THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 5 #1 August, 1983

* * * * * * * * *

This Newsletter is published by the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). Although efforts will be made to present accurate, factual information, the NCGSTDS, as a volunteer, nonprofit organization, or its officers, members, friends, or agents, cannot assume liability for articles published or advice rendered. The Newsletter provides a forum for communication among the nation's gay STD services & providers, and encourages literary contributions, letters, reviews, etc. The Editor/Chairperson reserves the right to edit as needed, unless specific requests to the contrary are received. Articles for the Newsletter, or inquiries about membership in the Coalition may be addressed to Mark P. Behar, PA-C, Chairperson, NCGSTDS, PO 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!

GAY PRESS ASSOCIATION

****

TABLE OF CONTENTS (NONALPHA): STDs [p. 2-25, 46-7]

TABLE OF CONTENTS (NONALPHA): AIDS [p. 26-44, 48-51]

(Continued in Left Column)

* * * * * * * * * * * * * * * * * * * *

NEW NEWSLETTER FORMAT

With this first issue of the fifth volume of the NCGSTDS Newsletter, there are several noticeable changes--a table of contents section, to help facilitate information retrieval, greater use of a computer for page headings, and a double page format. Let us know what you think, and by all means, share your other suggestions! We've come a long way since 1979, thanks to your help!

* * * * *

GAY PUBLIC HEALTH WORKERS SPONSOR PROGRAMS AT APHA, NOVEMBER IN DALLAS

The Gay Public Health Worker's Caucus of the American Public Health Association (APHA) is sponsoring several sessions at the 111th Annual Meeting in Dallas. Tentatively, the following will be presented:

Monday, November 14, 2-5 pm Dallas Hilton Vista Room
- Self Help for Herpes--Suzann Gage, Presider, Feminist Women's Health Center

Tuesday, November 15, 8:30-10 am Dallas Convention Center
- Passages: Gays & Lesbians and Society and Perspectives--Frances Hanckel, Presider
  - Self Help for Sex: Feminists Redefine the Clitoris--Suzann Gage
  - Changes in Labeling Homosexuality--Sandra Schwanberg
  - Lesbians Growing Older: Self-identification, Coming Out and Health Concerns--Ellen Glascock
  - Discussion

Tuesday, November 15, 2-5 pm Dallas Convention Center Parquet Ballroom Section A
- Acquired Immune Deficiency Syndrome: Science and Social Action in Conflict--Viktor Andersson, Presider
  - AIDS: The Funding Quest--Honorable Henry Waxman
  - Epidemiology of AIDS and Kaposi's Sarcoma in the US--James Curran
  - AIDS: Characteristics of a Male Homosexual Study Population in Toronto, Canada--Colin Soskolne, Randall Coates, Abby Sears
  - AIDS: The San Francisco View--Selma Dritz
  - Development of a National AIDS/Pre-AIDS Epidemiology Network--David Ostrow
  - Discussion & Late Breaking Reports

Wednesday, November 16, 2-5 pm Dallas Convention Center
- Guidelines & Recommendations for Healthful Gay Sexual Activity--Mark Behar, Presider
  - Perceived Health Care Needs of Gay Men with STDs--William Sabella
  - Guidelines & Recommendations for Healthful Gay Sexual Activity--Discussion

Other activities are being planned! The next issue of the Newsletter will provide a more complete schedule. Incidentally, the NCGSTDS will be holding its semi-annual meeting, as will the National AIDS/Pre-AIDS Epidemiology Network.

* * * *

NEW BOOK ON GAY MEN'S HEALTH PUBLISHED

Included with this Newsletter is a brochure advertising a new book by author Dr. Jeanne Kassler: Gay Men's Health: A Guide to the AID Syndrome and Other Sexually Transmitted Diseases, New York: Harper & Row. Gay health issues are examined in descending order of urgency: AIDS, hepatitis, enteric diseases, herpes, and syphilis & gonorrhea. Urethritis, proctitis, epididymitis, and prostatitis are also discussed, along with the medical examination, health resources (with a list), costs of STD testing, the male anatomy, and a glossary of terms. This 166 page paperback book is an excellent, easy to understand resource--a must for gay/lesbian health providers and services, for $7.95.

* * * * *

NCGSTDS FIFTH ANNUAL MEETING: REPORT

from notes compiled by Doug Johnston & Mark Behar

The 5th Annual Meeting of the NCGSTDS was convened at the 5th National Lesbian/Gay Health Conference, Saturday, June 11, 1983, at Denver's Executive Tower Inn, by Mark Behar, Chairperson. Doug Johnston, Milwaukee, volunteered to be the recording notetaker for the meeting. After a brief welcome, introduction & history of the Coalition, reports were solicited from NCGSTDS members and friends. A brief summary follows (clinics or services in parentheses following names do not necessarily presume official representation

John Palmer (New York: St. Marks Clinic, Gay Men's Health Project)--**The** major problem in New York is dealing with homophobia secondary to AIDSphobia, and the actual AIDSphobia--e.g., landlords don't want people with AIDS as tenants, etc. NYC is setting up a clinic to treat lesbians and gays; we are interested in any written materials on training programs, tax-exempt status, articles of incorporation, fundraising, etc. Please send them to me (or the NCGSTDS & we will forward).

Janice Dady (Detroit: Palmer Clinic)--Palmer Clinic had a major fundraiser expected to generate many thousands of dollars, in July. They saw 700 men during the first 9 months of operation; now attempting to start an AIDS info service.

Bob Bolan (San Francisco)--Bob is a physician associated with Presbyterian Hospital's Gay Clinic.

Harley McMillen, Tom Klein, Sara Gross, David Ostrow, Ron Sable, Gregg Shipman (Chicago: Howard Brown Memorial Clinic)--The Clinic has about 350 active volunteers and has an overall budget of about $750,000, serving over 8000 clients in about 14-15,000 patient-visits per year. Between ¼ and 1/3 of all patients are nonpaying; registration fees account for about 25%, fundraising, about 30%, and the rest from research contracts. One of the major fundraising projects is a resale store, which is expected to generate about $60,000. The AIDS Action Project provides screening, referrals, support groups, eduational services, among other things. Any clinic interested in advertising the hep. vaccine should contact David.

Roger Gremminger, Doug Johnston (Milwaukee: Brady East STD (BEST) Clinic)--BEST Clinic has recently acquired its own building and has noted a 29% increase in clinic visits during the first quarter of this year. The Clinic has a sliding scale fee hepatitis B vaccination program, which is self-sufficient. An average of $6 per patient is collected. Attempting to establish a statewide AIDS network of practitioners.

Ian Anderson (New Orleans)--Little local interest in establishing any type of gay STD or AIDS service. People in New Orleans are seeking services in Houston or Chicago. Homophobia is also a fairly great obstacle, as is the lack of funding.

Terry Gayle (Seattle: Seattle Gay Clinic)--The Clinic has a very productive relationship with the public health department & the infectious disease officials at the University. The Clinic is open one day a week and sees about 40 people per session. The Clinic also has a "Chicken Soup Brigade," a volunteer group providing support services for people with AIDS.

J.B. Molaghan (Boston: Fenway Clinic)--The Clinic is a general primary care center that serves the gay & lesbian community, and is involved in several areas of research--AIDS, warts, and others.

Al Obermaier (Tucson: Tucson Gay Health Project)--Six MDs involved with Project. Involved with general STDs & AIDS. Developed a computer program to assist in assessing risk for STDs & AIDS. Information about Apple Computer's free computer hard- & soft-ware program to eligible tax-exempt agencies [see elsewhere in Newsletter for details--Ed]. Project attempted to sponsor an AIDS Conference for area MDs, although none of the 250 people contacted came. It was felt that in order for a program to be maximally attractive to MDs, the program sponsor must be a medical center or some other "esteemed stata" of the medical hierarchy, rather than a lay group or community hospital. Everyone was encouraged to compile a list of all the "influential" medical names they could think of, for potential use later. Russ Jaffe from Washington, DC participated in the discussions.

Bernard Branson (Baltimore: Gay Community Center Clinic & Health Education & Resource Organization)--Now cooperating with the State Health Department; having success in community & professional education, with over 500 people attending various programs.

In order to improve efficiency of communication of information, it has been recommended that each Clinic or Service prepare a one page written report that could be reproduced for distribution, a few weeks prior to the meeting.

(CONTINUED)

NCGSTDS ANNUAL MEETING, Continued

Minutes of past meetings were dispensed with, since they were printed in past Newsletters and no objections or corrections were received. The annual report was then presented by Mark:

The year's accomplishments can probably best be described by looking at what member services have accomplished; these have been aptly described in the Official Newsletter, which is the major accomplishment of the Coalition, and really assures communication among STD service providers and a much needed outreach to those not living in major urban areas. We've produced the 2nd and 3rd editions of the Guidelines and Recommendations for Healthful Gay Sexual Activity brochure, which has been distributed to more than 20,000 nationwide this year. The brochure continues to grow and evolve as we learn new information and incorporate that information. The 4th edition will be ready for the 6th National Lesbian/Gay Conference in New York in June, 1984, and will have a section on S & M practices, as well as lesbian sexuality, two areas which have been inadvertently omitted. Operations were streamlined, with membership renewals now in a tickler file, and the confidential mailing & membership list on a computer, able to generate mailing labels. A new typewriter facilitates Newsletter production and other communications. We almost produced an exciting Current Aspects of Gay STD Symposium & steamboat cruise fundraiser in Seattle; we will try again for August, 1984 in Chicago, with our colleagues in American Association of Physicians for Human Rights (AAPHR). Any Coalition member wishing to get more involved in this program should contact me immediately. We do need help. The NCGSTDS was the recipient of the prestigious Jane Addams-Howard Brown Award for service to the gay & lesbian health communities, by the National Gay Health Education Foundation. I have attempted to hold our growth to a very slow pace, just to prevent an inundation of work. On the negative side, the Chairperson's responsibilities occupied approximately 500 hours of time during the year (rough estimate)--this includes compiling information and distributing the Newsletter, & Guidelines brochure, as well as answereing over 1000 pieces of correspondence--quite a task for volunteers! I must appeal to our membership--both individuals and services, to offer assistance. One task that could be completely delegated out would be the publication & distribution of the Guideline brochure. Any suggestions or volunteers would be much appreciated. The year's "statistics" are as follows (for 1982-83, with comparisons as noted):*correspondence received and answered: 1138 pieces; *membership categories: 1 ($250)-1; category 2 ($50)-2; category 3 ($30)-47; category 4 ($30)-30; category 5 ($15)-75; category 6 ($10)-46; category 7 (complimentary--i.e., free)-36; Total paid memberships-201, with 15.2% of all memberships being free. This category 7 requires further explanation--it is offered to those groups that absolutely can't afford category 6 membership (who can't afford $10?!) or to other groups that we exchange publications with. My feeling is that this category should not exceed 5% of the total membership, since maintaining such freebies are too costly, even if it is noble or altruistic. *Guidelines brochure, 2nd & 3rd editions generated $2364.50 in income, cost $1783.45 to publish, for a net of $581.05 (profit margin of about 25%); due to increases in cost of publication (we get a one year fixed price from our printer), the price structure was made more equitable and adjusted for the greater cost (thanks to Frank Greenberg of Houston for his assistance!). *Cost of volume 4 of Newsletter: 5 issues with a total of 196 pages (!!); total printing--$1892.52; total postage--$1183.34; Total--$3184.92. The big question is whether we can significantly save by having the Newsletter typeset (costly?) and published in a different format--perhaps what would cost us in printing would be made up by postage. Any suggestions would be very appreciated! *Long distance calls:

	1981-82 (Bell Telephone)	1982-83 (SPRINT Satellite)
Total number of calls	140	300
Total costs	$396.63	$514.02
Average cost per call	$2.83	$1.71

An overview of all income, expenses, and net profit from 1979 to present is listed:

	1979-80	1980-81	1981-82	1982-83
Total Income	$526	$2328.21	$3329.48	$8278.10
Total Expenses	$372.17	$ 750.68	$2877.47	$7604.28
Net	$153.83 (29%*)	$1577.53 (68%*)	$ 452.01 (14%*)	$ 673.82 (8%*)

(*--This number is % net of total income)

Although the income has increased dramatically, so have the expenses, resulting in very modest net profits; a new dues proposal was submitted, discussed, and approved, effective July 1, 1983: category 1, Associate/Corporate Membership--$250 (no change); category 2, Group Medical Practice--$55 (went up $5); category 3, Individual Practicing Physician--$35 (went up $5); category 4, STD Service--$35 (went up $5); category 5, Individual--$20 (went

(CONTINUED)

NCGSTDS ANNUAL MEETING, Continued

up $10); category 6, Subscription to Newsletter Only (nonvoting)--$20 (went up $10); category 7, Overseas Subscription (nonvoting)--$55 (new category); and category 8, Complimentary (for limited use at discretion of Chairperson; goal: no more than 5% of all paid members). Any objections or comments about the new revised dues structure should be immediately addressed to the NCGSTDS!

Other agenda items were discussed. The Guidelines brochure was briefly discussed above; gay organizations that are members of the NCGSTDS may freely reproduce the brochure for their own distribution & fundraising. Nonmembers must bulk order from the Coalition. Exceptions will rarely be made (judged on merit; we do wish to get "the word" out). The 4th edition is scheduled for June, 1984 release. Any comments or suggestions for revision, different format, etc. will be considered. The 4th edition will have items on S & M practices and lesbian sex, 2 topics that were just recently brought to our attention. Current Aspects of Sexually Trasmitted Diseases Symposium (CASTDS)--III was discussed. There was disappointment about CASTDS being cancelled in Seattle, however inadequate number of program submissions was the chief reason for cancellation. It was moved, seconded, and unanimously approved that the NCGSTDS cosponsor CASTDS-III with American Association of Physicians for Human Rights (AAPHR) in Chicago, for August, 1984. A call for papers will be issued soon. The Coalition is in dire need of funds and members must therefore support CASTDS--III in Chicago with great zest, not only in attendance, but also in program planning. A boat cruise fundraiser on the scenic shores of Lake Michigan, will be planned. Profits from the Symposium and the Cruise will hopefully be shared between the two groups. Such agreements must yet be made. David Ostrow, is the Symposium director. [See elsewhere in Newsletter for details about the program.] Alcoholism & chemical/substance abuse recognition & screening is an area of great importance, as is aptly brought out by members of the National Association of Gay Alcoholism Professionals (NAGAP). NAGAP is interested in involving STD service providers in this important area. Asking screening questions during STD service intake interview would be one way of bringing the issue of substance abuse to the consciousness. NCGSTDS will soon be in contact with NAGAP for specific suggestions. It was moved, seconded and unanamously approved that the NCGSTDS be represented at the Seattle Meetings by Mark Behar, and that roundtrip airfare be reimbursed. It was moved, seconded, and unanamously approved that the NCGSTDS officially affiliate with the newly formed Federation of AIDS Related Organizations (FARO) and pay the $50 annual fee. The role of the NCGSTDS Newsletter as the "official interim national communication devise" since the First AIDS Forum (August, 1982, Dallas), was discussed. No official statement from FARO has been received, but it was felt that until another viable newsletter was in production, the NCGSTDS has a responsibility to its members to continue to publish information on AIDS. Jane Addams-Howard Brown Awards were presented to the NCGSTDS and NAGAP by the National Gay Health Education Foundation. [Details are written elsewhere in Newsletter.] Coalition's next meetings: during the APHA Meetings, November 13-17; during the 6th National Lesbian/Gay Health Conference in New York in June, 1984; and possibly during CASTDS-III/AAPHR in Chicago, August, 1984. Details will be published in the Newsletter. Election of Chairperson: Mark Behar was reelected without opposition. The meeting was then adjourned.

* * *

CHARLESTON GAY LEADERS OFFER STD TESTING

excerpted from July, 1983 VD Interchange

The Charleston, South Carolina STD Clinic and members of the gay community there are working together to make STD services more available to local gay citizens. STD workers set up operations once a month at one of three gay bars for STD screening. For more information, contact: Charleston STD Clinic, 334 Calhoun St., Charleston, SC 29407, 803/724-5900.

* * *

NCGSTDS & AAPHR TO COSPONSOR CASTDS-III

The NCGSTDS and the American Association of Physicians for Human Rights (AAPHR) will be cosponsoring Current Aspects of STDs Symposium (CASTDS)-III, originally scheduled for August, 1983 in Seattle. CASTDS-III will be held in conjunction with AAPHR's 1984 Annual Meeting, to be held in Chicago, August, 1984. Coalition members interested in working on the Symposium, either educational or recreational aspects, are urged to contact Mark Behar, NCGSTDS, POB 239, Milwaukee, WI 53201, immediately!

The overall educational objectives of CASTDS-III are 1) to provide a solid information basis for physicians treating the gay/lesbian patient, especially in special diagnostic and treatment problems presented by that patient population, and 2) to present the most up-to-date information, including recent research findings on AIDS, intestinal syndromes, psychological problems and other timely topics of interest to primary care providers. Two formats are planned:

1) A two day STD training course covering the essentials of the diagnosis, treatment, and counseling aspects of STDs in gay men and lesbians. This course will be aimed at the practicing physician, physician assistant, nurse practitioner, public health worker, nurse, student or housestaff officer who wants to obtain a basic fundamental understanding of this problem. Audio-visual presentations and poster sessions will expand on the lectures which will be given by a select faculty of well-known teachers in the field. The course will be oranized by Dr. Chris Mathews and will use Ostrow, Sandholzer, and Felman's monograph, "Sexually Transmitted Diseases in Homosexual Males" for its outline and background reading.

2) Concurrently or sequentially, the second objective will be met by a 2 day "Homosexual Health Update" program presented by leading researchers, clinicians, and others working in the following specific areas of current interest and rapid developments. It is primarily aimed at the leaders in the field of gay health care, i.e., persons interested in increasing their knowledge and skills beyond that required for normal medical practice into areas of research, special services, and educational programs in their own communities. AIDS-related topics include: diagnosis, quackery, & "alternative treatment;" treatment, especially controlled studies; psychological aspects of AIDS--depression-suicide, phobias-denials, lovers-families. Non-AIDS-related topics: intestinal syndromes in gay men; lesbian health issues in artificial insemination; helping patients attain positive self images; stages of gay male relationships; and impaired gay physicians.

Finally, a major overall objective will be to further educate primary care providers the societal problems affecting themselves and their patients. To do this, a prominent invited speaker will present the keynote address, "Psychological and Political Barriers to Quality Health Care for Gay and Lesbian People." Details about CASTDS-III will be presented in future Newsletters. As always, your input is invited! David Ostrow, chair of AAPHR's education committee, is co-chairing the Symposium.

* * *

CALL FOR PAPERS: LESBIAN & GAY AGING

The Journal of Homosexuality will devote a special issue to aging. Authors are invited to submit theory or empirical articles for the special issue on aging to: John DeCecco, PhD, Editor, Journal of Homosexuality, CERES, San Francisco State University, San Francisco, CA 94132. Possible topics for manuscripts include physical health, sexual relationships, friendship circles, intellectual and aesthetic pursuits, beliefs about sex, and so on.

Manuscripts must be no longer than 25 pages, typed in double space, including tables and references, and should follow the APA Style Manual. Additional details may be obtained by writing to Dr. DeCecco. Authors wishing to have topics considered for the forthcoming special issue should submit a short statement of intent (500 words or less) as soon as possible. The tentative date for submission of complete manuscripts is December, 1983. Papers presented at the annual conference of the National Association of Lesbian & Gay Gerontologists (NALGG) will be especially welcomed.

* * * * *

FREE COMPUTER SYSTEMS AVAILABLE FROM APPLE

Apple Computer's Community Affairs Program provides small to medium-sized community groups with the tools they need to better organize and use information critical to effective community work. Apple's microcomputer technology will allow organizations to develop and share resources in ways not previously possible. Apple especially believes that cooperative effort among groups leads to a beneficial whold greater than the sum of its individual parts. For this reason, the primary goal of the Community Affairs Program is to support the formation of microcomputer networks between nonprofit organizations by providing equipment, software, and training.

Networks, as we all know, are an organization of individuals or groups who hold common values and who cooperatively share information and activities. Microcomputer networks are cooperative groups which share information (called databases) by connecting computers through the telephone system. They permit resource-draining tasks, such as collecting and cataloging community resources, to be spread over several organizations, while allowing the information to be shared immediately. Especially important, they bring to their member groups the advantages of electronic mail, teleconferencing, community bulletin boards, and public information services. These advantages allow groups to communicate rapidly and efficiently, as well as to have instant access to large volumes of information. Why microcomputer networks? To paraphrase an old proverb, if you give a man a fish, he eats for a day. But if you give him a hook, he learns to feed himself. By extension, Apple believes that if those women and men who staff community organizations are given a net rather than single hooks, and are shown how to use the net to become more productive, entire communities will be nourished and will benefit.

Guidelines for Systems Donations: 1) The primary goal of the Community Affairs Program is to improve the efficiency of community groups thrcugh the seeding of microcomputer networks. Equipment donations for non-network purposes and cash contributions are made on a limited basis. 2) Grants are made only to nonprofit, tax-exempt organizations. The focus is on small to medium-sized organizations which form cooperative networks. [The NCGSTDS is not a tax-exempt organization and therefore does not qualify; however many Coalition members are, and are encouraged to apply. What will benefit your clinic will ultimately benefit the NCGSTDS and other members!] 3) No grants are made to individuals, nor for political or religious reasons. 4) In determining the merits and priority of a grant request, Apple will ask: a) Is a microcomputer network an appropriate tool for the needs you've identified? How will you use shared databases, teleconferencing, and electronic mail? b) What is the potential for widespread demonstration of the network? c) Are the proposed procedures and resources adequate to complete the project? d) What are the benefits to the target group? e) Are the organizations and their personnel capable of achieving the expected results? f) How real are the time estimates for task completion? g) What non-network computer tasks will be used by the organizations? Will other sources support the project in the future? 5) Recipients must agree to participate at their own travel and lodging expense in a three-day, intensive training program at a time and location determined by the Community Affairs Program. Usually, the training session occurs within one month after official notification of a grant in a location convenient to a majority of recipients. Travel grants provided by outside funding sources and coordinated by Apple may be available, but each recipient group must be prepared to participate at its own expense. 6) No grants will be made to organizations that do not provide adequate reporting procedures. Recipients will be required to submit regular progress reports as specified in the grant. 7) Grant equipment cannot be diverted from the purpose for which the grant was made for a period of two years. During this time, if the grant equipment is used for purposes other than those stated in the proposal, or if the organization terminates operations, the grant equipment must be returned to the Community Affairs Program. 8) Apple retains the right to discuss the donation, the recipient organizations, and the application in promotional programs. Such activity may require that a photographer and reporter visit the recipients to develop a story. 9) Maintenance, security, and insurance for grant equipment will be the responsibilities of the recipients.

How does a microcomputer network get started? To start such a network, several related groups would organize among themselves and present a proposal to Apple's Community Affairs Program for the donation of a network consisting of three to five Apple computer systems.

(CONTINUED)

FREE APPLE COMPUTER SYSTEMS, Continued

Proposals are reviewed quarterly; due dates are February 15, May 15, August 15, and November 15. Decisions are made within 4 weeks of these dates. For additional information, contact: Apple Computer Community Affairs Program, 20525 Mariani Av., M/S 9L, Cupertino, CA 95014, or phone 408/996-1010. The NCGSTDS will assist eligible, 501(c)(3) status clinics & services in establishing a network. Address a letter of interest/intent to: NCGSTDS, PO Box 239, Milwaukee, WI 53201. All letters received will be shared; it remains the responsibility of those agencies to develop their own proposal. Let's hear from you!!

* * *

SEATTLE'S MOONLIGHT CRUISE GREAT SUCCESS

Even without much of a moon, Moonlight on the [Puget] Sound II was both a great party and a great fundraiser, generating over $6000 for the Seattle Gay Clinic and the Seattle Counseling Service. Over 800 people (it is said many more) partied on the large cruiseship, according to organizer Josh Joshua.

* * *

GONORRHEA EPIDEMIC SLOWING DOWN

Centers for Disease Control Director [now former Director] Dr. William Foege told a Congressional committee that the gonorrhea epidemic is slowing down. In a statement prepared for a Senate Appropriations subcommittee, Foege said that the incidence of the disease had been reduced by about 14% by the end of 1982 from a high of nearly 450 cases per 100,000 population in 1975. The greatest problems in countering the spread of the disease, he said, have been the increase in sexual activity and the fact that "an aspect of life that is considered both private and sensitive" is involved.

* * *

DOUBLY RESISTANT GONORRHEA LOOMS AHEAD

(excerpted from Journal of the American Medical Assn., 5/20/83, with thanks)

While sexually transmitted herpesvirus infections and AIDS have been making headlines, there recently have been some equally dramatic developments in connection with the continuing gonorrhea pandemic. The latest concerns spectinomycin hydrochloride resistant, penicillinase-producing Neisseria gonorrhoeae (PPNG), a double-trouble strain first seen about two years ago. Recently, there was a confirmation that this doubly resistant organism can be transmitted vertically (person-to-person). At the CDC, officials are asking: does this multiple resistance result from natural selection associated with increased use of spectinomycin? Why in some patients are pretreatment isolates susceptible to spectinomycin, but post-treatment isolates resistant, emphasizing that resistance may emerge in a single treatment period? At the recent CDC sponsored, 1983 National Conference on STDs in Dallas, public helth officials said they were unaware of any indigenous spectinomycin-resistant PPNG in the United States up to now. Ward Cates, MD, director of the CDC's VD Control Division, emphasized that Public Health Service personnel are still attempting to block importation of all PPNG to the country. It was noted that the largest single group of spec-resistant PPNG cases has come from US military facilities in the Pacific. At present, the CDC is recommending that such spec-resistant PPNG be treated with cefoxitin (plus probenecid) or with cefotaxime.

In the 7 years since PPNG was isolated, these antibiotic-resistant strains have been found in more than 40 countries. In the U.S., reported incidence has been about 400 cases per month, compared with more than 80,000 reported cases of gonorrhea monthly that are attributed to non-PPNG gonococci. Only gonococci with hairlike pili appear to be pathogenic. These projections help the bacteria adhere to the cells of any nearby surface, then colonize. The gonococcal vaccine being tested in the US military trial is created by isolating and purifying a pilus protein. Some of the pioneering work in this area has been done by Charles Brinton, PhD, of the University of Pittsburgh, and colleagues. The idea is that, after the vaccine is injected, antibodies are produced that would coat the pili of any N. gonorrhoeae invading the body, preventing adherence to the host's cell walls. Several other gonorrhea vaccine approaches are being tested.

* * *

Sexually Transmitted Diseases in Homosexual Men: Diagnosis, Treatment, and Research-- edited by David Ostrow, Terry Sandholzer, and Yehudi Felman. Plenum Publishing, 233 Spring St., New York, NY 10013, 1983, 260 pages. $29.50 if ordered before publication (Sept. 15, 1983); $35 thereafter.

Since the emergence of the gay liberation movement nearly 15 years ago, identifiable homosexual communities have developed in most major urban areas in the US and in other countries. In the early 1970s, clinicians treating homosexually active men in these communities recognized that "traditional" STDs may occur in atypical sites and published this knowledge in the medical literature. By the mid-1970s, physicians reported the venereal transmission of a number of enteric diseases in homosexually active men. In the late-'70s, articles describing a number of traumatic complications of intercourse appeared in the literature. The association between sexual intercourse and immunologic deficiency in male homosexuals was not appreciated until the early 1980s. The first comprehensive review of STDs and traumatic problems in homosexual men was published only as recently as 1980. This volume represents the first attempt to bring together in one reference textbook all of our knowledge in this rapidly developing and changing field. The editors, Drs. Ostrow and Felman, and Mr. Sandholzer, and their authors have succeeded admirably in their efforts. The textbook is truly comprehensive and up-to-date. Since the topics of sexuality in general and of STDs in homosexually active men in particular have been long neglected in the curricula of our medical schools and residency and postgraduate programs, the editors have wisely chosen to discuss the scope of the problem in the first chapter. Most physicians have not been taught how to obtain a sexual practices history, and the authors succinctly provide this information in chapter 2. I particularly enjoyed the table listing a differential diagnosis of diseases associated with specific sexual practices. Chapter 3 deals with exactly how a clinician would set up a medical office for the diagnosis and treatment of STDs, very practical information one cannot find in any standard reference. The remainder of the book is devoted primarily to specific diseases, reviewing the epidemiology, clinical aspects, diagnosis & treatment of syphilis, gonorrhea, nonspecific urethritis, amebiasis, giardiasis, shigellosis, viral hepatitis, anal disorders and dermatologic disorders. Pearls of wisdom one might not be able to easily locate elsewhere are also included, such as, a discussion on "consort contact dermatitis". Most of the authors also remember their responsibilities to public health and preventive medicine by including paragraphs on prophylaxis and control. Topics that I would like to see in a second edition include campylobacter infections, cytomegalovirus disease in the non-immunocompromised host, and a more thorough discussion of the various causes of proctitis, including chlamydia trachomatis and herpes simplex. An entire section of the book is devoted to AIDS, and is an outstanding and timely part, considering how rapidly our ideas about AIDS are changing. Kaposi's sarcoma, the various opportunistic infections, and the enigmatic lymphadenopathy syndrome are discussed in depth to the extent that our present state of knowledge will allow. There are also useful and compassionate recommendations on counselling patients encountering these life threatening disorders. The book concludes with a section about the medical consequences of volatile nitrite inhalation, another topic that cannot be easily found elsewhere. An appendix presents the Centers for Disease Control guidelines for the treatment of STDs (1982). This volume is well written, clinically sound, and thorough yet concise. It is destined to become an indispensable reference in the libraries of those clinicians treating substantial numbers of homosexually active men. But ultimately, throughout our professional careers, we will all encounter many homosexually active men, even though we may not always be aware of these encounters. For this reason, STDs in Homosexual Men will prove to be a useful adjunct for all health providers at every level of training.

* * *

CDC DISTRIBUTES STD WALL CHART

Enclosed with this Newsletter for STD SERVICES ONLY, is a copy of the Centers for Disease Control's VD Control Division's new green STD wall chart, that lists 16 different conditions by clinical presentation, diagnosis & treatment, complications, and behavioral messages to emphasize with each. The chart incorporates the newly revised 1982 STD treatment recommendations. For those wishing additional copies, please contact the CDC, 404/329-1819 (publication #00-3380).

* * *

DENVER MEETINGS BRING TOGETHER MANY

(excerpted from an article by Arthur Felson & Michael Shernoff, New York Native, July 4-17, 1983, with thanks, by Mark Behar)

"Health Pioneering in the '80s" was the theme that drew almost 400 professional & lay people from around North America to Denver for the 5th National Lesbian/Gay Health Conference, which included the 2nd National AIDS Forum and the First Medical Symposium of the American Association of Physicians for Human Rights (AAPHR). The most notable outcome of the Conference was the establishment of a series of national and local lesbian & gay alliances that promises to have a profound effect on gay life nationwide. Another positive aspect of the meetings was the prominent and critical leadership role played by women.

National Gay Task Force Executive Director Ginny Apuzzo chaired a workshop on political strategies with such recognized gay movement leaders as Morris Kight of Los Angeles, Bill Kraus, an aide to the late Rep. Phil Burton of San Francisco, and Steve Endean of the Gay Rights National Lobby. The core of New York City's activists, including Paul Popham & Mel Rosen from Gay Men's Health Crisis, Roger Enlow, MD, of the city's Office of Gay & Lesbian Health, and Ron Vachon, PA, director of the National Gay Health Education Foundation & until recently the convenor of the NY AIDS Network, also participated. The panel brainstormed on how to develop the most effective political strategy for dealing with AIDS. Apuzzo discussed the grave difficulties inherent in trying to balance protection of civil rights with the need to respond to the health crisis, warning that this could eveolve into a "fatal polarization." The issues of civil rights protections and health were also addressed by Dr. Jim Curran of the CDC's AIDS Task Force, who emphasized theat the gay community must not simply accept AIDS as a part of the sexual terrain, as perhaps has been done with hepatitis B or amoebas.

It was remarkable to see diverse segments of the nation's gay & lesbian communities brought together over an issue. While the Conference was respectably scientific, in many ways it was also nontraditional, becoming more than a mere exchange of facts, figures & arcane theories. For one thing, the MDs, psychologists, and epidemiologists present admitted, time and time again, that there was so much they did not know about AIDS. The women and people with AIDS brought a new dimension to what might otherwise have been a dry and impersonal affair, offering a new way of understanding, or integrating scientific data and emotional realities. The prevalent anxiety about sexual patterns and lifestyles was addressed with considerable insight and candor. "People With AIDS," a group formed in the course of the Conference, emerged as a trailblaser, forming a national network. Part of their statement read: "We condemn attempts to lavel us 'victims,' which implies defeat, and we are only occasionally 'patients,' which implies passivity, helplessness, and dependence upon the care of others." These individuals became a key emotional catalyst for the Conference, and ultimately a unifying force for the entire meeting. They were a moving reminder that whether the ailment under treatment is AIDS or anything else, the role of health care providers is to serve people. Demanding to be their own advocates, they insisted on their right to control their own lives, their healing, and their own destinies. The Denver Conference provided an opportunity to share ideas, expertise, and foster cooperation between all these diverse national organizations. For example, Mel Rosen, Executive Director of New York's Gay Men's Health Crisis, offered to assist any group in developing outlines for writing grant proposals to local and state governments.

A national federation of initially 38 AIDS-related organizations was formed. The Federation of AIDS Related Organizations (FARO) is represented by an interim steering committee of 7 local and 4 national organizations, as well as 3 persons with AIDS. FARO will lobby and pool information and resources among member organizations. FARO's resource/information project will be headed by Ron Vachon, Executive Director of the NGHEF. Charged with ascertaining the needs of FARO members, a budget, long-range strategy, and means of making information available to members and the lobbying project will be developed. A lobbying project designed to obtain adequate AIDS funding will hire a lobbyist, who will report to the steering committee. Although AIDS was the primary focus of the Conference, various other gay/lesbian health issues were also discussed. Other workshops included: lesbian health care; lesbian feminist views of medicine; sexism, racism, & homophobia; rape; positive effects of AIDS on the gay community;

(CONTINUED)

DENVER MEETINGS, Continued

and the social and psychological effects of donor insemination on the lesbian community. The impact of chemical dependency was also a topic of wide concern, with specific workshops on alcoholism & other addictions. One of the authors of this article, Michael Shernoff, spent two days at a New York hospital undergoing minor surgery during the writing of this article. With reports and notes about AIDS strewn about the bed, it was no time at all before members of the hospital staff were in turmoil, convinced, no doubt, that they had yet another person with AIDS on their hands. And what a turmoil it was! It took some persuasion to calm them, but it provided a vivid session of consciousness-raising for Shernoff, who in fact, does not have AIDS. For a few minutes he could share the loneliness and fear of the person with AIDS --Arthur Felson, the co-author of this article, for example. The episode was a poignant reminder of what the Conference in Denver was all about, and it brought home the human aspects of AIDS in a way that all the seminars, meetings, and reports never could.

[ED NOTE: Specific recommendations & summaries of the AIDS Forum workshops are presented elsewhere in this Newsletter.]

* * *

JANE ADDAMS-HOWARD BROWN AWARDS PRESENTED TO NCGSTDS & NAGAP

Paul Paroski, Jr., MD, Past President of the National Gay Health Education Foundation, Inc. (NGHEF), has announced that the National Coalition of Gay STD Services (NCGSTDS) and the National Association of Gay Alcoholism Professionals (NAGAP) have been named the recipients of the 1983 Jane Addams-Howard Brown Award. The award, named after Jane Addams, the well known lesbian and founder of Hull House, and Dr. Howard Brown, MD, the openly gay former New York City Health Commissioner, is granted to individuals or organizations that have had a significant impact on health care delivery to members of the gay and lesbian community. NCGSTDS has worked extensively to develop and provide humane and medically sound care in the areas of sexually transmitted diseases as it relates to gay and lesbian individuals. NAGAP has advanced the networking and research around the issue of alcohol abuse/usage within the lesbian/gay community, and in such manner has provided valuable insights into these issues. "It is of great importance that both the lesbian and gay community as well as the non-lesbian, non-gay community realize the valuable and needed contributions made to society, at large, through the hard work and efforts of gay and lesbian health care organizations. The Foundation is proud to present this award to two groups that have demonstrated their excellence," stated Paroski. The award was created by the National Gay Health Coalition in 1978 and represents the only national recognition of achievement within the lesbian/gay health care community. Previous recipients of the award include Evelyn Hooker and Walter Lear. Mark Behar will accept the award on behalf of the NCGSTDS, and Emily McNally and Dana Finnegan will accept the award on behalf of NAGAP, at the conclusion of the 5th National Gay/Lesbian Health Conference in Denver ("Health Pioneering in the '80s"), June 12, 1983.

JANE ADDAMS-HOWARD BROWN AWARD ACCEPTANCE SPEECHES

[Accepting the Award on behalf of the National Coalition of Gay STD Services was chairperson Mark Behar.] "I am honored to accept this prestigious Award on behalf of the members of the NCGSTDS....This Conference marks the beginning of our 5th year....One of the reasons the Coalition has been successful is that there are a large number of very dedicated individuals who agree with our basic goal: sharing of information. We do this by encouraging people to write in, and then without censorship, print opinions and other information in a regular Newsletter, that is widely circulated among gay STD services & providers....Those of us in gay & lesbian health have accomplished so much by cooperating and sharing--much more than could have been done by working alone. But we can do so much more by just extending our network. Our newly formed Federation of AIDS Related Organizations (FARO) is the new beginning to help extend this process. What else can we do? By getting together and setting aside our personalities--indeed, cherishing our personal differences. By realizing our one central goal--not for personal gain and empire building as may exist among the straight world, but for providing

(CONTINUED)

JANE ADDAMS-HOWARD BROWN AWARD, continued

much needed services to benefit our lesbian/gay communities! By remembering the history and scope of the gay health movement and calling upon those of us who have been around a long time--even before AIDS, to learn from our mistakes, so that the wheel need not be reinvented. We need to educate our fellow L/G health workers about the past so we can better understand and cope with the present and future. By being constantly reminded of the national perspective of L/G health. We live everywhere, not just on the east & west coasts. Those of us in middle America should not feel guilty for not living on the coasts! In fact, being away from the storms has occasionally given us a clearer perspective. In my home state, Wisconsin, Archbishop Weakland has supported L/G rights. In fact, our gay rights bill easily passed the state legislature 2 years ago with the help of a coalition of religious groups. Wisconsin is unique in having not only a gay rights and consenting adults law which provided a much needed framework, but also a Governor's Council on L/G Issues which is addressing itself with education for combating homophobia and implementing the laws....What else can we do? By understanding that L/G health means more than AIDS, or STDs, or hepatitis, or alcohol & chemical abuse, or mental health; it is all of these, and much more. By sharing our own personal enthusiasm, charisma, commitment, and love with others. By understanding that love is not just a 4 letter word; that it implies reaching out for companionship, not just sex. Reaching out here for building a spirit of cooperation with one another. By understanding that just as our communities were mobilized after Stonewall in 1969, and more recently with Anita Bryant & Jerry Falwell, and now with AIDS, that these crises have had positive impact in spite of our suffering. I spoke to reporter for a local gay paper who told me that AIDS was challenging him to positively evaluate his life; instead of 3 or 4 different sex partners a week, he cut down to 1-2 per month. And you know hwat he was ashamed to admit? That he felt good about the change. He believed that AIDS was the number 1 reason for getting him out of what he thought was a rut; an unhealthy lifestyle of late nights & little sleep, excessive alcohol, inadequate diet, and lots of partners. What wlse can we do? By understanding that dying is a part of life, and that the quality of life must be cherished more than the duration of life. We must encourage the involvement of all members of our community to participate--people of color and other minorities, including the elderly & youth, women, the economically disadvantaged, the handicapped, and those of us without lovers or significant others. We must not abandon the L/G business people who have heavily invested in our communities. We must not hysterically abandon the bars, bookstores, or bathhouses out of fear. We must show our business friends how keeping an eye open for health maintenance is good for business. We must teach our friends & communities about health care so that they can make well informed decisions about their own lives. And most importantly, we ourselves must do what we preach to serve as role models for our peers to emulate. We must understand the role fo burn out on individuals, local organizations, and the entire L/G movement. We must learn how to focus our activities & interests, say "no, I won't do another project" when we need to, and share both emotional highs & lows with our friends & loved ones. We also need to let our friends know that it's okay to say no about sex and not be influenced by the social pressures that influence us to smoke, use drugs or drink, or have sex. These are times when some people are demanding more & more services and are willing to give less & less, with the notable exceptions of fundraising events of local AIDS organizations. Everyone is talking about coalition forming & networking and we must now work for it and transcend the differences of local & regional politics. We must transform our words into meaningful positive actions! There are no magic formulae or profound solutions. We can only offer a forum for exchange of ideas and a commitment to work for positive change. It is this exchange of words and actions, this networking that is the essence of the Coalition, this Conference, the newly formed FARO,and the entire L/G health movement. Please stay with us! Let's ask our Conference organizers to collect & distribute reports from all areas covered by the Conference and help us channel this high energy level into positive activities.

There are several individuals who deserve special thanks for teir unending support and friendship, and inspiration: Bob Bolan, Dave Ostrow, Roger Gremminger, Dan William, Ron Vachon, Walter Lear, Jeff Richards, Helen Schietinger. We have brainstormed solutions for what seemed like all the world's problems; we have generated inexhaustible energy levels, delegated tasks, mobilized resources, shared positive strokes & constructive criticisms, calm analyses, and damn good jokes! Thank you.

(CONTINUED)

JANE ADDAMS-HOWARD BROWN AWARD ACCEPTANCE SPEECHES, Continued

[ED NOTE: The following speeches were transcribed from cassette tapes & were edited for clarity.]

[Accepting the award on behalf of the National Association of Gay Alcoholism Professionals (NAGAP) were Emily McNally and Dana Finnegan, chairpeople.] Emily McNally: "When I was thinking about what I wanted to say today, I really wanted to speak for as many members of NAGAP as I could & I tried to think about what NAGAP members would want to say. First, they'd thank Dan Pfeffer and Fran Miller [Conference coordinators] for helping to put on this Conference and in seeing that so much attention would be given to alcoholism & chemical dependency here....Our members would want you to know that NAGAP doesn't exist as a 2 member organization. Dana and I would never have been able to do in the last 4 years without the many people who have contributed...so many things. We have accomplished a few things in the past 4 years as a result of the work of many people. First, we've given workshops & seminars at all of the major national [and many of the state and local] alcoholism conferences....We print and distribute a NAGAP bibliography and facility & services directory for many universities and people doing research [from all over the world]....We distribute a newsletter which Jack Bryant from Indiana has taken over and is currently editing & distributing. This newsletter has reached many members from all over the country who don't have support groups [like those that exist] in New York, San Francisco, Los Angeles, or other major urban areas. Its been very meaningful to many people. We have heard people finding lovers, jobs, contacts, & friends by networking through the national organization. We answer phone calls from [people in need] and from counselors. The organization provides referral sources for this. Many members work in various aspects of the field in treatment centers, in referral places, and I think they would want to say to you that many of them are not seeing a lot of gay/lesbian alcoholics for treatment. However, there are many of our brothers and sisters who we see in the community, suffering from problems getting the treatment they need. I guess the major message that I have is that we can't do it alone. We really need your help and support; we need your recognition of the problem; and we need your help in getting through the denial of the problem and seeing it in its earlier stages when its not as devastating, and then referring people for treatment. The most wonderful thing about alcoholism and chemical dependency is that people can recover. It's a progressive, fatat, incurable disease, but it is treatable. Many [of us] myself included, are recovering. Look at the energy, the love, warmth, concern, time, the effort that we've all contributed to the gay health movement; if we can get the chance to do that. You can help. You really must help. It is a responsibility of all of us to help the suffering alcoholic & chemically dependent person to get the help that he or she can use."

Dana Finnegan: "Alcoholism & drug abuse and dependency--these things are now considered to be the 3rd major health problem in the United States, after heart diseases and cancer. Approximately 10% of the population in the US is alcoholic; each of those people affects 4-5 other people. Now if you take it into the gay/lesbian community, the statistics begin to skyrocket. No one really knows what the statistics are but the educated guesses run something like this: 30% of the gay community are estimated to be at risk; 10% are alcoholic, 20% are at high risk. Many of us feel this is a very conservative estimate. Others begin estimating as high as 90%, if you begin adding all the chemicals that are floating around and are used in a destructive way by members of our community. We are at higher risk for many reasons. We deny the disease--a major symptom of alcoholism & chemical dependency is denial from those that have it and from those that are around it. In addition, it's very hard to see in its early stages, because about 80-90% of the people who have alcohol/drug abuse problems are still functioning--they hold jobs, have relationships, they're doing their own thing. They aren't in the gutter. 95% of the general population [of alcohol/drug abusers] are still functioning. It isn't easy to see the problem until it's very late in the game. Use of alcohol & drugs are a part of our lifestyle. We are not against the use of social or recreational drug use. It's difficult when our community, like the overall society, sees a "good time" as involving alcohol and/or other drugs. Our denial, however, has been challenged most recently by the tragic and ironic turn of events constituting AIDS. It has drawn us together perhaps in a way that nothing else could have and has turned out eyes more sharply on the health issues that are in our community and as others have said, it has its own, ironically, positive effect. One may begin to look and

(CONTINUED)

JANE ADDAMS-HOWARD BROWN AWARD ACCEPTANCE SPEECHES, Continued

see what's in our community--what's known as a family disease in the alcoholism profession. That is, not just the alcoholic/drug abuser is affected but those in his/her family including all the people around the person affected. They get the disease too, in the sense that they are called, "co-alcoholics;" they get into denial, making excuses, and unwittingly enable the continuation of the course of active alcoholism & drug dependency. The family gets involved and gets crazy too; if you look at our community as a family, that's what's happening to us. Now there is bad news and good news. I'll deliver the bad news first. The terrible effects of the disease are incredible. If it's not treated, it is fatal....we guarantee it, if the disease goes untreated...people die. It is slow,...very painful, it is subtle, very hard to see, it is insidious, but for sure it is fatal if untreated. It has many masks: accidents, ...homicide, suicide, illnesses, poor judgement which gets people into terrible positions & difficult situation which sometimes gets them killed. I am reminded, and I wish to dedicate what we're saying now to one of the founders of NAGAP--15 people started the organization at Rutgers Summer School of Alcohol Studies in 1979. Fourteen of us, at last count, are still alive. Robert is dead. He was recovering at the time but he went back. He killed himself out of dispair. That's what happens. The waste that comes from this disease is incredible--of minds and hearts, of creativity, of political power--it all goes down the tubes when people are addicted. It robs our functioning; it interfaces with AIDS and other health problems. With AIDS, because it weakens the immune system. It distorts judgement. And it is tied in with racism, sexism, homophobia, as the 4th destructor which I have termed "alcophobia"--an irrational dread and fear of dealing with alcohol and drug dependency issues....Addiction is a form of oppression which keeps us down. I'm not talking about social drinking or drug use; when it becomes a problem, when it drains off our energy, when it makes us feel terrible about ourselves. That is the effect of these diseases. That's the bad news. The good news...is that it is treatable and these diseases can be arrested and people can turn their lives around when theyrecover. The energy that gets loose is phenomonal and is often termed in Alcoholics Anonymous (AA) terms, a kind of miracle. I am a recovering alcoholic and I cannot tell you how my life has changed....Recovery is possible and it is important that the role models of recovering people be out and visable and we want support for coming out of the closet as recovering alcoholics or drug dependent people in the gay/lesbian community. If we stand up tall and proud than others can do it too....The job of dealing with this problem is just incredible. If the saying that gays & lesbians are everywhere, alcoholism and drug dependency is everywhere also; much needs to be done to begin really addressing this within our own community. We have to have needs assessments. We don't know [the real extent of the problem--we can only guess]. We've got to address prevention and outreach. We have to get everyone in the gay/lesbian health care community to know what the early signs and symptoms of these diseases are. There are things that you can see if you just know what you're looking for.... We need to train one another...to work with STD workers...to provide information and guidelines and questions that they can ask [ED NOTE: see future Newsletter] because they could reach a lot more people. Sometimes you plant a seed and maybe years later a person will remember that someone said that maybe they had a problem....That becomes the turning point....It becomes imperative that we all know how to help someone get to AA....Another thing we need help with is to begin to change the norms of our culture. To say that it's okay not to drink; it's okay to not use drugs....It's hard to resist the types of pressures [that encourage us all to drink or drug]--anybody that doesn't, what's wrong with them? So we do need to change our own norms, just to make it okay that there are alternatives for chemically free socializing....The problems are vast. They're too big for one organization such as NAGAP to address. Since the problems are everywhere, we have to have help. There are too few of us to do it. We need your support and we need your help....This award is the beginning, perhaps of spreading out the job so we can all do it. Because together we can do it. And that's the way it has to be done."

* * *

NGTF'S APUZZO PROVIDES PERSPECTIVE AT DENVER CONFERENCE

(transcribed from cassette tapes)

My dear, dear brothers. Do you have any idea what you've given us? I think what you've done for so many of us is to take that large dead space that has separated us for so long and filled it up with so much that if we are in fact pioneers, you are trailblazers. You have corageous hearts and you have exquisite spirits and we love you. Thank you....

I was going to say what I've said to you many times before and it has to do with the fact that before there was gay pride, there really was gay rage. And everyone of us knew that feeling. Every one of us knew what it was like to explode with the realization inside of ourselves that intolerance is simply intolerable. I call it our own personal Stonewall. I really bring that up frequently, because I carry my own personal Stonewall with me, and I think you carry your own personal Stonewall with you. And the value of it for me and I think the value of it for you and the value of it for us historically, is that it impowers us. After we experience it, we bring a new energy and a new resolve to the challenges and the things we choose to define as intolerable. People going through that personal Stonewall, coming together and sharing their energy and their resolve and their love, and their hopes and their fears, create that phenomenon that we call gay pride. And it's a wonderful, exquisite feeling. The phenomenon, unlike anything most of us have ever felt before, especially when we feel it for the first time. But it must continue to grow and it must continue to move us beyond ourselves lest it become what I call "gay smug." You've seen gay smug. You know what it looks like. You know how it walks. You know where it shops. It's constant, it's contained, and it's narrow. Gay smug is satisfied, and unfortunately is an end in and of itself. It's a tempting place to stop. But we are pioneers and gay smug is hardly a frontier. Now after our pwn personal Stonewall and after our own sense of gay pride, there comes something that's not terribly romantic, and it's not terribly eloquent. It's work, and it's ensuring and expanding that sense of being impowered. Now we've all just been impowered [by the preceding presentation], so we know the value of that. I'd like to offer some reflections regarding that stage of work and that period or that feeling of impowerment. And it was said eloquently to us earlier and we'll say it again: we can never forget that in coming out we made a decision not to come out for ourselves alone. In point of fact, our coming out has been a message of courage to each other. Anybody need any proof about that? It also sends a message to the larger society whether it's our parents or our politicians. Our coming out informs them that they may no longer think that they have the right to fashion all of the questions and all of the answers about our lives. In coming out we acknowledge that we need each other. We recognize the importance of the struggle in so far as matters of identity and self worth. We say a single yes to ourselves and in doing so we say a series of nos as well. We say no to the myth that bent our spirits of self hate. We say no to the abusive substances that destroyed our bodies and wrecked our lives. We say no to the second class citizenship that eroded our dignity. We say no to institutionalized neglect which conspired with our own apathy. The capacity to say each no was a hard one by us but having to resolved to be participants in the matters that affect our lives, we have caught a homophobic society red handed. There is no longer any debate regarding the ling between the lethargy in the federal government's response to AIDS and the fact that so many of those stricken are gay men and over 40% are people of color. Many of those are also gay, however while that may no longer be an issue to debate, it is one that has yet to be confronted. The implications are shocking, unacceptable, and unavoidable: that because they are gay, or Haitian, or IV drug users, these lives are thought to be expendable. The import of that statement is so devastating; it has such an awesome confirmation of not only institutional neglect, but out & out institutional resistance that frankly, brothers and sisters, it should put us back in the streets.

As if that's not enough, there are those who are using this crisis to further inflame hatred, prejudice, and all the other stuff we've seen that flourishes in this society. By the callous disregard of those who have this illness, of their families, of those of us who love them, tin horn moralists have shown that they will stop at nothing. For years, they've peddled the lie that all they wanted was to keep us in the closet. Now, in the most ugly form possible, they've demonstrated what we knew all along. It is their intention to deny every homosexual a right of personal privacy and the innate decision of when and to whom one declares the most meaningful and yet most intimate commitments of our lives. They want that privacy denied so that gay people in each and every case can be yoked to a second class citizenship that forever bars us, so they think, from rights enjoyed by other citizens. It's not just the blood screening. It's also entering the military, fighting for child custody; it's lie

(CONTINUED)

APUZZO PROVIDES PERSPECTIVE, Continued

detector tests for employment in the workplace. Look around. It's not new. Thirty years ago last April, gays and lesbians faced the charge that we were unemployable because we contaminated the workplace. The word "contaminate" was actually used in a Senate report that stated even one homosexual could contaminate! One "esteemed" member of the US Supreme Court also saught to brush aside the humanity of lesbians & gay men by a similar metaphor. He regarded us as being similar to measles--having the capacity to be both contageous and contaminating. And it's taken decades for us and the American people to understand that gays & lesbians are not contaminants in the body politic. That we do not suffer from mental illness by definition; nor are we criminals merely allowed to exist in everyday life on a parole basis. Lest I be misunderstood, let me say what we all know: oppression is a health hazard!

It's a health hazard in the gay & lesbian community; in third world communities; among the poor and unemployed; in the women's community; among the aged; it's a health hazard stalking our youth. Oppression is a #1 killer. Confronting that oppression--how, why, with whom, may constitute our frontier for the '80s. Pioneering has always suggested the frontier for me. I'm from the Saturday afternoon movie generation. You know all the films that had all the violence on Saturdays, so that the kids could get their dose of what was wholesome, and before Saturday night when the films had a solid dose of heterosexism to keep mom & dad going for the week. Some of you stayed after the matinee, I can tell! As an adult, I had to unlearn, as did most of you what those films taught me about the frontiers. But I did learn that the frontier was frought with the unknown; that most groups that live on a frontier are forced to live in danger, often from the pioneers. That the surist security is each other --a community with whom one shares resources, tasks, little victories. And a community with whom we can console ourselves in moments of sorrow. We are pioneers in the '80s, joined by the armies of those, like ourselves who have been disenfranchised. Our survival demands nothing less than acknowledging our common peril and our resolve not to conspire with our own destruction by refusing to see that reaching our and working together with all those who have been disenfranchized will produce a world infinitely healthier than the one we share today. If we are to pursue power and that has become a matter of life and death, than we must be prepared to address a question as complex and as challenging as any addressed at this Convention [5th National Lesbian/Gay Health Conference, 2nd National AIDS Forum, American Association of Physicians for Human Rights Medical Symposium] this weekend, namely, "What's the power for?" Unless we are prepared to commit the use of that power for addressing the generic issue of oppression, we will have wasted more than our individual hopes & energy. We will have forfited on the promise of our movement a promise that just maybe we can truely change this unhealthy society. We will have abandoned ourselves and we will have betrayed many whose lives have been staked on our willingness to make a commitment to change, and perhaps tragically, we would have abandoned tomorrow's children. Trying to keep us away from children may have constituted the most insidious strategy used against us. Just suppose children grew up to see the reasonability of our demands for justice. That might just cause social change.

Perhaps the most significant and long term contribution we make is one we rarely focus on. That is the contribution we make when we begin the process of making a demand on the system. I made this point at the Public Policy Workshop [at the Conference] and I repeat it here today. We renew government when we force it to consider the implications of providing access to a new constituency. When we force ourselves to forego what little access the system may have provided us as individuals for the purpose of forcing that system to be responsive to all of us. Then we can claim to have made a distinctive contribution. And so some of us have found ourselves flattered by temporary excursions in the walls and halls of power. It feels secure even for just a moment. The people there seem to be doing the best they can. They assure us they are. They assure us too that uner the circumstances, things are really moving along at a remarkable pace, considering... Considering what? Considering we've been dying of alcoholism and substance abuse at an outrageous rate for decades? Considering we've been driven to suicide at an alarming rate until we found mechanisms to relieve the pressures of homophobia in our own communities? Considering we have died alone because our lovers were'nt their idea of what next-of-kin is all about? Considering our children have grown up separated and alienated from hundreds and thousands of us over the years? Considering what?! The next time some bureaucrat smiles that abuncular smile--anybody seen one lately?--and the digs seem really comfortable, and access seems like process, remember, it ain't worth a damn to the millions of lives that have been dissipated and destroyed. And unless you have them up the anty, we will never teach, yes, teach government that is must be responsive to the people.

(CONTINUED)

* *

APUZZO PROVIDES PERSPECTIVE, Continued

You see, we have allowed some of them to think that access to power was enough. Access enables us to talk about our problems. Responsiveness demands that they deal with the problem, and work with us toward the solution. And so the issue is not access, period; it's access, comma, responsiveness. Beyond that, government doesn't decide what the people need. People decide what people need. The most telling characteristic of oppression practiced by democracies, is the refusal to acknowledge that people have the fundamental right to participate in the decisions that affect their lives. What does that mean to us as health care providers? What does it mean to our alcohol and substance abuse programs? What does it mean in the course of research pursued with regard to the possible cause of AIDS? What does it mean about treatment? What does it mean about blood donor policy? What does it mean about definition of family? What does it mean about the vast resources of this rich country being diverted to destruction. I'll tell you what I think it means.

In the response to our AIDS crisis and each and every health emergency we have witnessed, it means we have been failed by government and it means that if government continues to fail us, we will have conspired with it in that failure. I mean that. I mean that every person in this room now understands, having had this experience this weekend, a grappling with some very difficult problems about the rights related to people participating in the questions and pursuing together the answers that affect matters regarding their lives, in every workshop around every health issue. To deal with that here and to go back to "business as usual" religating our responsibility to participate, will indeed be a conspiracy in which we participate. We cannot do that. Too much is at stake. We hear a great deal about the need to be responsible in light of the AIDS crisis, especially in regards to the blood donor policy, and this is not an easy concept. If responsible behavior means casting aside the issues of individual rights such as confidentiality, than we are not being asked to be responsible. We are being told to be obedient. You must have choices and the right to choices in order for responsibility to have any meaning at all. Then the issue is not a matter of responsiblity--it is a matter of obedience. And we are grownups. We have a right to participate, demanding these choices, and demanding these explanations. And we are not subversive because we take a little longer to grapple with those issues. And I'm so pleased that so many grappled for so long about some of those issues this weekend.

There have always been those who've resisted such challenges to the system to change either because they didn't understand the nature of those who thirst for freedom, or because they've found it politically expedient to oppose such changes. It is lamentable indded that so many years of so many lives have had to be spent for fighting for such elimentary principles of justice. But let there be no mistake. We have been fighting the good fight, and we have won a few victories. Perhaps the healthiest victory is the ever increasing number of us daring to live our lives visably and with dignity as a 24 hour a day, 7 day a week rebuke to the myths, the lies, and distortions by the newest brand of bigots. We're not about to retreat now, and we will use every resource we have, call upon every commitment made to us to respond to the crisis that threatens the lives of our brothers & sisters stricken with AIDS. The tens of thousands whose lives have been stalled because they live in fear. The victims of violence; the thousands who will die this year because of alcohol related deats. When we come together to speak with one voice it must be with an agenda that doesn't permit the system to simply shift the populations it selects to ignore. And with that in mind, I'm pleased to utilize this forum to make a modest but potentially significant announcement. On June 21, the National Gay Task Force (NGTF) will meet with Special Assistant to the President for Health Issues, Judy Buckaloo. OUr concerns will include a spectrum of health issues and we ask you to join us to demand an increase in the current Administration's proposal of $17.6 million for AIDS in fiscal 1984. That pressure must begin and must not let us until they have heard our demand!

Accordingly, I'm asking each organization here to send a mailogram to the White House, urging an increase in AIDS research for fiscal 1984. Please send a copy of your communication to the NGTF immediately. We'd like to go into that meeting fortified with the evidence of the concern of our entire community around this particular issue. Similarly, we will be shortly addressing the US Conference of Mayors Special Task Force on AIDS. Our presentation is a statement on the local response to AIDS, a community challenge. The text includes a spectrum of action mayors can and have taken in some cities. These actions include measures which will focus on public education, the need for interdepartmental task forces, the appropriations of funds, and the provision of inkind services for community organizations

(CONTINUED)

APUZZO PROVIDES PERSPECTIVE, Continued

providing support services to persons with AIDS, housing, the importance of working closely with health care workers, and finally the need for mayors as public officials with significant clout, to lend the weight of their offices to join us in pressing for that increased funding for the cause and the cure of AIDS. If you give us a few days, we're sending to every organization in every city in which there are persons with AIDS, a copy of what it is we will present to those mayors so that you'll know, and they'll know you'll know; and that's called putting a little pressure on, turning up the heat as we used to say in the Bronx.

Pioneering in the '80s is not just a piece of rhetoric. We really are pioneers. We have an immense body of oppression and it is killing people in this country. We have an enormous strength. We have an enormous charge from a community that has entrusted us with a public trust. Those of us who are priviledged to lead in any respect in this community indeed have a sacred and public trust. We have some of the best people in the country helping us, supporting us, challenging us. They used to say that the quest is the greatest adventure. I look around the room, I see the pioneers that are joining as we confront this frontier and I say to you, "I am proud to serve with you making history." Thank you.

[Ginny Apuzzo, Executive Director of the National Gay Task Force, gave the following address at the closing session of the 5th National Lesbian/Gay Health Conference, June 12, in Denver. Her address followed a moving presentation by a group of people with AIDS; the first paragraph is specifically addressed to them.]

* * * * * * * * *

INCREASED INCIDENCE OF MEDICATION ERRORS IN HOSPITALIZED GAY MEN

Los Angeles registered nurse Genievieve Clavreul and psychotherapist Sue Caviness have reported an increased incidence of errors in administering medications in hospital infections among gay men. They are currently working on an extensive study entitled, "An Evaluation of 'AIDS Apprehension' Among Nursing Personnel and Its Observed Effects on Level of Patient Care Quality," which sould be complete in a couple of months. The July/August, 1982 issue of NursingLife solicited 5000 responses on nursing ethics. Among the findings reported in the January/February, 1983 issue:

23% of the respondents are uncomfortable giving care to homosexuals; 41% to criminals; 33% to drug abusers; 27% to alcoholics.

90% admit to having given a patient a wrong drug or dose of a drug at some time.

36% have falsified records or know someone who's falsified records to disguise a mistake.

If a doctor seemed incompetent and his patient asked the nurse what was thought of him, 33% would avoid the question by reassuring the patient or dodging the inquiry.

Nurses who considered themselves religious and whose morals are closely tied to their religious views are slightly more uncomfortable giving care to homosexuals; this os also true for nurses over the age of 50. Feeling uncomfortable is quite different from withholding adequate care. More details in a future Newsletter.

* * *

GAY HEALTH DIRECTORY PUBLISHED

The National Gay Health Education Foundation recently published a compendium of health services by and for lesbians and gay men, The National Gay Health Directory, 3rd Edition. The 34 page glossy covered directory sells for $5, and is available from NGHEF, PO Box 834, Linden Hill, NY 11354. For inclusion in the next directory, please send a self-addressed stamped envelope to the NGHEF for a listing form.

* * * * * *

AN OPEN LETTER TO THE AMERICAN LIVER FOUNDATION

[Ed note: The following letter was sent to Ms. Thelma King Thiel, Vice Chairman & Executive Director of the American Liver Foundation, 998 Pompton Av., Cedar Grove, NJ 07009 (201/857-2626) by Harley McMillen, Executive Director of Howard Brown Memorial Clinic, 2676 N. Halsted, Chicago, IL 60614 (312/871-5777). Please feel free to correspond to either of them, or to the NCGSTDS for publication in the Newsletter.]

"Dear Ms. Thiel: I am in receipt of your letter of July 29 requesting that the Howard Brown Memorial Clinic co-sign the new ad being run by your organization for the Hepatitis B vaccine. I am very upset and disturbed by the advertisement and feel that it is insensitive to the current medical crisis affecting the gay community. Although the picture of the dying male may be in reference to hepatitis, in the minds of practically every gay male, it will immediately conjure up images of AIDS and the high fatality rate. I do not believe that the heavy duty scare tactic employed by this ad is either appropriate to a gay male or to the promotion of good health practices. The gay community is experiencing a major medical crisis right now and every activity that feeds that fear and hysteria is downright insulting. The Clinic does not wish to participate in this type of advertising. I have also discussed this with other providers of gay health services; I am sure they will also be providing you comments relative to this advertisement. There are much better ways of designing this ad and I suggest you investigate them before you receive a backlash from the gay community. Sincerely, Harley E. McMillen."

EDITOR'S NOTE/OPINION--I was unable to obtain an official reply from Thelma Thiel, Executive Director of the American Liver Foundation. (The invitation stands.) However, it's important for all of us to understand that we share a common goal--of reducing the incidence of hepatitis by education of our communities and by promotion of the vaccine. Every community has different characteristics that may necessitate different strategies and approaches for optimal effectiveness. An ad campaign in one community may be a terrific success and in another, a dismal failure. And even within a single community, a campaign may have different effectiveness. We can only hope that if it doesn't work this time, if we work harder and try another approach, it may work the next time. Some communities may wish to write their own ad copy and request that the ALF endorse and underwrite the campaign for their local gay media. We should all send in our suggestions about education, tailored to our respective communities, to the ALF; we should also realize that as a nonprofit agency with a board of directors they are similar to our own gay STD services with limited finances & resources, with well-meaning but sometimes ill-advised staff. Almost all nonprofit social service agencies share these same problems and frustrations. We must constantly focus on the end, and be flexible with the process. And if an agency needs a friendly reminder about being responsive to its constituency, then let it be understood in the spirit of the health of our communities.

* * * * *

LETTER FROM BOSTON

by Ken Mayer, MD

It's a shame that I didn't get to see you and share in the pride of the recognition of the NCGSTDS at the 5th National Lesbian/Gay Health Conference in Denver, but things have been too frenetic. Boston was wll represented and I have gotten several reports about the meetings from friends. Unfortunately, I don't think that this will be the last of this kind of gathering. At least the networking and the support of the meeting will energize the participants and their colleagues back home, but much work remains to be done. I have just begun my first post-training job, as an assistant professor of medicine at Brown, working mainly as an Infectious Disease person at a 350-bed hospital in Rhode Island. Even though the lab I am setting up is for the study of problems in antibiotic resistance, my work at the Fenway Clinic is known, so I now get to do AIDS consultations in 2 states. There have been 5 cases of AIDS in the Providence area, with 3 of them in heterosexual drug users. I presented a Grand Rounds on the topic, with my boss in infectious diseases and a closeted lesbian immunologist at a large Rhode Island hospital, with over 250 medical personnel in attendance. I expect to do the same at several other hospitals. Things have hardly let up at the Fenway. While everyone was in Denver, I was following a young man who illustrated why the CDC case definition of AIDS is too restrictive and why a national network that is fully operational

(CONTINUED)

LETTER FROM BOSTON, Continued

(i.e., funded) is needed. [Ed note: see related artilcle on the National AIDS/Pre-AIDS Epidemiology Network.] I have enclosed some of the recent medical notes I wrote about his case [see elsewhere in Newsletter: AIDS Case Study]. The Clinic has applied for the NIH contract to study the natural history of AIDS in 1000 gay men in a nonepidemic area. I understand from David Ostrow that there are many community health centers applying for the same grant. I hope that all our proposals are well enough written that all are approved. Then, if the Feds only fund 2 or 3, we can network politically to force the issue. The potential benefit that this kind of work might yield is incredible. It would have been nice if they had the foresight 2 years ago to set up serum banks in all major US cities, so that for example, now human T-cell leukemia virus (HTLV) antibodies or alpha thymosin, or whatever marker of the day, could be assayed from the large numbers of persons at risk. The lag in information is incredible. For example, no one who was in Denver learned whether all men who have developed AIDS have had passive anal intercourse. This would be just one useful fact to know in terms of counseling people on risk reduction; it should be fairly accessible, yet we still don't know it.

There has been much AIDS related community activity in Boston. Brian McNaught, the Mayor's Liaison, hosted a fundraiser for an AIDS lobbyist with Gay Rights National Lobby (GRNL). During Gay Pride week, the grass roots AIDS Action Committee had a fundraiser at the pre-Broadway premier of "La Cage Aux Folles," which was an uplifting event and a gay positive message. The next night, the Boston Gay & Lesbian Political Alliance (BLGPA) sponsored a town meeting in Faneuil Hall, cradle of the American Revolution. With the portraits of various Adams' and such looking on, John Mazzullo and Marshall Forstein discussed the medical & psychological issues the community faces vis a vis AIDS, and a person who has AIDS addressed the community as well. This was followed by a candle-light march to the State House. The following Saturday, 18,000 people marched in Boston's Gay Pride March. We have been meeting with the commissioner of health and hospitsls, lobbying for a full-time AIDS coordinator for the city, as well as a monthly meeting of all the Boston medical researchers and clinicians who are involved with AIDS. He is slowly responding. The Governor of Massachusetts is setting up his own AIDS panel for the state. There are over 30 CDC-confirmed cases of AIDS in the Boston area, over 20 in gay men, which has more than doubled since the end of 1982. Will keep NCGSTDS members in touch in future Newsletters; looking forward to reading from others!

* * * * *

THOUGHTS ON NEGATIVITY

by Jeff Richards (with apologies for editing)

By all normal criteria, we have made some incredible inroads towards problem-solving in some enormously difficult tasks in the area of gay/lesbian health. The strides that our collective efforts and organizations have made in the last four years are frankly staggering, and perhaps without precedent in the health field. But I continue to be concerned by the frequent tones of negativity and unrelenting criticisms against gay/lesbian leaders and organizations by other, probably well-intentioned members of the community. We must all appreciate the "newness" of such efforts as health conferences, STD clinics & services, and AIDS community organizations & foundations, and the fact that they are of course experimental in nature, to some extent. For the number of people that are dissatisfied with such activities, there are probably an equal or greater number of those that are more than satisfied. But why do we hear just the unhappiness, the dissatisfaction? It sounds petty and it is potentially isolating, especially when such non-constructive criticisms are made public. We're truly fortunate in that we have few "evil" people in our vast gay/lesbian health network; incompetant, sometimes; ignorant, occasionally; well-intentioned, definitely. Even a few power-hungry types. But will criticisms of people and organizations and events help the movement, or cause a person to be viewed as negative? Let's try to remember what effects our comments will have, before they are made public.

* * *

LETTERS TO THE EDITOR

"I always find the Newsletter very informative. In [the last issue, volume 4:5], I thought the article by Nancy Lord, MD, was most interesting and provocative; certainly the theory has plausibility and should be easy to test. I attended a seminar recently given by Robin Weiss from England--his topic was Human T-cell Leukemia Virus (HTLV) and he mentioned that some chimpanzees that he has been working with were HTLV positive and also some of them were hepatitis B antibody positive. The HTLV positive status is in contrast to what a group of German workers found--all of their chimps were HTLV negative--I don't know what their HBV status was. At any rate, a light bulb turned on--is there some connection between hepatitis B and HTLV? Also enjoyed the reprint from the Body Politic ("Living with Kaposi's..."). I thought that certain parts were very thought evoking. Looking forward to read what happened in Denver. I had conflicting travel at that time." --F.L., Boston

"Encouraged as I am to "communicate" to the May, 1983 issue of the NCGSTDS Newsletter, I am doing so now. First, I am dismayed by your reprinting (from the November, 1982 Body Politic) texts by Michael Lynch and Bill Lewis. Both articles contain severe distortions of fact and judgement as well as direct personal attacks on Drs. Dan William and Lawrence Mass, both of whom have served their people heroically and have been repaid for their effort with vandalism. Second, I am truly appaulled that you excerpted at great length passages from Larry Kramer's original New York Native (March 14, 1983) article. This emotional Walpurgisnacht was written, by the author's own admission, to "scare the shit out of you." Obviously, by reprinting Kramer's piece you share his intent. Third and last, reprinting the Bay Area Reporter piece by Tom M. Smith, MD, would lead one to believe that you share Dr. Smith's opinion that a great number of gay men cannot marshal enough intelligence to convey even the most basic English sentence. So, examples are set in a Dick-and-Jane vernacular. I find this insulting. Dr. Smith's attitude of condescension in his article in nonpareil, at least in my own experience." --Nathan Fain, New York

[The following reply was sent to Mr. Fain:]

"Thanks for your [recent] letter....I sincerely appreciate your expressing your feelings about those articles....I wish more people would be less hesitant to articulate their feelings and opinions. The articles were printed for several reasons: 1) I received several inquiries and requests to print them, from people never having seen the originals. Many of our readers do not subscribe to [the Body Politic, New York Native, or Bay Area Reporter]. 2) Controversial as they may be, the articles have been quoted by gay health leaders and therefore offer a certain historical perspective. Although they may now seem dated, they charged our communities to positive action. 3) The NCGSTDS has always encouraged an open dialog without censorship. 4) The gay health community is sufficiently mature to withstand selfcriticism without feeling personally attacked. Dan William, for example, has been "tarred & feathered" for promoting ideas and activities unpopular to mainstream gay lifestyle for years--even before AIDS. Yet he has not withdrawn from providing outstanding & sensitive care to his patients, nor has he withdrawn from working with the gay health movement. I too, have received criticisms, as I'm sure you and all other gay/lesbian leaders have. But we still work for the betterment of our respective communities, and we have been responsible for positive change and growth. I hope this clarifies the issue. I welcome your response, and continued open dialog on all gay health issues...." --Mark Behar, Chairperson, NCGSTDS, Milwaukee

[The following reply was received:]

"It was good to see you again in Denver and good as well to have your kind letter when I returned. Your points answering my letter are well put and well taken. I can see what you mean. Editing any publication requires a sensitivity to what your readers want, and I haven't spent all these years toiling on Grub Street not to know that. It isn't easy, I know, staying on top of that. Good luck on the Newsletter and on all your many projects. I'm sure you know how appreciated your work is, as signified by [the NCGSTDS'] distinguished award in Denver." --Nathan Fain, New York

* * * *

GAY & LESBIAN COMMUNITY SERVICES CENTER APPOINTS NEW DIRECTOR

Tom Kurz, a 15 year veteran in public health fields and a Santa Barbara businessperson, has been selected as the new Director of Health Services at the Gay and Lesbian Community Services Center (GLCSC) in Los Angeles. Kurz replaces Thom Nylund, who resigned in December after 5 years of service with the Clinic. Simon Moreno, a long-time GLCSC health services employee, has been promoted to the position of Clinic Director, a position responsible for the day-to-day operation of the Clinic. Commenting on Kurz's selection, GLCSC Deputy Director Don Kilhefner stated, "The Center undertook a national search to fill the Health Services position. Our Clinic is seen as the flagship of gay and lesbian health care programs around the country, and as an important community institution. In Tom Kurz, the Center has been able to attract a uniquely qualified person to direct that important program."

Kurz's background includes 10 years of service with the US Public Health Service in positions ranging from field epidemiologist to assistant to the director of health services for the federal bureau of prisons. In 1970, he pioneered the first state-level environmental health planning post in New Mexico. On assuming his new position, Tom stated, "The GLCSC Clinic has been the granddaddy of facilities of its type and as the mid-80's approach, presenting medical problems never known in the history of humankind, GLCSC is faced with the challenge of leading the way with renewed committment to our community."

The GLCSC Health Services Program has been in operation since 1973 and has developed into one of the largest community based medical programs in California. The program currently reports approximately 1300 patient visists each month, and operates with an annual budget of over $310,000. The Clinic is staffed by 12 full time employees and a staff of 20 volunteer physicians and 120 additional professional and paraprofessional volunteers. Currently, the Health Services Program focuses almost entirely on STDs. However, in talking about the program's short range goals, Kurz stated, "During the coming year we would like to broaden the program to respond more directly to the current AIDS crisis as well as to begin addressing lesbian health care problems and the needs of older gays and lesbians. The years ahead will be an exciting time in the Clinic's already distinguished history."

* * * * *

HOW TO PREVENT BURN OUT

by anonymous

The key ingredients to avoiding high pressure stress is to first be aware of the problem and its causes. Then you can take steps to reduce tension and regain control of your life. Sounds easy, doesn't it! These steps include:

Planning your work and following your plan; establishing yearly, quarterly, & monthly goals; working from a priority list; delegating responsibility; accepting help; taking on only those jobs for which you are qualified; tackling only one major project at a time; setting limits; communicating your needs to those who can help meet them; learning to say "no"; competing with yourself rather than with others; eliminating procrastination; avaoiding grumpy, complaining companions; admitting your failures; claiming your successes; and being ready to try again.

More importantly, time needs to be set aside daily for you; have a daily meditation or quiet spiritual time; exercise; pamper yourself weekly or daily (bubble bath, manicure, dinner, movies, etc.); take a 15-20 minute "breather" before charging into fresh tasks; share your experiences & dreams with a trusted friend; have planned recreation; accept the things you cannot change; and don't try to be wonder woman or superman.

* * * * *

GAY HEALTH & STD GUIDE AVAILABLE FROM NY GAY MEN'S HEALTH PROJECT

excerpted from July, 1983 VD Interchange

The Gay Men's Health Project in New York City has published, and is selling for $3, a 38 page book on STDs, written specifically for a gay male audience. For more information, contact: Gay Men's Health Project, 74 Grove Street, #2RW, New York, NY 10014, 212/691-3969.

* * *

DIAGNOSING HERPES SIMPLEX

by K. Koe, MD

[Ed. Note: The following article was kindly written by dermatologist K. Koe, MD, formerly of Milwaukee's Brady East STD Clinic; he is now in practice in southern California.] The diagnosis of herpes simplex virus (HSV) has been neglected by most sexually transmitted disease (STD) clinics, even though herpes is one of the most common and oldest diseases of mankind. If herpes is suspected by the patient or health care worker, professional or laboratory confirmation should be obtained when possible. Although having herpes should not be a physically or emotionally disabling condition, incorrect diagnosis should be abhorred. This article is aimed at encouraging all STD clinics to perform in-clinic cytologic confirmation of HSV. Secondly, we will review the cause and terminology of HSV.

CAUSE: HSV is due to a virus that is related to, but different from the virus that causes chickenpox and shingles (herpes zoster). Researchers class herpes simplex into Types 1 and 2, but for lay people and most health care workers, this distinction can presently be ignored. Herpes is contagious, but only by direct inoculation from a fresh wet herpes lesion to a wet, cut or open microscopic break in the skin/mucous membrane of another person. Herpes is very labile off human skin. It dies (becomes inactive) within minutes of being off skin or being at room temperature on a culture swab, glove, or toilet seat. It is not transmitted via air or water. (You can't catch it by being in the same room or hot tub with someone who has even severe herpes.) Infection is spread during sexual intercourse from a fresh or healing vesicle on one of the partners. Washing with soap after intercourse probably reduces the chance of infection.

TERMINOLOGY: The most common HSV lesions are ordinary cold sores or fever blisters that occur periodically on people's lips, including the lip surfaces touching the teeth or gums. The sores on the gums or within the cheeks or mouth (aphthous ulcers/canker sores) are rarely due to herpes. By age 5 years old, nearly 95% of all children have had clinical or blood antibody evidence of having had herpes (from all that kissing!). These antibody levels diminish within a few years and rise with new herpes infection, however these antibodies do not give immunity nor are they useful for diagnosis. Lay people need not be confused by the vast terminology describing herpes at exact body locations--herpetic gingostomitis (mouth), herpetic keratoconjunctivitis (eyes), H. vulvovaginitis (vulvo-vagina), H. progenitalis (penis), neonatal herpes (newborns), H. whitlow (fingers), and Kaposi's varicelliform eruption (total body herpes). The name "Kaposi" is from the doctor who clinically described wide spread body herpes in the 1800s. In 1872, he also described Kaposi's sarcoma, which is related to the Kaposi's sarcoma of present day acquired immune deficiency syndrome (AIDS). Herpes and AIDS are not directly related, but herpes is very frequently seen in AIDS patients. However, having herpes does not mean a patient is more likely to develop AIDS.

CLINICAL: Briefly stated, herpes presents as a group of three or more (usually over four, almost never one or two) small vesicles, each about one to four millimeters in size with the group covering an area one to several square centimeters wide. Lesions break, dry, and heal in 10 to 14 days. Clinical herpes recurs in less than 60% of cases, and less than 30% get a third recurrence but these people may get new lesions in the same area periodically for several years. The recurrent lesions are usually smaller in vesicle size, smaller in area covered, less painful, and faster to heal than the primary episode.

LABORATORY DETECTION: HSV can be cultured and is very commonly done by obstetrics departments. However, high costs, lack of laboratory personnel prevents every suspicious lesion from being cultured. Culture swabs done at night give very low yields if allowed to sit refrigerated overnight before planting on media. Assuming the above technical factors are overcome, the culture is obtained from several fresh intact blisters. Wiping with alcohol is unnecessary and may kill the virus. With a sharp blade, break the vesicles at their at their base and pull back the vesicle roofs. Try not to induce bleeding. Rub the vesicle floor with a sterile cotton swab and place in the liquid viral transport solution (usually called Hank's solution) obtained from the laboratory. Break the swab so that only the sterile stick is inserted. Place Hank's solution in wet ice until ready for culture plating.

CLINICAL DETECTION: Microscopic cytology preps similar to gram stain preps for gonorrhea can be a quick test for herpes. As with gram stains, the difficulty is consistency in staining and finding someone who knows what to look for on the microscope slide. The Tzank smear is the original stain for diagnosis of herpes and chickenpox. (Check dermatology & laboratory

(CONTINUED)

DIAGNOSING HERPES SIMPLEX, Continued

texts for color photographs of giant cells on Tzanck smear.) But now there are quicker stains, and all are used to color the multinucleated viral giant cells. Herpes destroys cell walls, so several cells will look joined together but their nuclei are large because of intranuclear viral reproduction. Polymorphonucleocytes (PMNs), red blood cells, or epithelial cells should be seen on the slide but viral giant cells are at least 3-20 times larger. Gloves should be worn when breaking herpes blisters. The best skin material for staining is obtained by scraping the base of a freshly broken vesicle, avoiding hemorrhage. Air dry the slide, don't heat. Fix with 95% ethanol or hair spray (e.g., Final Net, or any Pap smear spray). Many different stains can be used: Wright, Papanicolaou, hematoxylin-eosin, Giemsa, or Gram. For ease, I recommend Paragon Multiple Stain for Frozen Sections (PMS), methylene blue, or Quik stain. To the fixed slide, cover with PMS for one minute, rinse well with water, decolorize with a few drops of 95% ethanol (or same decolorizer in Gram stain kit), water rinse, and air dry. Gram stains can give inconsistent colors, but if used, stain as if for gonorrhea. The giant cells will look like enormous gram negative (pink) PMNs. Quality controls should be run periodically. Unstained positive and negative herpes slides can be obtained from the following companies, or make slides from people's lip cold sores that are known to give positive results (positive & negative herpes slides can be obtained from: Bartels, Inc., POB 3093, Bellevue, WA 98009, 206/453-1953; Electro Nucleonics, 4809 Auburn Av., Bethesda, MD 20014, 800/638-8305). When there is clinical suspicion of herpes, culture or cytology smears should be done when possible. Cytology stains are obtainable from most hospital supply companies, or Scientific Products Company (toll free number). Herpes zoster (shingles), chicken pox, and herpes simplex have similar cytologies with these stains, so if a differentiation is needed, cultures are probably indicated.

* * *

VD NATIONAL HOTLINE NAMES NEW DIRECTOR

The American Social Health Association recently announced the appointment of Remy Lazarowicz as the new director of the VD National Hotline and editor of the Hotliner, the Hotline's official newsletter. The following is an open letter:

"When I was assistant director of the Hotline, I ofen wondered what it would be like to run the show--to be in charge of the most successful VD intervention/prevention program in the United States. As director, my first question was "How can I improve an already successful program?' Intense deliberations with both Hotline and ASHA staff yielded a solution: 1) The Hotline will provide additional service to California residents, adding another toll-free line. 2) Hotline operators will undergo specialized training on AIDS, a growing concern not only to gay men but also to the non-gay community. 3) Hotline staff and volunteers will develop new techniques to improve services to callers. 4) The Hotline will increase its volunteer staff from the present 60 to 120, in order to provide more comprehensive service on existing lines as well as the new California line. The goals and objectives for the Hotline pose exciting and new challenges. We will need new strategies to recruit volunteers, new training techniques for volunteers, and ongoing inservice training for the 'old guard.' These priorities will be major projects for the near future. With the dedication and support of the assistant directors, Helen Shaw and Gwen Dyason-Wood, and the loyalty of Hotline volunteers, I feel confident that the growth and success of the Hotline will continue. Thank you for your continued support."

* * * * *

WARNING TO READERS

The NCGSTDS has received several requests to either not print certain articles of questionable information or print disclaimers with each such article. The Coalition does not have the resources to verify the content of an article, or make a psychological assessment of the author's intent. We therefore must refer the reader to the general disclaimer printed on page one, and warn all readers to critically review all articles and send in your comments. Although we may edit for space (trying not to), we won't censor a timely submission on STDs or AIDS. As always, we welcome your responses: NCGSTDS, POB 239, Milwaukee, WI 53201.

* * *

FEDERATION OF AIDS RELATED ORGANIZATIONS INVITES OTHERS TO JOIN

The 38 founding members of the newly formed Federation of AIDS Related Organizations (FARO) are extending an invitation to all organizations around the world who have AIDS on their agenda to join with them in an exciting effort to coordinated AIDS activities both here in the US and internationally. FAROs first projects, the Lobbying Project and the Resource/ Information Project were created at the June, 1983, Fifth National Lesbian/Gay Health Conference & Second National AIDS Forum, in Denver. Permanent steering committee members are currently being chosen to represent seven local communities (NY, LA, SF, Atlanta, Denver, Houston, and Philadelphia), four national groups (National Gay Task Force, National Gay Health Education Foundation, Women's AIDS Network, and American Association of Physicians for Human Rights), and three persons with AIDS. The permanent steering committee met in New York, August 13-14 to determine the course of the first two projects.

Paying for the Lobbying Project has begun with commitments of more than $100,000. The Resource/Information Project, currently in a needs-assessment phase, is being funded by assessing each of the associated groups a fee of $50. Future financial underwriting of these and other projects will be determined at later meetings. Donations for the Lobbying Project may be sent to: Paul Popham, Treasurer, FARO Lobbying Project, Gay Men's Health Crisis, Box 274, 132 W. 24th St., New York, NY 10011; Donations for the Resource/Information Project may be sent to: Ron Vachon, FARO Interim Director, R.I.P., 506 W. 42nd St., #E5, New York, NY 10036. AIDS related organizations wishing to affiliate with FARO may direct inquiries to Ron Vachon at the above address.

* * *

PUBLIC TELEVISION TO EXPLORE AIDS

with thanks to Seattle Gay Clinic

Seattle's public television station, KCTS-TV9, has received a grant to produce a half-hour documentary on AIDS. The special will present up-to-date medical information and also explore the impact that AIDS is having on both the gay and straight communities in the Pacific Northwest (primarily the greater Seattle area). The program is expected to be broadcast nationwide on public television stations in September or October.

* * *

AIDS EPIDEMIOLOGY/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of August 22, 1983, the Centers for Disease Control AIDS Activity reports a total of 2157 United States cases of AIDS (CDC definition), and 123 foreign cases from 20 different countries. Homosexually active men account for 71.6% of the cases; 16.8% from IV drug users; 5.1% from Haitians; 0.8% from hemophiliacs; and 5.7% in no apparent risk group or unknown/unidentified. 22.1% are from individuals aged 20-29; 46.9% from ages 30-39; 21.7% from ages 40-49; 8.5% from ages 50 and over, and the remainder are in all other age groups. 57.4% of the individuals are white; 26.4% are black; 14.2% are hispanic; 2.0% are others/unknown. 41 states (including Washington, DC & Puerto Rico) have reported cases; New York state has 46.8%, California--21.5%, Florida--6.9%, New Jersey--6.4%, Texas--2.6%, Pennsylvania--2.0%; all other states account for less than 2% each. It is important to note that these cases represent only those meeting the CDC's strict criteria for what constitutes a case. (This data is updated weekly by the CDC.)

* * *

IMMUNE FUNCTION DEPRESSED WITH EXPOSURE TO SUNLIGHT & COMMERCIAL UV IRRADIATION

The March 12, 1983 Lancet featured an article on the "Immunological Effects of Solarium Exposure," which stated that OKT4 helper T cells were reduced (and a concomitant decrease in the T4:T8 ratio) and some skin tests for anergy were reduced after exposure to ultraviolet radiation found in sunlight & tanning salons. Tests of immune function were reduced several weeks after exposure. It is well known that the incidence of melanoma (a dangerous form of skin cancer) is related to exposure to sunlight, and the nature of this association seems to be indirect, in that tumors often develop at sites not exposed to excessive sunlight. This may be just another piece to a rapidly expanding & confusing jigsaw in AIDS research--however one that has not been previously considered.

* * *

"CAN WE TALK?"--A NEW BROCHURE ON AIDS RISK REDUCTION

San Francisco's Harvey Milk Gay Democratic Club's AIDS Education and Information Committee is distributing an educational brochure on AIDS risk reduction, based on information from Bay Area Physicians for Human Rights (BAPHR). For further information, write: Harvey Milk Gay Democratic Club, PO Box 14368, San Francisco, CA 94114.

* * *

REPORTS FROM THE SECOND NATIONAL AIDS FORUM
(abstracted by Mark Behar)

[ED NOTE: It was hoped that the coordinators of the 2nd National AIDS Forum in Denver would have prepared summary statements from each of the workshops, especially since a few of the workshops (e.g., Networking Workshop) did not finalize their reports in time for the preliminary report, distributed at the close of the Forum. This was no small job! Anyone wishing to receive copies of the entire report may address their requests to: Jeff Richards, 41 Landers, Apt. 2, San Francisco, CA 94114--send $5 to cover copying & postage expenses! The following are selected abstracts from that preliminary report. The NCGSTDS will consider publishing abstracts of the final report if it is written. Your comments, as always, are invited. There were eight identifiable workshops during the Forum; abstracted reports from 4 are below; those not abstracted are: Public Policies, Epidemiology, Infection Control, & Networking.]

ADVISORY COMMITTEE OF PEOPLE WITH AIDS: "We condemn attempts to label us as 'victim,' a term which implies defeat, and we are only occasionally 'patients,' a term which implies passivity, helplessness, and dependence upon the care of others. We are 'People with AIDS.'

We recommend that health care professionals: 1) Come out, especially to their patients who have AIDS. 2) Always clearly identify and discuss the theory that they favor as to the cause of AIDS, since this bias may affect the treatment and advice they give. 3) Get in touch with their feelings (e.g., fears, anxieties, hopes, etc.) about AIDS and not simply deal with AIDS intellectually. 4) Take a thorough personal inventory and identify and examine their own agendas around AIDS. 5) Treat people with AIDS as whole people, and address psychological issues as well as biophysical ones. 6) Address the question of sexuality in people with AIDS specifically, sensitively, and with information about gay male sexuality in general and the sexuality of people with AIDS in particular.

We recommend that all people: 1) Support us in our struggle against those who would fire us from our jobs, evict us from our homes, refuse to touch us, separate us form our loved ones, our communities or our peers, since available evidence does not support the view that AIDS can be spread by casual, social contact. 2) Do not scapegoat people with AIDS, blame us for the epidemic or generalize about our lifestyles.

We recommend that people with AIDS: 1) Form caucuses to choose their own representatives, to deal with the media, to choose their own agenda and to plan their own strategies. 2) Be involved at every level of decision-making and specifically serve on the boards of directors of provider organizations. 3) Be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge. 4) Substitute low-risk sexual

(CONTINUED)

REPORTS FROM THE SECOND NATIONAL AIDS FORUM, Continued

behaviors for those which could endanger themselves or their partners, and we feel that people with AIDS have an ethical responsibility to inform their potential sexual partners of their heazth status.

People with AIDS have the right: 1) To as full and satisfying sexual and emotional lives as anyone else. 2) To quality medical treatment and quality social service provision without discrimination of any form including sexual orientation, gender, diagnosis, economic status or race. 3) To full explainations of all medical procedures and risks, to choose or refuse their treatment modalities, to refuse to participate in research without jeopardizing their treatment and to make informed decisions about their lives. 4) To privacy, to confidentiality of medical records, to human respect and to choose who their significant others are. 5) To live and die with dignity.

WOMEN'S AIDS NETWORK: Issues discussed were personal: our friends & brothers are dying. Issues were also related to our jobs as health care providers and health activists. Our issues were social: many of us feel isolated within our lesbian communities because we do work to fight AIDS; because we see it as a priority for women. And our issues were political: as women working within predominantly male groups dealing with AIDS, we once again face invalidation, invisibility, and sexism. We came together to discuss strategies, both national and local. As a network of women involved with AIDS, we see a need for national communication and coordination for education, for support, for action. The specific goals & objectives of the Women's AIDS Network were divided into 3 categories: Education--1) To gay men and to all people about the action women are taking in our communities on the issue of AIDS. 2) To our women's and lesbian communities, to counter anti-AIDS sentiment and negative attitudes about gay male lifestyles. 3) To ourselves and our communities about AIDS. 4) To health workers about lesbian and gay lifestyles. 5) To gay men about feminism about lesbians and women in general. 6) To the general public about AIDS and lesbian and gay issues, particularly homohphobia. Support--1) Of ourselves as people who are caring for and losing friends and brothers. 2) Of ourselves as health activists, health workers, and health care providers. 3) Of ourselves as women working in largely male groups. 4) Of all people who have AIDS, are at risk, or are working to combat AIDS. Action--1) To involve the lesbian & feminist communities in the AIDS issue, and to encourage and promote active participation in local organizations. 2) To become a national network of women doing AIDS work. 3) To involve women in the Federation of AIDS Related Organizations (FARO) on an equal basis with men, in terms of participation and decision-making.

MAKING POSITIVE CHANGES IN SEXUAL MORES: The workshop began with a discussion of current risk reduction guidelines and community education efforts. The consensus off the group was that community education efforts were extremely important. The further concensus was that any edcuation around risk reduction needed to be sex-positive and gay-affirmative. Specific risk reduction guidelines were discussed in terms of essential information versus elaborations. Some of the current guidelines focused on: characteristics which are correlated with the incidence of AIDS, e.g., number of sexual parters. Other risk reduction guidelines focus on the means of transmission of infectious agents and recommend proceudres for the reduction of transmission of infectious agents. The advantages & disadvantages of both approaches were discussed. It was recognized that specific groups need to be targeted in the development of risk reduction guidelines. Specific sub-groups of gay men (those that go to leather bars, those that meet each other through friendwhip networks, e.g.) are likely to need recommendations that address different issues. It was also noted that public information for the general population was important. No concensus could be reached with regard to essential versus elaborations of current risk reduction guidelines. It was concluded that further debate was necessary. It was further thought that discussion of these issues on a local level was advantageous, in that these guidelines need to be tailored to the specific needs of individual communities.

The second part of the workshop focused on strategies for implementation and acceptance of positive changes in sexuality. A model was presented for health promotion, patterned on the "Friends Can Be Good Medicine" project in California. The essential elements of the model are to keep the message extremely simple. If this simple message were to be agreed upon, the strategy would be to locate community resource people who would serve on steering committees in specific localities, e.g., each bar in a city, church groups, etc. The steering committee

(CONTINUED)

REPORTS FROM THE SECOND NATIONAL AIDS FORUM, Continued

would be charged with getting the infomration on risk reduction out to their group. The guidelines developed would likely differ from group to group. One of the advantages would be that people at a local level would be involved in the discussions leading to guidelines on how they might reduce risk. The use of television and radio presentations for the general public, awareness workshops for groups at risk,and innovative community based projects as means of public inforamtion were all discussed and encouraged.

The third part of the workshop focused on restructuring the gay male community toward positive and healthful expressions of sexuality. Examples of positive gay community change around the issue of alcohol abuse were presented as a model of what could be done to address a gay community problem. This type of a model puts emphasis on restructuring the environment and socialization patterns in such a way as to promote healthier options. Wellness/holistic approaches were generally agreed upon. However, workshop members voiced a range of responses from wanting broadly based psychological and existential changes in the gay male community to wanting purely biological risk reduction information. Several community efforts have already been effective in promoting safer sexual expression. One group produced a pamphlet on their model of AIDS transmission. Their experience was that once people agreed to the model that they were also likely to agree to the limits of sexual expression which followed that model. As limits were set and agreed upon, those participating reported feeling much more positive and less fearful with regard to their own personal sexual expression. Another group formed guidelines partly out of a preference for mutual masterbation as a means of sexual/sensual expression and partly out of a growing concern over STDs. Peer pressure was reported to be successful as a means of assuring conformity to the mutually agreed upon limits. In both these groups, guidelines for healthful sexual expression were developed by the group members themselves based on their models of level of risk associated with differnt forms of sexual behavior. The participation of the group members in the evolving of the guidelines was thought to have made the acceptance by group members possible. When mutually agreed upon limits were set, anxieties about AIDS and other STDs were greatly reduced. Friendships were also formed, and intimacy needs met. Others at the workshop reported the formation of local support groups in many cities for gay men who believed that their sexual expression was compulsive. Mutual support in such cases has led to increased intimacy and better physical health. The process of the workshop appeared to parallel the model that was bieng presented for the purpose of AIDS risk reduction in our communities. That model was individualizing information for specific target groups. Educational, ethnic, cultural, age and subgroup differences were all thought to be important considerations. The model would include gay positive and sex positive messages, countering authoritarian directives and considering the stage of reaction or acceptance to receiving in-fprmation. It would be implemented in environments conducive to health maintenance and health positive socialization. Any risk reduction information must contain a message delivered through many possible techniques. The interpretation of current epidemiologic information seems to differ widely throughout the country. Varying AIDS prevalence in different geographical locales and varying populations within the cities which have AIDS cases results in different rankings of social, political, and health priorities. Thers variables will also be manifest in differing degrees of receptivity and resistance to risk reduction information in groups and individuals. These important realities influence the interpretation of available data. This confounds the urgent pressure for specific guidelines, i.e., the community shapes and interacts with risk reduction information according to community and subgroup needs. Therefore, the recommendation is that this process continue. A second recommendation is that the honest efforts of health care providers to give the most up-to-date, scientifically based information about AIDS risk reduction continue.

POLITICAL STRATEGIES WORKSHOP: Recommendations: 1) Unanimously voted to support the development & implementation of a lobby project to be based in washington, DC for the sole purpose of lobbying for more money for research. 2) Local groups should actively lobby their local city & state governments for education/awareness and for ther support and influence on local, state and congressional levels (i.e., funding, research, health support services, etc.) 3) Local groups were urged to support Gay Right's National Lobby (GRNL) constituent lobby network effort. 4) Local groups should meet with their local blood banks (both voluntary & commercial) and

(CONTINUED)

REPORTS FROM THE SECOND NATIONAL AIDS FORUM, Continued

users (such as hospitals & hemophilia groups). Vigilance against an exclusionary policy of screening out people in a discriminatory way should be the watchword in the blood issue. There was much debate over the issue of screening people vs. screening blood. A separate report was prepared. 5) Legal and civil liberties groups should be encouraged to form committees of concerns regarding AIDS. 6) It was felt that there will probably be a strong backlash building as time goes on. Violence towards our community will take many forms: legal, legislative, physical, etc. The Dallas Gay Alliance just won a legislative battle regarding the Texas consenting adults law. 7) Support of the concept of equal participation of women working in AIDS in FARO or any other governing body dealing with AIDS. 8) All groups working on AIDS are urged to support the candlelight vigil in Washington, DC, Columbus Day Weekend, October, 1983, as called by the Americans for Democratic Action and we ask them to include in their planning people with AIDS and members of FARO. 9) AIDS has caused the medical and scientific communities to seek out an explanation and cure for this dreadful disease complex. We applaud and support all efforts of research that hasten the end of this health crisis, but we caution and demand that the National AIDS Forum neither endorse nor promulgate any one unproven theory over another. While we welcome the input and information the CDC has given at this Forum, we hasten to point out that the single virus theory is just that--a theory. We expect other theories, including the multifactor theory to be presented at such forums. We believe the premature endorsement of any one theory prior to scientific proof will be devastating to the civil rights of the gay & lesbian community. The Political Strategy Workshop developed a blood donor policy that significantly differed from that of the Public Policy Workshop. It takes an assertive political stance, pointing out that the issue of whether AIDS is in fact transmissable by blood is still a matter of scientific controversy. The Political Strategy Blood policy statement is an offensive position which places the fundamental responsibility for improving blood screening with the government; in contrast, we feel the Public Policy statement is a defensive position. [ED NOTE: After reviewing the pages of both workshop reports on blood policy, I am unable to substanciate andy major differences; both have been promulgated previously, and I am therefore not going to reproduce the 9 pages of reports. Anyone wishing to receive the entire report may send $5 and a request to Jeff Richards, address above.]

* * *

AIDS VIDEOTAPE PRODUCED BY SAN DIEGO'S OWEN CLINIC

An edited videotape of the University of California--San Diego Owen Clinic Health Forum on AIDS, presented in January, 1983, is available as a one hour presentation on Beta-max, VHS, and 3/4" Umatic for $125 (purchase) or $35 (rental). Drs. J. Allen McCutchen, Chris Mathews, and Henry Lim discuss the definition and history of AIDS, basic immunology, manifestations and diagnosis of AIDS, etiologic considerations, and guidelines for suggested risk reduction. For more information, call 619/452-4134, or write: Office of Learning Resources-Television M-015, UCSD, La Jolla, CA 92093.

* * *

NIMH HAS FUNDS FOR AIDS-RELATED PSYCH RESEARCH

by Arnie Kahn, PhD

In June, I received a phone call from Dr. Jane Steinberg at the Prevention Center of National Institute of Mental Health. She informed me that NIMH has been given the go-ahead to fund research on the mental health aspects of AIDS. In order to do this, NIMH needs to establish research priorities. They need to know the initial, first-step research that has to be conducted, how it should be conducted, etc. Ideas, suggestions, proposals, etc., should be reality-based and clearly related to AIDS and mental health. Topics might include effects of stress on AIDS, homophobia and hysteria in the lesbian/gay and heterosexual communities, and behavioral medicine approaches to modify high-risk behaviors. If you are knowledgeable about mental health aspects of AIDS, or if you have suggestions, please send them to me immediately: Arnold Kahn, PhD, American Psychological Association, Committee on Gay Concerns, 1200 17th St., N.W., Washington, DC 20036. NIMH also needs the names & addresses of researchers who are ready to conduct research on AIDS. If you know of such persons, please send me their names.

* * *

NATIONAL AIDS/PRE-AIDS EPIDEMIOLOGY NETWORK (NAPEN) MEETS IN SEATTLE

(meeting minutes by David Ostrow, MD, PhD; abstracted by Mark Behar)

The National AIDS/Pre-AIDS Epidemiology Network (NAPEN) meeting was called to order on August 4, 1983 at the Seattle Department of Public Health. Those attending included: David Ostrow, MD, PhD, Howard Brown Memorial Clinic, Chicago; Mark Behar, PA-C, NCGSTDS, Milwaukee; Patricia Canova, Seattle-King Dept. of Public Health, Seattle; Lisa Davis, Massachusetts Dept. of Public Health, Boston; Terry Gayle, MD, Seattle Gay Clinic, Seattle; Bill Gransden, MD, St. Thomas Hospital, London; Roger Gremminger, MD, Brady East STD Clinic, Milwaukee; Hunter Handsfield, MD, Seattle King Health Dept., Seattle; Steven Helgerson, MD, Seattle-King Co. Dept. of Health, Seattle; Will Jones, Seattle-King etc.; Lisa Kaplowitz, MD, Medical College of Virginia, Richmond; Tom Marsella, MD, NW AIDS Foundation, Seattle; Dennis Osmund, University of California, San Francisco; Marc Robin, NP, Beach Area Community Clinic, San Diego; and Thomas Quinn, MD, National Institute of Allergy & Infectious Diseases & Johns Hopkins Hospital, Baltimore. Dr. Ostrow reviewed the history of NAPEN over the last 18 months and the development of the 3 major goals of the Network: A) To serve as a forum for the exchange of ideas, methodologies, and information among AIDS epidemiologic investigators. B) To develop a uniform national AIDS/pre-AIDS data base allowing the study of national trends and a condensed prospective examination of major risk and protective factors. C) To assist investigators throughout the US and Canada in the development of AIDS/pre-AIDS epidemiologic investigations by the development and distribution of uniform reporting/data collecting instruments and procedures and the provision of assistance to such investigators. A fourth underlying aspect of the Natwork's evolution has been the attempt to preserve a role for the involvement of individuals and gay community organizations in AIDS research, in the face of the increasing complexity and cost of such investigations. It is felt by Ostrow that those investigators with large-scale government funded projects have a responsibility to assist grass roots projects which can ultimately contribute significantly to the total body of knowledge concerning the epidemiology and spread of AIDS. All persons sharing these beliefs and wishing to see as rapid progress as possible made in the understanding and prevention of AIDS on a national level to join NAPEN. Three categories of membership/participation were approved: 1) Voting members: individuals actively involved in AIDS epidemiologic research, agreeing to abide by the confidentiality provisions of the Epidemiology Workshop of the 2nd AIDS Forum and willing to contribute data to the Network. 2) Non-voting, non-participating observers: persons not meeting the criteria of membership but representing organizations interested in furthering AIDS epidemiologic investigations. 3) Non-voting-consultants: individuals involved with the Network for a particular purpose and/or lending expertise to Network operations. Under special circumstances, and at the vote of the members, consultants may be given voting privileges for particular issues. The need for involvement from a person with AIDS was discussed, and it was decided that the first NAPEN consultant would be a person with AIDS involved with the issues of confidentiality/protection of research subjects. Meanwhile. each member would be asked to be sure that the organization/group which they represented be apprised of the requiement for AIDS patient involvement in the decision-making process and that assurance of compliance with this requirement be made part of NAPEN membership requirements. A Member-at-Large/Secretary (voting) position was established for Mark Behar, and the NCGSTDS Newsletter was selected as interim communications medium for NAPEN.

Initial dues of $10/member were established and made payable to: "NAPEN Fund/HBMC." Expected expenses from this fund were for membership in FARO, which was joined, postage & telephone bills. Limited secretarial support was available would be provided by Howard Brown Memorial Clinic in Chicago, but the need for funding of a Network secretary was underscored, and will be included in the initial funding proposal. The difficulty of raising the projected large sums of money which might be needed for assembly, storage, an analysis of such a large data base as NAPEN's objectives would necessitate was discussed. Dr. Marsella noted that the real task of the Network at this time was to raise the necessary money for more precise formulation of Network goals and methods, which would largely entail funding for the next 2-3 meetings of the membership. In contrast, Dr. Ostrow felt that once established, the Network would be self-supporting through fees to users of teh data base. Ways to bridge the gap between the concept and actual realization of the data base were then considered. It was decided to seek funding for a limited interim budget (not to exceed $25,000) for

(CONTINUED)

NAPEN MEETING, Continued

organizational activities of NAPEN over the next 12-16 months from a gay community-based AIDS foundation. Drs. Ostrow, Gremminger, and Helgerson will prepare an interim funding proposal, for consideration at the November 13th meeting in Dallas. Dr. Ostrow pointed out that he would be presenting a paper on NAPEN at the APHA Annual Meeting, Nov. 15, in Dallas, in a symposium that would include Drs. James Curran and Selma Dritz and Representative Henry Waxman.

Further organizational aspects of NAPEN were approved. The Steering Committee will be composed of all voting members. Regional coordinators for each of 9 geographical regions will be saught, but these persons' roles will be that of information transmission to & from members. The idea of an executive committee was rejected at this time. Dr. Quinn informed the group of the status of NIAID's activities in establishing 4-6 major AIDS/pre-AIDS epidemiologic studies. Since the decisions on which cities and what core epidemiologic data base would be used in the NIAID-funded studies would be made relatively soon [details in the next Newsletter], he suggested that NAPEN defer action on adoption of a core data base until after NIAID's decision. IT SHOULD BE NOTED THAT A WORKSHOP ON THE EPIDEMIOLOGY OF AIDS WILL BE HELD IN ROCKVILLE, MARYLAND ON SEPTEMBER 12 & 13. IT IS BEING CO-SPONSORED BY NIAID, NATIONAL CANCER INSTITUTE, AND THE NATIONAL HEART, LUNG, & BLOOD INSTITUTE, AND WILL DEVELOP RECOMMENDATIONS FOR RESEARCH ON THE EPIDEMIOLOGY & NATURAL HISTORY OF AIDS. THE WORKSHOP WILL PERMIT PARTICIPANTS TO IDENTIFY AREAS PARTICULARLY RIPE FOR RESEARCH AS WELL AS PROVIDE AN OPPORTUNITY TO DISCUSS EPIDEMIOLOGICAL STUDY DESIGN AND THE OBSTACLES IMPEDING VALID EPIDEMIOLOGICAL STUDIES OF AIDS. THERE WILL ALSO BE AN ATTEMPT TO REFINE A COMMON DEFINITION FOR A VARIETY OF CONDITIONS PREVIOUSLY REFERRED TO AS "LYMPHADENOPATHY SYNDROME," "AIDS PRODROME," ETC., AND TO DEVELOP A MINIMUM COMMON DATA SET TO BE COLLECTED ON ALL PATIENTS AT THEIR INITIAL EVALUATION. INTERESTED PERSONS ARE ENCOURAGED TO ATTEND AND JOIN THE DISCUSSION, HOWEVER THE NIH CANNOT REIMBURSE ANY EXPENSES. BECAUSE SEATING IS LIMITED, ADVANCE "RESERVATIONS" ARE NEEDED (BE PERSISTENT!): MR. MARK BROWN, SOCIAL & SCIENTIFIC SYSTEMS, INC., 4405 EAST WEST HWY, SUITE 508, BETHESDA, MD 20814 (301/656-6346). NAPEN members will be in attendence, and reports will be distributed via this Newsletter. NAPEN discussed the proposed common definition of "lymphadenopathy syndrome," also known as "pre-AIDS," and "AIDS related complex;" the "Chinese menu" approach first proposed by Dr. Ostrow in November, 1982, and most recently reiterated by the NIAID's working group, was supported enthusiastically but with some changes, which will be brought to the NIH meetings. The discussion then turned to whether NAPEN's activities would be limited to studies involving gay men as would be the NIAID studies. It was decided to similarly focus on activities on the epidemiology of AIDS/pre-AIDS in gay men, but to be sure to include other risk groups in our data base to the extent that they overlap with the risk factors being studied in gay men. The need for liaison with other agencies which are planning epidemiologic studies in drug abuser (NIDA), hemophiliac (NHLBI), and Haitian populations was stessed. Dennis Osmond then brought up the need for NAPEN to consider early in its formulation of goals such issues as the types of hardware which will be required, the availability of software for data acquisition/compiling/analysis and the availability of paid vs. volunteer staff at each participating site. Dr. Ostrow pointed out that questions aimed at the acquisition of information regarding existing and planned resource availability at each participating center were included in the registration forms given to each participant. Please write to NAPEN (address below) for additional registration forms. The need for staged participation by Network members, depending upon local funding and other resource availabilities was raised by Dr. Gremminger and was considered later in terms of laboratory testing priorities. All persons who have developed AIDS/pre-AIDS epidemiology data base questionnaires were again encouraged to submit copies of the latest versions to Dr. Ostrow for use in formation of a core data base and Network resource library. The next meeting will take place Sunday, November 13, 8 pm, at the Dallas Hyatt Hotel, preceding the 1983 APHA meeting. For more information contact: Dr. David Ostrow, MD, 155 N. Harbor Dr., #5103, Chicago, IL 60601 (312/565-2109).

* * *

SAN FRANCISCO HOSPITAL TO OPEN SPECIAL AIDS UNIT

The nation's first medical special care unit for people suffering from AIDS is now open at San Francisco General Hospital. The 12 bed unit will be staffed by 12 nurses specially trained to deal with the life-threatening illness and the psychosocial support needed by those suffering from AIDS, according to hospital administrator Geoffrey Lang.

* * *

TRANSMISSION OF AIDS AND RISK OF AIDS TO THE GENERAL POPULATION

by AAPHR

[The American Association of Physicians for Human Rights (AAPHR), is a national organization of gay & lesbian health providers with members in over 35 states. This statement is being distributed to help calm the AIDS hysteria that is presently affecting our nation. For more information about AAPHR, please contact: POB 14366, San Francisco, CA 94114 (415/673-3189).]

Although the cause or causes of AIDS is still unknown, evidence gathered by the Centers for Disease Control and others, shows that AIDS seems to be spread sexually, or by blood or blood products. There is no evidence to suggest that casual social contact with people with AIDS or with healthy members of groups at increased risk for AIDS has resulted in acquisition of AIDS. By casual social contact we mean shaking hands, hugging, working with or otherwise being near others. In addition, there is no evidence for airborne spread (which includes coughing and sneezing). This is strongly supported by the failure to identify cases among friends, relatives and co-workers of people with AIDS who are not themselves independently at increased risk. Because of presumed spread of AIDS sexually we have distributed risk reduction guidelines targeted primarily to homosexually active males. We find no reason for altering usual and ordinary patterns of non-sexual interaction in the home and workplace. We are deeply concerned by attempts to isolate healthy members of groups at increased risk for AIDS. We condemn such attempts which may result in denial of ordinary civil freedoms--including the right to work in fields of choice and expertise and the right of equal access to public services and facilities.

* * * * *

DONOR DIRECTED BLOOD TRANSFUSIONS--NEW TACT OF THE "NEO-RIGHT"?: AN OPINION

Recently, an unemployed Orlando (Florida) man made public appeals on television for donating his own blood for his leukemia-stricken child. Shortly thereafter, the man appeared on Boston television, appealing for the opportunity for donor-directed transfusions (DDT), a policy that has been condemned by blood centers nationwide. A well-intentioned White House staff member (not Secretary Brandt) wondered if legislation banning gays from donating blood would be supported by the American Blood Commission. The response was an emphatic "no!"

There are many factors why such DDTs should not be allowed, according to Dr. Jay Menitove, Medical Director of the Blood Center of Southeastern Wisconsin in Milwaukee. Aside from autologous transfusions, where a person may donate his/her own blood for anticipated surgical needs, or where blood lost during surgery is recycled in "intraoperative salvage" and retransfused, DDTs are offering only the dangerous illusion of safety. There are absolutely no guarantees that the friends or relatives interested in DDTs are free from blood-borne infectious agents (e.g., CMV). Wouldn't it be interesting if the parents were found to not be histocompatible with their own child? That would call into doubt who the actual biological parents were! Those pushing for DDTs are actually saying that their blood is safer than general donors, a position absolutely not supported by evidence. However, the potential for a two tier system is very great--good vs. bad blood, male vs. female blood, Catholic vs. Jewish blood, gay vs. straight blood, white vs. black blood. The capability of abuse is astounding, and it is unethical. Roger Gremminger, MD, of Milwaukee's Brady East STD Clinic, paralleled the DDT system with President Reagan's ill-motivated, opportunistic, and emotional appeal for liver transplants for 5 or so babies while quietly taking away all the money for maternal & child health and nutritional programs. We must respond to such immoral, emotional appeals with intelligent, logical arguments, appealing to the public's altruistic and ethical intent. And the man from Orlando, probably financed by the "moral majority" or some other "neo-right" group, continues to appeal, "I just want to help my child, and <u>they</u> won't let me." [Compiled from information by Mark Behar.]

* * *

NEW BOOK ON AIDS

Another new book on AIDS, <u>The AIDS Epidemic</u>, edited by Kevin M. Cahill, MD, (New York: St. Martin's Press, 175 Fifth Av., NY 10010) addresses the medical aspects of the syndrome, as discussed by a recent national symposium on AIDS held in New York City. This 176 page paperback serves as an important reference that all providers should consider.

* * * * *

"FACE-SAVING" BLOOD PROGRAM INITIATED IN WISCONSIN

(with thanks to Chicago's Gaylife)

The Blood Center of Southeastern Wisconsin has initiated a "face-saving" program to protect blood donors who might be at high risk for AIDS. Steven Penzer, communications officer for the Center, explained that the program involves a special telephone number that a donor can call after donating blood to request that his donation be withdrawn. The system is useful in cases where a donor might give blood in the presence of others--such as at an on-work donation site--and might not want to have his high-risk status known by by his fellow donors. High-risk groups include gay men and intravenous drug users. All donors within the Center are given a card with two telephone numbers--one for daytime, another for evenings--which can be called within 4 hours after the donation to request withdrawal. So far, five people have used the telephone numbers since the program's inception in mid-April. All five were gay men. Dr. Jay Menitove, medical director of the Center, said that to his knowledge, the program is unique. [Dr. Menitove was one of the featured speakers during the Second AIDS Forum in Denver.] Other blood bank directors to whom he has spoken, have indicated they do not believe such a "face-saving" program is necessary because all blood banks now issue statements to potential donors concerning possible AIDS risk. Cindy Ryskamp, public relations officer for the Mid-America Red Cross in Chicago, said the program is not in effect at Chicago's Red Cross blood collection centers, nad to her knowledge, is not being used anywhere by the American Red Cross. Blood donations that are withdrawn through the program, Menitove said, are incinerated.

* * *

PUBLIC HEALTH SERVICE OPERATES AIDS HOTLINE

The United States Public Health Service is now answering a toll-free hotline, providing information and referrals on AIDS. Several additional lines were added when it was determined that no one could get through the perpetually busy signal. National Gay Task Force Crisisline volunteers are complaining that frequently, only their number is given out by the feds as a referral, substancially increasing their work (NGTF's number is 800/221-7044 for continental US excluding NY state). The line is answered 8:30-5:30 pm Eastern time, and may be reached by dialing 800/342-AIDS.

* * *

NEW BOOK ON AIDS PUBLISHED

Boston's Ken Mayer, MD, and Hank Pizer, PA, have published an excellent resource for those wanting more on AIDS: The AIDS Fact Book, New York: Bantam, $3.95. In addition to chapters on the epidemic/epidemiology, the immune system, signs & symptoms and some of the diseases associated with AIDS, there are chapters on preventing AIDS/lowering your risk, coping with it, social consequences of AIDS, choosing a medical provider, research & controversy, and additional precautions. This 135 page paperback is an excellent resource--a must for gay/lesbian health providers and services. Ken Mayer, incidentally, is a member of the NCGSTDS.

* * * * *

SAN FRANCISCO LESBIANS DONATE BLOOD

excerpted from an article written by Michael Helquist in Coming Up!

Eighteen lesbians from the Jewish congregation Sha'ar Zahav in San Francisco, recently donated 18 pints of blood to the city's Irwin Memorial Blood Bank. "We women did it because the screening process is very vigorous, and many men can't pass the screening," stated Nancy Meyer, one of the group's board members. "In Hebrew, there are 18 letters in the word L'Chiam, which means "To Life," a special affirmation of the Jewish Community.

The day the donors gathered, it was done with the usual gay flair. The Congregation has a special room to itself. As each woman donated, she was offered a Walkman with her choice of musical recordings. Afterwards, home-baked muffins and juice prepared by men from the group who acted as "candy-stripers," were offered. Sha'ar Zahav is very active in other community affairs, related to AIDS and other areas. For more information, write: 201 Caselli Av., San Francisco, CA 94114.

* * *

* *

NATIONAL AIDS VIGIL ANNOUNCED FOR OCTOBER 8

The National AIDS Vigil Commission has recently announced the organization of a national candlelight march and rally on the national mall in Washington, DC, Saturday, October 8, 1983, at 5 pm. The Vigil is intended to provide an opportunity for diverse groups and individuals gay and non-gay, who are concerned about AIDS, to voice their anger and concern in a national effort--and to show our support of the various AIDS and related networks across the country. The Vigil is also a forum in which we can show persons with AIDS that we do care about their lives; that we will support their struggle to overcome the discrimination in health care, housing, jobs directed at them and to demand necessary federal funding for more AIDS research. The Vigil is also a memorial to those hundreds of human beings who have died due to the disease. In addition, the march is being organized to increase public and private sector awareness of AIDS; to demonstrate to Congress, the President, and other elected officials, the deep national worry and concerns about this health crisis; to urge the creation of an independent federal advosory commission on AIDS to oversee research and funding; and to encourage adoption of a comprehensive patient's bill of rights and a federal statement on patient confidentiality. For more information, contact: National AIDS Vigil Commission, 2335 18th St., NW, Washington, DC 20009.

* * *

AIDS ARCHIVES INFORMATION SAUGHT

There are four organizations that are compiling reference listings on AIDS and/or have an AIDS archives at this time. Several governmental agencies and private concerns are also maintaining such resources--most notably the National Institutes of Allergy & Infectious Diseases (NIAID) and the National Cancer Information Service, among others. The four gay organizations are New York's Gay Men's Health Crisis, San Francisco's AIDS/KS Research and Education Foundation, Toronto's Canadian Gay Archives, and the AIDS Project/Los Angeles. At the 5th National Lesbian/Gay Health Conference in Denver a few month's ago, a Federation of AIDS Related Organizations (FARO) was created, with one of its intentions to avoid the duplication of efforts by nationwide AIDS organizations. Agreeing with this idea, the AIDS Project/Los Angeles would like to work with any others on developing a National AIDS Archives and pool all resources into one effort instead of several. A National AIDS Archives would be a valuable source of medical information for both the medical profession and the public. In addition, it would help to free up limited resources by preventing duplication of services, thereby improving the efficiency of the various organizations. Any input concerning such an Archives, and your contribution to it, would be greatly appreciated. The four above mentioned groups are working together--won't you join us? Contact Steve Strigle, Archives Committee, AIDS Project/Los Angeles, 937 N. Cole Av., Suite 3, Los Angeles, CA 90038, 213/871-1284.

* * *

NY CONGRESSMAN INTRODUCES HEALTH EMERGENCY TREATMENT FUND BILL

Congressman Ted Weiss of New York has introduced a bill in the House of Representatives that would create a revolving federal fund to assist state and local efforts in treating and preventing public health emergencies. The legislation, HR 3702, would make available $60 million on an emergency basis through grants and contracts to state and local governments grappling with health crises. The governing bodies would have the option of contracting out services to institutions such as hospitals, hospices and non-profit institutions. HR 3702 would amend the Public Health Emergency Fund recently enacted into law. That act, authored by Representative Henry Waxman of California, provides emergency funds for research into the cause, treatment, and prevention of health crises. The new bill would complement the Public Health Emergency Fund by providing for actual treatment and prevention.

* * *

AIDS AND HEALTHFUL GAY SEXUAL ACTIVITY: NEW AAPHR BROCHURE

The American Association of Physicians for Human Rights recently announced the availability of their new brochure directed to the gay community, "AIDS and Healthful Gay Sexual Activity" First Edition. For more information, contact, AAPHR, PO Box 14366, San Francisco, CA 94114 (415/673-3189).

* * *

NGTF URGES PEOPLE WITH AIDS TO APPLY FOR SOCIAL SECURITY BENEFITS

The Social Security Administration announced on July 15 that it had made permanent its temporary April 26th directive authorizing people with AIDS to collect social security benefits. People with AIDS may qualify for a variety of government benefits. Supplemental Security Income (SSI) is a needs-based grant program available to people with limited income and resources. Title II "early retirement income" grants, on the other hand, are available to FICA contributors who are no longer able to work because they have AIDS. Because the great majority of people with AIDS who are no longer employed are eligible for SSI or Title II grants, NGTF urges people with AIDS to apply for such benefits. To find out if they qualify financially, people with AIDS should contact the nearest Social Security Administration office. Applicants who meet the SSA's economic criteria must then contact a state Disability Determination Office, where they or their health care provider will be asked to provide objective medical verification of an AIDS-related opportunistic infection (including, but not limited to Kaposi's sarcoma and pneumocystis carinii pneumonia) before they can receive benefits. Despite the widespread availability of social security benefits, the number of people with AIDS who have applied to date is surprisingly low. Although over 2000 cases of AIDS have been confirmed by the Centers for Disease Control, SSA reports only 230 applications for benefits as of August 5. SSA officials add that fully 96% of these applications have been accepted. "We are extremely concerned that so few people with AIDS are applying for benefits to which they are clearly entitled," stressed NGTF Executive Director Virginia Apuzzo. "Once again we see a critical need for a government-funded public education campaign about AIDS." NGTF encourages people with AIDS who have questions about benefits to call its crisisline (800/221-7044, NY, AK, HI states call 212/807-6016), and further urges AIDS service organizations and the gay media to continue their efforts to inform people with AIDS about available benefits.

* * *

NGTF INVOLVED WITH AIDS

The National Gay Task Force has been deeply involved with the AIDS crisis over the last several months. Representatives of the gay/lesbian community met with Reagan Administration officials on June 21 to discuss national health issues, emphasizing AIDS. The Reagan Administration has already termed AIDS the nation's number one health priority, however Virginia Apuzzo, Executive Director, pointed out that AIDS funding represented only 0.2% of the Public Health Service's budget. NGTF officials also hope to formally meet with Secretary of Health & Human Services Margaret Heckler. Apuzzo called upon the nation's mayors to commit local funds to fight against AIDS in testimony before the Denver meeting of the U.S. Conference of Mayors' AIDS Task Force, June 12. The mayor's AIDS task force is chaired by San Francisco Mayor Diane Feinstein and is comprised of mayors from Atlanta, Boston, Chicago, Houston, Los Angeles, Miami, Newark, New York, Philadelphia, and Washington, DC. Among the areas outlined in a briefing paper on AIDS that presented to the mayors, were the kinds of services that were needed from local governments--direct funding and in-kind services from cities to community-based programs, health care planning, public education, and blood bank policies. Apuzzo urged local gay/lesbian political and health community leaders to follow up on the Conference of Mayor's meeting by presenting new or additional proposals of their own--if they haven't already done so--building on the outline presented in the briefing paper in the context of their own cities.

* * *

SHANTI PROJECT'S AIDS SWEEPSTAKES FUNDRAISER

In response to the AIDS epidemic, San Francisco's Shanti Project has launched a fundraising campaign in the form of a sweepstakes. By entering the sweepstakes, you can help provide free support services, including housing, for people with AIDS in Northern and Southern California. A ten dollar donation is requested per ticket, with the drawing scheduled for October 15 (ticket holders need not be present to win). Among the many prizes are: $25,000 cash (first prize), Kawai console piano, a sailing weekend for two from Los Angeles to Catalina Island, $1000 travel & jewelry gift certificates. Shanti is a nonprofit agency founded in 1974 to help people who face life-threatening illnesses. For more information, write: Shanti Project, 890 Hayes St., San Francisco, CA 94117 (415/9625).

* * * * *

CRITICISM VOICED AGAINST AIDS FOUNDATION & REPLY

[ED NOTE: The following letter and reply was sent by a volunteer from one of the nation's AIDS foundations. It is a good example of why being a gay/lesbian health worker is often a frustrating, thankless job. Your comments are invited.]

Editor: "I have lived in [city] almost all my life, and what I see happening now is extremely disturbing. We are being confronted by a great tragedy, or more accurately, a double tragedy. The AIDS crisis would be devastating enough all by itself. That problem, however, is being compounded by neglect. I am not speaking of governmental or medical neglect, but rather neglect within our own community by an organization that was founded to provide support. The [name] AIDS Foundation was started with high hopes. So far, however, about all they have been able to do is have some buttons made with money that could have been better spent, and draft a huge budget, as yet unfunded, all the while patting themselves on the back. The officers of the board of directors--half of whom served as "interim" members--have dropped the ball so many times that to call them inept would be kind. Perhaps they need reminding that AIDS is here now, and is not something that is just around the corner. One can not help but feel that they joined this project because they felt it was the "chic" thing to do. They seem too interested in a power trip, not realizing that with power goes responsibility. Their lack of action so far has been a case study in insensitivity, and surprisingly, a sort of gay homophobia. If the board members of the [name] AIDS Foundation do not see the light and see it soon so they can get down to business, they should submit their resignations. They have been primping in front of their mirrors long enough."

Response: "The above letter evokes both surprise and anger and demands a response. It is indeed surprising how much misinformation, and accusation has been related by an individual who has participated in no activities of [the foundation]. No constructive criticism or alternative thoughts are offered, only vague, negative, and derisive comments. [The Foundation] is an all volunteer organization of business and medical professionals and lay people committed to raising, allocating, and accounting for funds for patient support services, and to educating the general public, the gay community, health providers, and the media regarding AIDS issues. We are a non-profit, tax-exempt organization and have legal responsibilities as such. Our accomplishments include the recruiting of talented professionals for fundraising and finance management. We have made grants to [various gay community service groups] for direct patient relief. Our first community educational brochure is in press. A button to raise community awareness during city council testimony, and during gay pride week served as an early fundraiser. We have received generous contibutions from private individuals, businesspeople, and other community organizations and businesses--we hold them in deep gratitude for their contributions. We have recognized the mistakes made in other cities setting up AIDS related organizations, and have avoided them here. The critical need for a voting board member with personal experience with AIDS or its related conditions is recognized: he has been elected. The mistake of giving fundraising a back seat to other activities will not be made here. Some may like to see as many dollars raised and spent as quickly as possible; there are others who recognize a wise investment of time, effort, and money wno will have enormous payoff in the future. The author is correct in stating that AIDS is here now. However, one wonders if he realizes that within 2 or 3 years, AIDS may completely overwhelm the fundraising capability of our community. We have no "huge budget, as yet unfunded." We are developing a broad-based, well-planned, long-term general community fundraising organization, with a two year goal of $250,000. We hope to do better. "Patting on the back?" "Dropped the ball?" "Insensitivity?" These criticisms without documentation or specific citation is empty and destructive. It is offensive to us, our contributors, and our beneficiaries. We welcome constructive criticism and involvement." [Ed Note: The author of the response requested that both he and the other writer remain anonymous. Dr. Tom Marsella, MD, of the Seattle Gay Clinic responded below (paraphrased):]

"Many interesting points are raised and highlight some of the bitching and backbiting in the gay community regarding the AIDS crisis. I think there is tremendous frustration, anger, and hostility in many gay people due to years and generations of oppression. It is indeed unfortunate that the most vocal of the critics don't realize how angry they are and that they should not target organizations genuinely interested in dealing with AIDS issues as objects of thinly disguised rage."

* * *

NIAID TO PUBLISH AIDS MEMORANDUM

In addition to its AIDS Bibliography Update, which lists medical & scientific articles of interest on AIDS, the National Institute of Allergy and Infectious Diseases (NIAID) is planning to publish the AIDS Memorandum, designed as a vehicle for rapid exchange of both preliminary and fully documented information on AIDS, according to NIAID Scientific Director Dr. Kenneth Sell. Contributions are being solicited that will describe significant experimental and clinical data, including interesting clinical findings on single or small numbers of patients, negative experimental results and promising clinical leads. The Memo will offer a forum for requests for information and for commentary on published AIDS reports. Publication of findings in the Memo will not preclude later publication of the same information in a refereed journal. Articles and letters will be edited by NIAID's scientific and editorial staffs. For additional information, contact Dr. Ruth Guyer or Mrs. Betty Sylvester at 301/496-9537 or at NIAID, National Institutes of Health, 9000 Rockville Pike, Bldg. 5 Room 135, Bethesda, MD 20205.

* * *

AID ATLANTA ESTABLISHES NEWSLETTER

AID Atlanta (AIDA) recently announced the publication of a bimonthly newsletter to help keep the gay community informed of the latest medical, political, & social developments in AIDS. Contact David Harris, Project Coordinator, or Peter Aliberti, Vice President, Community Relations, AIDA, 1801 Piedmont Road, Suite 208, Atlanta, GA 30324 (404/872-0600) for additional information. Rob Kingston and Caitlin Ryan are the co-editors, and invite literary and financial contributions.

* * *

COVERAGE OF INTERLEUKIN-2 TRIAL SHOWS MEDIA EAGERNESS FOR AIDS INFORMATION
(reprinted with thanks, from Medical World News, August 8, 1983)

The media's willingness to latch onto any bit of information concerning AIDS was amply demonstrated when Health & Human Services announced the National Institutes of Health was about to begin a clinical trial of interleukin-2 in AIDS patients. The news was broadcast by TV networks, discussed on the Phil Donahue show, and printed by most major newspapers. But the stories had no clinical results to report, and the in vitro tests that spawned the trial had begun months earlier. Also, the use of interleukin-2 in AIDS patients isn't new. Memorial Sloan-Kettering researchers have given the lymphocyte-produced peptide to AIDS patients for more than 9 months to try to restore lost immunity....Even Sloan-Kettering researchers are reluctant to speculate on the peptide's eventual role in AIDS therapy. Dr. Roland Mertlesmann, associate professor of medicine, says they have been able to show a biological effect in the 13 patients treated thus far with interleukin, but added that whether or not it'll have any long-term effect is really not known. The media awareness began when FDA's Dr. Alain Rook presented the test-tube work at an American Society for Virology Symposium at Michigan State University. He reported that lymphocytes from 6 homosexual AIDS patients showed a marked enhancement of killer-cell activity and cytomegalovirus specific cytotoxicity when exposed to interleukin-2.

[Ed note: Is it media eagerness or sensationalism to sell papers & public hysteria?! See adjoining article.]

* * *

AIDS PANIC: WHO'S TO BLAME?
(reprinted with thanks, from Medical World News, August 8, 1983)

"Nurses Quit Jobs, Won't Treat AIDS." The San Antonio Express used its biggest and boldest type for that front-page headlind in its June 12, 1983 issue. The story wasn't about nurses in San Antonio but about three RNs in San Jose, California, half a continent away. That was the first in a succession of titillating headlines--most concerning events form afar--that greeted Express readers over the next few weeks. Others read: "AIDS--Fatal Medical Mystery," "Fear of AIDS Curbs Sex," and "Paramedics Want Protection from AIDS." Only the last, and a

(CONTINUED)

AIDS PANIC, CONTINUED

speculative story claiming San Antonio women were avoiding their (presumably) homosexual hairdressers out of fear of contracting the disease, were local stories....In San Antonio and across the nation, AIDS has suddenly become big news. Hardly a day passes without an AIDS story making the morning paper or the six o'clock news. From Science '83 to Mother Jones, the syndrome has been featured in most of the nation's magazines and newspapers. Time and Newsweek explored AIDS' elusive cause and cure, reporting that cases are doubling every 6 months and may reach 20,000 in two years if something's not done. And those stories, in turn, begat more stories, this time aimed at squelching AIDS fear and panic. Is the nation...really in the grip of AIDS hysteria? If so, does the relentless media coverage just fuel the panic? Or is the press merely the proverbial messenger who's killed for bearing the bad news? Anecdotes certainly support the notion of an AIDS panic. Morticians who won't embalm AIDS victims, street sweepers who demand face masks before cleaning in gay neighborhoods, AIDS patients evicted from their homes, and one dismissed from a jury are by now all familiar stories. The impact on blood banks is well known: donors are staying away in droves, driven by the mistaken notion that giving blood puts donors at risk of contracting the syndrome. Potential donors are questioned, and the banks are refusing to comply with growing demands from patients in need of transfusions who want to name their own donors. And there have been excesses in AIDS reporting....Only a few months ago, editors of other publications might have yawned at AIDS coverage, but they now--presumably in response to reader interest [Ed note: read $$$!]--appear to have an insatiable appetite for the subject. Television, too, has responded to the public's demand for AIDS information. Handicapped by having too little time to present the information completely, TV news has often performed poorly. In July, for example, TV network broadcast--as fast-breaking news and amid hints of an AIDS breakthrough--the interleukin-2 story. Though the interleukin-2 research was preliminary and not new, the impression left by much of the reporting was one of imminent clinical applications. The medical press offers its own horror stories: doctors shunning hepatitis B vaccine even when it's free or refusing hyperimmune globulin after they've been exposed. A physician at Yale-New Haven Medical Center says it took a "massive educational campaign" to convince his colleagues that medical or sugical procedures could be done safely on AIDS patients if commonsense precautions were taken. But there are examples of people's fears being exploited. Omni magazine bought newspaper display ads in cities with large homosexual populations to plug its July issue, which it described as "critical reading for anyone who may be threatened by AIDS." Those who paid $2.50 for the magazine may have been disapointed. Inside was an interview with Nobel laureate Baruj Benacerraf, who briefly discussed the immunology of AIDS. But for most of the interview, he simply refused to speculate when the reporter asked leading and seemingly uninformed questions. These examples of questionable reporting, however, have been for the most part overshadowed by accurate and responsible journalism. Restrained reporting has been particularly apparent in the cities where AIDS is epidemic. For example, just last November, a Wall Street Journal reporter complained to fellow science writers that he and New York Times reporters had trouble getting AIDS stories in their papers. When they did crack that editorial barrier, it was with factual, unemotional accounts. Similarly, science writers for the San Francisco Chronicle and San Francisco Examiner have demonstrated reason and balance, even when writing about AIDS' most controversial aspects....It might be argued that media attention is helping to quell potential AIDS panic. The CDC's oft-repeated admonition that "you can't get AIDS from casual contact" has been liberally sprinkled through AIDS reports. And the Washington Post ran a front-page story on HHS Secretary Margaret Heckler's donating blood to show that it's safe. For its part, the medical press has reported that the CDC's recommended precautions for health care workers dealing with AIDS patients are the same as for hepatitis patients and has emphasized the small risk of infection. If there is AIDS hysteria, perhaps it has resulted from the nature of the disease itself--and the government's slow response in helping to solve the mystery. The media should be interested in AIDS. It's a new and deadly disease, apparently caused by a still unidentified transmissible agent, and one that does something no other has done: destroy cell-mediated immunity. That it has hit 2000 high risk Americans so far is irrelevant given those facts.

--Judy M. Ismach

* * *

FDA APPROVES FIRST LOZENGE FOR ORAL CANDIDIASIS (THRUSH) THERAPY

The Food & Drug Administration recently approved the first throat lozenge as an alternative to rinses, swabs, or systemic therapy for oropharyngeal candidiasis (thrush). The 10 mg troche is taken five times daily, and delivers clotrimazole (Mycelex, Miles Labs.), a broad spectrum antimycotic, over a period of 2½-3 hours. According to the head of the National Institutes of Health clinical allergy and hypersensitivity section, Dr. Charles Kirkpatrick, the troches are extremely effective, offering relief to patients that had not responded to long term therapy with full doses of traditionally used topical medications.

* * * *

A GUIDE FOR PEOPLE WITH AIDS

A newly published booklet intending to provide one location where people with AIDS may find answers to questions & concerns is available from Allan R. O'Hara, AIDS Action Committee, PO Box 4073, Key West, FL 33041. Although the booklet is provided without charge, contributions are needed to help pay for printing and postage. Some of the topics covered in easy to understand language: AIDS--what it is and is not; what to expect from others; "but they don't know I'm gay" (and other problems); "what about sex?"; "how do I pay for all of this?"; the future; medical terms defined; for more information--a brief listing of other resources; and an evaluation sheet in preparation for the booklet's second edition.

* * *

PROVISIONAL SUCCESS IN TREATING CRYPTOSPORIDIOSIS

Dr. Mark Whiteside, MD, Director of AIDS Research and Co-Director of the Tropical Medicine Program at the University of Miami's School of Medicine has reported provisional success with a Canadian drug for the treatment of cryptosporidiosis, a parasite responsible for severe diarrhea in some AIDS patients. The medication, spiramycin (Rovamycin), resulted in a dramatic relief of symptoms and absence of any evidence of the parasite in one patient, and is the first chemotherapeutic agent that may be curative of this dreaded complication. Dr. Whiteside is interested in collaborative research, and will provide the medication to other clinicians: 305/547-6980 (or write: 1550 NW 10th Av., #100, Miami, FL 33136. The medication is also used in Europe to treat toxoplasmosis in pregnant women. As the drug is not yet approved for use in the United States, an investigational (IND) permit is needed.

* * *

LAMBDA VOLUNTEERS HELP PEOPLE WITH AIDS IN SOUTHERN FLORIDA

Lambda Volunteer (LV) is an organization of people assisting individuals who suffer from AIDS in the Key West, Florida area. LVs are caring people who receive training and on-going supervision to enable them to work effectively on a one-to-one basis with people who have AIDS. For more information, contact: Ms. Betty Campbell or Dr. Tom Puroff (Florida Keys Memorial Hospital, 305/294-5531 days), or Allan O'Hara (AIDS Action Committee, 305/294-5359 evenings).

* * * * *

ROLE OF ISOPRINOSINE IN AIDS THERAPY BEING INVESTIGATED

A nation-wide call for information is being issued by Lazuli Research Foundation of Portland, Oregon. The Lazuli Research Foundation (LRF) is presently preparing a report on AIDS research, and is attempting to learn about any research involving a broad-spectrum antiviral, isoprinosine, which is manufactured by Newport Pharmaceuticals in California. Contact: LRF, POB 19291, Portland, OR 97219 (503/244-1336).

* * *

HOUSEPETS LINKED TO CRYPTOSPORIDIOSIS TRANSMISSION

Household pets such as kittens, puppies, and mice, as well as traditional farm animals such as goats and cows, may transmit the parasitic protozoan cryptosporidium, which produces a severe, as yet incurable diarrhea. People with AIDS could suffer especially severe consequences with the disease, which can also be transmitted between humans, according to Dr. William Current of Alabama's Auburn University. Anyone with a compromised immunity should be especially cautious about exposure to sick animals.

* * *

CALIFORNIA, NEW YORK, & WISCONSIN REQUIRE REPORTING OF AIDS CASES

California, New York, and most recently the state of Wisconsin, now have issued directives to doctors, health officials, and institutions that require all cases of AIDS be reported to the state's health departments. The reporting of such cases had previously been voluntary, and officials hope the new requirement will lead to more accurate statistics on AIDS. According to Wisconsin's Chief Epidemiologist Dr. Jeff Davis, "We're not interested in a "box-score" mentality in reporting cases." Forty other states have some official reporting systems for AIDS, however according to Chicago's Gaylife, only California and New York require the reporting; in Wisconsin, the requirement goes into effect September 1st.

* * * * *

SURVEY: ASSESSING THE RISK OF CONTACT & CARE FOR PERSONS WITH AIDS
by Robert W. Wood, MD

At the Risk Reduction Workshops portion of the recent national meetings of gay/lesbian health workers in Denver, considerable controversy arose regarding the risks of personal and professional contact with persons with AIDS. Clearly, the data on risks are as yet incomplete and many factors may play a role in AIDS transmission. Nevertheless, risk reduction guidelines are being drawn up by different groups, distributed, and advocated for the gay and straight communities; people are already making decisions about how they will conduct their personal and professional lives. The thought occured that a survey of those participants and others might serve a useful purpose. We could expect of those persons a high level of sophisticated understanding of the issues around AIDS as well as great personal and professional involvement with the gay community. Similar information is being saught from the straight, knowledgeable physician groups, such as the American VD Association, and the International Society of STD Research. A clearer understanding of what actions and practices MDs and other health care workers are willing to undertake will help others formulate their own policies. If you are interested in filling out the survey and assisting with this project, please contact me: Robert Wood, MD, Seattle Public Health Hospital, 1131 14th Av. South, Seattle, WA 98144.

* * *

CHICAGO SEEKS AIDS STUDY COORDINATOR

Chicago's Howard Brown Memorial Clinic will be employing a study coordinator, either a physician assistant or nurse practitioner, for the NIH/NIAID longitudinal study of risk factors for AIDS. These positions are subject to the availability of funds to be awarded. A graduate degree with suitable experience is necessary. For further information, please send resume and letter of interest to: Harley McMillen, Executive Director, Howard Brown Memorial Clinic, 2676 N. Halsted, Chicago, IL 60614.

* * *

EMPLOYMENT OPPORTUNITY FOR NURSE PRACTITIONER IN AIDS

A family nurse practitioner is wanted for an AIDS screening & surveillance project with Seattle-King County Department of Public Health (1406 Pub. Sv. Bldg., Seattle, WA 98104, 206/587-2761; contact persons are: Willma Elmore or Durlyn Finnie). Salary range is $11.58-13.57/hour. Responsibilities include screening of clients for compromised immunity and any symptoms that may suggest the presence of AIDS; education & counseling, and referral where necessary; and assisting in community education, including compilation of data.

* * * * *

AIDS/PRE-AIDS CASE STUDY

by Ken Mayer, MD

The difficulties encountered in attempting to follow persons with chronic lymphadenopathy, and to ensure that clinical AIDS is not supervening, is best illustrated by a patient who is currently being followed at the Fenway Clinic (Boston). A.B. is a 26 year old white gay man who was in good health until March, 1982, when during a three day episode of low grade fever and diarrhea, he noted generalized lymphadenopathy. His symptoms rapidly resolved and initial work-up revealed a CMV titre of 1:1024 that did not change over a three week period and a normal complete blood count. His chest X-ray was normal, but erythrocyte sedimentation rate (ESR) was persistently elevated over 65. This prompted a left axillary lymph node biopsy since the glands appeared to increase over a 6 week period, although focal symptomatology was absent. The pathologist revealed "reactive follicular hyperplasia." During this period his toxoplasmosis titres remained flat (1:16). He developed oral thrush without esophageal involvement. His lymphocyte helper/suppressor ratio (OKT4/OKT8) was 0.33. He was anergic to multiple antigens. His ESR gradually increased to 100, and Epstein-Barr Virus (EBV) titres were 1:640 without any change over time. He remained totally asymptomatic until the last week of May when he developed nightly spiking fevers to 104 degrees. His hematocrit progressively dropped 12 points over a one week period. Chest X-ray revealed adenopathy. He was hospitalized and relevant work-up included a hypercellular bone marrow without evidence of malignancy and negative bacterial, fungal, and viral cultures. CT scanning confirmed splenomegaly (over 2 times normal) and 2 cm paratic nodes. Liver function tests began to rise and the patient became lymphopenic, as well as profoundly anemic, with a crit as low as 20, necessitating transfusions. Hemolysis workup was negative. Complement studies and other parameters of autoimmunity were normal except for persistent cold agglutinins, despite negative serologies for mycoplasma and elevated polyclonal IgG. The patient continued to have fevers to 104 for a 3½ week period. Biopsy of a 4 x 3 cm node from the right axilla revealed "follicular involution" pattern, which has been associated with the development of AIDS in a series of patients followed at Sloan-Kettering in New York (C. Metroka, NYU Symposium on AIDS, March 17-20, 1983, New York). Despite this sign of progressive disease, the patient spontaneously defervesced and his hematocrit became stable at about 30, so that he was discharged. As of this writing, he remains afebrile and regained some strength. His ESR is still 85; multiple CMV cultures of urine and buffy coat are still negative, and his EBV titre increased four-fold over the last month. IgM is negative.

This case dramatically illustrates the need to follow individuals with symptomatic and asymptomatic lymphadenopathy in order to delineate the full natural history of AIDS. This person does not have AIDS by the CDC case definition, but he has had three months of unexplained persistent generalized lymphadenopathy, hypersplenism, hypergammaglobulinemia, anemia, oral thrush, intermittent fevers, and lymphopenia. His lymph nodes reveal a progressive pathologic process, yet he is once again asymptomatic. It is possible that many of his findings could be explained by an Epstein-Barr virus infection since he demonstrated a dramatic rise in titres, but since he had a titre of 1:640 initially, this could be called a "reactivation" of mononucleosis, which would be a surprising presentation of an individual who was immunocompetent at the start of the process. So after a month of meticulous investigation at a major Harvard teaching hospital by a team including hematologist, infectious disease specialists, gastroenterologists, and pathologists, he is still without a definative diagnosis. His future is not clear, and he will continue to receive careful follow-up. Even if this is not part of the "true" spectrum of AIDS, then individuals with these problems that represent the larger base of the iceberg, will still need to be studied systematically to determine the etiology and natural history of this burgeoning symptom complex.

[Ed's Translation: This patient, who was a member of a "high risk" group, developed several clinical symptoms associated with AIDS: fever, diarrhea, swollen lymph glands, oral thrush, and generalized signs of chronic, progressive disease. Laboratory findings were nonspecific, showing signs of common infections such as CMV & EBV infections; some of the tests are associated with but not specifically indicative of an acquired immune deficiency (T lymphocyte ratio, anergy, decreased white blood cell counts (specifically lymphopenia), and an increased immune globulins). No specific conclusions can be made other than to reinforce Ken's plea to closely watch anyone with these symptoms! See related article on the National AIDS/Pre-AIDS Epidemiology Network (NAPEN) elsewhere in this Newsletter.]

* * *

AIDS MEDICAL FOUNDATION ESTABLISHED

A new foundation has been established to find a solution to the problem of AIDS. The AIDS Medical Foundation (AMF), a not-for-profit organization, will support selected outstanding scientists in their research efforts to determine definitely the cause(s), and means of treatment and prevention of AIDS. The Foundation is one of the first private efforts to address this national health crisis through basic scientific research. Initial funding has already been generously contributed by the Mathilde and Arthur B. Krim Foundation. The Foundation's Board of Trustees includes Drs. Mathilde Krim, Terry Fonville, and Michael Lange, and Frank Hoffey, Esq., and Graham Berry, Esq. The AMF's Chief Medical Officer is Dr. Joseph Sonnabend. The AMF will establish a Review Board, to insure that all of the experimental work it supports will conform to accepted ethical and legal standards for the protection of human subjects. This group will include representatives from the community at large and from AIDS patients. The AMF intends to seek funding from government, private individuals and corporate donors. Dr. Krim, the Foundation's chairperson, said, "Our intention is to see that the maximum possible proportion of contributions received will do directly to research. Overhead and staff expense will be kept to a minimum."

In general terms, the initial research goals of the AMF are:
1) To develop methods for the early and definitive diagnosis of AIDS. At present, it is still unclear at what point in time and on the basis of what critical evidence a person can be said to have AIDS. 2) To establish the cause, or causes, of the disease. The popular notion that a new infectious agent has appeared, capable of being transmitted through a single intimate contact, is based, so far, on the most tenous of circumstantial evidence. This notion may be incorrect; but if proven correct, it certainly will have very serious socio-political consequences. [Ed note: The AMF seems to confuse the notion of single virus, as in hepatitis B as a model, where a single exposure may or may not produce disease, with a single exposure to a toxic substance, such as a deadly poison, where a single exposure invariably results in morbidity & mortality. This "hepatitis B like" model is also known as the "single virus" theory.] A multiplicity of factors, including the effects of two viri that are common in the population at large, cytomegalovirus and epstein-barr virus, perhaps interplaying with environmental and/or genetic factors may be responsible. In certain groups, these ubiquitous viri could become able to sufficiently damage certain of the body's immune functions so as to cause progressive, and ultimately irreversible breakdown. 3) To develop methods of treatment appropriate to different "stages" of AIDS and to their various infectious and malignant complications.

Research priorities are also being examined by the Foundation's Scientific Committee. Several distinct areas of endeavor are planned: 1) The establishment of a repository of biological specimens obtained from volunteers. 2) The development of proper and effective methods to protect privacy and confidentiality of research subjects. 3) The support of existing and continuing research efforts, which have included to date: a) study of epidemiology & immunomodulatory effects of CMV in humans, as a possible role in the etiology and pathogenesis of AIDS. b) development of a rapid diagnostic method for AIDS and CMV infection using anti-CMV monoclonal antibodies, and investigation of its application to the study and prevalence of CMV. c) Investigation of the role of Epstein-Barr virus (EBV) in the polyclonal activation of antibody producing B-lymphocytes and in acquired auto-immunity and immunodeficiency in AIDS. d) studying the origin, prevalence, and immunosuppressive role of immune complexes in AIDS and auto-immunity against the asialo-GM1 antigen shared by sperm and certain white blood cells. e) prospective analysis of the prevalence, level, and characteristics of a novel alpha interferon species in patients with AIDS. f) pharmacological studies of exogenous and endogenous interferon treatment in AIDS patients and related studies with non-immunosuppressive drugs. g) understanding the bio-ethical issues raised by research on humans with AIDS and its complications, including training of, and consulting with, medical and paramedical personnel, and counseling of selected patients. 4) The establishment of a decent and efficient specailized AIDS clinic, which will combine free outpatient treatment and counseling with on-going research and management of the aforementioned sample repository. 5) The definition and planning of further laboratory and clinical studies based upon the results of current on-going

(CONTINUED)

AIDS MEDICAL FOUNDATION, Continued

research efforts. 6) The publication of the results of present research and future research direction for the scientific, medical, and lay communities, and the implications of those results for an accurate understanding of the cause(s), treatment and prevention of AIDS. 7) The development and implementation of a program directed both at the medical community and the public for education about AIDS, its complications and treatment. For further information about the AMF or any of its programs, please contact: David Heaps, Administrative Director, AIDS Medical Foundation, 10 East 13th St., Suite LD, New York, NY 10003 (212/242-4029.

* * * * *

$100,000 "IN-KIND" DONATION FOR AIDS

The Sacramento-headquartered organization, American International Data Search, Inc. (which uses the acronym, AIDS) has announced that it is donating $100,000 worth of data search time to researchers currently battling the disease AIDS. The company provides computer access to over 500 data bases worldwide for legal, medical, and business professionals. To access AIDS medical data through the information network, medical practitioners and researchers may contact medical researchers at American International Data Search, POB 254480, Sacramento, CA 95825. Research staff at the company will enter information requests into the AIDS computer; from there, questions will be directed, via land lines or satellite transmission, to applicable data bases worldwide. When the requested information is returned to the research office in Sacramento, it will be consolidated, then sent to the requestor.

* * *

PENNSYLVANIA GROUPS DEVELOP AIDS BROCHURE
excerpted from July, 1983 VD Interchange

"For Gay Men About AIDS" is a brochure developed by the AIDS Task Force of Philadelphia Community Health Alternatives (PCHA) and Philadelphia Health Professionals for Human Rights (PHPHR) and reprinted by the State of Pennsylvania. The brochures were distributed by the Pennsylvania Department of Health to STD Clinics and gay bars, clubs, organizations, and resource centers. For more information, contact: Edward Powers, STD Control, PA Dept. of Health, 407 S. Cameron St., POB 90, Harrisburg, PA 17108 (717/787-3981).

* * * * *

KEY WEST, FLORIDA PUBLISHES MONTHLY AIDS NEWSLETTER

Florida Keys Memorial Hospital is publishing a monthly newsletter to provide updated and useful information about AIDS to the Key West medical and lay community. For additional information, contact the AIDS Education Programs Office, FKMH, PO Box 4073, Key West, FL 33041 or by phoning Allan R. O'Hara, Coordinator, 305/294-5531 (Wednesdays) or 305/294-5359 (other times). Other services provided include emotional and psychological support, information and a resource library for the community, and training for medical personnel.

* * * * *

NEW YORK GAY MEN'S HEALTH CRISIS SPONSORS RODEO BENEFIT FOR AIDS

Shortly after their successful Circus Benefit for AIDS, New York Gay Men's Health Crisis is gearing up for another blockbuster. The Rodeo Benefit is Saturday, October 1, 1983, 8 pm, so get your gear together, hook up with your sidekick and come on down to Madison Square Garden for "The World's Toughest Rodeo." You'll be swept away by a stampede of sounds, smells, and sights! The sounds of: chute gates bursting open, and the fury of one-ton bulls exploding into the arena; the Star Spangled Banner rising up from the band; leather creaking, as a bronc rider eases down onto a rank bucking horse; laughter as clowns wrestle stuffed alligators. The smells of: gummy rosin being warmed on a bull rope by a bull rider's glove; rough-out chaps that have been worn astride a thousand twisting Brahmas [a type of fowl]; linament trying to ease the kinks out of a steer wrestler's strained knee; crackling kerosine as trick riders maneuver horses through spectacular flaming hoops. The sights of: Old Glory leading a hundred horseback cowboys & cowgirls through the stirring grand entry; spotlights on a lone cowboy about to challenge the fightin'-est, buckin'-est bull in the herd; that same cowboy tossing his dusty black hat into the air after conquering that "unrideable" bull. The spirit of: the thousands of cowboys who rode the open ranges of America more than a century ago; a sport born on the cattle trails of this country, and then invited into its cities as a unique celebration; and the nomadic ProRodeo cowboy, who stuffs his dreams into a travel bag and cruises the highways of America in search of prize money and a coveted gold belt buckle.

Tickets for the event are available through the GMHC by mail (GMHC Rodeo, Box 200, 132 West 24th St., New York, NY 10011) or phone (212/807-7517 with Mastercharge or Visa). Prices are $10, $15, $25, or $50. Special tickets are also available for $100, $250, and $500. All proceeds fund GMHC's work of patient services, community education and research support.

* * *

GAY MEN'S HEALTH CRISIS "POLITICAL POSTCARD PROJECT"

The New York Gay Men's Health Crisis recently initiated a new project designed to pressure our political representatives into being more properly responsive to the AIDS crisis. They have developed a package of postcards to offer concerned citizens a quick and effective avenue for making their concerns known to those who are in a position to positively respond. Tens of thousands of postcards have already been mailed from concerned New Yorkers, and it was felt that an even more impressive response would be generated with a sincere outreach to the rest of the country. If interested in participating in the project, send your name, address, city, & zipcode to: Jerry Johnson, GMHC, Inc., NY AIDS Network, Box 274, 132 West 24th St., New York, NY 10011.

* * * * *

CENTERS FOR DISEASE CONTROL

June 17, 1983 / Vol. 32 / No. 23

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Condyloma Acuminatum — United States, 1966-1981

From 1966 to 1981, the estimated number of consultations* for condyloma acuminata (genital and venereal warts) with office-based, private physicians in the United States increased 459%. CDC analysis of data on condylomata collected by the National Disease and Therapeutic Index (NDTI)† shows that the number of consultations rose from 169,000 in 1966 to 946,000 in 1981 (Figure 3). By comparison, in 1981, the number of consultations with private physicians for genital herpes was 295,000; thus, in that year genital and venerealwarts accounted for more than three times as many consultations with private physicians as genital herpes.

From 1966 to 1978, the number of consultations for condyloma acuminata increased 398% for males and 684% for females. Although the number of visits or calls declined slightly in 1978-1981, this may have been due in part to sampling error. For example, at the 95% confidence level, the associated relative sampling error in the NDTI survey for 900,000 consultations is 22% (range 703,000-1,096,000).

In 1978, the year when consultations for the disease peaked, 62% of all visits and calls were made by females. Except in 1980, more consultations were with females than males during all these years.

Females and males consulted different specialists. Over half the females (54.4%) visited or called obstetrician-gynecologists. For males, the largest percentage (24.4%) of consultations was with dermatologists; general practitioners, internists, and urologists also handled a sizeable percentage (Table 1).

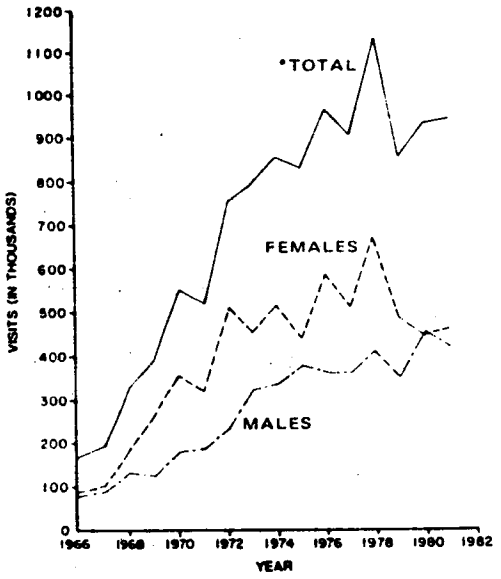
As with other sexually transmitted diseases (STDs), young adults comprised the group most frequently consulting physicians for genital warts. In 1981, more than 65% of such consultations were with persons aged 15-29 years. The highest risk group was the 20- to 24-year age group (33% of total), followed by the 25- to-29-year group (23%). The mode was 23 years.

Reported by Evaluation and Statistical Svcs Br, Operational Research Br, Div of Venereal Disease Control, Center for Prevention Svcs, CDC.

*Included are all consultations between patients and sample physicians in an office, hospital, or nursing home or in the form of a house call or telephone conversation.

†The NDTI survey is a national, stratified random sample of patient consultations with physicians in fee-for-service, office-based practice in the continental United States.

FIGURE 3. Number of visits to private physicians for treatment of genital warts, by year — United States, 1966-1981



*Includes visits by patients with gender not stated.
Source: National Disease Therapeutic Index, IMS, Inc. Ambler, Pa.

TABLE 1. Number of consultations for genital warts by physician specialty — United States, 1981

Physician specialty	Males		Females		Total	
	No.	%	No.	%	Visits*	%
General practitioners	75,210	17.9	41,350	8.9	136,010	14.4
OB/GYN	7,130	1.7	252,000	54.4	273,160	28.9
Dermatologists	102,360	24.4	52,740	11.4	167,980	17.8
General surgeons	39,340	9.4	32,600	7.0	71,940	7.6
Internists	64,020	15.3	7,340	1.6	71,360	7.5
Urologists	44,280	10.6	13,430	2.9	64,230	6.8
Other	87,070	20.8	63,760	13.8	161,590	17.1
Total	419,410		463,220		946,270	

*Includes visits by patients with gender not stated.

Condyloma Acuminata — Continued

Editorial Note: Condyloma acuminata are Papillomavirus-induced soft, pink growths that appear singly or in clusters in moist areas around the genitalia and rectum. This disease is one of the most common STDs in the United States. Morbidity and complications associated with it can be severe. One study has shown a positive epidemiologic association between genital warts and cervical carcinoma (*2*).

Because the NDTI survey does not include visits to public health, hospital outpatient, or military medical facilities, it is impossible to estimate the total number of consultations in the United States for genital warts. The data collected do indicate, however, the relative importance of various STDs among persons visiting private practitioners.

A limited study by CDC of visits to public clinics for STDs supports the NDTI findings that visits for genital warts may surpass those for genital herpes in this country (*1*). For males attending public STD clinics, 4.3 cases of venereal warts were diagnosed for every 100 visits, compared with 3.4 cases of genital herpes and 24.0 cases of gonorrhea. For every 100 visits by females, 4.0 cases of venereal warts were diagnosed, compared with 2.1 cases of genital herpes and 23.5 cases of gonorrhea.

Unlike the more publicized STDs, such as gonorrhea, syphilis, genital herpes, and genital chlamydia infections, relatively little is known about the epidemiology, microbiology, and complications of genital warts. Although they tend to recur, no specific treatment is available to prevent further episodes. Small condyloma acuminata usually result in dyspareunia and rectal pain, while large condylomata can cause tenesmus and may result in transmission to neonates during childbirth. Such neonatal transmission is thought to cause childhood laryngeal papillomatosis (*3*). Additional studies are needed to better define the epidemiologic relationship between condyloma acuminata and genital malignancies.

The NDTI data show an increased number of consultations for condyloma acuminata during the 1970s. The rate of increase in consultations for genital warts is particularly notable because visits to physicians for all reasons did not increase after 1972, while visits for genital warts continued to rise until 1978. As with some other STDs, this overall increase may be partially due to changing social and demographic factors, including changes in marriage and family institutions, shift in the age pyramid as a result of the "baby-boom," increased urbanization of the American population, and changes in casual and non-marital sexual behavior (*4*).

Diagnostic and therapeutic practices have lowered the incidence of STDs for which laboratory tests can detect asymptomatic or incubating infection and which readily respond to therapy (e.g., syphilis and gonorrhea); however, they have had little influence on the incidence of genital warts. At present, no laboratory tests exist to detect incubating condyloma acuminata; moreover, therapy can be difficult, prolonged, and only marginally efficacious (*5*). These are areas in which research is needed.

References

1. CDC. Nonreported sexually transmitted diseases—United States. MMWR 1979:28;61-3.
2. Reid R, Stanhope CR, Herschman BR, Booth E, Phibbs GD, Smith JP. Genital warts and cervical cancer. Cancer 1982;50:377-87.
3. Cook TA, Cohn AM, Brunschwig JP, Butel JS, Rawls WE. Wart viruses and laryngeal papillomas. Lancet 1973;1:782.
4. Aral SO, Johnson RE, Zaidi AA, Fichtner RR, Reynolds GH. Demographic effects on sexually transmitted diseases in the 1970's: The problem could be worse. Sex Trans Dis (in press).
5. Margolis S. Therapy for condyloma acuminatum: a review. Rev Inf Dis 1982;4:S829-36.

CENTERS FOR DISEASE CONTROL

June 3, 1983 / Vol. 32 / No. 21

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

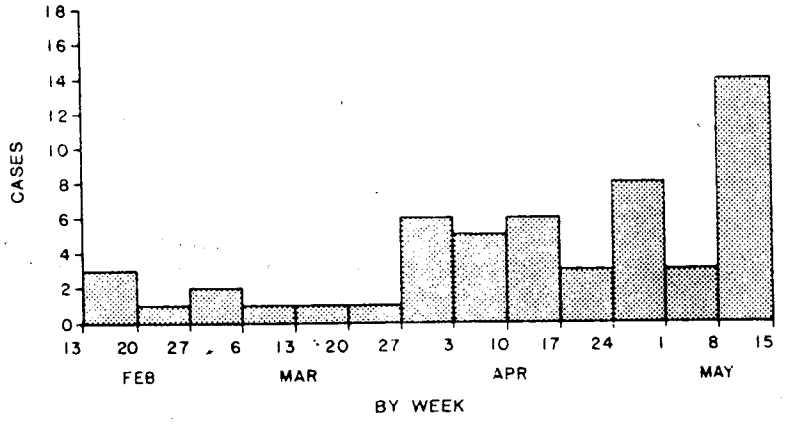
Penicillin-Resistant Gonorrhea — North Carolina

Between February 14 and May 15, 1983, 56 cases of penicillin-resistant gonococcal infection, occurring in 55 persons, were reported in Durham County, North Carolina (Figure 1). These cases represent the first reported outbreak of gonorrhea caused by strains that are resistant to penicillin but that do not produce penicillinase. Thirty (55 %) of the 55 affected patients were men. Ages ranged from 15 to 50 years (median 24 years). All patients were reported to be heterosexual.

The first case involved a 31-year-old man who reported to the local health department on February 14 with a 1-day history of urethral discharge. Intracellular, gram-negative diplococci were demonstrated in a urethral smear. The patient was initially treated with 4.8 million units of aqueous procaine penicillin G (APPG) but returned on February 23 because of persistent urethral discharge. He was re-treated with 4.8 million units of APPG along with 1 g probenecid. A urethral culture subsequently grew *Neisseria gonorrhoeae* resistant to penicillin by disc susceptibility testing and negative for penicillinase by the rapid paper-strip method. On March 8, the patient was treated with spectinomycin 2 g intramuscularly (IM).

The second recognized case involved a 22-year-old prostitute; she was a partner of a patient with gonorrhea. She was first treated on February 17 with 4.8 million units APPG. She returned on February 23 as an asymptomatic contact of the same patient with presumtive non-gonococcal urethritis (NGU) and was given a 7-day course of tetracycline. Her pretreatment cultures at both visits grew *N. gonorrhoeae* resistant to penicillin but non-penicillinase producing. This patient, her asymptomatic male partner, and his female partner (a prostitute)

FIGURE 1. Reported penicillin-resistant gonorrhea cases, by week — Durham County, North Carolina, 1983



Penicillin-Resistant Gonorrhea — Continued

were treated on February 28 with spectinomycin 2 g IM. Cultures from the latter two persons (the third and fourth cases) also grew non-penicillinase-producing gonococci resistant to penicillin. Interviewers determined the female prostitute (the fourth case) had also had sexual contact on February 10 with the first patient who had presented on February 14.

Sporadic cases continued to occur through April, with three or more cases being reported each week. Intensive screening measures implemented on May 2 led to increased recognition and reporting of cases. All gonococcal isolates from Durham County were tested for penicillin susceptibility using both the disc diffusion test and gonococcal agar base containing 1 μg ml penicillin. Hospital and commercial laboratories in Durham County were notified of the outbreak and encouraged to perform similar laboratory tests for gonococcal isolates.

Isolates from all 55 patients were studied and confirmed as penicillin-resistant and non-penicillinase-producing at the Department of Microbiology and Immunology, University of North Carolina—Chapel Hill. Thirty-six of these isolates were further studied. All 36 were prototrophic auxotypes. They were highly resistant to penicillin (minimal inhibitory concentration [MIC] 2-4 μg ml) and moderately resistant to erythromycin (MIC 2-4 μg ml) and tetracycline (MIC 2-4 μg ml), but all were susceptible to spectinomycin. The principal outer membrane protein I (POMPI) was identical in all 20 isolates tested.

Control measures have included obtaining specimens for culture and then treating all men whose urethral smears show gram-negative intracellular diplococci with spectinomycin 2 g IM; sexual partners are treated similarly. Efforts will be made in Durham County to promptly refer and treat sexual partners of patients, obtain specimens for gonorrhea cultures from prostitutes approximately every week, and promptly identify and treat those from whom gonococci are cultured.

Reported by JD Fletcher, MD, JD Stratton, MD, CS Chandler, Durham County Health Dept, PF Sparling, MD, Dept of Microbiology and Immunology, University of North Carolina School of Medicine—Chapel Hill Venereal Disease Control Br, North Carolina Div of Health Svcs, MP Hines, DVM, State Epidemiologist, North Carolina State Dept of Human Resources; Div of Venereal Disease Control, Center for Prevention Svcs, Div of Field Svcs, Epidemiology Program Office, CDC.

Editorial Note: Non-penicillinase-producing strains of *N. gonorrhoeae* that are highly resistant to penicillin are apparently uncommon in the United States. Among 11,103 isolates tested at CDC between 1972 and 1979, 38 (0.3%) had MICs to penicillin of 2 μg/ml or greater (*1*). This outbreak, therefore, represents an unusual event due to transmission of a single resistant strain, as demonstrated by the antibiotic resistance pattern, auxotyping data, and outer membrane protein studies. Such transmission of a single strain of gonococcus once introduced into a community has previously been described (*2*).

The importance of this type of penicillin resistance is still undetermined. Treatment failures increase as the MICs of gonococci increase (*3*). Several tests can be used to detect penicillinase-producing gonococci (PPNG); however, procedures to identify non-PPNG penicillin-resistant strains have yet to be standardized and adopted for routine laboratory use. Reports of these strains may rapidly increase as screening procedures are employed. In Southeast Asia, more than 20% of gonococcal isolates are non-PPNG strains resistant to penicillin. Some countries have already identified these strains (*4*), and it is possible that similar strains are already widely distributed but unrecognized in the United States.

Non-PPNG penicillin-resistant strains should be suspected when increases in treatment failures not due to PPNG are noted. Screening for these strains may be accomplished by disc diffusion tests (10 μg penicillin disc) on post-treatment isolates. Isolates with a zone size less than 25 mm can be considered resistant to penicillin and should be forwarded to a reference laboratory for confirmation by MIC studies. When necessary, CDC can perform these MIC studies. To avoid continued transmission of these resistant strains, control measures similar to those for PPNG outbreaks should be employed (*5*).

References

1. CDC. Unpublished data.
2. Handsfield HH, Sandstrom EG, Knapp JS, et al. Epidemiology of penicillinase-producing *Neisseria gonorrhoeae* infections: analysis by auxotyping and serogrouping. N Engl J Med 1982;306:950-4.
3. Jaffe HW, Biddle JW, Thornsberry C, et al. National gonorrhea therapy monitoring study. In vitro antibiotic susceptibility and its correlation with treatment results. N Engl J Med 1976;294:5-9.
4. Brown S, Biddle J, Warnimont T, Panikabutra K, Traisupa A. Antimicrobial resistance of *Neisseria gonorrhoeae* in Bangkok: is single-drug treatment passé. Lancet 1982;2:1366-8.
5. CDC. Penicillinase-producing *Neisseria gonorrhoeae*—Los Angeles. MMWR 1983;32:181-3.

CENTERS FOR DISEASE CONTROL

June 24, 1983 / Vol. 32 / No. 24

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Acquired Immunodeficiency Syndrome (AIDS) Update — United States

As of June 20, 1983, physicians and health departments in the United States and Puerto Rico had reported a total of 1,641 cases of acquired immunodeficiency syndrome (AIDS). These cases were diagnosed in patients who had Kaposi's sarcoma (KS) or an opportunistic infection suggestive of an underlying cellular immunodeficiency. Of these patients, 644 (39%) are known to have died; the proportion of patients with KS alone who have died (22%) is less than half that of patients with opportunistic infections who have died (46%). Fifty-five (3%) cases were diagnosed before 1981; 225 (14%), in 1981; 832 (51%), in 1982; and 529 (32%), to date in 1983. *Pneumocystis carinii* pneumonia (PCP) is the most common life-threatening opportunistic infection in AIDS patients, accounting for 51% of primary diagnoses; 26% of patients have KS without PCP, and 8% have both PCP and KS. Many of these patients may also have other opportunistic infections, and 15% of AIDS patients have such infections without KS or PCP. Over 90% of AIDS patients are 20-49 years old; almost 48% are 30-39 years old. Cases have occurred in all primary racial groups in the United States. Only 109 (7%) cases have been reported in women.

Groups at highest risk of acquiring AIDS continue to be homosexual and bisexual men (71% of cases), intravenous drug users (17%), persons born in Haiti and now living in the United States (5%), and patients with hemophilia (1%)*. Six percent of the cases cannot be placed in one of the above risk groups; approximately half of these are patients for whom information regarding risk factors is either absent or incomplete. The remainder includes, in order of decreasing frequency, patients with no identifiable risk factors, heterosexual partners of AIDS patients or persons in risk groups, recipients of blood transfusions, and KS patients with normal immunologic studies. Of the 109 cases among females, 52% occurred among drug users and 9% among Haitians; for 39%, the risk group is unknown.

In addition to the 1,641 reported AIDS cases, 21 infants with opportunistic infections and unexplained cellular immunodeficiencies have been reported to CDC. Infant cases are recorded separately because of the uncertainty in distinguishing their illnesses from previously described congenital immunodeficiency syndromes.

*The risk groups listed are hierarchically ordered; cases with multiple risk factors are tabulated only in the risk group listed first.

AIDS – Continued

Most cases continue to be reported among residents of large cities. New York City has reported 45% of all cases meeting the surveillance definition†; San Francisco, 10% of cases; and Los Angeles, 6% of cases. Cases have been reported from 38 states, the District of Columbia, and Puerto Rico (Figure 1).

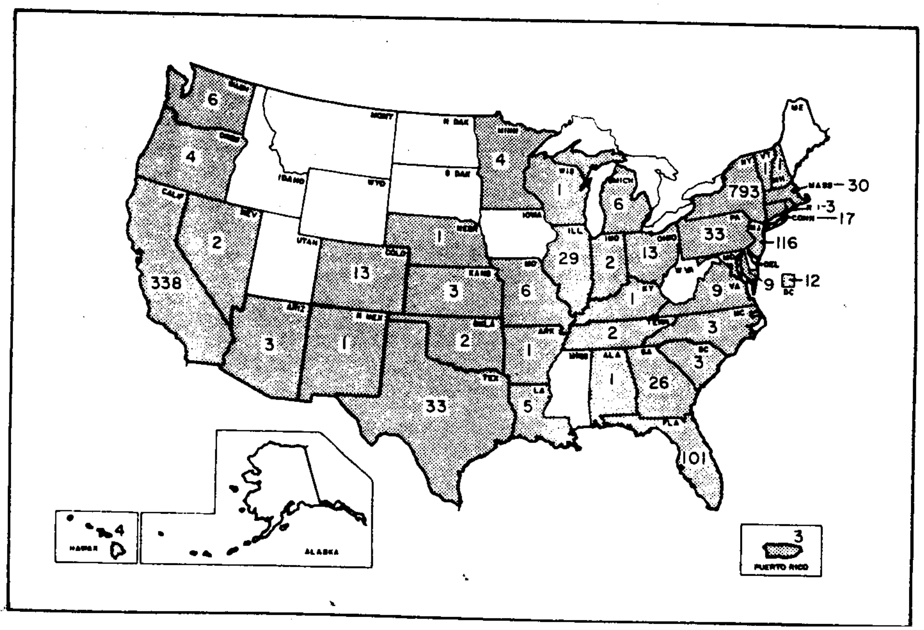
Reported by State and Territorial Epidemiologists; AIDS Activity, Center for Infectious Diseases, CDC.

Editorial Note: During 1982 and early 1983, city and state health departments throughout the United States began assuming an increasingly active role in the surveillance and investigation of AIDS. At the annual Conference of State and Territorial Epidemiologists in May 1983, the group affirmed the urgency of AIDS as a public health problem and passed, as one part of a resolution on AIDS, the recommendation that AIDS be added to the list of notifiable diseases in all states. The method of making a disease notifiable varies markedly in different states, ranging from a change in state law to regulatory action by the Board of Health or executive decision by the health officer. Several states have already made AIDS notifiable; other states are taking similar action.

Case counts of patients with AIDS listed by cities or states may differ from those listed by CDC. The standard surveillance definition of AIDS does not apply to suspected subclinical or mild cases of AIDS—to the extent they occur—or to cases involving persistent generalized lymphadenopathy or other conditions in persons from high-risk groups. Some AIDS patients

†For the limited purposes of epidemiologic surveillance, CDC defines a case of AIDS as a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has had no known underlying cause of cellular immunodeficiency nor any other cause of reduced resistance reported to be associated with that disease.

FIGURE 1. Acquired immunodeficiency syndrome (AIDS) cases meeting the surveillance definition reported to CDC, by state – United States



AIDS – Continued

may seek treatment in cities other than those in which they reside and may be reported through health departments in cities where they are treated. CDC eliminates duplicate reports and assigns each patient to the city and state of residence at the time of reported onset of illness. In addition, the processing of case reports may result in a delay between diagnosis, reporting, and entry of a case into the registry at the different health departments or CDC.

Physicians aware of patients fitting the case definition for AIDS are requested to report such cases to CDC through their local or state health departments. AIDS patients who do not belong to any of the recognized risk groups or who are recipients of blood or blood products (including anti-hemophiliac factors) should be reported immediately.

The vast majority of cases continue to occur among persons in the major identified risk categories. The cause of AIDS is unknown, but it seems most likely to be caused by an agent transmitted by intimate sexual contact, through contaminated needles, or, less commonly, by percutaneous inoculation of infectious blood or blood products. No evidence suggests transmission of AIDS by airborne spread (*1*). The failure to identify cases among friends relatives, and co-workers of AIDS patients provides further evidence that casual contact offers little or no risk. Most of the 21 infants with unexplained immunodeficiency have been born to mothers belonging to high-risk groups for AIDS (*2*). If this syndrome is, indeed, AIDS, the occurrence in young infants suggests transmission from an affected mother to a susceptible infant before, during, or shortly after birth. Previously published guidelines to prevent the transmission of AIDS and precautions for health care and laboratory workers are still applicable (*1,3*).

References

1. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
2. CDC. Unexplained immunodeficiency and opportunistic infections in infants-New York, New Jersey, California. MMWR 1982;31:665-7.
3. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-3.

CENTERS FOR DISEASE CONTROL

July 15, 1983 / Vol. 32 / No. 27

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

An Evaluation of the Acquired Immunodeficiency Syndrome (AIDS) Reported in Health-Care Personnel — United States

As of July 11, 1983, physicians and health departments in the United States and Puerto Rico had reported a total of 1,831 patients meeting the CDC surveillance definition of the acquired immunodeficiency syndrome (AIDS) (*1*). Of these, four were reported to be health-care personnel not known to belong to groups at increased risk for AIDS. Onset of illness in these patients occurred between June 1981 and April 1983. The source of AIDS in these four patients is unclear, and none had documented contact with another AIDS patient. Additional cases have been reported in health-care personnel; however, these have either occurred in persons belonging to AIDS risk groups or in persons for whom information is insufficient to determine if they belong to such groups. The case histories for the four patients follow.

Patient 1: A 32-year-old black man living in Baltimore, Maryland, was in good health until January 1983, when he complained of lower abdominal discomfort, relieved by urination, and blood in his stools. Medical evaluation, which included a renal sonogram and an abdominal CAT scan, revealed no cause for his complaints, and his symptoms subsided without treatment. At the same time, he began to lose weight. On May 13, he presented to his private physician with complaints of fever and cough of 2-3 days' duration. His temperature was 37.8 C (100 F). Chest x-ray showed a questionable right upper lobe infiltrate, and he was given oral erythromycin.

On May 21, 1983, the patient went to a Baltimore hospital, where he was found to have bilateral pulmonary infiltrates. He was hospitalized and sulfamethoxazole/trimethoprim was added to his therapy. On May 24, a transbronchial lung biopsy showed *Pneumocystis carinii* pneumonia (PCP); results of immunologic studies were consistent with AIDS. Despite the addition of pentamidine isethionate to his therapy, his condition worsened, and he died on June 2. At autopsy, no evidence of malignancy was found.

The patient had worked for the housekeeping department of a hospital since 1968. Beginning in August 1981, he worked exclusively in the ambulatory surgery area, where his duties included removal of surgical drapes and disposable surgical equipment, which were often contaminated with blood. Reportedly, he usually did not wear gloves.

On February 26, 1982, the patient went to the employee-health nurse for treatment of a needlestick injury. The patient stated that, while disposing of a cardboard box containing used needles, he had been stuck on the hand by a needle protruding from the box. Blood samples were drawn for hepatitis B virus serologic tests, and a single 2-ml dose of immune globulin (IG) was given intramuscularly. (IG therapy has not been reported in other AIDS patients not belonging to known risk groups.) The serologic tests were positive for antibody to hepatitis B surface antigen but negative for the antigen. No other injuries had been recorded on his employee-health record.

When interviewed by his physicians, the patient denied homosexual activity, intravenous (IV) drug use, foreign travel, or transfusion. After the patient's death, interviews by the Baltimore City Health Department of his family and friends confirmed his history. Four of his female sexual partners were interviewed, and all denied IV drug use; none had a history compatible with AIDS. The patient had no history of treatment for venereal diseases, and serologic tests for syphilis (RPR, MHA-TP, FTA-ABS), done during his hospitalization for PCP, were negative.

No patient meeting the CDC surveillance definition of AIDS was reported to have been seen at the hospital where patient 1 worked. In June 1982, 4 months after the needlestick injury and 7 months before patient 1 became ill, a homosexual man with a history of chronic, unexplained lymphadenopathy underwent a lymph node biopsy in the ambulatory surgery area of the hospital. Although patient 1 was working in this area on the day of the biopsy, the extent of his contact, if any, with the lymphadenopathy patient or materials used in the biopsy procedure is unknown.

Patients 2-4: Less epidemiologic information is available for patients 2-4 than for patient 1. They appear either more likely to have belonged to AIDS risk groups or less likely to have had exposure to blood than patient 1. All had immunologic studies consistent with AIDS.

Patient 2, a 32-year-old American Indian woman, was living in New Jersey when she became ill in 1981. She was found to have PCP, recovered following treatment, but died of cerebral toxoplasmosis in 1982. She had worked in a hospital laundry since 1980. During her employment, a patient with possible AIDS had been admitted to the hospital where she worked, but she had no direct contact with this person. Although she used marijuana, cocaine, and mescaline, she denied IV drug use. She also denied foreign travel, receipt of blood, and sexual contact with men who were bisexual or IV drug users: (This patient has been previously reported elsewhere [*2*].)

Patient 3, a 34-year-old Jamaica-born man, was living in Miami, Florida, when he became ill in 1982. He was found to have PCP and recovered following treatment. He had come to the United States in 1979 and had worked as a private-duty nurse in Miami since then. He denied contact with AIDS patients; a subsequent review of his work assignments showed that he had not cared for any patients reported to have AIDS. He did not recall ever having a needlestick injury. He also denied homosexual activity, IV drug use, and receipt of blood. One of his female sexual partners was interviewed. She was in good health and denied IV drug use. Another of his female partners could not be located.

Patient 4, a middle-aged man, was living in New York City when he became ill in 1983. He was found to have PCP and recovered following treatment. He worked as a nurse's aide in the outpatient department of a hospital. AIDS patients had been seen at this hospital, but he apparently had not cared for any of them. In the past, he had had needlestick injuries and had received bites from patients, but could recall no such injuries for more than 2 years. Although he admitted to a homosexual encounter as an adolescent, he denied homosexual activity as an adult. He also denied IV drug use and receipt of blood and had no foreign travel since 1976. His serologic tests for syphilis (FTA-ABS) and hepatitis B virus (antibody to hepatitis B core antigen) were positive.

Reported by S Rosen, MD, Baltimore, M Levin, MD, R Berg, MD, D Dutta, MD, S Baker, Sinai Hospital, Baltimore, D Williams, C Campbell, R Dunning, D Glasser, MD, Baltimore City Health Dept, J Horman, DVM, E Israel, MD, State Epidemiologist, Maryland State Dept of Health and Mental Hygiene; U Setia, MD, R Kapila, MD, University of Medicine and Dentistry New Jersey, Newark, W Parkin, DVM, State Epidemiologist, New Jersey State Dept of Health; J Ehrenkrantz, MD, South Florida Hospital Consortium for Infection Control, Miami, R Morgan, MD, Dade County Health Dept, J Sacks, MD, Acting State Epidemiologist, Florida State Dept of Health and Rehabilitative Svcs; S Friedman, MD, New York City Dept of Health, R Rothenberg, MD, State Epidemiologist, New York State Dept of Health; Div of Field Svcs, Epidemiology Program Office, Hospital Infections Program, AIDS Activity, Center for Infectious Diseases, CDC.

Editorial Note: Although the etiology of AIDS remains unknown, epidemiologic evidence suggests that AIDS is caused by an infectious agent transmitted sexually or, less commonly, through exposure to blood or blood products. The disease has not been shown to be transmitted through casual contact with affected individuals.

Continuing surveillance of AIDS confirms earlier observations that 94% of patients come from the high risk groups previously described (*3*). The source of AIDS in the patients reported here is unknown. They denied belonging to known AIDS risk groups; however, the accuracy of data concerning sexual activity and IV drug use cannot be verified. None gave a history of caring for an AIDS patient, and none had known contact with blood of an AIDS patient, however, the possibility that these patients had forgotten or unknown exposure to the blood of AIDS patients cannot be entirely excluded

These four cases provide no new information regarding occupational risk related to health-care personnel. Transmission of AIDS within hospitals has not been reported. Recommendations for prevention of AIDS in health-care personnel have been previously published (*4*), and these personnel are urged to become familiar with and adhere to these recommendations.

References

1. CDC Update on acquired immune deficiency syndrome (AIDS)—United States. MMWR 1982;31:507-8, 513-14.
2. Masur H, Michelis MA, Wormser GP, et al. Opportunistic infection in previously healthy women. Initial manifestations of a community-acquired cellular immunodeficiency. Ann Intern Med 1982;97:533-9.
3. CDC. Acquired immunodeficiency syndrome (AIDS) update—United States. MMWR 1983;32:309-11.
4. CDC. Acquired immune deficiency syndrome (AIDS): Precautions for clinical and laboratory staffs. MMWR 1982;31:578-80.

CENTERS FOR DISEASE CONTROL

August 5, 1983 / Vol. 32 / No. 30

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

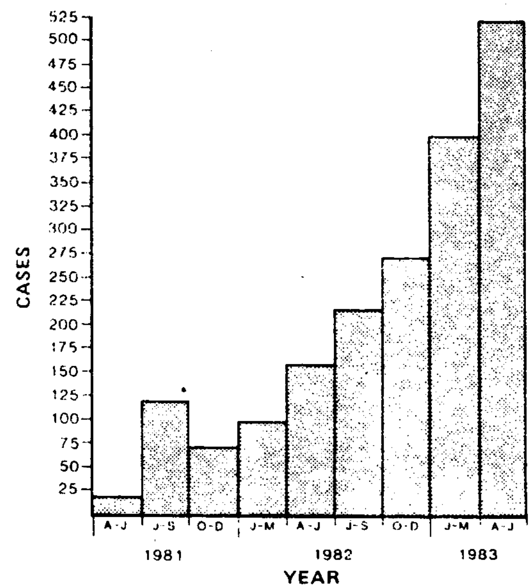
Current Trends

Update: Acquired Immunodeficiency Syndrome (AIDS) — United States

Between June 1981 and August 1, 1983, physicians and health departments in the United States and Puerto Rico reported 1,972 cases of acquired immunodeficiency syndrome (AIDS) meeting the surveillance definition*. These cases were diagnosed in patients who have Kaposi's sarcoma (KS) or an opportunistic infection suggestive of an underlying cellular immunodeficiency. Three hundred thirty-one cases (17% of the total) were reported to CDC over the last 6 weeks; the average of 53 cases reported per week during July 1983 compares

*For the limited purposes of epidemiologic surveillance, CDC defines a case of AIDS as a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has had no known cause of underlying cellular immunodeficiency or any other underlying reduced resistance reported to be associated with that disease.

FIGURE 1. Cases of acquired immunodeficiency syndrome (AIDS), by quarter of report — United States, second quarter 1981 — second quarter 1983



*Includes backlog of cases identified at beginning of CDC surveillance

AIDS – Continued

with an average of 11 per week in July 1982 and 24 per week in January 1983 (Figure 1). Of all patients, 759 (38%) are known to have died; the mortality rate for patients with opportunistic infections continues to be over twice that of patients with KS alone. *Pneumocystis carinii* pneumonia (PCP) is the most common life-threatening opportunistic infection in AIDS patients; many of the patients may have multiple opportunistic infections, either sequentially or simultaneously. Of the reported cases, 71% have homosexual or bisexual orientation; 95% of the patients with KS are in this group.

Over 90% of AIDS patients are 20-49 years old; almost 47% are 30-39 years old. Cases have occurred in all primary racial groups in the United States. One hundred twenty-nine (7%) cases have been reported in women; the ratio of male to female patients (14:1) has been almost constant over the last year. Most cases are reported among residents of large cities. New York City has reported 44% of all cases meeting the surveillance definition; San Francisco, 10% of cases; and Los Angeles, 6% of cases. Cases have been reported from 39 states, the District of Columbia, and Puerto Rico (Figure 2).

Reported by city, state, and territorial epidemiologists; AIDS Activity, Center for Infectious Diseases, CDC.

Editorial Note: To date, CDC has been notified that at least 18 states and territories have made AIDS reportable, and approximately 26 have introduced or are considering measures to make it reportable. Some states that have not taken specific action have cancer registries or already require many opportunistic infections to be reported. Physicians aware of patients fitting the case definition for AIDS are requested to report such cases through their local or state health departments. AIDS patients who do not belong to any of the recognized risk groups or who are recipients of blood or blood products (including anti-hemophiliac factors) should be reported immediately. CDC will soon make available a reporting format by which patients' names need not be sent to CDC.

Concern has been expressed about potential transmission of AIDS from hospitalized patients to health-care personnel (*1*). Although no instance of direct transmission has been reported (*2*), accidental needlestick injuries or similar types of accidents occasionally occur. To evaluate the possible risk of AIDS transmission after such accidents, the Hospital Infections Program, CDC, in cooperation with several state health departments, has initiated a study at selected hospitals of health-care personnel who have had documented parenteral or mucous membrane exposure to blood of definite or suspected AIDS patients. This study is being expanded to include additional hospitals. Hospital infection control staff who have been notified of these types of personnel exposures in their hospitals and wish to obtain additional information about participation in the study should contact the Hospital Infections Program, (404) 329-3406.

References

1. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
2. CDC. An evaluation of the acquired immunodeficiency syndrome (AIDS) reported in health-care personnel—United States. MMWR 1983;32:358-60.

FIGURE 2. Acquired immunodeficiency syndrome (AIDS) cases reported to CDC, by state – United States, as of August 1, 1983