: Gayellow Pages, Renaissance House, Box 292 Village Station, New York, NY 10014 (212/929-7720). Special format cassettes for the visually handicapped are available (special playback machines required) from Lambda Resource Center for the Blind, 3225 N. Sheffield, Chicago, IL 60657 (312/274-0510 evenings).

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JOURNAL OF PSYCHOSOCIAL ONCOLOGY--CALL FOR PAPERS

The Haworth Press, Inc., announces the forthcoming publication of the new quarterly Journal of Psychosocial Oncology (JPO), under the Editorship of Grace H. Christ, MSW, Director of Social Work at the Memorial Sloan-Kettering Cancer Center. JPO is scheduled for publication in the Spring, 1983. JPO has been established to meet the identified need by all disciplines for greater accessibility of up-to-date information on psychosocial oncology. The journal will provide a multidisciplinary perspective and now invites the submission of clinical and research articles from the broad range of health professionals concerned with the psychosocial needs of cancer patients and their loved ones. Articles are planned to cover such areas as: the relationship of stress to cancer etiology & prognosis; prevention of cancer and of its psychosocial sequelae; psychosocial problems of the long-term survivor; informed consent; patient compliance with evaluation and treatment and the patient's decision making process; the psychosocial impact of research treatment; special psychosocial problems occuring during different points in the life cycle from infancy to geriatrics; pain control; hospice and other models of extended care; the role of the volunteer with cancer patients; and education of the oncology care giver. The journal will also present articles that present hypothesis generating and hypothesis testing, as well as program evaluation research. Prospective authors are invited to request the "Instructions for Authors" brochure from Ms. Christ, Dept. of Social Work, Memorial Sloan-Kettering Cancer Center, 1275 York Av., NY, NY 10021. Subscriptions may be ordered from The Haworth Press, 28 E. 22nd St., NY, NY 10010; $25 for individuals ($19 introductory offer), $48 for institutions, $75 for libraries.*****

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NEWS FROM SAN DIEGO'S BEACH AREA COMMUNITY CLINIC

by Terry Cunningham, Coordinator, Gay Male & Hepatitis B Screening Programs

Sorry that I am so late in getting this information about San Diego's efforts to you. I was in Los Angeles recently and saw a copy of the NCGSTDS Newsletter. I would appreciate it if you would let the gay community know that San Diego is definitely concerned about gay health! We are cooperating with the Owen Clinic at the University Hospital here.

One of the local beach bars, The El Matador, raised $2100 so that the hepatitis B vaccine could be given to anyone who needs it before payment. We are offerring the hepatitis B screening for $10 and the shots at our cost, $100. Patients can either pay $35 a shot or make any type of payment arrangements that they can--even working it out at the Clinic. Our response to the Well Gay Male Screening Program has been very good, however, only about 10% of those who need the vaccine have been receiving the injections. This month, the Beach Area Community Clinic (BACC) is sponsoring a media blitz to inform the community of the necessity of getting the vaccine.

In addition to hepatitis B vaccine screening & administration, BACC offers gay & staight male VD services, well male examinations, general medical services, and a sports medicine clinic and chiropractor & masseur.

The new screening program for well gay males was established in response to the alarming increase in some diseases among gay men. The program consists of a genital, rectal & prostate exam; urinalysis; gonorrhea cultures; syphilis blood test and complete blood count; screening for hepatitis B; stool culture for ova & parasites, culture & sensitivity, & campylobacter; and last, a thorough medical history. The cost will be $40 (normally, over $100 in most other medical settings). For more information, contact the BACC, 3705 Mission Blvd., San Diego, CA 92109, 619/488-0644.

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CINCINNATI PRINTS NEW STD PAMPHLET FOR GAY MEN

Members of the Cincinnati gay community along with narrative contributions from the Pennsylvania Department of Health resulted in the publication of a new STD pamphlet for gay men entitled, "Some Thoughts to Share...With Gay Men Who Care." For additional information, please contact: Michael Ritchey, Director, STD Center, 3101 Burnet Av., Cincinnati, OH 45229.

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WHY SUCH POOR ACCEPTANCE OF THE HEPATITIS B VACCINE?

by Neil R. Schram, MD, Southern California Physicians for Human Rights

When the American Association of Physicians for Human Rights first was established, I proposed to Merck, Sharp, & Dohme [the hepatitis B vaccine manufacturers] that cooperation between AAPHR and Merck could help with the distribution of the caccine to susceptible gay males. As we are all aware, Merck offered little help. Abbott Laboratories [who makes the hepatitis B antibody & antigen test kits] is preparing a booklet on hepatitis B directed to gay men. I believe they will work with gay groups to help with distribution, hopefully at no cost. I believe the poor acceptance of the vaccine is due to two major factors. The first is, of course, cost. The second is inadequate education of not only gay males, but also physicians (gay and nongay--blame Merck again--they marketed the vaccine to physicians for health care workers who are at lower risk than gay men for acquiring the disease.

The cost factor can, I believe, be overcome only by physicians the patient knows and trusts. Those patients of mine who have agreed to spend the money ($100 for the cost of the vaccine only, through Kaiser Permenente in Southern California) have done so because I convinced them. None came to me requesting the vaccine. Thus STD Clinics are at a disadvantage because there are no established practitioner-patient relationship.

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WHY SUCH POOR ACCEPTANCE OF THE HBV VACCINE? Continued

Many young gay men do not discuss their sexuality with their primary care providers and go to STD Clinics for gay-related illnesses. This is something gay physician/health workers' groups must overcome by educating gay patients and all physicians & health workers to discuss patients' sexual orientation & practices.

Letters from county or city public health officials anc stimulate Merck to spend money to assist public health officials in their efforts to educate physicians (such as a symposium on the vaccine sponsored by the Health Offices Association of California and the California Academy of Preventive Medicine, planned for March 4, 1983).

Finally, we must accept that patients see the hepatitis statistices differently than we do. We talk of 200,000 people getting hepatitis B and 150,000 not being aware of it. We also talk of 5-10% of patients who get the disease becoming carriers. This is interpretted to mean that there is a 75% chance of not getting sick from the disease, and a 90-95% chance of not becoming a carrier. Thus, gay men are prepared to take the risk.

To summarize, the following must be done to get the vaccine to those who need it most:
1) Encouraging patients and practitioners to discuss sexual orientation, since heterosexual men are at low risk for hepatitis B (unless they're IV drug abusers, etc.).
2) Education of gay men for the need of the vaccine and of the potential problems of the carrier state.
3) Working with city and or county public health officials to promote health education program development for physicians, other health workers, and the high risk patients.

These are steps that Physicians for Human Rights groups or their counterparts can and must take. I welcome your comments: Neil Schram, MD, 1050 West Pacific Coast Highway, Harbor City, CA 90710 (213/517-3228).

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CLINIC & MEDICAL DIRECTORS NEEDED IN LOS ANGELES

The Gay & Lesbian Community Services Center (1213 N. Highland Av., PO Box 38777, Hollywood, CA 90038, 213/464-7400 x491, attention Don Kilhefner, Personnel Director) is announcing two job openings with the Health Services Department: 1) Clinic Director (full time, salary range $21-23,000 + medical & dental benefits); qualifications include a master's degree in public health, nursing, public administration, or related areas of knowledge, or equivalent, relevant experience. The Clinic Director administers the STD control project, health education, AIDS hotline, and other relevant activities. 2) Medical Director (20 hours/month, salary $5000); qualifications include a current California physician's license, two strong references based on previous medical experience, good communication, human & community relations skills, and demonstrated awareness of gay & lesbian health issues. For additional information (this article is abridged), contact Don Kilhefner at the above address/phone AS SOON AS POSSIBLE!

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NEWS FROM WHITMAN-WALKER CLINIC IN WASHINGTON, DC

Washington, DC's Whitman-Walker Clinic makes a significant contribution in the ongoing fight against the STDs. In the 18 month period from April, 1981 through September, 1982, the Clinic screened 9662 patients, and one of every three of those patients received treatment for one ailment or another. In the past year, of all persons tested at the Clinic for gonorrhea, approximately 10% had a positive rectal culture, approximately 12% had a positive urethral culture, and about 3% had a positive pharyngeal culture. In addition, the Clinic diagnosed 200 cases of syphilis involving individuals who had no previous history of the disease--fully 10% of all new syphilis cases in the District of Columbia last year.

This good work is largely a result of volunteer efforts. The VD Clinic has over 150 active volunteers who work in patient services, laboratory testing, phlebotomy and patient screening.

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NEWS FROM WHITMAN-WALKER, Continued

In 1982, we conducted two training sessions, each lasting six weeks, which added 30 new certified volunteers to the Clinic staff. Our new Medical Director, Peter Hawley, MD, has also been active in recruiting physicians--our staff of MDs now totals 14. These efforts have prompted DC Mayor Marion Barry to characterize the Clinic as being, "...an integral part of the VD control effort in the District of Columbia."

The Clinic has expanded and improved its professional laboratory services and is quickly becoming self-sufficient in terms of doing most in-house testing. Here are some of the major achievements of 1982:

*The Clinic now employs a full-time, board-certified medical technologist.
*Three clinic sessions every week.
*The Clinic laboratory is fully licensed by the District.
*The Clinic purchased a $6000 Nikon Labophot microscope with dual viewing lenses which increases both testing and volunteer training capabilities.
*Determination of gonorrhea of the throat is now performed in our lab.
*Tests for strep throat infections are now performed in-house.
*Penicillin-resistance testing, very important due to the rise in penicillin-resistant strains of gonorrhea, is now routinely performed on all positive lab cultures.
*Tests for syphilis (previously performed by the District) are now part of the Clinic's lab operations.

While these improvements mean less demand on District health agency services, they have added increased Clinic costs, and will require continued public and private funding to maintain the necessary level of community services.

Whitman-Walker is a free Clinic that requests donations from those who can afford to give. Even though one out of every four persons examined makes no donation, the VD Clinic raised $61,097 in patient donations last year. In 1982, our Friends of the Clinic fundraising effort brought in over $12,000, and "Brother, Help Thyself" contributed $5000. The Clinic is proud of the fact that those and other efforts mean that 78% of our operating budget comes directly from the community we serve. The Clinic is also pleased that the DC public health agencies view our efforts as essential medical services. In 1982, contracts with the City government accounted for 22% of the Clinic budget. James Buford, Director of the DC Department of Human Services, said this about the Clinic's program: "The control of venereal disease is a formidable undertaking not easily obtained. Without the invaluable assistance provided by the Clinic in the District of Columbia, this task would be even more formidable. Indeed, the initiative, productivity, and spirit of cooperation demonstrated by the staff of the Clinic is commendable."

Whitman-Walker Clinic was first established in November, 1973, and is one of the oldest gay clinics in the United States for the detection and treatment of STDs. It is also one of the largest, nonprofit health facilities in the Washington metropolitan area. In addition to the Gay Men's VD Clinic, Whitman-Walker Clinic also includes the Gay Hotline, the Counseling Group, the Gay Council on Drinking Behavior, and the Lesbian Health Center. For additional information, contact: WWC, 2335 18th St., NW, Washington, DC 20009 (202/332-5295).

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HERPES HYSTERIA PARTIALLY FOSTERED BY AMERICAN SOCIAL HEALTH ASSOCIATION--AN EDITORIAL

by Mark Behar, Chairperson, NCGSTDS

I was rather disturbed by an appeal for funds letter recently received from Bea Mandel, RN, Director of Education Services of the American Social Health Association (and Director of the VD National Hotline). The letter encouraged membership and financial support for the ASHA's Herpes Resource Center (HRC), certainly a laudable program worthy of support. What was disturbing to me was the letter's introduction. Excerpts follow for your own judgement: [emphasis is mine]: "As you no doubt know, the prevalence of genital herpes simplex virus disease (HSV) has reached frightening, unprecedented proportions throughtout the US. Current estimates of the infected reservoir now exceed 20 million persons. Furthermore, because

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HERPES HYSTERIA, Continued

genital herpes is a viral disease and hence cannot be cured, that number is increasing annually at an alarming rate. "Incurable as it presently is, HSV resembles a chronic disease that patients must learn to endure, hopefully with a minimum of disruption and pain...." The appeal closes with the following: "...Please join me in combatting this public health threat...."

Again, let me emphasize that the programs of the ASHA--the VD National Hotline, the Herpes Resource Center, and others, are very important, and deserve much needed support. But it's easy to see how use of inflammatory and emotionally charged words help to fuel the public's perception of a "sexual leprosy." Politics and money aside (is that possible in medicine?), herpes is nothing more than a cold sore, especially when compared to such diseases as gonorrheal or chalmydial pelvic inflammatory disease, hepatitis B, and AIDS--all substancially more devastating than herpes. Herpes can be quite disruptive, both physically and emotionally, but it is rarely fatal in otherwise normal adults. The strong visceral response elicited by patient's diagnosed with herpes is attributable to the manner by which patients first learn about the disease--frequently by well meaning journalists whose copy originates from news releases replete with emotionally charged & descriptive passages. Sam Nixon, MD, director of Houston's Division of Continuing Education at The University of Texas Health Sciences Center, writes in a booklet entitled, "Talking to Patients About Sex and Genital Herpes," distributed by Burroughs Wellcome: "It's important to avoid the word "incurable." True, the virus causes recurrences, but there are hygienic and other measures that must be taken with each recurrence that require the patient's compliance. The word "incurable" militates against compliance...."

Health care leaders need to be concerned not only about STD recognition, diagnosis & treatment, and prevention, but also with the manner in which the public learns about these matters. Your comments about how to best accomplish such programs are always welcome.

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GAY MEN'S HEALTH COLLECTIVE OF BERKELEY ANNOUNCES NEW TRAINING

The Gay Men's Health Collective of Berkeley, which has provided free, confidential VD testing and treatment by and for gay men for the past six years, is offering a volunteer medic training program for eight consecutive weeks, beginning Sunday, April 10. Trainees will acquire an indepth knowledge of the various STDs and diagnostic, treatment and health education skills. Completion of the training and internship qualifies the trainee for membership in the Collective, which requests a 6 month commitment and attendance at a minimum of 3 clinic sessions per month. Those interested are encouraged to contact: John Day, GMHC, 2339 Durant Av., Berkeley, CA 94704 (415/548-2570).

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NEW QUICK TESTS FOR GONORRHEA, HERPES & CHLAMYDIA ON HORIZON

The February 11th issue of Science, devoted to the booming field of biotechnology, reported on three new diagnostic tests using monoclonal antibodies. Tests for gonorrhea, herpes simplex type II, and chalmydia take only 15-20 minutes to perform, as compared to the several days of culturing presently required for diagnosis. The FDA has already approved the chlamydial test, and approval for the other two tests is expected for later this year.

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SECOND NATIONAL CONFERENCE ON LESBIAN & GAY AGING

The National Association of Lesbian & Gay Gerontologists is sponsoring the 2nd National Conference on Lesbian & Gay Aging, June 24-25, 1983 at San Francisco State University. The Conference is part of San Francisco's Lesbian/Gay Freedom Celebration including a Benefit Tea Dance and the Freedom Day Parade. If you are interested in presenting a paper, presentation, life history, exhibit, film, demonstration, etc. or wish additional registration information: NALGG, 1290 Sutter St., Suite 8, San Francisco, CA 94109. ***** ***** *****

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GAY PRESS ASSOCIATION MEETS IN SAN FRANCISCO

The first Western Regional Conference of the Gay Press Association, entitled "Creeping Professionalism," will review the progress toward professionalism of the gay/lesbian media from before Stonewall to extending into the future, March 12-13. Many workshops will be held on topics such as working with elected officials and gay political groups, the broadcast media, and many others, along with the GPA's new world-wide computerized Wire Service will be demonstrated. For additional information, contact Doug Wright (415/929-0760) in San Francisco, or Mike Rutherford (202/387-2430) in Washington, DC.

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WILLARD CATES REPLACES PAUL WIESNER AS DIRECTOR OF THE CDC's VD CONTROL DIVISION

Willard (Ward) Cates, Jr., MD, MPH, has been selected to succeed Dr. Paul Wiesner as the Director of the CDC's VD Control Division. Paul has become the Assistant Director of Medical Affairs and the Director of Chronic Diseases for the Center for Environmental Health at the CDC. Ward graduated from Yale University in 1964; received his MA from Cambridge University in 1966; his MD and MPH (epidemiology) from Yale in 1971; he completed his internship in internal medicine at the University of Virginia in 1972, and served as a resident in Preventive Medicine at the CDC from 1975-77. He came to the Division of VD Control in March, 1982 as Deputy Chief of the Epidemiology and Special Studies Section.

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NEWS FROM TUCSON'S GAY HEALTH PROJECT
by Al Obermaier, Director

Enclosed with this Newsletter [for Services only!] is a copy of our Lesbian & Gay Health Fair Newspaper, which described the events at Arizona's First Lesbian & Gay Health Fair. Why was a Health Fair needed? The Fair was seen as a self-affirming day, a time to join together as a community; a time that is signalling a change in attitudes through education. Over 300 participants attended workshops on such topics as relationships, substance abuse, anal health & pleasure, STDs, among others; a forum on AIDS; and actual physical examinations for men and women. The men's and women's clinics were so popular, that we had to extend them two hours! Local businesses purchased advertising in the Health Fair Newspaper, which helped purchase clinic materials and refreshments. Over $200 profit was made. In addition, there was considerable straight media coverage of the event--three newspaper articles on AIDS including a 4 page spread in a local feminist paper, 5 radio station & 3 television interviews. One of the byproducts of the Fair was the addition of three new doctors to the Project's referral list; they will be checked out for their sensitivity and knowledge. Although the Fair was produced by less than 8 people working only in our spare time, we hope to make this a yearly event. We look forward to your comments & suggestions: Tucson Gay Health Project, Box 2807, Tucson, AZ 85702.

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NEWS FROM DENVER
by Carol Lease

The Gay & Lesbian Community Center of Colorado announces the publication of "Be Well," a project of the Center's Health Task Force. The brochure explores issues not usually associated with gay health such as legal rights during an arrest, nutrition, and the role self-image constitutes to health. Information about hepatitis B, STDs, and AIDS are featured along with resources for health, counseling and support groups for gay men as well as common sense health ideas. Pat Gourley, who initiated the idea, sees the brochure as an attempt for gay men to focus on a wide range of health issues, instead of the few that get attention these days. "Being well is being balanced, being whole and integrated. We need to focus on wellness, not illness," he stated. The brochure is available from: GLCCC, POB 18467, Denver, CO 80218, or call the Center at 303/831-6268. A brochure on lesbian health issues will be published this Spring.***** ***** ***** *****

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AAPHR UPDATES AFFILIATE GROUPS

American Association of Physicians for Human Rights (AAPHR) is a national organization of physicians and medical students dedicated to the elimination of discrimination on the basis of sexual or affectional orientation in the health professions, and to the delivery of supportive, unprejudiced, and well-informed medical care for gay and lesbian patients. As of January, 1983, there were 19 affiliate groups in various cities around North America. Some of them have extended membership to all medical professionals, recognizing the necessity of involvement of all health professions. Your involvement in the national group (AAPHR) and your local group will help improve the health care of the gay & lesbian community and the important networking function between the different groups. This list will be periodically updated. Additions & corrections are invited.

AAPHR--American Association of Physicians for Human Rights, PO Box 14366, San Francisco, CA 94114, 415/327-6642; President: Dr. Denny McShane, MD

Atlanta--Atlanta Physicians for Human Rights, c/o Atlanta Business Guild, 1 Rhodes Center North, Atlanta, GA 30509, 404/874-3398; Contact: Tom Drum

Boston--Gay & Lesbian Physicians of New England, PO Box 971 Back Bay Annex, Boston, MA 02117, 617/482-6874; President: Robert P. Cabaj, MD

Chicago--Contact: David Staats, MD, 312/477-6748

Dallas--Contact: Ron Wtegman, DO, 214/233-9222, or James Wheeler, MD, 214/559-2590

Dayton--AAPHR-Ohio, c/o 1113 Charleston St., Fairborn, OH 45324, 513/879-1220, Contact: Bob Brandt, MD

Houston--Contact: Gary Brewton, MD, 713/522-7360

Los Angeles--Southern California Physicians for Human Rights, 7985 Santa Monica Blvd., #109, Los Angeles, CA 90046, 213/658-6261; President: Dan Fast, MD

Milwaukee--Medical Professionals for an Alternate Lifestyle, c/o PO Box 239, Milwaukee, WI 53201

Minneapolis--Contact: Hanan J. Rosenstein, MD, 612/729-3300

Montreal--Contact: Bob Dent, MD, 514/849-0178

New York--New York Physicians for Human Rights, c/o Peter Seitzman, MD, 311 E. 79th St., New York, NY 10021, 212/420-0226; Contact: Roger Enlow, MD

North Carolina--Carolina Association of Physicians for Human Rights; [address inquiries c/o AAPHR, above]

Philadelphia--Philadelphia Health Professionals for Human Rights, 1901 Sansom St., Philadelphia, PA 19103, 215/545-1071; President: Brett Cassens, MD

Sacramento--Sacramento Lesbian & Gay Mental Health Professionals, 820 24th St., Sacramento, CA 95816, 916/447-2282; President: Elizabeth Harrison, MD

San Diego--San Diego Physicians for Human Rights, PO Box 16242, San Diego, CA 92116, 714/584-4958

San Francisco--Bay Area Physicians for Human Rights, PO Box 14546, San Francisco, CA 94114, 415/673-3189; President: Ric Andrews, MD

Seattle--Northwest Physicians for Human Rights, 3408 S. King St., Seattle, WA 98144, 206/327-3927; President: Robert Wood, MD

Toronto--Gays in Health Care, PO Box 7086 Station A, Toronto, Ontario M5W 1X7 Canada, 416/920-1882; Contact: Stephen Atkinson, MD

Washington--Capitol Area Physicians Association, PO Box 32068 Calvert St. Station, Washington, DC 20007, 703/276-9410; Contact: Alan Valgamae, MD

[See related articles in this issue about AAPHR.]

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MMWR REPRINT ON SPECTINOMYCIN RESISTANT PPNG

Included with this Newsletter is the Feb. 4th Morbidity & Mortality Weekly Report (MMWR) article on "Spectinomycin Resistant Penicillinase-Producing Neisseria Gonorrhoeae," for your review.

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NCGSTDS NONCONFIDENTIAL MAILING LIST

The NCGSTDS regularly makes available its nonconfidential membership & mailing list to members to aid in the networking process. Please send corrections & updates to the NCGSTDS, PO Box 239, Milwaukee, WI 53201 (414/277-7671). Due to a fixed number of spaces allowed for last name on the word processor, some individuals had titles (MD, RN, etc.) omitted--our apologies! "Xxxs" indicate unknown or unlisted telephone. Special thanks to Don Schwamb, President of Milwaukee's GAMMA, for the use of his word processor for this compilation!

ABRAMSON, MD	LARY	3765 16TH ST	SAN FRANCISCO	CA	94114	415/565-6288
ADAMS	ROBERT	2223 WOODVIEW CT. #10	MADISON	WI	53713	608/251-3394
AMODIA, RN	ANTHONY	324 W. 77TH ST, APT 1	NEW YORK	NY	10024	212/873-9430
AYERS	JOYCE	CENTERS FOR DISEASE CONT	ATLANTA	GA	30333	404/329-3971
BABL	JAMES	213 FOURTH AV	VENICE	CA	90291	213/396-3575
BALES, MD	R. CRAIG	812 HAROLD	HOUSTON	TX	77006	713/XXX-XXXX
BALINT	RON	235 E. 202 ST.	BRONX	NY	10458	212/220-1689
BEHAR, PA-C	MARK	PO BOX 239	MILWAUKEE	WI	53201	414/277-7671
BELLIN, MD	EUGENE	3205 GRAND CONCOURSE	BRONX	NY	10468	212/364-3322
BERRILL	KEVIN	80 FIFTH AV. #1601	NEW YORK	NY	10011	212/000-0000
BLACK	MARK	251 W. 74TH ST., #6C	NEW YORK	NY	10023	212/877-0026
BOLAN, MD	ROBERT	667 LAKEVIEW AV.	SAN FRANCISCO	CA	94112	415/587-5569
BOWERS, MD	DANIEL	897 PORTLAND AV.	ST. PAUL	MN	55104	612/227-6983
BRANSON, MD	BERNARD	101 W. READ ST. SUITE 815	BALTIMORE	MD	21201	301/244-8484
BRAUNER, MD	GARY	1995 BROADWAY	NEW YORK	NY	10023	212/877-2800
BREWTON, MD	GARY	1661 HAWTHORNE	HOUSTON	TX	77006	713/522-7360
BUSTERNA	ROSEMARY	506 N. 48TH ST.	SEATTLE	WA	98103	206/783-2747
CACERES, MD	CESAR	1759 Q STREET, NW	WASHINGTON	DC	20009	202/667-5041
CALDERWOOD	DERYCK	27 HARVEY DR.	SUMMIT	NJ	07901	212/273-6278
CALIFIA	PAT	ADVOCATE PO BOX 5847	SAN MATEO	CA	94402	213/000-0000
CARR, RNP	GARY	222 MOULTRIE ST.	SAN FRANCISCO	CA	94110	415/821-0951
COHEN	BILL	69 WEST 9TH ST	NEW YORK	NY	10011	212/228-2800
CONTROL DIV	VD	CDC, BLDG. 1 ROOM 4017	ATLANTA	GA	30333	404/329-3343
DASSEY, MD	DAVID	1133 BLANE #48	RIVERSIDE	CA	92507	213/854-3011
DAVID, MD	HARRY S.	8733 BEVERLY BLVD. #408	LOS ANGELES	CA	90048	213/657-2202
DAVIS, MD	ROBERT	566 S. SAN VICENTE	LOS ANGELES	CA	90048	213/655-6331
DAVIS, RN	LISA	BOX 386 171 HARRISON AV	BOSTON	MA	02111	617/956-5292
DEYTON	BOPPER	5444 N. 22ND ROAD	ARLINGTON	VA	22205	703/000-0000
DIETZ, RN	SUSAN	2204 E. IVANHOE #3	MILWAUKEE	WI	53202	414/276-6071
DIGGIN	JERRY	PO BOX 2361	DALLAS	TX	75221	214/641-1677
DISABATO	JOE	POB A OLD CHELSEA STATION	NEW YORK	NY	10011	212/242-6863
DODGE, MD	WAYNE	5763 27TH AV., NE	SEATTLE	WA	98105	206/527-1196
DOREN	JACK	95 HORATIO ST. #10M	NEW YORK	NY	10014	212/691-0687
DOUGLAS, MD	ALBERT	227 E. HILDEBRAND AV	SAN ANTONIO	TX	78212	512/826-2311
DREISBACH	DYAN	61 JANE ST. #4F	NEW YORK	NY	10014	212/255-2174
DULL, MD	BRUCE	1447 PEACHTREE, NE #1010	ATLANTA	GA	30309	404/XXX-XXXX
FALK, PHD	LARRY	464 SHAWMUT AV	BOSTON	MA	02118	617/353-1024
FONVILLE, MD	TERRY	315 RIVERSIDE DR.	NEW YORK	NY	10025	212/222-7516
FOX, MD	FRED	9263 FAUNTLEROY WAY SW	SEATTLE	WA	98136	206/938-1390
GALVIN	JOHN	8640 CROMWELL DR.	SPRINGFIELD	VA	22151	703/978-9223
GASPARD	BARRY	720 FOX	DENVER	CO	80204	303/893-5653
GAUTHIER	THOM	7981 EASTERN AV.	SILVER SPRING	MD	20910	301/565-0333
GAYLE, MD	TERRY	2443 5TH AV. WEST	SEATTLE	WA	98119	206/283-2347
GOLDFIELD	MARK	292 PARK PLACE	BROOKLYN	NY	11238	212/789-0062
GORMAN	MICHAEL	1290 HOPKINS #38	BERKELEY	CA	94702	415/524-8141
GREMMINGER	ROGER	929 N. ASTOR ST. #1608	MILWAUKEE	WI	53202	414/765-0849
HICKEY, MD	TOM	435 E. 70TH ST. #9H	NEW YORK	NY	10021	212/628-8014
HILL	WILLIAM	5801 SPRING VALLEY #1712	DALLAS	TX	75240	214/386-5388
HOLDER	WILLIAM	3441 FORBES AV.	PITTSBURGH	PA	15213	412/578-8080
HUNT	KEN	2816 COLLEGE ST	JACKSONVILLE	FL	32205	904/389-8879
ISAAC, MD	RICHARD	190 ST. GEORGE ST. #605	TORONTO ONTARIO	M5R 2N4		416/968-2808
JOHNSON, PA	JOSEPH	1119 DAUPHINE APT. 10	NEW ORLEANS	LA	70116	504/524-7901

(CONTINUED)

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JOSHUA	JOSH	4800 FREMONT NORTH #218	SEATTLE	WA	98103	206/545-7165
KAHN, PHD	ARNOLD	1200 17TH ST., NW	WASHINGTON	DC	20036	202/833-7572
KEITH, MD	PAUL	6200 WILSHIRE BLVD #1510	LOS ANGELES	CA	90048	213/931-1463
KIMMEL	DOUG	PO BOX 3	HANCOCK	ME	04640	XXX/XXX-XXXX
KISSLING,PA	ALBERT	21 REDDING ST	HARTFORD	CT	06114	203/249-2660
KLEIN, MD	TOM	4200 MARINE DR. #501	CHICAGO	IL	60613	312/472-4677
KOODEN	HAL	154 8TH AV.	NEW YORK	NY	10011	212/243-3582
KRISTAL	ALAN	316 W. 75TH ST. #4C	NEW YORK	NY	10023	212/580-2562
LEAR, MD	WALTER	206 N. 35TH ST.	PHILADELPHIA	PA	19104	215/386-5327
LEMLEY	CRAIG	225 ADAMS ST. APT 9A	BROOKLYN	NY	11201	212/522-1123
LEWIS, RN	ANGIE	POB 710	WOODACRE	CA	94973	415/488-0381
LOOMIS, PHD	MAURICE	570 61ST ST.	OAKLAND	CA	94609	415/653-3336
LOVE	MARJORIE	4714 WARRINGTON AV	PHILADELPHIA	PA	19143	215/724-5793
MANDEL, RN	BEA	VDNH--260 SHERIDAN AV	PALO ALTO	CA	94306	800/227-8922
MATHEWS, MD	CHRIS	4621 VISTA ST.	SAN DIEGO	CA	92116	714/584-4958
MAYER, MD	KEN	369 TAPPAN ST. APT. 18	BROOKLINE	MA	02146	617/232-9861
MCGOVERN	JOHN	626 WEST END AV.	NEW YORK	NY	10024	212/874-0075
MCGRAW, MD	PATRICK	450 SUTTER ST. #1504	SAN FRANCISCO	CA	94108	415/391-0103
MCMILLEN	HARLEY	2676 N. HALSTED	CHICAGO	IL	60614	312/871-5777
MCSHANE, MD	DENNY	152 HEDGE RD	MENLO PARK	CA	94025	415/327-6642
MILLER	ALAN	CGA--PO BOX 639 STA. A	TORONTO ONTARIO	M5W	1G2	416/XXX-XXXX
MILLER, DO	STEPHEN	4212 KENSINGTON	DETROIT	MI	48224	313/886-4412
MILLIGAN	WILLIAM	69 HADDONFIELD-BERLIN RD	CHERRY HILL	NJ	08034	609/429-4179
MULCAHEY	PATRICK	144 MAIN ST #5	NORWALK	CT	06851	203/847-6229
MYERS, MD	LONNY	10947 S. LONGWOOD DR.	CHICAGO	IL	60643	312/445-7656
NICHOLS, PHD	MARGARET	300 RARITAN AV	HIGHLAND PARK	NJ	08904	201/229-7949
NYLUND	THOMAS	4422 CLINTON ST.	LOS ANGELES	CA	90004	213/665-8943
OLIVER, MD	DENNIS	140 WEST 71ST ST. #5B	NEW YORK	NY	10023	212/724-6832
OSTROW, MD	DAVID	155 N. HARBOR DR. #5103	CHICAGO	IL	60601	312/565-2109
OWEN, MD	WILLIAM	1580 VALENCIA ST. #202	SAN FRANCISCO	CA	94110	415/826-2400
PALMER, PA	JOHN	301 W. 22ND ST.	NEW YORK	NY	10011	212/253-3620
PAROSKI, MD	PAUL	114 WILLOUGHBY AV.	BROOKLYN	NY	11205	212/622-3000
PEACOCK	ROSS	985 MADISON AV.	NEW YORK	NY	10021	212/535-7200
PFEFFER	DAN	347A MERMAID	LAGUNA BEACH	CA	92651	714/494-0293
PICKETT,MD	ROGER	4052 N.W. 61ST ST.	OKLAHOMA CITY	OK	73112	405/942-3189
POMERANTZ	SANDY	(SEE THOMPSON, MD HARVEY)				
READ, MD	STAN	11 BROOKLYN AV	TORONTO ONTARIO	M4M	2X4	416/461-4371
RICE	HUGH O.	1426 N. FORMOSA AV., #2	LOS ANGELES	CA	90046	213/851-2134
RICE, RN	KEVIN	11235 OAK LEAF DR. #1713	SILVER SPRING	MD	20901	301/593-3021
RICHARDS	JEFF	41 LANDERS APT. 2	SAN FRANCISCO	CA	94114	415/861-1880
ROBERTS, MD	BOB	8315 N. BROOKLANE #801 W	BETHESDA	MD	20814	301/652-2840
ROBERTS, PA	CRAIG	511 W. JOHNSON ST. #301	MADISON	WI	53703	608/256-0768
RUTHERFORD	MIKE	GPA PO BOX 33605	WASHINGTON	DC	20033	202/387-2430
RYBICKI	NEAL	1709 SHATTUCK AV. #225	BERKELEY	CA	94709	415/843-4714
SABELLA	WILLIAM	BOX 7	NORTH HAVEN	CT	06473	203/239-7881
SABLE, MD	RON	3719 N. MAGNOLIA	CHICAGO	IL	60613	312/929-4439
SCHRAM, MD	NEIL	6200 VIA SUBIDA	PALOS VERDES	CA	90274	213/548-0491
SCHUMAN, PA	ERIC	5817 S.W. 22ND TERR. #4	TOPEKA	KS	66614	913/272-5394
SHASKEY	DALE	713 W. WRIGHTWOOD AV.	CHICAGO	IL	60614	312/000-0000
SIROTY, MD	WILLIAM	222 EAST 19TH ST. #1E	NEW YORK	NY	10003	212/673-8452
SMITH	ROY	1420 N ST., NW, #502E	WASHINGTON	DC	20005	202/234-7197
SMITH, MD	J.R.M.	601 CORYDON AV.	WINNEPEG MANITOBA	R3L	0P3	204/475-3540
STAEBLER	JAMES	2222 FULLER RD. #713A	ANN ARBOR	MI	48105	313/995-0956
STARRETT, MD	BARBARBA	88 UNIVERSITY PL.	NEW YORK	NY	10003	212/691-4383
STEFFEN, PA	GEORGE	6300 N. KENMORE	CHICAGO	IL	60660	312/262-6789
STEINMAN,PHD	RICHARD	U.S.ME--96 FALMOUTH ST	PORTLAND	ME	04103	207/780-4174
TAYLOR, MD	ROBERT	1755 BEACON ST.	BROOKLINE	MA	02146	617/232-1459

(Continued)

BURSAW	MIKE	9715 5th St.	Highland	IN	46322	219/924-0963

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THOMAS	JOHN	PO BOX 840	ELIZABETH	NJ 07207	XXX/XXX-XXXX
THOMPSON,MD	HARVEY	912 A 21ST ST.	SACRAMENTO	CA 95814	916/441-2636
TILLOTSON	TIM	1552 UNIVERSITY AV.	MADISON	WI 53706	608/256-8476
TRUAX, MD	A. BRAD	3340 KEMPER ST. SUITE 102	SAN DIEGO	CA 92110	619/224-2921
VACHON, PA	RON	506 W. 42ND ST. #E5	NEW YORK	NY 10036	212/563-6313
VOELLER	BRUCE	MARIPOSA-66 W. 88 ST. #1D	NEW YORK	NY 10024	212/000-0000
WAITKEVICZ	JOAN	1 HAVEN PLAZA	NEW YORK	NY 10009	212/475-6030
WAKIL	AIDA	PO BOX 2901	DURHAM	NC 27705	919/286-2275
WESTMORELAND	TIM	2415 RAYBURN HOB	WASHINGTON	DC 20515	202/225-4952
WHEELER, MD	JIM	3613 FAIRMOUNT	DALLAS	TX 75219	214/559-2590
WHYTE, MD	JOHN	1831 OLIVER AV., NORTH	MINNEAPOLIS	MN 55411	612/521-0625
WILLIAM, MD	DAN	69 5TH AV., #10J	NEW YORK	NY 10003	212/924-0139
WOOD, MD	BOB	3408 S. KING ST.	SEATTLE	WA 98144	206/329-3927
ZALTZBERG	ELLEN	40 MULBERRY ST. #4R	NEW YORK	NY 10013	212/477-2005

PEOPLES GAY ALLIANCE	413 STUDENT UNION	UNIV. OF MASS.	AMHERST	MA 01003	XXX/XXX-XXXX
STD CLINIC OF ANCHORAGE	LAUREL STOLPE, RN	825 "L" STREET	ANCHORAGE	AK 99501	907/264-4611
LAMBDA HEALTH PROJ OF ANN ARB	3118 MICHIGAN UNION	530 S. STATE ST.	ANN ARBOR	MI 48109	313/763-4186
AID ATLANTA	JOHN KOPCHAK, PA-C	PO BOX 52785	ATLANTA	GA 30305	404/872-0600
PHYSICAL HEALTH COMMITTEE	ATLANTA GAY CENTER	848 PEACHTREE ST N.E.	ATLANTA	GA 30308	404/876-5372
GAY COMMUNITY CENTER CLINIC		241 W. CHASE ST.	BALTIMORE	MD 21201	301/837-5446
GAY MEN'S HEALTH COLLECTIVE		2339 DURANT AV.	BERKELEY	CA 94704	415/524-2570
FENWAY COMMUNITY HEALTH CTR	KEN MAYER, MD	16 HAVILAND ST.	BOSTON	MA 02215	617/267-7573
MAYOR'S TASK FORCE ON AIDS	BRIAN MCNAUGHT	CITY HALL	BOSTON	MA 022??	617/424-5916
HOWARD BROWN MEMORIAL CLINIC	HARLEY MCMILLEN, DIREC.	2676 N. HALSTED	CHICAGO	IL 60614	312/871-5777
GAY & LESBIAN HEALTH ALLIANCE	OF DENVER--JEFF ADAMS	PO BOX 6101	DENVER	CO 80206	303/777-9530
PALMER CLINIC	JANICE DADY, DIRECTOR	22750 WOODWARD AV. #309	FERNDALE	MI 48220	313/823-5653
KS COMMITTEE OF HOUSTON	PO BOX 1155	3317 MONTROSE	HOUSTON	TX 77006	713/666-8251
THE MONTROSE CLINIC	FRANK BERRIER, DIR.	104 WESTHEIMER	HOUSTON	TX 77006	713/528-5535
MONROE COUNTY HEALTH DEPT	PUBLIC SERVICE BLDG.	JR. COLLEGE ROAD	KEY WEST	FL 33040	305/294-1021
LA SEX INFORMATION HOTLINE	JOHN KERR	8405 BEVERLY BLVD.	LOS ANGELES	CA 90048	213/653-2118
THE CLINIC--GAY & LESBIAN	COMMUNITY SERVICES CTR	1213 N. HIGHLAND AV.	LOS ANGELES	CA 90038	213/464-7480
BLUE BUS CLINIC	TIM TILLOTSON	1552 UNIVERSITY AV.	MADISON	WI 53706	608/262-7440
AMERICAN ASSN PHYS HUMAN RTS	DENNY MCSHANE, MD	152 HEDGE ROAD	MENLO PARK	CA 94025	415/327-6642
BRADY EAST STD CLINIC		1240 E. BRADY ST.	MILWAUKEE	WI 53202	414/272-2144
LESBIAN & GAY COMMUNITY	SERVICES CENTER	124 WEST LAKE ST., #E	MINNEAPOLIS	MN 55408	612/827-5614
MONTREAL HEALTH PRESS	DONNA CHERNIAK, MD	POB 1000 STATION "G"	MONTREAL QUEBEC	H2W 2N1	514/272-5441
YALE SELF CARE NETWORK	PEACHES QUINN	17 HILLHOUSE AV.	NEW HAVEN	CT 06520	203/XXX-XXXX
GAY MEN'S HEALTH CRISIS	PO BOX 274	132 WEST 24TH STREET	NEW YORK	NY 10011	212/685-4952
GAY MENS HEALTH PROJECT		74 GROVE ST., #2J	NEW YORK	NY 10014	212/691-6969
NATIONAL GAY TASK FORCE		80 FIFTH AV. #1601	NEW YORK	NY 10011	212/741-5800
NEW YORK DEPT. OF HEALTH	YEHUDI FELMAN, MD	93 WORTH ST., #306	NEW YORK	NY 10013	212/566-7685
SIECUS	LEIGH HALLINGBY	80 FIFTH AV. #801	NEW YORK	NY 10011	212/929-2300
ST. MARKS CLINIC		88 UNIVERSITY PLACE	NEW YORK	NY 10003	212/691-8282
PHILADELPHIA COMMUNITY HEALTH	ALTERNATIVES	PO BOX 7259	PHILADELPHIA	PA 19109	215/624-2879
PITTSBURGH FREE CLINIC		121 S. HIGHLAND AV.	PITTSBURGH	PA 15206	412/661-6604
NEW HAMPSHIRE FEMINIST HEALTH	CENTER	232 COURT STREET	PORTSMOUTH	NH 03801	603/436-6171
LESBIAN & GAY PEOPLE IN	MEDICINE--AMSA	1910 ASSOCIATION DR.	RESTIN	VA 22091	703/620-6600
HEPATITIS B PROJECT	KEN BROCK, MSW	PO BOX 160486	SACRAMENTO	CA 95816	916/453-8995
BEACH AREA COMMUNITY CLINIC	TERRY CUNNINGHAM	3705 MISSION BLVD.	SAN DIEGO	CA 92109	619/488-0644
SAN DIEGO PHYS FOR HUMAN RTS	CHRIS MATHEWS, MD	PO BOX 16242	SAN DIEGO	CA 92116	619/XXX-XXXX
KS CLINIC	A--312	UCSF HOSPITALS & CLINIC	SAN FRANCISCO	CA 94143	415/666-1407
KS RESEARCH & EDUCATION FOUND.	470 CASTRO ST. #207	BOX 3360	SAN FRANCISCO	CA 94114	415/864-4376
THE RESOURCE FOUNDATION		130 CHURCH ST.	SAN FRANCISCO	CA 94114	415/864-0550
SEATTLE GAY CLINIC		PO BOX 20066	SEATTLE	WA 98102	206/329-8390
TUCSON GAY HEALTH PROJECT		PO BOX 2807	TUCSON	AZ 85702	602/748-7339
OKLAHOMANS FOR HUMAN RIGHTS	AL KRUMREY	1932 "C" S. CHEYENNE	TULSA	OK 74119	918/583-7323
WHITMAN-WALKER GAY MEN'S VD	CLINIC	2335 18TH ST., NW	WASHINGTON	DC 20009	202/332-5295

AIDS PROJECT/LOS ANGELES	MATT REDMAN	937 North Cole #3 Los Angeles CA 90038	213/650-4123
GAY & LESBIAN COMM. CTR.		1436 Lafayette St. Denver, CO 80218	303/831-6268

NCGSTDS PROVIDES AIDS INFORMATION

The NCGSTDS Newsletter was designated "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) is relegated to this special section in the back of each issue. Your literary contributions are invited!

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NEUROPSYCHIATRIC SIGNS SEEN IN AIDS PATIENTS

According to the January, 1983 Clinical Psychiatric News, neurologic or neuropsychiatric symptoms may be the initial symptoms in AIDS patients, according to Dr. Carolyn B. Britton, MD, of the Columbia University College of Physicians & Surgeons Neurological Institute of New York, and Dr. Sandra L. Horowitz, MD, of St. Vincent's Hospital and the University of Massachusetts Medical School in Worcester. Neurologic complications of AIDS can be devastating regardless of when symptoms appear, which may be at any time during the course of the illness, and may involve any level of the central nervous system. Yet neurologic symptoms frequently are misdiagnosed as being caused by metabolic or psychiatric illness; or these symptoms are overlooked among the multiple opportunistic infections and myriad complications present in patients with AIDS. The first symptom of neurologic involvement may be personality change, progressive neurologic dysfunction leading to death, or other nonspecific symptoms in a person who already has numerous infections and complications. Nonspecific symptoms may include fever, gastrointestinal complaints, weight loss, seizures, or mental impairment. Neurologic symptoms may appear as lethargy, depression, weakness, hallucinations, painful paresthesias, focal deficits, seizures, and progressive dementia. Although these symptoms reflect CNS involvement, they can all be treated. One of the patients studied was a 28 year old previously healthy homosexually active man who presented with PCP and progressive dementia that manifested as decreased ability to function, memory loss, and lack of spontaneity in action. His condition progressed to hyperreflexia & seizures; computerized tomography (CT) scans demonstrated cerebral atrophy. Autopsy findings revealed a discolored and gray white matter, with necrotic foci, blood vessels that were prominent in the diseased tissue, and inflammatory cells arranged in a perivascular pattern with eosinophil cells. Cytomegalovirus (CMV) was grown in culture from samples taken from the diseased brain tissue. Another patient presented with KS, retinopathy due to CMV, depression, and confusion. He progressed to a stuporous state, and despite dexamethasone treatment, brain tissue rapidly degenerated, as shown on CT. On autopsy, the victim's basal ganglia had been replaced with a boggy mass of necrosis, inflammation and edema. Personality changes are often misdiagnosed when they are the first symptom of the condition. One AIDS patient was originally diagnosed as a paranoid schizophrenic when he became hostile, disagreeable, irritable, and anxious. When the man's condition worsened, AIDS was finally diagnosed due to the more apparent physical findings--thrush & CMV of the eyes & esophagus; disseminated atypical mycobacteria was present at autopsy.

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AIDS EPIDEMIOLOGY UPDATE

As of March 3, 1983, the Centers for Disease Control AIDS Task Force reports a total of 1128 US cases of AIDS (KS, PCP, and other opportunistic infections), and 70 foreign cases from 15 other countries. 72.0% of the cases are identified as homosexually (& bisexually-) active, 16.6% IV drug user, 4.4% Haitian, 1.0% Hemophiliac, and 6.0% in no apparent risk group or unknown. This data reflects US cases only. 21.6% are from individuals aged 20-29, 48.4% from 30-39, and 21.3% from 40-49; the remainder are in all other age groups. Thirty-five states have reported cases, with New York State having 49.7% (NY City--45.6%); California, 20.7%; New Jersey, 6.7%; Florida, 5.9%; Texas, 2.3%; and Illinois, 2.0%. Remaining states have less than 2%: Pennsylvania, Georgia, Massachusetts, Connecticut, and Ohio. All other states (those not listed) have less than

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AIDS PROJECT/LOS ANGELES EXPANDS SERVICES

The AIDS Project/Los Angeles (AIDS-PLA) has announced an expansion of its services in response to increased community awareness of AIDS and increasing numbers of patients requiring assistance. AIDS-PLA hopes to serve the needs of the greater Los Angeles area regarding AIDS by: 1) dissemination of correct, up-to-date information through the AIDS hotline, printed materials, and community meetings; 2) provision for patient support and services through home help assistance, individual counseling, support groups, medical and mental health referral, legal advice, and direct financial aid; and 3) provision for clinical screening. This work is being accomplished by the work of over 120 dedicated volunteers, and by the institution of a professional advisory committee which includes members of the medical, legal, and mental health communities who are especially concerned and knowledgeable about AIDS.

More specifically, public services include 4 areas. Education: provides medical briefings, public forums, and published materials to groups and individuals that are concerned about AIDS and related diseases; it also provides training for professionals that may be directly involved with AIDS patients (eg, physicians, psychologists, social workers, attorneys, clergy). AIDS Hotline (213/461-1333, M-F 9 am-9 pm; answering service during off hours): provides up-to-date information to the community at large regarding AIDS & related diseases and issues. Referrals to other community resources, ie, physicians, psychologists, are made so more extensive assistance can be received. Hotline staff consists of trained listeners that assist the callers in problem solving methods in order to reach a resolution to their problems. Complete confidentiality & anonymity is assured. Patient Support: provides direct services to identified AIDS patients through weekly group support sessions located throughout the greater LA area; also provides individual counseling, legal and financial aid, as well as home help assistance (Hospice program) for seriously ill patients. Clinical Screening: will screen persons who suspect they may have AIDS or AIDS related diseases, and refer them when necessary for medical evaluation.

There are 7 project support services, as well. Personnel: involved with maintaining up-to-date records on all volunteers directly working with the Project, as well as doing active recruitment, screening, and assigning of volunteers to various project areas. Fund-raising: responsible for raising funds to provide direct services to AIDS patients and to educate the community at large. Training: responsible for training Hotline volunteers, establishing an on-the-job training program for Hotline listeners, and training new instructors for teaching Hotline training methods. All listeners are trained in the medical aspects of AIDS and related diseases as well as "active listening" techniques. Networking: responsible for keeping the entire Project staff informed on all aspects of Project functioning; and for distribution of up-to-date published information about AIDS to the staff. Graphics: responsible for all matters in teh Project that require design assistance; eg, logos, pamphlets, brochures, fliers, posters, stationery, etc. Public Relations/Publicity: responsible for press releases and conferences; encompasses all media relations. Archives: responsible for collecting and maintaining all materials relative to AIDS and related diseases & issues.

For additional information, contact Matt Redman, AIDS-PLA, 937 North Cole, #3, Los Angeles, CA 90038, 213/650-4124.

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CHICAGO'S AIDS ACTION PROJECT PUBLISHES QUARTERLY NEWSLETTER

The Newsletter is designed to bring up to date and keep informed all contributors, volunteers, interested parties, and sponsors who have provided support to the AIDS Action Project of the Howard Brown Memorial Clinic in Chicago. In addition to its being a continuing source of current information about AIDS, it will contain news regarding AIDS Action Progress & development, editorials, & upcoming fundraising projects & benefits. Activities that have benefited the AIDS Action Project include: *"Cornucopia" benefit presenting an evening of music, mime, dance, magic, & comedy (it grossed $23,000!); * A "slave auction" & weekend of entertainment at several area bars; *A winter softball game; *A pajama party; *A tupperware party; *A raffle for 2 roundtrip tickets to New York City; and many others. For more information, contact AIDS Action Project Coordinator Sarah Gross, HBMC, 2676 N. Halsted, Chicago, IL 60614 (312/871-5777).

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AIDS ARCHIVES BEGUN BY GAY MEN'S HEALTH CRISIS

from Press Release

A central source of information about the outbreak of Acquired Immune Deficiency Syndrome (AIDS) from sources all over the world has been started by New York City's Gay Men's Health Crisis (GMHC).

GMHC Secretary Brad Frandsen, coordinator of the Archives Project, said that the Archives now contains a comprehensive list of medical and scientific professional journal articles in the US and Western Europe, as well as major general press articles. Special attention is being paid to compiling a file of clippings from all gay publications all over the world. Contributions of clippings (dated and with the name of publication) may be sent to Brad at the GMHC, PO Box 274, 132 W. 24th St., New York, NY 10011 (212/807-6655). The Archives will be available to anyone having a serious interest in AIDS research. GMHC Executive Director Mel Rosen recommends that prior arrangement to visit the GMHC Archives be made by mail or telephone.

Founded in early 1982, GMHC is a non-profit corporation of volunteers working to assist AIDS patients and to inform the public with accurate and up-to-date information about the spectrum of rare and sometimes fatal diseases to which the syndrome disposes.

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CANADIAN GAY ARCHIVES PRODUCES AIDS BIBLIOGRAPHY

compiled by Alan V. Miller

The first major bibliography to deal with material on and about AIDS, "Gays and Acquired Immune Deficiency Syndrome (AIDS)" is now available from Canadian Gay Archives for $2. The 22 page bibliography is listed alphabetically by author up to November, 1982, and was compiled by Alan V. Miller. For more information, write to: The Canadian Gay Archives, PO Box 639 Station A, Toronto, Ontario M5W 1G2 Canada, 416/977-6320.

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GMHC PUBLISHES SECOND AIDS NEWSLETTER

The second issue of the AIDS Newsletter published by New York's Gay Men's Health Crisis features epidemiologic updates, articles about risk reduction, blood donation, among others, and information about New York City referrals, and AIDS groups in other metropolitan areas. The 62 page newsletter also has an updated list of gay, mainstream & medical references on AIDS. For a free copy of the newsletter, write or call: GMHC, Box 274, 132 West 24th Street, New York, NY 10011, 212/807-6655. Over 100,000 copies of the second newsletter were published.

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SAN FRANCISCO KS FOUNDATION PRODUCES ANNOTATED BIBLIOGRAPHY

A comprehensive, annotated bibliography on AIDS is now available from the Kaposi's Sarcoma Research & Education Foundation in San Francisco. Included are listings from American, Canadian, and British medical and research journals addressing the recent outbreak of acquired immune deficiency syndrome (AIDS), Kaposi's sarcoma, pneumocystis carinii pneumonia, and other associated opportunistic infections. Being updated monthly under the direction of qualified medical professionals & researchers, it draws from a wider resource base and is more timely than similar listings obtained through commonly accessed data bases, such as MedLine, et al. In addition to the general bibliography which contains over 300 listings, field-specific bibliographies will be available upon request. For additional information, please contact: Rick Crane, KS Research & Education Foundation, PO Box 14227, San Francisco, CA 94114, 415/864-4376.

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FDA AUTHORIZES NEW MEDICATIONS FOR OPPORTUNISTIC INFECTIONS

from FDA Drug Bulletin, December, 1982

"...Treatment of patients with AIDS is challenging because they often have multiple opportunistic infections, and there are a limited number of drugs available to treat these ailments. Some suggestions concerning therapy, including an overview of commercially available drugs, were made at a recent conference of the AMerican Society for Microbilogy at the Memorial Sloan-Kettering Cancer Center. FDA is working to facilitate the availability of an Investigational New Drug Application (IND) to permit the New York City Health Dept. to store and distribute to qualified clinicians Ansamycin, a rifampicin derivative that is an investigational drug. Ansamycin is useful in treating infections caused by Mycobacterium avium, one of the opportunistic infections that has been seen in patients with AIDS. (Mycobacterium avium is an avian type of tuberculosis, commonly producing disease in chickens and swine, but rarely in humans.) FDA is also investigating whether the veterinary drug Amprolium can be used safely in humans to treat cryptosporidiosis, a protozoan infection usually found in cattle, but which has been reported in persons with AIDS...."

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WASHINGTON, DC FORMS NEW AIDS GROUP

Washington, DC's Whitman-Walker Clinic established a new unit within the Clinic's structure to assist with AIDS related issues in the Washington metropolitan area. The AIDS Education Fund will initially provide up-to-date information about AIDS to bothe the gay and non-gay communities, according to Whitman-Walker President Jim Graham. The Fund may also expand its activities to include counseling and other services to AIDS patients similar to services by AIDS groups in New York, San Francisco, and other cities. One of the first projects of the group will be to improve surveillance of AIDS cases, and to inform patients and their physicians of the availability of support groups from the gay community. Another project will be an official proposal to Mayor Marion Barry calling for the creation of a city task force on AIDS which would examine the availability of various city agencies and programs that may be used to assist AIDS patients. For additional information, contact: AIDS Education Fund, Whitman-Walker Clinic, 2335 18th St., NW, Washington, DC 20009 (202/332-5295).

--from The Washington Blade, 2/4/83

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SAN FRANCISCO AIDS CLINIC

by Helen Schietinger

San Francisco now has an AIDS Clinic, in which symptomatic patients who have been seen by a primary care physician can be extensively worked up by a multidisciplinary team for opportunistic infections. The history of how this came about is somewhat complex, so I'll begin chronologically.

The first institution in San Francisco to actively address AIDS was University of California--San Francisco (UCSF), where the Kaposi's Sarcoma Clinic was established 1½ years ago. Diagnosed KS patients are referred to the Clinic for a systematic workup to determine the extent of their disease. They are monitored at the Clinic, while either being referred back to the diagnosing physician for treatment or to the San Francisco General Hospital Oncology Clinic directed by Paul Volberding, who is also co-director of the KS Clinic. (This oncology clinic is both the county hospital and an affiliate of UCSF.) To date, over 60 diagnosed KS patients have been seen at the KS Clinic, most receiving treatment by Volberding. Many community physicians have visited the Clinic to increase their knowledge of KS and AIDS.

As the number of persons with AIDS symptoms has increased, the City of San Francisco has responded to the crisis. Primary screening for KS and oppertunistic infections (OI) has been established in one primary health care clinic and will soon occur in another. There are frequent AIDS workshops and trainings offered to health department personnel, and health department physicians are trained to recognize signs and symptoms through what is now the AIDS Clinic at San Francisco General Hospital. The Health Department hosts the AIDS Coordinating

(Continued)

SAN FRANCISCO AIDS CLINIC, Continued

Committee, a monthly or bimonthly meeting of representatives form all organizations, agencies and institutions in the city which are dealing with the AIDS crisis in some capacity. This has been an invaluable forum for dialog and communication for practitioners within San Francisco

As the number of persons with generalized AIDS symptoms has increased and the need for a specialty clinic has grown, the City of San Francisco has funded additional staff for the San Francisco General Hospital KS/Oncology Clinic, expanding it into an AIDS/Oncology Clinic. Already the pulmonary and infectious disease services had worked closely with the oncology clinic in treating AIDS patients, establishing diagnostic protocols for OIs and a treatment protocol for pneumocystis carinii pneumonia (PCP). Now this expertise has been officially combined into a multidisciplinary team within the AIDS/Oncology Clinic.

Symptomatic patients are referred to the AIDS Clinic form elsewhere, to be first seen in the nurse-screening clinic, and a history is taken and appropriate basic tests are ordered. The person is then seen in the AIDS Clinic where a more extensive history & physical exam, and testing are done. There are weekly orientation workshops offered to new patients, one to answer medical questions, and the other to focus on psychosocial and lifestyle issues which are of concern to both diagnosed and potential AIDS patients. Community physicians regularly visit the clinic to learn to recognize and diagnose AIDS illnesses.

Ironically, the month the AIDS Clinic openned at SFGH with its multidisciplinary staff, the staff stopped funding health care for its "medically indgent adults," a category in which many AIDS patients find themselves, having lost insurance coverage along with their jobs because of being ill, or having no insurance in the first place. These people are now dependent on the county hospital for medical care. Fortunately, San Francisco now has an AIDS clinic which is well equipped to address the needs of the AIDS patient in its county hospital. There is a wide range of hospitals and private physicians in San Francisco with the specialized expertise needed to treat the AIDS patient medically.

For more information, contact: Helen Schietinger, KS Clinic, A312, UCSF Hospital & Clinics, San Francisco, CA 94143, 415/666-1407.

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BLOOD CENTER SCREENS DONORS FOR SYMPTOMS, NOT SEXUAL/AFFECTIONAL ORIENTATION

The Blood Center of Southeastern Wisconsin, Inc. (also known as the Milwaukee Blood Center) has initiated a new uniform screening procedure for all volunteer donors, after extensive negotiations with medical staff of the Brady East STD (BEST) Clinic. In addition to the usual questions asked of all volunteer donors (such as, "Ever had yellow jaundice, hepatitis, or a positive hepatitis test?" "Ever injected yourself with any drugs?" etc.), five additional questions are being asked: "Experienced night sweats?" "Had unexplained fevers?" "Had unexpected weight loss?" "Had massively enlarged lymph nodes?" and "Had Kaposi's sarcoma (a form of cancer)?" The Center rejected the suggestion to ask potential donors about sexual preference, as certain other blood collection agencies have done. The medical director of the Blood Center, Jay Menitove, MD, has served as one of the representatives of the Council of Community Blood Centers, which along with the American Red Cross and the American Association of Blood Banks, among several other groups, issued the joint statement on AIDS related to transfusion. The Blood Center will be assisting the BEST Clinic in distributing wallet-sized AIDS information cards to members of the gay community in the Milwaukee metropolitan area. Dr. Roger Gremminger, MD, medical director, and Mark Behar, member of the board of directors of BEST Clinic (and of the NCGSTDS) have met every 2-3 weeks with Menitove, helping to raise issues about gay health concerns with Menitove.

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HOMOPHOBIC BACKLASH AMONG DALLAS PHYSICIANS

Dallas, Texas is the site of a new group of physicians, "Dallas Doctors Against AIDS," which plans to file an amicus curiae (friend of the court) in the 5th District Court on behalf of an appeal of the case that struck down the Texas sodomy law as unconstitutional. They plan to argue that sodomy is a public health hazard, due to its purported relationship to AIDS.

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RESPONSE TO "YOUR IMMUNE SYSTEM AND NUTRITION" SENT TO ADVOCATE & EDITORIAL COMMENT

by Peter McKnight, Registered Dietitian

The following letter was sent to the Advocate in response to the article, "Your Immune System and Nutrition." The article recommended some potentially dangerous nutritional practices, recommendations inconsistent with those made by scientists & researchers. This is probably not the first time misinformation will be promulgated on AIDS, and certainly won't be the last. I would like to add that as health professionals, we should be on the watch for health quacks who might use this sad epidemic to their profit.

"Dear Editor: I'm disappointed that the Opinions column has had no letters from health professionals warning that following the advice in "Your Immune System and Nutrition" (issue 360) may be hazardous to your health.

"Malnutrition will result in a severely impaired immune system, hence adequate nutritional intake is important; however the dangers of overnutrition are just beginning to be understood. The article seems to say that taking megadoses of vitamins and minerals could help protect against AIDS. This practice could be dangerous, and is certainly inconsistent with the recommendations made by nutrition professionals regarding nutrition and good health.

"AIDS is a scary phenomenon, and we all want to do what we can to prevent its spread, but we must be careful to take a rational and scientific approach to this very serious problem."

[Editorial comment by Editor: I totally agree with Peter's comments and am very glad he responded. The Advocate article sounded like a promotion for vitamin & mineral sales. Although the article suggested the use of numerous vitamins & minerals in megadoses for promotion of health and enhansing the body's immune system, no mention is made of the interaction of those megadoses of vitamins & minerals when used together. Finally, the article seems to offer a simplistic solution to what is turning out to be one of the most challenging medical mysteries of all time. Many of the readers are at high risk and are scared & vulnerable, eager to try any reasonable or logical approach, especially if it's as easy as popping some pills--considerably easier than modifying one's sexual activities. Unlike laetrile, which was proven to be worthless in scientific trials, effects of megadose vitamin & mineral therapy are not well known. It is imperative that we gay health professionals inform our communities about these uncertainties so that they can make well informed decisions about health maintenance. --Mark Behar]

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CANCER INFORMATION SERVICE OFFERS RESOURCES

by Michael Wilson

Wondering how to acquire information about Kaposi's sarcoma for your agency's files? Contact the closest Cancer Information Service (CIS) for extensive information not only on specific diseases, but also on training of people working in information calling services. Local United Way agencies, or local chapters of the National Alliance of Information & Referral Services may also have valuable resources.

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CAUSATIVE THEORIES REGARDING AIDS: A REVIEW OF CURRENT EVIDENCE

by David G. Ostrow, MD, PhD

Reprinted with permission, Homosexual Health Report (Volume 1:3)

Many theories have emerged during the past 18 months regarding the cause(s) of the current epidemic of AIDS cases among sexually active gay men, IV drug abusers, Haitian immigrants to the US, heterosexual prostitutes, and perhaps some hemophiliacs and rare blood transfusion recipients. The search for a causative agent or agents has been both helped by the diversity of groups affected (resulting in a variety of different risk situations which can be independently examined for consistency of causation) and hindered by the ultimate "acid test" for a unitary AIDS agent: If there is a single causative agent, then it must be present in all groups currently affected. As attractive as such a unitary hypothesis/test of causation is, I believe that it is an extreme oversimiplification of reality and ignores the massive body of evidence available to us regarding other chronic disease states, such as lung cancer and arteriosclerotic heart disease (AHD). Risk factor research in those and other fields has resulted in long laundry lists of established, probable, and even improbable risk factors. While certain of those risk factors do indeed apply to all groups affected (eg. cigarette smoking and both lung cancer and AHD), other risk factors are dependent on the presence of "cofactors" such that their absence in a particular group at risk does not rule out their involvement in other groups in which the cluster of necessary cofactors is present. Using the above analogy to AHD research, I have been told by Dr. Jeremiah Stamler, the inventor of the term "risk factor", that lack of exercise is only a significant and probable risk factor if an individual also smokes and is overweight. With these concepts in mind, I would like to review the evidence for and against the major putative AIDS agents. Remember that all of these agents are still only to be considered as putative, and none fulfills more than 2 or 3 of the 7 or 8 criteria for an established risk factor at this time. Individuals may quarrel with my emphasis on the "risk factor" criteria in contrast to straightforward etiologic evidence. However, the current state of research on AIDS is restricted entirely to the epidemiolgoical investigation of associations between specific risk factors and the syndrome(s). While research is ongoing on laboratory models, it will be some time before such models have progressed to the stage where they can be used to independently prove/disprove risk factors identified from epidemiological investigations. Persons dispairing over this slow rate of progress should take note of the fact that after 30 years of experimental research on the relationship between cigarette smoking and lung cancer, we have yet to establish the exact mechanism(s) of oncogenesis in human lung tissue. However, this has not prevented the formulation and institution of educational and public health policy programs aimed at reducing the incidence of lung cancer in the general population.

Behavioral risk factors: The CDC case control studies as well as individual city studies (NYC, SF and Chicago) have repeatedly identified number of different sexual partners (both lifetime and recent past period), past history of STDs, and increased use of certain drugs (namely marijuana, volatile nitrites or "poppers", and cocaine in some but not all studies) as the major "behavioral" risk factors differentiating AIDS cases from homosexually active male controls. However, it is rather uniformily agreed upon that all of these factors co-vary together very closely in homosexually active men, and so probably represent non-independent risk factors relating to one or more underlying causes. The presence of individuals with AIDS who are relatively monogamous is often pointed to as evidence against "promiscuity" as a major risk factor. As noted above, this may be a misleading factor: certainly hepatitis B (HB) is transmitted both sexually and non-sexually and the presence of non-sexually acquired cases does not rule out the role of "promiscuity" in the epidemic nature of HB infection among homosexually active men. In terms of more specific behavioral risk factors, the CDC has identified "fisting" as a more common practice in their cases vs. controls, while we have identified annalingus to be significantly more frequent in Chicago cases when compared with "healthy" control subjects. Percent partners met in bathhouse settings has also been a consistent finding in various investigations, but again the "facilitating" rather than causative nature of this association appears most likely.

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CAUSATIVE THEORIES, Continued

Infectious Agents: To date, the single most prevalent agent commonly found in all high-risk groups is HB. However, few persons would argue that this is indicative of HB as a causative agent. However, the HB "model" is an attractive concept for other reasons: there are a variety of outcomes following HB infection, ranging from totally sub-clinical infection to fulminant fatal disease to chronic infection with possible oncogenic potential, a picture consistent with the spectrum of outcomes seen in persons sharing similar exposure to AIDS cases. Furthermore, the time course of development of overt clinical symptoms and pattern of spread of epidemic HB are both similar to what we are seeing in the spread of AIDS. Of course, if HB were the causative agent for AIDS, we certainly would have seen it appear earlier and in more cities simultaneously than has been the case with AIDS. However, the "HB model" provides much help in thinking about the modes and patterns of spread of viral agents by both sexually and non-sexually routes.

Serologic studies have substantiated an increased prevalence and titre of CMV, EBV and syphilis antibodies in AIDS cases. While CMV infection may be endemic in homosexually active men, CMV has been shown to be immunosuppressive, is a transforming virus in vitro, has been shown to be incorporated into the genome of at least some KS tissues, and the virus has been isolated from at least one KS cell line. A recent report (Spiers and Robbins, Lancet, i:1248-1249, 1982) of a patient with reversible lymphadenopathy, splenic infarction, weight loss, night sweats and malaise associated with probable CMV epididymitis suggests the occurence of a subchronic AIDS-like syndrome as a possible consequence of CMV infection. We have seen a number of similar cases, sometimes given the waste-basket diagnosis of "non-A/non-B hepatitis", in which infection with CMV, EBV or another similar viral pathogen is the presumed (but unproven) agent. But a similar problem exists with CMV and/or EBV as for HB: Why now, and why only in a relatively small subset of persons repeatedly exposed to these agents?? Again, the expression of viral infection as full-blown AIDS may well require co-factors which weaken the cellular immune system in such ways as to assist in the breakdown of normal homeostatic mechanisms.

Autoimmune Mechanisms: Several groups of investigators have noted an increased occurrence of the HLA-DR5 locus in KS patients, there appears to be a predilection for persons of Mediterranean descent in both the current and "classical" KS cases, we and others have noted a high incidence/titre of anti-HLA antibodies and/or anti-sperm antibodies in AIDS cases, and a number of autoimmune syndromes have been observed in homosexually active males during the current AIDS epidemic (including lupus, ITP, hemolytic anemias and multi-focal leukoencephalopathy). However, these findings are certainly not uniformly found in all current AIDS cases and are, in fact, strongly suggestive of at least dissimilar etiopathologic mechanisms in KS vs. OI cases. Other evidence against a unitary hypothesis for both KS and OI cases is epidemiological: In NYC, the occurence of KS in heterosexual AIDS cases is much less frequent than in the homosexual AIDS cases. These findings have suggested to a number of investigators the possibility that various mechanisms exist for the perturbation of the cellular immune surveillance system, with different "paths" of cellular immune suppression perhaps leading to differring clinical outcomes. Autoimmune mechanisms are therefore far from exonerated at present. However, they must be seen as possibly secondary to infectious primary etiologies and/or possibly contributing to the eventual clinical outcome depending on the particular level at which they are involved. A particularly elegant model for this has been proposed by Gottlieb as presented at both the recent ICAC meetings (Miami Beach) and the San Francisco AIDS Symposium sponsored by BAPHR. His "two virus" model of cellular immune dysfunction is presented in simplified form below. In Dr. Gottlieb's experience, OI correlates rather specifically with absolute lymphopenia and a profound elimination of the T helper cell population. Patients with KS or unexplained lymphadenopathy have less severely disturbed helper/suppressor ratios, while both KS and OI patients have elevated IgG, IgA and circulating immune complex levels.

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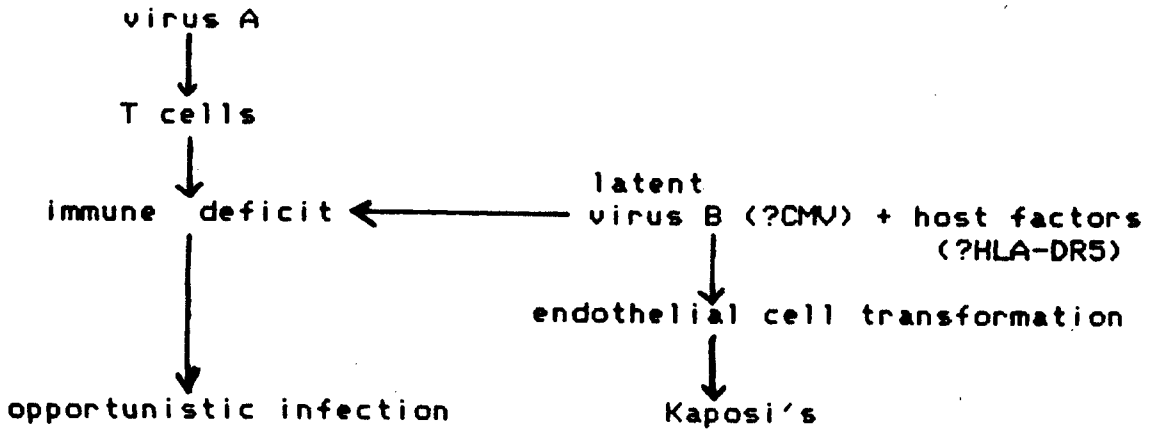
CAUSATIVE THEORIES, Continued

Gottlieb's "Two Virus" Model



In conclusion, there is a growing concensus that AIDS involves the juxtaposition of a variety of risk factors or putative causative agents. Infectious agents (most notably CMV and EBV), genetic predispositions, behavioral factors (number of sexual partners, specific sexual practices and use of specific drugs), close proximity with other AIDS cases (both sexual and household contacts), malnutrition or other non-specific causes of immunosuppression, etc. all have their advocates and all may be involved, to a greater or lessor degree in the specific clinical syndrome(s) and most (but not necessarily all) groups ultimately identified as being at high risk for AIDS. I believe that multi-factorial models, incorporating a variety of causative agents and a variety of clinical outcomes depending on the particular "cluster" of risk factors present in that group, will ultimately serve us better than any sort of "unitary" hypothesis.

AN UPDATED AIDS GLOSSARY

In an attempt to define specific disease entities which may ultimately clarify the relationship between "full-blown" AIDS and the various "pre-AIDS" syndromes, the National AIDS Case-Finding Network Steering Committee has proposed the following preliminary case definitions **for the purposes of discussion and program developement only.** Persons wishing to comment on these proposed definitions should contact the **Editor.** I have added several additional "tongue-in-cheek" definitions at the end of the list for the benefit of individuals working with AIDS patients.

I. AIDS ("idiopathic," "CDC-criteria"): A biopsy or culture proven, life-threatening neoplasm and/or opportunistic infection, in an individual with unexplained cellular immune system dysfunction.

II. **Possible AIDS:** Persons meeting the clinical and laboratory definitions of AIDS, but falling outside the idiopathic or CDC criteria categories for one or more of the following reasons:

a. Infection or neoplasm as yet unconfirmed by biopsy or positive culture/serology, but patient in critical condition.

b. Other known cause for immunosuppression, such as steroid treatment, chronic active hepatitis, etc., but clinical picture consistent with AIDS.

c. Multiple specific risk factors, such as hemophilia, IV drug use and/or prostitution in addition to being homosexually active.

III. **Pre-AIDS** ("AIDS prodrome"): The presence of two or more of the following symptom pictures:

a. Lymphadenoapthy involving two or more separate lymph node chains, progressively enlarging over a two month or greater period and not related to aknown acute, localized and self-limited infectious process.

b. Fever of unknown origin, greater than 101°F for three weeks or greater.

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CAUSATIVE THEORIES, Continued

c. Diarrhea and/or anorexia, lasting two months or more, unassociated with identifiable enteric infection and resulting in loss of 25 pounds or at least 10% ideal body weight loss.

d. Severe fatigue and/or malaise without known functional, neoplastic or infectious etiology which lasts at least two months, is unrelenting and does not respond to sufficient rest.

IV. **Suggestive Pre-AIDS:**

a. Only one of the criteria of category II is met.

b. Atypical or disseminated infection (eg. extensive mucocutaneous herpes, oral thrush or mycobacteriosis) in the presence or absence of cellular immune system abnormality.

c. Repeated STD or enteric infections, with definite remissions between relapses and/or re-infection.

d. Proctitis of unknown etiology, persisting for greater than one month and/or resistant to standard treatments if the etiologic agent has been identified.

If cellular immune system evaluation is available, then both class III and IV cases would be further classified as to the presence or absence of definite (greater than one or two S.D.s from an appropriate control subject population) cellular immunosuppression.

A draft of the current information reporting form being field tested by the AIDS Casefinding Network and which provides the information necessary for the above classifications as well as sufficient confidential identifying information for potential follow-up and/or case verification purposes follows. However, here first are some additional syndrome definitions of potential usefulness to persons working in this area:

V. **AIDS Overload Syndrome** (AIDSOS): Depression, weight loss, fatigue and anorexia in a person with an entirely normal cellular immune system but one or more of the following:

a. Attendance at four or more AIDS symposia, case conferences or training sessions in the previous 6 months.

b. Presentation of three or more talks, conferences or symposia on AIDS in the past year.

c. Being asked at 12 or more social occasions during the past year "What is AIDS" and/or "What can I do to prevent getting AIDS?"

VI. **AIDS Phobia:** A specific variant on "Cancer Phobia" but with one or more of the following identifying features:

a. The person has had one or more homosexual contacts or near contacts within his or her lifetime.

b. The person presents with a congenital angioma, allergic dermatitis, pigmented nevus, scabies rash or some other benign or congenital skin blemish and is requesting punch skin biopsy, full battery of cellular immune tests and referral to KS treatment facility.

c. The person has a sore throat, recurrence of prior herpes lesion, primary syphilitic chancre, or hemorrhoids and presents wearing full body condom, face mask, surgical scrub gown or in plastic bubble. When reassured following cellular immune system evaluation, enlists in celibate religious order or moves to Iran.

d. Person who does not find any of the above definitions the least bit funny.

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JACK DOREN'S REPORT: NEW YORK CITY AIDS NETWORK NEWS

by Jack Doren, for the AIDS Network and the NCGSTDS

The NY AIDS Network is an informal group of heads and representatives of various NY and national gay health professional organizations, including Gay Men's Health Crisis (GMHC) and the National Gay Health Education Foundation (NGHEF), along with the National Gay Task Force (NGTF) and community groups. It meets weekly - Thursdays at 8 am.

(Continued)

NYC AIDS NETWORK NEWS, Continued

Latest surveillance statistics (as of Feb. 9, 1983):
National total of cases with AIDS reported to CDC: 1051 (with 406 dead)
NYC total of cases with AIDS: 489 (with 191 dead)

(CDC's operational definition of a case of AIDS requires the presence of an opportunistic disease, e.g., KS, PCP. These figures, therefore, do not include cases of AIDS alone, and are as a result relatively "low".)

The frequency of newly reported AIDS cases is significantly accelerating. In the 28 days from Jan 13 and Feb 9, 1983, the number of newly reported AIDS cases in the US was 164, and 73 deaths.

The Network, in the last 2 months, has had 2 priorities: the blood donor policy issue, and the very limited governmental funding of AIDS research, treatment, etc.

A. Blood Donor Policy Issue

There has been a great deal of pressure from and on various national and local blood industry-related organizations to support a policy of barring "homosexual men" (defined as men who have had at least one sexual contact with another man), along with other groups, from donating blood. Whereas all organizations have been reluctant to take such a stand, the National Hemophilia Foundation (NHF) did so in a Jan 17 press release, which included:

> "Serious efforts should be made to exclude donors that might transmit AIDS. These should include...identification, by direct questioning, individuals who belong to groups at high risk of transmitting AIDS, specifically male homosexuals; intravenous drug users; and those who have recently resided in Haiti."

It went on to recommend ceasing using plasma from these groups.

Whereas this would seem an expedient and simple solution on first glance, it inherently has several problems and limitations, along with serious implications. Screening of blood donors has notoriously proven ineffective, screening of blood being the alternative of choice. Also, not all gay men are at risk. It further does not deal with the fact that contaminated blood was the 2nd leading cause of deaths of hemophiliacs in the US before AIDS was ever heard of. The issue is contaminated blood. The issue is having safe blood.

In this light, the NY AIDS Network, in conjunction with over 50 national gay health and community organizations, came out with a position recommending screening the blood, rather than the donors, for surrogate markers - other factors in the blood whose presence highly correlates with the presence of, or risk for, AIDS. Roger Enlow, MD (coordinator of the NY AIDS Network) and Bruce Voeller, PhD (Mariposa Educational Foundation) have attended various meetings called by CDC and National Institutes of Health (NIH) of groups with interests in the blood donation issue (NHF, National Association of Blood Banks, etc.), officially representing the gay community

The NHF press release, if enacted, in addition to having limited effectiveness, was seen by the Network and others as a political response to a health issue. The blood industry, a billion dollar industry in the US, has 2 components - the blood donation agencies, to which individuals donate blood, and the blood businesses, which, as profit-making enterprises, pay individuals for their blood (drawing significantly from skid row persons and students). If the focus

(Continued)

NYC AIDS NETWORK NEWS, Continued

were on blood screening, it would raise the business' costs. If the focus would be on blood donor screening, this would significantly decrease the amount of blood available from the blood donor agencies, thereby making the blood from the businesses more in demand. The latter's lobbying on the NHF, a group dependent on, and vulnerable to, the blood industry, is being seen now as having been successful.

One might ask, so what's the big deal if we stop donating blood?

The difficulty is how we, as a community, are being used as a politically expedient seeming solution and scapegoat for a larger contaminated blood issue. The public can be given the impression that "they are doing something". Will anyone be surprosed when gays in general are increasing being seen as having "bad blood" and sources of contamination. How long will it be for gays to be seen as inappropriate for working in food distribution facilities, as health care professionals and workers, as teachers, etc.?

In light of this, the Network, along with NGTF, formulated a statement, the text of which follows. It received an endorsement of over 50 national and regional gay health and community organizations and/or their heads.

"In response to recent statements by the National Hemophilia Foundation, we have asked you all together to hear the gay community's concern and response in the hopes that we will together fight the national health emergency called Acquired Immune Deficiency Syndrome (A.I.D.S.).

"On behalf of gay men and lesbians across the United States, we join the National Hemophilia Foundation (NHF) and others in expressing our deep concern that a national blood program be formulated which safeguards the health of all Americans.

"As the NHF noted, 'the issues surrounding A.I.D.S. remain complex, there are no simple answers.' Unfortunately, the NHF wasn't successful in following its own advice. As indicated by recent surveys and both published and unpublished data, there are no simple answers regarding A.I.D.S. and our national blood donor program.

"The concern of the NHF has been the safety of the blood product upon which the survival of hempphiliacs is based. But to single out any segment of our society as the source of unsafe blood is divisive and dangerous. Unfortunately, as it exists today, we are all potential victims of our present national blood program.

"In fact, the nation's blood products industry, upon which the lives of many Americans depend, is, in some cases, a business venture planned at the expense of medical and scientific safeguards. Ineffective verbal screening, spot medical testing, and questionable commerical sources taint the product for all.

"This long-term failure, coupled with the A.I.D.S. health emergency these last two years, is cause for great concern, but if we are brave enough to combine the talents of our voluntary agencies, the business community, the blood industry, and government agencies, we could create hope where there is fear, life where there has been death.

"Therefore, we urge:

1) Every effort be made by the blood industry to test blood and blood products for agents which indicate a

(Continued)

NYC AIDS NETWORK NEWS, Continued

current or past infection, e.g. Hepatitis B, which may also indicate a high risk for A.I.D.S.

2) Funds be made immediately available to government agencies, medical institutions, and voluntary community groups, to research the cause(s), effects, and cure of A.I.D.S.--which remain unknown--as well as to offer patient services to those suffering from this disorder.

3) All individual blood donors screen themselves, recognizing that in giving the 'gift of life,' there is the responsibility to give the safest gift possible.

4) The medical and scientific community acknowledge what has been known for many years: that the direct or indirect questioning of donors is an inadequate safeguard to the quality of blood; moreover, a policy to exclude any group from blood donation, whether mandated or voluntary, would be both ineffective and inappropriate.

"Above all, it is incumbent upon the blood industry and the government agencies that regulate blood donor policy to refrain from suggestion or implementation of a blood donor screening program which, by whatever means or under whatever name, amounts to a political solution to a medical problem. Pitting victim against victim will serve only to divert attention from the vital medical and ethical concerns that lie at the heart of this health crisis."

A press conference was held on Jan 27, with the statement read by Ginny Apuzzo, executive director of NGTF. (NGTF, under Ginny along with John Boring and Kevin Berrill, has been extremely active, supportive, and highly desirous of and receptive to our input, in these and other areas. We are all appreciative of our mutual working relationship.)

The national dialogue continues...

B. Governmental Funding

In spite of the escalating national health crisis, the 1983 budget of the National Institutes of Health (NIH) allots 0.2% for AIDS ($7.92 million out of a total budget of just over $4 billion). There are also additonal difficulties, such as the need for educating hospital personnel about AIDS to avoid irrational fears (that reportedly are arising), and eligibility definitional requirements for social security disability requirements.

A special meeting of the NY AIDS Network was held on Feb 17, 1983 to explore how the gay/lesbian community can more radically express its outrage at this governmental and media apathy. At this meeting, chaired by Ron Vachon, Larry Kramer, and Ginny Apuzzo, there were over 40 participants, representing professional, political, and community interests and perspectives. Many ideas were presented, both for agenda items to be included in a set of expectations the gay community has regarding governmental response to AIDS, including:

- research funding
- patient care

(Continued)

NYC AIDS NETWORK NEWS, Continued

- education of health care workers
- support services to persons with AIDS

and more radical public responses if these expectations are not met.

Several committees were formed, including an Agenda Committee, Hospital Care Services Committee, and a "Public Events" Committee. These committees will have met by Feb 24, at which time a second special meeting of the Network has been called. Committees will report, and how we'll proceed as a group and as a community will be the focus.

In spite of the tragedies of this crisis, it is heartwarming to see so many aspects of the gay community working together, with former barriers breaking down.

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NEWS FROM ATLANTA & AID Atlanta
by John Kopchak, PA-C

AID Atlanta (AIDA) is thriving and being well received by the community. Since our medical presentation on December 14th, we have had a number of fund raisers by several of the gay bars and restaurants. The donations form these events were much needed for covering the cost of printing brochures, mailings, etc. We recently had our second community presentation on AIDS that was sparsely attended but was well covered by the straight press. The Atlanta Journal-Constitution, our local press, as well as on of the free community papers, Creative Loafing, covered the presentation. Dr. Lew Katoff, a clinical psychologist, is organizing our support group for AIDS victims and those affected by AIDS. So far his initial efforts are very positive and the mental health workers locally are going to be very helpful. I'm a bit disappointed with the response of the medical community, the gay docs, however, in their lack of interest or initiative in volunteering their time to AIDA. We have had a few say, "Call me if I can be of help," but none are "eager" to give or attend our meetings without direct solicitation. It certainly is disappointing! We are an aggressive group, however, and will continue to confront them. We are glad to have with us Dr. Bernie Short, who is a public health physician who works for the Fulton County Health Department. He's not only actively working with AIDS, but he is meeting with the county's Health Commissioner, the City Council, and other helath officials to alert them to the special needs of the gay community. One of his proposals is to make the hepatitis B vaccine available to the community in the public health system. This is pending. Finally, the 1983 Southeastern Conference for Lesbians & Gays will be held in Atlanta, April 28-May 1. Many topics will be highlighted, including gay/lesbian health concerns. AIDA will be involved, along with other community organizations, and physicians. For additional information, readers may contact: 1983 Southeastern Conference, PO Box 7151, Atlanta, GA 30357, Attention: Caitlin Conor Ryan.

AIDA has two basic objectives: education & patient support. Educating our community about the current research findings on the signs and symptoms of AIDS is the group's major task. The group has developed communication ties with the CDC which is based in Atlanta. Information received from the CDC is disseminated by AIDA through the gay media, direct mail, and other communications forms. AIDA also works with the city's medical community to facilitate the exchange of information and educational materials. AIDA has established a system for counseling, therapy, and self-help for patients with the disease. A list of physicians & psychologists familiar with AIDS is available. Fundraising is one of the group's other functions. For additional information, write AIDA, PO Box 52785, Atlanta, GA 30305, or call 404/872-0600.

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GENERALIZED KAPOSI'S MAY NOT BE A NEOPLASM

[Excerpted from The Lancet, January 1/8, 1983, p. 58, Letters to the Editor, by Jose Costa & Alan S. Rabson, National Cancer Institute, without permission.]
"...The epidemic of the generalized form of Kaposi's sarcoma (KS) among patients with AIDS is regarded by many as an opportunity to gain insight into the pathogenesis, prophylaxis, and treatment of neoplasia. That may well be so but the idea that KS, in its disseminated form, is not a neoplasm is seldom considered. Sarcomas are usually derived from mesenchymal cells. They present as a single mass and metastasize via the blood, first to the lung in most cases.... Histopathologically the lesions of KS are consistent with a benign proliferation of the endothelium--indeed in its incipient phases the lesion is not easy to differentiate from granulation tissue or stasis dermatitis....It is tempting to draw parallels between KS and infectious mononucleosis (IM), a benign multicentric, and polyclonal lymphoproliferative lesion, which in some cases mimics a malignant disease histologically, especially in immunosuppressed patients. Death in a patient with IM or generalized KS is more often due to complications of tissue involvement, such as splenic rupture in IM, or gastrointestinal bleeding in KS, than to involvement and/or functional compromise of vital organs by tumor bulk. The parallel becomes even more tantalizing when one considers the evidence linking cytomegalovirus (CMV) infection to KS. Could an endothelium-seeking strain of CMV, or even Epstein-Barr virus itself, induce a proliferative capillary lesion with the histological appearance of KS? Regarding generalized KS as a multicentric proliferative lesion of the endothelium would not exclude the possibility of malignant transformation. Emergence of lymphoma from IM has been reported. It would not be surprizing if malignant lesions in KS patients were to arise most often in an immunodeficient population."

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EPIDEMIC OF AIDS IN RHESUS MONKEYS AT CALIFORNIA PRIMATE RESEARCH CENTER

[Excerpted from The Lancet, February 19, 1983, pp. 388-90, by Roy Henrickson, et al., without permission. This article is important in that it reports about the first animal model of AIDS, which may greatly facilitate research into AIDS.]
"...A group of 64 rhesus monkeys in one outdoor cage at the California Primate Research Center are experiencing a striking outbreak of disease with a relentlessly progressive clinical course ...paralleling that observed in human AIDS...The etiology of such episodes remains obsure but similar mechanisms may be at work in the outbreaks occurring at the CPRC and the current epidemic of human AIDS [IV drug use?! homosexual contact with many anonymous partners?!--ED]. This outbreak may serve as a valuable model for AIDS by providing insight into immune function, transmission of the disease, and the role of viral or toxic agents that might contribute to the disease process...."

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ELEVATED ALPHA-1 SERUM THYMOSIN LEVELS ASSOCIATED WITH AIDS

According to the January 6, 1983 New England Journal of Medicine Correspondence section (and announced at the American Society of Microbiologists Meeting in New Orleans this month), a retrospective study revealed elevations of serum alpha-1 thymosin in otherwise healthy homosexuals & 2 KS patients, suggesting "end-organ failure," as compared to heterosexual controls. This is analogous to the high hormone levels that occur after removal or atrophy of the target organ, the thymus gland. Low hormone levels have been noted in several primary immune deficiency states, viral infections, and other states of impaired host defense; elevated levels have been associated with immune deficient patients with cancer. Authors Hersh, et al. from M.D. Anderson in Houston, and McClure & Goldstein from George Washington in Washington, DC, conclude that measurement of thymic hormones in serum may provide a sensitive approach to the evaluation of host defense in AIDS patients (or possibly individuals at high risk?). It can be argued however, that we really don't know what such measurements mean, in the same way we don't really know what measurements of T cell subsets mean.

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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 AIDS foundations & organizations--request to be on their mailing lists and please contribute generously! Following is an updated listing, alphabetized by city:

ATLANTA: AID-Atlanta, PO Box 52785, Atlanta, GA 30305
404/872-0600

BALTIMORE: Baltimore Gay Community Center, 241 W. Chase St., Baltimore, MD 21201
301/837-2050 (evenings only)

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 St., Chicago, IL 60614, 312/871-5777

DENVER: Gay & Lesbian Health Alliance of Denver, PO Box 6101, Denver, CO 80206
303/777-9530

HOUSTON: Kaposi's Sarcoma Committee of Houston, PO Box 1155, 3317 Montrose, Houston, TX 77006, 713/666-8251, 792-3245

LOS ANGELES: AIDS Project/Los Angeles, 937 N. Cole #3, Los Angeles, CA 90038
213/650-4123

NEW YORK: Gay Men's Health Crisis, Box 274, 132 West 24th St., New York, NY 10011
212/685-4952 (hotline), 807-6655
AIDS Crisisline, National Gay Task Force, 80 Fifth Av., #1601, New York NY 10011, 800/221-7044 (toll-free), 212/741-5800

PHILADELPHIA: AIDS Task Force, Philadelphia Community Health Alternatives, POB 7259, Philadelphia, PA 19101, 215/232-8055

SAN FRANCISCO: Kaposi's Sarcoma Research & Education Foundation, 470 Castro St., #207, Box 3360, San Francisco, CA 94114, 415/864-4376
Kaposi's Sarcoma Clinic, A312, University of California--San Francisco Hospitals & Clinics, San Francisco, CA 94143, 415/666-1407

WASHINGTON, DC: AIDS Education Fund, Whitman-Walker Clinic, 2335 18th St., NW, Washington, DC 20009, 202/332-5295

Remember, we need to work together! Please share your information & resources with the above groups and the NCGSTDS, PO Box 239, Milwaukee, WI 53201 (414/277-7671).

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OPINION: AIDS CRISIS REQUIRES THOUGHT, NOT PANIC

reprinted without permission, The Sacramento Star, February 9, 1983

"A couple of months ago, we used the word "panic" in a headline about gay San Franciscans' reaction to the spreading epidemic of AIDS--acquired immune deficiency syndrome. Now it seems as if a preoccupation with AIDS, if not a full-fledged panic has hit Sacramento's gay male community. Everywhere we go, it seems, people are talking about it. It hsa become such a universal topic that people can ask, as one did the other night, "What did we talk about before AIDS came along?" We are tempted to add another question: "Can't we talk about anything else?" This is not to say that the community should not discuss AIDS and the few solid facts that we know about it. But there is a danger in dwelling too much on it--the danger of self-induced panic inflamed by rumors, half-truths, and outright misinformation.

"At the recent forum on AIDS and its effect on lifestyles, several panelists and members of the audience accused the press, gay as well as non-gay, of playing up the sensational aspects of this health phenomenon. These speakers felt that the press was declaring major breakthrough in research when in fact scientists have only begun to chip away at the mass of evidence and speculation. They felt that the press was contributing to negative attitudes in and toward the gay community by using such terms as "gay cancer" and ignoring the other groups afflicted with AIDS. And finally, they charged that the press was overstating the case with its contin-

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OPINION: AIDS CRISIS REQUIRES THOUGHT, Continued

ual references to "victims" of AIDS. Part of the problem here is the nature of journalism, which aims for quick, readable transmission of information. Unfortunately, most news is complex and subtle, and some of the complexities and subtleties inevitably get lost in the transmission.

"We must agree that some of the coverage in the gay press has been somewhat sensational and negative. One San Francisco paper, for example, seems to feature an AIDS-related death on the front page of every issue. The Star and other papers in Sacramento have steered clear of this approach. We feel that the story is important, even vital--but what is important is not so much the tragedy as the efforts to understand, to communicate, to cooperate, to go on building our community. And that attitude is what we all need to cultivate and keep foremost in our minds as we think about and talk about this shadowy threat in our midst. Because AIDS has hit hardest in the gay male community, it is important for that community to take responsibility for leading the fight to find out more about it and to communicate that information to those who need to know it.

"It is equally important for the gay male community not to take blame for AIDS. As many people have pointed out, a crisis like this, which seems to strike at some of the basic attitudes and practices of gay life, can bring out the ugly dregs of internalized homophobia from deep within us. Let us be quite clear on this point: AIDS is not some kind of supernatural punishment for being gay. Let's be realistic about it: the way to combat AIDS is not to close all the bars and baths; it is to launch a massive lobbying effort in Congress and every state legislature. The way to combat AIDS is not to swear off sex forever; it is to take care and responsibility in our sexual relations. The way to combat AIDS is not to believe every hysterical rumor or to refuse to listen at all because it's just too unpleasant; it is to find and absorb all the facts and evidence we can, and then act accordingly."

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AAPHR RELEASES STATEMENTS ON AIDS & BLOOD DONATION AND HEALTHFUL GAY SEXUAL ACTIVITY

by American Association of Physicians for Human Rights (AAPHR)

Printed below are the position statements on AIDS relative to risk reduction in blood donation and healthful gay sexual activity of the American Association of Physicians for Human Rights (AAPHR). These statements were prepared by the Research & Scientific Affairs Committee and Education Committee and approved by the AAPHR Genreal Board at its midwinter meeting held in Honolulu, Hawaii, February 19, 1983. These statements reflect our understanding of the currently available information about AIDS and address the issues of risk reduction applicable to person to person transmission of AIDS via blood products & sexual activity. At the present time, this country is facing a medical crisis of potentially major dimension as this dangerous illness spreads to more and more individuals and groups. There is a woeful lack of information about the cause and management of this disorder while opinion and conjecture abound. What is clear to AAPHR is the urgent need to aggressively pursue the cause, diagnosis, treatment, and prevention of AIDS at all governmental, scientific and medical levels. AAPHR is committed to the rapid solution of this health crisis and stands ready to work with all responsible groups to this end. [The NCGSTDS concurs.--ED]

THE A.A.P.H.R. STATEMENT ON A.I.D.S. AND BLOOD DONATION

Acquired Immune Deficiency Syndrome (AIDS) a new disease of unknown cause, is characterized by abnormal function of the body's immune system which makes an individual susceptible to a number of life-threatening diseases. Although a majority of the reported cases have occurred in homosexually active men, about 30% of cases are known to be Haitian entrants, intravenous drug users, hemophiliacs, and others. Of the homosexual groups, lesbians are not at increased risk for AIDS. Preliminary information suggests that the immune dysfunction may be, at least in part, initiated by an agent which is acquired sexually or by receiving blood products. It is not known whether the disease may follow a single exposure or requires multiple exposures.

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AAPHR STATEMENT ON AIDS, Continued

The rapidly increasing number of AIDS cases is cause for grave concern. Current evidence suggests that the time between exposure and the onset of illness may be eighteen months or longer. During that period, an affected person may be able to transmit the disease to sex partners or recipients of donated blood products. To date no agent has been isolated, and there is no direct test for the disease or for the possible carriers of the agent. However, blood test evidence of past infection with Hepatitis B is presently found in most AIDS cases, suggesting similar risk factors for both diseases.

Though far from ideal, testing for previous hepatitis B infection (with antibody to hepatitis B core antigen) and measuring the absolute lymphocyte count are probably the best current indicators or markers of blood that may be at high risk for carrying an AIDS agent. There is no evidence that hepatitis B virus causes AIDS, and the vast majority of people with such hepatitis B markers do not develop AIDS. Because of these uncertainties, our immediate efforts to reduce possible blood product spread of AIDS will necessarily be imprecise.

We object strongly to the attempts by some members of the blood products and blood banking community to identify gay men by questionnaire and exclude them from blood donation. These attempts are an unnecessary invasion of individual privacy and grossly misrepresent the issues to the American people. They cannot guarantee safe blood. At the same time we recognize there are segments of our community for whom the risk of AIDS is increased.

We concur with the conculsion expressed in the January 13, 1983, Joint Statement on AIDS Related Transfusion by the American Association of Blood Banks, American National Red Cross, and Council of Community Blood Centers. We, therefore, think the following recommendations are justified and responsible:

1. We recommend that plasma centers, where paid donation is the rule, immediately initiate testing of plasmapheresis donors on a regular basis for antibody to hepatitis B core antigen together with absolute lymphocyte counts.

2. Within the community blood banks, where altruism motivates donation, discouraging blood and plasma donation from high risk groups seems the best course. Therefore, persons should not donate blood if they have definite AIDS or if they have unexplained fevers, night sweats, or generalized lymph node enlargement or other symptoms of AIDS. In addition, it is advisable that sex partners of these persons should not donate blood. However, it is indicated for the volunteer blood banking community to begin feasibility studies to determine the need for measuring the above mentioned markers for their donors.

3. It is impossible to know how many different sex partners would constitute a "significant risk" for acquiring an AIDS agent. Within our current understanding of a communicable disease, a single partner may be sufficient, but the greater the number of different partners the higher the risk. Individuals who think they may be at increased risk for AIDS should not donate blood. The decision to withdraw from the blood donor pool if one is apparently well must be an individual one. AAPHR views this voluntary withdrawal as a temporary action until a specific test to identify AIDS is developed.

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AAPHR STATEMENT ON AIDS, Continued

4. The gay community's altruistic donation of blood represents a significant contribution to the total supply of vitally needed blood products, and so to help avert any shortage we encourage the individual who removes himself from the donor pool to urge another person (friend, colleague, parent or other relative) without the above constraints to donate.

In this unprecedented health crisis, sound scientific judgment and compassion must guide our decisions. We think that the above recommendations are a positive step; however, they are only an interim approach.

Finally, we most urgently call for legislative and administrative action to fund public health agencies at all levels for an unprecedented research effort. It is imperative that this effort include the clinical, laboratory, and basic science research necessary for the discovery of accurate markers for this disease, its effective treatment, and ultimate prevention.

THE A.A.P.H.R. STATEMENT ON A.I.D.S. AND HEALTHFUL GAY MALE SEXUAL ACTIVITY

Healthful sexual behavior is an expression of one's natural sexual drive in a satisfying, disease-free way. We are supportive of gay sexual expression. As health educators, we believe that knowledge of specific gay sexual practices and their implications for health and disease are essential for a safe and satisfying sexual life.

As gay physicians, we wish to support and encourage the increasing demand for information regarding various sexually transmitted diseases (STD) and Acquired Immune Deficiency Syndrome (AIDS) in order to minimize your risks. Space is limited and recommendations will change as new information becomes available. Lest we appear to some to be too judgmental, we, too, have experienced these diseases and are trying to practice what we preach. We would rather be safe than sorry.

AIDS - A NEW SEXUALLY TRANSMITTED DISEASE

Your body's immune system is essential to fight off diseases. People who have AIDS cannot fight organisms that normally would not cause disease; they also cannot fight certain kinds of cancers. As a result they develop Kaposi's Sarcoma, Pneumocystis Pneumonia or several other more rare diseases.

General symptoms of AIDS include the following:

1. Swollen glands (enlarged lymph nodes, with or without pain, usually in the neck, armpits, or groin) lasting for more than one month.

2. Pink to purple flat or raised blotches or bumps usually painless, occurring on or under the skin, inside the mouth, nose, eyelids, or rectum. Initially they may look like bruises that do not go away, and they usually are harder than the skin around them.

3. Persistant white spots or unusual blemishes in the mouth.

4. Weight loss that is unexpected and greater than approximately ten pounds in less than two months.

5. Drenching night sweats which may occur on and off and last at least several weeks.

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AAPHR STATEMENT ON AIDS, Continued

6. Cough and shortness of breath (a persistent and often dry cough that is not from smoking and has lasted too long to be from a usual respiratory infection).

7. Fever (an elevation of temperature above 99 degrees) which has persisted for more than ten days.

8. Diarrhea (persistent and not explained by other causes).

REDUCING RISKS

Two major steps you can take to dramatically reduce your risk of AIDS are the following:

1. Decrease the number of different men with whom you have sex, and particularly with those men who also have many different sex partners. This does not mean to reduce the frequency of sex with any one partner, but only the number of different partners.

2. Do not inject any drugs not prescribed for you; avoid sexual contact with IV drug users.

Certain sexual practices are known to be associated with an increased risk of sexually transmitted diseases (STD). Reducing these factors may decrease your risk of AIDS:

1. One-time encounters with anonymous partners and/or group sex.

2. Oral-anal contact ("rimming").

3. Fisting (both giving and receiving).

4. Active or passive rectal intercourse (use of condoms may be helpful).

5. Fecal contamination (Scat).

An additional probable risk factor may be mucous membrane (mouth or rectum) contact with semen or urine.

POSITIVE STEPS YOU SHOULD TAKE

1. Know your sex partner and ask about his health. When in doubt, back out!

2. Increase touching and general body contact; the risk of kissing on the lips is unknown.

3. Shower before sex and inspect your partner.

4. Take good care of your body and general health (adequate rest, good nutrition, physical exercise, reduction of stress, reduction of toxic substances - alcohol, cigarettes, marijuana, poppers, non-prescription drugs).

[Continued]

AAPHR STATEMENT ON AIDS, Continued

If you know or suspect that you have any disease you could give to someone else, don't risk the health of others by having sex. Consult a personal physician who is up to date on gay health issues, and have the courage to tell the physician you are gay and wish to discuss AIDS.

We have taken the position that the following individuals should not donate blood at this time:

1. Any individual who has AIDS (or one of its symptoms).

2. Any individual who has had sexual contact with someone with AIDS.

3. Any individual who has had sexual contact with many different partners or with IV drug users.

4. Any individual who may be uncertain about his medical state with regard to AIDS should consult his physician prior to donating blood.

In order to make healthy choices about our sexual expression, ideally we should be able to draw on clear, factual information. However, with the incomplete information we currently have and with the seriousness of this disease it is better to be perhaps overly cautious in our recommendations than to find later that we have not been cautious enough.

As we offer these guidelines, we are actively working to marshall the manpower and funds necessary to solve this health crisis as soon as possible.

Your comments about these statements are invited. Please address them to: AAPHR, P.O. Box 14366, San Francisco, CA 94114, or phone: 415/327-6642; or you may comment directly to the NCGSTDS, POB 239, Milwaukee, WI 53201. Comments published in the Newsletter.

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MMWR REPRINTS ON AIDS

Included in the back of this Newsletter are reprints of the Morbidity & Mortality Weekly Report: January 7th (Volume 31:52), "Immunodeficiency Among Female Sexual Partners of Males with AIDS--New York," and "AIDS in Prison Inmates--New York, New Jersey;" March 4th: "Prevention of AIDS: Report of Inter-Agency Recommendations."

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CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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Epidemiologic Notes and Reports

Immunodeficiency among Female Sexual Partners of Males with Acquired Immune Deficiency Syndrome (AIDS) — New York

CDC has received reports of two females with cellular immunodeficiency who have been steady sexual partners of males with the acquired immune deficiency syndrome (AIDS).

Case 1: A 37-year-old black female began losing weight and developed malaise in June 1982. In July, she had oral candidiasis and generalized lymphadenopathy and then developed fever, non-productive cough, and diffuse intestitial pulmonary infiltrates. A transbronchial biopsy revealed *Pneumocystis carinii* pneumonia (PCP). Immunologic studies showed elevated immunoglobulin levels, lymphopenia, and an undetectable number of T-helper cells. She responded to antimicrobial therapy, but 3 months after hospital discharge had lymphadenopathy, oral candidiasis, and persistent depletion of T-helper cells.

The patient had no previous illnesses or therapy associated with immunosuppression. She admitted to moderate alcohol consumption, but denied intravenous (IV) drug abuse. Since 1976, she had lived with and had been the steady sexual partner of a male with a history of IV drug abuse. He developed oral candidiasis in March 1982 and in June had PCP. He had laboratory evidence of immune dysfunction typical of AIDS and died in November 1982.

Case 2: A 23-year-old Hispanic female was well until February 1982 when she developed generalized lymphadenopathy. Immunologic studies showed elevated immunoglobulin levels, lymphopenia, decreased T-helper cell numbers, and a depressed T-helper/T-suppressor cell ratio (0.82). Common infectious causes of lymphadenopathy were excluded by serologic testing. A lymph node biopsy showed lymphoid hyperplasia. The lymphadenopathy has persisted for almost a year; no etiology for it has been found.

The patient had no previous illnesses or therapy associated with immunosuppression and denied IV drug abuse. Since the summer of 1981, her only sexual partner has been a bisexual male who denied IV drug abuse. He developed malaise, weight loss and lymphadenopathy in June 1981 and oral candidiasis and PCP in June 1982. Skin lesions, present for 6 months, were biopsied in June 1982 and diagnosed as Kaposi's sarcoma. He has laboratory evidence of immune dysfunction typical of AIDS and remains alive.

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Immunodeficiency — Continued

Editorial Note: Each reported female patient developed immunodeficiency during a close relationship, including repeated sexual contact, with a male who had AIDS. Patient 1 fits the CDC case definition of AIDS used for epidemiologic surveillance (*1*). Patient 2 does not meet this definition, but her persistent, generalized lymphadenopathy and cellular immunodeficiency suggest a syndrome described among homosexual men (*2*). The epidemiologic and immunologic features of this "lymphadenopathy syndrome" and the progression of some patients with this syndrome to Kaposi's sarcoma and opportunistic infections suggest it is part of the AIDS spectrum (*3,4*). Other than their relationships with their male sexual partners, neither patient had any apparent risk factor for AIDS. Both females specifically denied IV drug abuse.

Epidemiologic observations increasingly suggest that AIDS is caused by an infectious agent. The description of a cluster of sexually related AIDS patients among homosexual males in southern California suggested that such an agent could be transmitted sexually or through other intimate contact (*5*). AIDS has also been reported in both members of a male homosexual couple in Denmark (*6*). The present report supports the infectious-agent hypothesis and the possibility that transmission of the putative "AIDS agent" may occur among both heterosexual and male homosexual couples.

Since June 1981, CDC has received reports of 43 previously healthy females who have developed PCP or other opportunistic infections typical of AIDS. Of these 43 patients, 13 were reported as neither Haitians nor IV drug abusers. One of these 13 females is described in case 1; another four, including two wives, are reported to be steady sexual partners of male IV drug abusers. Although none of the four male partners has had an overt illness suggesting AIDS, immunologic studies of blood specimens from one of these males have shown abnormalities of lymphoproliferative response (*7*). Conceivably, these male drug abusers are carriers of an infectious agent that has not made them ill but caused AIDS in their infected female sexual partners.

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Acquired Immune Deficiency Syndrome (AIDS) in Prison Inmates — New York, New Jersey

CDC has received reports from New York and New Jersey of 16 prison inmates with the acquired immune deficiency syndrome (AIDS).

New York: Between November 1981 and October 1982, ten AIDS cases (nine with *Pneumocystis carinii* pneumonia [PCP] and one with Kaposi's sarcoma [KS]) were reported among inmates of New York State correctional facilities. The patients had been imprisoned from 3 to 36 months (mean 18.5 months) before developing symptoms of these two diseases.

All ten patients were males ranging in age from 23 to 38 years (mean 29.7 years). Four were black, and of the six who were white, two were Hispanic. Four of the nine patients with PCP died; the patient with KS is alive. All nine patients with PCP also developed oral candidiasis. None of the patients was known to have an underlying illness associated with immunosuppression, and no such illness was found at postmortem examination of the four patients who died. PCP was diagnosed in all nine cases by means of transbronchial or open-lung biopsy, while KS was diagnosed by biopsy of a lesion on the leg.

Evidence of cellular immune dysfunction was present in the nine patients with PCP: eight were lymphopenic, and all nine were anergic to multiple cutaneous recall antigens. An abnormally low ratio of T-helper to T-suppressor cells was present in six of seven patients tested, and in vitro lymphocyte proliferative responses to a variety of mitogens and antigens were significantly depressed or negative in the six patients tested. The one patient with KS had cutaneous anergy and a decreased proportion of T-cells in his peripheral blood. The ratio of T-helper to T-suppressor cells was normal; studies of lymphoproliferative response were not done.

All ten patients reported that they were heterosexual before imprisonment; one is known to have had homosexual contacts since confinement. However, the nine patients with PCP were regular users of intravenous (IV) drugs (principally heroin and cocaine) in New York City before imprisonment. The seven patients who were extensively interviewed denied regular IV drug use since confinement, although two reported occasional use of IV drugs while in prison. The ten patients were housed in seven different prisons when they first developed PCP or KS. Three patients who developed symptoms of PCP within 1 month of each other were confined in the same facility. However, they were housed in separate buildings, and each denied any social interaction (including homosexual contact and drug use) with the other patients.

All inmates of the New York State correctional system receive a medical evaluation when transferred from local or county jails; this usually includes a leukocyte count. Of the nine AIDS patients who initially had leukocyte counts, seven did not then have symptoms of AIDS. Four of these seven asymptomatic males had leukocyte counts below 4000/mm^3. For these four, the time between leukocyte counts and development of clinical PCP symptoms ranged from 4 to 19 months (mean 11.5 months).

New Jersey: Of the 48 AIDS cases reported from New Jersey since June 1981, six have involved inmates of New Jersey State correctional facilities. All six had PCP. They were imprisoned from 1 to 36 months (mean 17.5 months) before onset of symptoms.

All six patients were males ranging in age from 26 to 41 years (mean 32 years). Three were black; three, white. Four of the six died within 1-8 months of onset of their illnesses. None of the six was known to have underlying illness associated with immune deficiency. Immunologic studies of the two survivors have shown cutaneous anergy, leukopenia, lymphopenia, and increased circulating immune complexes. T-cell studies were not done.

All six patients have histories of chronic IV drug abuse. Of the five for whom sexual orientation was reported, four were heterosexual, and one was homosexual. The two living patients have denied both IV drug use and homosexual activity since imprisonment. No two of the six patients had been confined in the same facility at the same time.

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Editorial Note: Since male homosexuals and IV drug abusers are known to be at increased risk for AIDS (*1*), the occurrence of AIDS among imprisoned members of these groups might have been anticipated. Increasingly, epidemiologic observations suggest that AIDS is caused by an infectious agent transmitted sexually or through exposure to blood or blood products. Because of the difficulties inherent in interviewing prisoners, data elicited in such interviews must be viewed cautiously. Given this caution, the histories obtained from the inmates indicate that all or most of their drug use, and, by inference, their exposure to a blood-borne agent, occurred before confinement.

The presence of leukopenia in some of the prisoners tested on admission to the prison system may imply that laboratory evidence of immune dysfunction may precede clinical illness by months.

Health care personnel for correctional facilities should be aware of the occurrence of AIDS in prisoners, particularly prisoners with histories of IV drug abuse. AIDS cases identified in prisoners should be reported to local and state correctional and health departments and to CDC.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations

Since June 1981, over 1,200 cases of acquired immune deficiency syndrome (AIDS) have been reported to CDC from 34 states, the District of Columbia, and 15 countries. Reported cases of AIDS include persons with Kaposi's sarcoma who are under age 60 years and/or persons with life-threatening opportunistic infections with no known underlying cause for immune deficiency. Over 450 persons have died from AIDS, and the case-fatality rate ex-

ceeds 60% for cases first diagnosed over 1 year previously (*1,2*). Reports have gradually increased in number. An average of one case per day was reported during 1981, compared with three to four daily in late 1982 and early 1983. Current epidemiologic evidence identifies several groups in the United States at increased risk for developing AIDS (*3-7*). Most cases have been reported among homosexual men with multiple sexual partners, abusers of intravenous (IV) drugs, and Haitians, especially those who have entered the country within the past few years. However, each group contains many persons who probably have little risk of acquiring AIDS. Recently, 11 cases of unexplained, life-threatening opportunistic infections and cellular immune deficiency have been diagnosed in patients with hemophilia. Available data suggest that the severe disorder of immune regulation underlying AIDS is caused by a transmissible agent.

A national case-control study and an investigation of a cluster of cases among homosexual men in California indicate that AIDS may be sexually transmitted among homosexual or bisexual men (*8,9*). AIDS cases were recently reported among women who were steady sexual partners of men with AIDS or of men in high-risk groups, suggesting the possibility of heterosexual transmission (*10*). Recent reports of unexplained cellular immunodeficiencies and opportunistic infections in infants born to mothers from groups at high risk for AIDS have raised concerns about in utero or perinatal transmission of AIDS (*11*). Very little is known about risk factors for Haitians with AIDS.

The distribution of AIDS cases parallels that of hepatitis B virus infection, which is transmitted sexually and parenterally. Blood products or blood appear responsible for AIDS among hemophilia patients who require clotting factor replacement. The likelihood of blood transmission is supported by the occurrence of AIDS among IV drug abusers. Many drug abusers share contaminated needles, exposing themselves to blood-borne agents, such as hepatitis B virus. Recently, an infant developed severe immune deficiency and an opportunistic infection several months after receiving a transfusion of platelets derived from the blood of a man subsequently found to have AIDS (*12*). The possibility of acquiring AIDS through blood components or blood is further suggested by several cases in persons with no known risk factors who have received blood products or blood within 3 years of AIDS diagnosis (*2*). These cases are currently under investigation.

for AIDS patients or processing laboratory specimens. To date, no person-to-person transmission has been identified other than through intimate contact or blood transfusion.

Several factors indicate that individuals at risk for transmitting AIDS may be difficult to identify. A New York City study showed that a significant proportion of homosexual men who were asymptomatic or who had nonspecific symptoms or signs (such as generalized lymphadenopathy) had altered immune functions demonstrated by in vitro tests (*2,13,14*). Similar findings have been reported among patients with hemophilia (*2,15,16*). Although the significance of these immunologic alterations is not yet clear, their occurrence in at least two groups at high risk for AIDS suggests that the pool of persons potentially capable of transmitting an AIDS agent may be considerably larger than the presently known number of AIDS cases. Furthermore, the California cluster investigation and other epidemiologic findings suggest a "latent period" of several months to 2 years between exposure and recognizable clinical illness and imply that transmissibility may precede recognizable illness. Thus, careful histories and physical examinations alone will not identify all persons capable of transmitting AIDS but should be useful in identifying persons with definite AIDS diagnoses or related symptoms, such as generalized lymphadenopathy, unexplained weight loss, and thrush. Since only a small percentage of members of high-risk groups actually has AIDS, a laboratory test is clearly needed to identify those with AIDS or those at highest risk of acquiring AIDS. For the above reasons, persons who may be considered at increased risk of AIDS include those with symptoms and signs suggestive of AIDS; sexual partners of AIDS patients; sexually active homosexual or bisexual men with multiple partners; Haitian entrants to the United States; present or past abusers of IV drugs; patients with hemophilia; and sexual partners of individuals at increased risk for AIDS.

Statements on prevention and control of AIDS have been issued by the National Gay Task Force, the National Hemophilia Foundation, the American Red Cross, the American Association of Blood Banks, the Council of Community Blood Centers, the American Association of Physicians for Human Rights, and others. These groups agree that steps should be implemented to reduce the potential risk of transmitting AIDS through blood products, but differ in the methods proposed to accomplish this goal. Public health agencies, community organizations, and medical organizations and groups share the responsibility to rapidly disseminate information on AIDS and recommended precautions.

Although the cause of AIDS remains unknown, the Public Health Service recommends the following actions:

1. Sexual contact should be avoided with persons known or suspected to have AIDS. Members of high risk groups should be aware that multiple sexual partners increase the probability of developing AIDS.
2. As a temporary measure, members of groups at increased risk for AIDS should refrain from donating plasma and/or blood. This recommendation includes all individuals belonging to such groups, even though many individuals are at little risk of AIDS. Centers collecting plasma and/or blood should inform potential donors of this recommendation. The Food and Drug Administration (FDA) is preparing new recommendations for manufacturers of plasma derivatives and for establishments collecting plasma or blood. This is an interim measure to protect recipients of blood products and blood until specific laboratory tests are available.
3. Studies should be conducted to evaluate screening procedures for their effectiveness in identifying and excluding plasma and blood with a high probability of transmitting AIDS. These procedures should include specific laboratory tests as well as careful histories and physical examinations.
4. Physicians should adhere strictly to medical indications for transfusions, and autologous blood transfusions are encouraged.
5. Work should continue toward development of safer blood products for use by hemophilia patients.

The National Hemophilia Foundation has made specific recommendations for management of patients with hemophilia (*17*).

The interim recommendation requesting that high-risk persons refrain from donating plasma and/or blood is especially important for donors whose plasma is recovered from plasmapheresis centers or other sources and pooled to make products that are not inactivated and may transmit infections, such as hepatitis B. The clear intent of this recommendation is to eliminate plasma and blood potentially containing the putative AIDS agent from the supply. Since no specific test is known to detect AIDS at an early stage in a potential donor, the recommendation to discourage donation must encompass all members of groups at increased risk for AIDS, even though it includes many individuals who may be at little risk of transmitting AIDS.

As long as the cause remains unknown, the ability to understand the natural history of AIDS and to undertake preventive measures is somewhat compromised. However, the above recommendations are prudent measures that should reduce the risk of acquiring and transmitting AIDS.

Reported by the Centers for Disease Control, the Food and Drug Administration, and the National Institutes of Health.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Spectinomycin-Resistant Penicillinase-Producing *Neisseria gonorrhoeae*

Transmission of spectinomycin-resistant penicillinase-producing *Neisseria gonorrhoeae* (PPNG) has been documented for the first time. Between August 1982 and January 1983, 27 cases of spectinomycin-resistant PPNG infection were reported by U.S. Air Force Facilities in the Pacific. Twenty-five of these cases occurred among U.S. Air Force personnel stationed at Osan or Kunsan, Republic of Korea. At least eight spectinomycin-resistant PPNG isolates were identified in pretreatment cultures obtained from individuals with recently acquired gonococcal urethritis.

Strains collected from six of the patients have already been confirmed by CDC as spectinomycin-resistant and penicillinase-producing. Additional analyses show that all these strains contain plasmids of 2.6, 4.4, and 24.5 megadaltons, are serogroup W-II, and require proline for growth.

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Editorial Note: Until now, person-to-person transmission of spectinomycin-resistant PPNG organisms had not been described. Previously reported cases of spectinomycin-resistant PPNG infection have been sproadic and have occurred among individuals without known contact (*1-4*). Factors contributing to the emergence and sustained transmission of these organisms are currently unknown.

Importation of spectinomycin-susceptible PPNG from Korea continued in 1982, and included at least 53 cases reported by 16 different states during the first 9 months (*5*). No spectinomycin-resistant PPNG originating from Korea has been identified in the United States, but continued transmission of this doubly resistant organism within Korea and continued importation of gonococci from that country make eventual importation probable.

In 1982, the U.S. Air Force (Pacific) began testing all gonococcal isolates for penicillinase production. All PPNG isolates and all isolates from patients who failed spectinomycin therapy were tested for spectinomycin-resistance. Because of the implementation of this surveillance system, the occurrence and distribution of this outbreak can be readily described.

Despite this outbreak, spectinomycin remains the drug of choice for PPNG infections treated in the United States. Recommended treatment of spectinomycin-resistant PPNG cases remains 2 g cefoxitin, plus 1 g probenicid or 1 g cefotaxime (*6*).

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[End of Volume 4 #4; next issue in May, 1983.]