THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 5 #2 November, 1983

TABLE OF CONTENTS (ALPHA): STDs

TABLE OF CONTENTS (ALPHA): AIDS

GAY & LESBIAN ACTIVITIES AT APHA MEETINGS IN DALLAS

The American Public Health Association's 111th Annual Meeting will be held in Dallas, November 13-17, 1983. Activities and events of interest ot gay and lesbian health workers have been tentatively scheduled as follows:

Sunday, November 13

Exhibit booth #628 at the Convention Center through November 16th

8 pm--National AIDS/Pre-AIDS Epidemiology Network Meeting; location to be announced (contact Caucus Booth, David Ostrow, or Mark Behar)

Monday, November 14

2-5pm, Self-Help for Herpes (Suzann Gage)--Dallas Hilton--Vista Room

6-7:30 pm, Cocktail Party, cosponsored with Women's Caucus, location to be announced.

9 am, National Coalition of Gay STD Services Semiannual Meeting, time & location to be announced

Tuesday, November 15

Reservations for Gay Public Health Worker's Annual Dinner Due Today!

8:30-10am Dallas Convention Center Room N210-211

Passages: Gays & Lesbians--Society & Perspectives, Fances 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

2-5pm Dallas Convention Center Parquet Ballroom Scetion A

AIDS: Science & Social Action in Conflict, Viktor Anderosson, Presider
AIDS: The Funding Quest, Honorable Henry Waxman (D, California)
Epidemiology of AIDS and KS in the US, James Curran, MD
AIDS: Characteristics of a Male Homosexual Study Population in Toronto, Colin Soskolne, Randall Coates, Abby Sears
AIDS: The San Francisco View, Selma Dritz
Development of a National AIDS/Pre-AIDS Epidemiology Network, David Ostrow, MD, PhD
Discussion & Late-breaking Reports

Wednesday, November 16

11:30-1pm Gay Public Health Workers, Annual Caucus Business Meeting, location to be announced

2-5pm Dallas Convention Center Room 5304

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

7pm Gay Public Health Workers Dinner, location to be announced. (Reservations are due by Tuesday at Booth.)

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NATIONAL AIDS/PRE-AIDS EPIDEMIOLOGY NETWORK & NATIONAL COALITION OF GAY STD SERVICES TO MEET

Dallas will be the site of official meetings of the National AIDS/Pre-AIDS Epidemiology Network (NAPEN) and the National Coalition of Gay STD Services (NCGSTDS) November 13 & 14. NAPEN will meet Sunday, November 13, 8pm at the Hyatt Regency (300 Reunion Blvd., Dallas, 214/651-1234) in Dr. David Ostrow's Suite; NCGSTDS will meet Monday, November 14, 9 am--contact Mark Behar (Roger Gremminger, MD) at The Plaza Hotel (1933 Main St., Dallas, 214/442-7271), for the site of the meeting. Agenda items include: elections for a new Chairperson [sic], Guidelines & Recommendations for Healthful Gay Sexual Activity brochure-the 4th edition, Current Aspects of Sexually Transmitted Diseases Symposium in Chicago, involvement with National AIDS/Pre-AIDS Epidemiology Network (NAPEN), Federation of AIDS-Related Organizations, and the 6th Lesbian/Gay Health Conference, and other items.

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CASTDS-III UPDATE--NCGSTDS & AAPHR TEAM UP FOR THREE DAY MEDICAL CONFERENCE

The NCGSTDS and the American Association of Physicians for Human Rights (AAPHR) will be cosponsoring a three day medical conference in Chicago, August 22-24, 1984. The Current Aspects of Sexually Transmitted Diseases Symposium--III (CASTDS) will feature a one day Clinical Update for the Diagnosis and Treatment of STDs on the first day, and will focus on the special problems of gay and lesbian patients. Mark Behar, PA-C, Chris Mathews, MD, Kenneth Mayer, MD, and David Ostrow, MD, will serve as the "course faculty." On Thursday & Friday, August 23-24, AAPHR and NCGSTDS will cosponsor Critical Gay & Lesbian Health Problems --New Diseases, New Approaches to Persistent Problems, and Prevention/Prophylaxis. The following topics and speakers have so far been confirmed: AIDS Diagnosis (Walter Blumenthal); The Immunology of AIDS (Roger Enlow); Panel on AIDS Therapeutic Trials and Alternative Treatments (Paul Volberding, Stephen Follansbee, William Siroty); Panel of "Lymphadenopathy Syndrome and its Relationship to AIDS" (Donald Abrams, Kenneth Mayer, Roger Enlow),;The Hepatitis B Vaccine and AIDS and Hepatitis B Infection in Gay Men (Cladd Stevens); The Etiology of AIDS--Keynote--Overview of NIH's AIDS Research Program (Kenneth Sell); Panel on Psychological Aspects of AIDS (Marshall Forstein, Stuart Nichols, David Ostrow); Intestinal Syndromes in Gay Men (pending); Lesbian Health Issues (pending); Helping Gay & Lesbian Youth Attain Positive Self Images (Emory Hetrick, Damien Martin); Stages of Gay Relationships (David McWhirter, Drew Mattison); Panel on Impaired Gay & Lesbian Physicians (Melvin Pohl, Max Schneider); Non-AIDS Keynote: Social and Political Barriers to Gay & Lesbian Health Care (Michael Ross).

In addition there will be a poster session on both afternoons for contributed papers (to be solicited in January, 1984; abstract deadline, April 10; selection committee consisting of David Ostrow, Robert Bolan, Mark Behar). Richard Krause, Director of National Institute of Allergic & Infectious Diseases, will be gining the first annual AAPHR Banquet address on the Sociology of AIDS & Infectious Disease Research. A fundraising cruise in the harbor overlooking the beautiful Chicago skyline is scheduled for Wednesday or Thursday evening, and will benefit the continued operations of the NCGSTDS. As always, your input is invited! Address comments to: NCGSTDS, PO Box 239, Milwaukee, WI 53201.

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BOSTON'S FENWAY SEEKS MD AND PA/NP FOR IMMEDIATE EMPLOYMENT

by Jerry Feuer, PA-C

There are two job openings at the Fenway Community Health Center in Boston. The first is an immediate opening for a full-time physician assistant or nurse practitioner. A large percentage of the parctice involves seeing gay men for both STDs and primary care. In addition, FCHC serves the local neighborhood comprised of many students, young adults, and the elderly. We offer a full benefits package with a salary beginning in the low 20s. Twenty percent of the job involves non-clinical duties including speaking engagements to both gay and lay professional groups on a variety of gay related medical topics. We would prefer an individual with experience in STDs and primary care. The other position is to replace a half-time family practitioner who is planning to leave by January, 1984. We are looking for either a family practitioner or interniest who is committed to working in a predominantly gay oriented health center. Although the practice has a predominance of young adults (including a large number of gay men) there are a fair number of elderly patients who rely on FCHC for their medical needs. Although we have a small medical staff, we have approximately 18,000 patient visits per year. As we have expanded, we offer services in such specialty areas as cryosurgery, dermatology, gynecology, infectious diseases, podiatry, and nutritional counseling. Interested individuals should send a resume to Jerry Feuer, Fenway Community Health CEnter, 16 Haviland St., Boston, MA 02115 or call 617/267-7573.

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DISCOVERY OF HBV IN LIVER TUMORS

abstracted with thanks from Medical World News, 9/12/83

Researchers have begun looking for a liver-cancer trigger mechanism after finding evidence that hepatitis B virus (HBV) DNA penetrates cell nuclei and integrates with the host DNA as a prelude to malignant transformation. Using recombinant DNA hybridization, Dr. David A. Shafritz and colleagues from New York's Albert Einstein College of Medicine, located HBV DNA in hepatic tumors of HBV carriers. The finding, which has been collaborated by other investigators, may help explain why HBV carriers are at increased risk for hepatic cancer. The search for the cancer link also has raised questions about the infectiousness of HBV carriers. Researchers had thought carriers with antibodies to the HBe antigen usually were'nt infectious, but the Einstein group has found HBV replicating in patients with antibodies to HBe. In a few patients, viral replication was occurring at the same rate as in patients with acute HBV infection. "At the extremes of the chronic carrier state there may be two kinds of carriers--those who are actively replicating and producing virus and who may have active liver disease, and those who are not replicating virus. In the latter cases, the viral DNA appears to be integrated into the host genome," said Dr. Shafritz. Viral and cellular genes may shift positions on cellular chromosomes after integration occurs. Once cell transformation is completed, surface antigen expression may cease. Patients could become anti-HBs positive and still have integrated HBV DNA in their livers. The HBV findings aren't new, according to Dr. John Cole, RNA virus studies program director for the National Cancer Institute Biological Carcinogenesis Branch. The findings are noteworthy, however, because they corroborate the previous research.

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FDA RULES AGAINST MERCK & AMERICAN LIVER FOUNDATION FOR ADS

by Denny McShane, MD, American Association of Physicians for Human Rights Newsletter

In the September/November, 1983 issue of the Newsletter of the American Association of Physicians for Human Rights (AAPHR), editor Denny McShane, MD, reports that Merck, Sharp, & Dohme Pharmaceuticals and the American Liver Foundation have been notified by the Food & Drug Administration (FDA) to stop running the advertisements in the gay and other press showing an individual in an intensive care setting with the headline, "He Took the Chance of Getting Hepatitis B--And Lost." This advertisement, as AAPHR, NCGSTDS, National Gay Health Education Foundation and others had repeatedly pointed out to Merck and the Foundation, showed lack of sensitivity to the current AIDS epidemic and did not promote health seeking behavior with regard to the hepatitis B vaccine. It seems that they prefer FDA suggestion rather than community involvement.

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CLEVELAND'S HEALTH ISSUES TASKFORCE (HIT)

The Health Issues Taskforce (HIT) is a group of concerned individuals who are actively addressing health issues which affect the Cleveland (Ohio) gay & lesbian community. The thrust of HIT is to attack AIDS, however there is an acute awareness to deal with other gay & lesbian health issues. Four committees comprize HIT: 1) Education, which attempts to help educate the medical & lay communities, the gay & lesbian community, and a self-education of HIT members, in the area of AIDS & gay/lesbian health concerns. 2) Support, which provides financial counseling, supportive counseling, and a buddy system for those who have AIDS. 3) The Public Awareness committee understands that all health issues, especially those involving gays & lesbians, have political and social ramifications which are almost as significant as the medical issues. The committee's primary task is to keep elected officials, community leaders, and the media informed of our concerns as well as to gain their support. The committee will also be involved with other national & local AIDS organizations. 4) The Financial committee will be involved with various fundraising techniques to generate much needed funds for the support of other committees in HIT. Meetings of HIT are on the first Monday of the month (except holidays, then the first Tuesday) at the Trinity Cathedral, 7:30 pm. For more information, please contact Ted Wilson, HIT Chairman, PO Box 14925 Public Square Station, Cleveland, OH 44114 (216/721-4414).

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NEW GENETICALLY PRODUCED HEPATITIS B VACCINE

Major progress toward achieving the first successful vaccine against hepatitis B through genetic engineering was announced by Biogen N.V., an international biotechnology company making products developed through recombinant DNA research. Dr. Walter Gilbert, Chairman, said that two chimpanzees were successfully immunized against the disease; two controls contracted the disease after all four had been exposed to it. Blood tests have confirmed immunity in the animals receiving the Biogen vaccine. The experiemntal vaccine was made from hepatitis B surface antigens produced by genetically engineered yeast. In 1979, the first synthesis of the hepatitis B surface antigen in bacteria was reported. Surface antigens are characteristic proteins that lie on the surface of the ivrus. The actual disease is not transmitted by these antigens but by the DNA contained in the virus core. However, it is the body's reaction to the surface antigens that stimulates the production of antibodies and the subsequent development of immunity to the specific virus. Therefore, it is unnecessary to inject the whole virus in a weakened or killed state to confer immunity. As a result, vaccines can be produced through recombinant DNA technology which do not involve handling hazardous, infectious material at any point in the production process. Currently available hepatitis B vaccines are made from surface antigens extracted from the blood plasma of human carriers of the disease. The dependence of the current vaccine on the supply of infected human blood plasma and the rigorous production and testing procedures results in a costly product that is in limited uspply. A vaccine produced through recombinant DNA technology can have significant advantages over current vaccines: 1) The recombinant product is produced only from the virus' surface antigen--the protein portion that confers immunity--which is not in itself infectious. 2) As a genetically engineered product, the new vaccine should be less expensive to produce since it eliminates many of the hazards of making a vaccine from infected human blood. 3) Vaccine production is not tied to the availability of blood donations from individuals infected with the disease. 4) The elimination of the use of a dwindling population of chimpanzees for the routine testing of the manufactured vaccine.

The molecular biology of hepatitis B virus (HBV) began to be understood after the cloning and propagation of HBV DNA in E. coli (a laboratory bacteria commonly used in the development of genetically engineered products). These advances enabled the nucleotide sequence of the DNA to be determined and has, in turn, revealed the general organization of the viral genome. When the correct DNA fragments were inserted into the E. coli, the core antigen of hepatitis B (HBcAg) could be produced in virtually any desired quantity. This material is now being produced commercially by Biogen for use in diagnostic kits to detect hepatitis B infection. However the development of E. coli for the production of surgace antigen proved more difficult than the production of the core antigen, and thought research in this area is continuing, it has not yet been fully determined that surface antigen made in E. coli would confer immunity if used in a vaccine. A method of producing quantities of surface antigens was needed. Certain DNA sequences can be propagated in both E. coli and in yeast, which means that gene manipulation experiences conducted in E. coli can then be transferred to yeast for the purpose of expression. In this manner, HBsAg was introduced in a functional form into yeast cells where the desired surface antigen was then synthesized. Extracts from the transformed cells contained HBsAg in a form that corresponded well with the antigen isolated from human plasma by traditional means. This material was processed, concentrated and tested by Biogen for toxicity and determined to be non-toxic. The next step was to test the experimental vaccine in chimpanzees to determine efficacy. Preliminary data supports the efficacy of this new recombinant vaccine. Further tests can be performed only in chimpanzees because they are the one animal species in which the course of the disease closely mimics its development in humans. No speculation was offered concerning when such a genetically derived HBV vaccine would be commercially available.

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GREAT LAKES REGION HOSTS LESBIAN/GAY HEALTH CONFERENCE

Of the many positive outcomes of the 5th National Lesbian/Gay Health Conference in Denver in June, 1983, one of them is the "Great Lakes Lesbian/Gay Health Conference," February 17-19, 1984, at the University of Wisconsin--Milwaukee Student Union, in Milwaukee. Five of the Milwaukee participants to the Denver Conference accepted the challenge of the National Gay Health Education Foundation to host such a regional conference. The Conference will focus on three topics: domestic abuse, AIDS, and alcoholism/addiction, all of major concern and importance to lesbian & gay health providers in the region that was identified as Minnesota, Michigan, Iowa, Illinois, Wisconsin, Indiana, and Ohio. An awareness of the prevalence of these problems, recognition of signs, symptoms, and risk factors, and intervention will be discussed in a format that will feature an introductory presentation followed by several optional workshops in each area. Finally, there will be an opportunity to share resources in dealing with these health problems by networking together. Former National Gay Task Force board member Karla Dobinski will provide the keynote address. Jack Ryan (Fort Wayne, IN) representing the National Association of Gay Alcoholism Professionals (NAGAP), Dr. David Ostrow (Chicago), representing Howard Brown Memorial Clinic and American Association of Physicians for Human Rights, and Jean Stellick (Milwaukee), representing the Task Force on Battered Women, will be featured speakers. The Conference is co-sponsored by: Wisconsin Governor's Council on Lesbian & Gay Issues, Brady East STD (BEST) Clinic (Milwaukee), Cream City Association Foundation (Milwaukee), and Howard Brown Memorial Clinic (Chicago). All NCGSTDS members residing in the above Great Lakes' states will receive a Conference brochure in a separate mailing; all other inquiries may be addressed to: GLLGHC, PO Box 239, Milwaukee, WI 53201. * * * * * *

CALL FOR PAPERS: SIXTH LESBIAN/GAY HEALTH CONFERENCE

The National Gay Health Education Foundation announces the Sixth National Lesbian/Gay Health Conference and the First International Lesbian/Gay Health Conference, "Toward Diversity," to be held in New York City, June 16-19, 1984. The theme, "Toward Diversity," reflects the meeting's multi-focus purpose with special emphasis on Third World, international, and lesbian health concerns. The Conference will be held in conjunction with the Third National AIDS Forum, co-sponsored by the Federation of AIDS Related Organizations (FARO). The NGHEF and FARO welcome participation by those wishing to share their contributions to the field of lesbian or gay health care. Papers: A formal, written presentation followed by discussion from the floor. Panels: A topic presented from several points of view. Speaker remarks should be brief to encourage discussion among panelists and audience. Workshops: Discussion of a topic facilitated by the person(s) who submit the idea. Participation by all is encouraged. We also invite suggestions for alternative formats. Feel free to submit ideas along these lines. Be creative, but specific. Some topics have already been identified. Proposals may include or relate to such areas as: Gay Male Health Care, Gerontology, Holistic Health, Substance Abuse, Mental Health, Lesbian/Gay Families, Physically-Challenged Lesbians & Gays. Those who wish to participate should submit a narrative abstract and/or topic outline of one page (maximum) by December 15, 1983. Language requirements and other specifics will be provided upon receipt of each proposal. Notification of acceptance will be mailed by January 30, 1984. Send narratives to: ILGHC, NGHEF, 80 Eighth Av., Suite 1305, New York, NY 10011. For further information contact: Fern Schwaber or Michael Shernoff, 212/206-1009.

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OPEN LETTER FROM NATIONAL GAY HEALTH EDUCATION FOUNDATION

by Ron Vachon, PA, Executive Director

Dear Friends: I am writing to you because I believe that you share my own belief that the wellness/health of all inidividuals matters. And those of us who share in that belief can--by acting together--affect the course of life for all people. Lesbian and gay people have historically been ignored by the health care system at best...and mocked and mistreated at worst. We cannot continue to tolerate the hate-mongering of the James Buchanan's of our land who would have lesbians and gay men removed from helping professions. Nor can we any longer put up with the ignorance and bigotry that leads a physician to lecture an 18 year old on the "evils" of homosexuality. You and I must do something concrete to protect lesbians and gay men; to provide knowledge and understanding where there has been ignorance and stereotyping; to form an institution for change where there has been homophobia/heterosexism. The National Gay Health Education Foundation, Inc. (NGHEF) is the result of years of work by concerned lesbian and gay health professionals. We are social workers, doctors, nurses, alcoholism counselors, physician assistants, psychologists...al working together in a rare example of interdisciplinary, co-sexual energy. Please join in this venture. Now, more than ever, people like you and me need each other to affect change. Your generous, tax-deductible contribution, added to that of thousands of other concerned and caring persons will strengthen this institution. And by joining us now you will receive our regular newsletter that will assist you in understanding the issues at hand and how you can personally affect change. We must succeed! Only with your help! Please address contributions to: NGHEF, PO Box 834, Linden Hill, NY 11354.

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SIXTH LESBIAN/GAY HEALTH CONFERENCE

by Michael Shernoff & Fern Schwaber

We would like to take this opportunity to introduce ourselves to any of you who we do not yet know. Plans are already underway for the Sixth Lesbian/Gay Health Conference (SLGHC) planned for June 16-19, 1984, in New York City. This will be an international event, and communications so far from Australia, The Netherlands, Canada, and Belgium show how much interest is being generated this far. The Third AIDS Forum will be held consecutively, and is being coordinated by the Federation of AIDS Related Organizations (FARO). The initial call for papers will be mailed out soon. The Conference promises to be the most comprehensive and diversified gathering related to lesbian/gay health issues ever held! We are planning a multi-lingual sourcebook to be distributed free to all Conference attendees. What makes this sourcebook so important is that it will be the first of its kind...abstracts of all workshops and panels given at the Conference, complete with biographical data on the presentors, relevant bibliographies, advertisers and the 1984-85 Lesbian/Gay Health Directory, all in one volume! In order to do all of this we need your help in the form of a contribution to the 1984 SLGHC. It has been a custom for each member organization of the National Gay Health Coaltion to donate $50 for "seed money." This year due to the higher costs of convening a conference in Manhattan, we are asking for a minimum contribution of $100 (though of course we'll accept more). Please, help us gather the needed seed money for this exciting and important event. Send contriubtions and inquiries to: SLGHC, c/o NGHEF, 80 Eighth Av., #1305, New York, NY 10011, or call 212/206-1009. Details will be provided in future issues of the Newsletter.

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MONTREAL HEALTH PRESS: A BOOK ABOUT STDs

Celebrating its 15th anniversary, the Montreal Health Press has recently published the second edition of its widely acclaimed, VD Handbook, now newly renamed, A Book About Sexually Transmitted Diseases. The 52 page, large format book is illustrated and costs $2 per copy, with a possible price increase scheduled for January, 1984. Bulk prices are available. The book deals with all major STDs of concern to gay and straight people, including AIDS, hepatitis, intestinal disorders, and prostatic disorders. This book is a highly recommended addition to your clinic's resources. For more information, write: Montreal Health Press, PO Box 1000 Station "G", Montreal, Quebec H2W 2N1 (514/272-5441). The book was written by Montreal physician Donna Cherniak, MD.

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DENVER, JUNE 9-12, 1983: A NOT SO GAY EVENT

by Lary Abramson, MD, with thanks to the BAPHRON (July, 1983)

"The Fifth National Lesbian/Gay Health Conference ("Health Pioneering in the '80's")" which was co-sponsored by the National Gay Health Education Foundation (NGHEF), American Association of Physicians for Human Rights (AAPHR), and the Gay and Lesbian Health Alliance of Denver, demonstrated early and loudly the frustrations involved with a multi-tiered political, social, and scientific meeting. Denver will never be the same and the Executive Tower Inn, dragged kicking and screaming into Twentieth Century Gay Awareness after trying to remove "gay," "lesbian," and "AIDS" posters from the lobby and other public places, will CERTAINLY never be the same. While individual camaraderie was abundant everywhere, a not very subtle undercurrent of anti-medical establishment feeling permeated the proceedings. The hostility surfaced in all out warfare during a panel, "AIDS Forum: Creating Positive Changes in Changing Sexual Mores," co-chaired by Tom Smith, Steve Moran, and Robert Bolan. A crowd of angry AIDS patients, dissenting gay doctors, sociologists, and lay persons faced the panel intent upon tearing apart "The San Francisco Secretions Thing." It was a reaction to the adverse results of the Bay Area Physicians for Human Rights (BAPHR) position that secretions and excretions are the most likely vehicles for AIDS agent transmission. A large number of participants felt this position being circulated to a large unsophisticated audience has led, and is leading, to untold grief in the gay community: the use of glove and masks by police, the refusal of health personnel to visit gay patients, the firing of gay food handlers, etc.

Bernice Goodman, the new president of the NGHEF, was a keynote speaker of the Conference. She spoke on "Confronting Homophobia in the '80's." After intoning a vast litany of cataclysmic events to which the human race is currently vulnerable, including third world conventional wars, abject poverty, and nuclear Armageddon, events, she made very clear which were not without clandestine helpmates in the United States Government, she turned to the subject of AIDS. The juxtaposition was not lost on an applauding crowd. She went on to suggest that there may very well be alternatives to the medical establishment theory of AIDS as a new virus arising denovo. Those alternatives might well be fathered by the same operatives in government who have shown their prowess in instigating genocide on more than one unfortunated minority group or nation. What possible mode would improve upon AIDS, she suggested, to rid the country, and cause less stir in doing so, than a disease which selectively affects homosexuals, unwanted Haitian immigrants, IV drug users and hemophiliacs? While the NGHEF Conference was going on, AAPHR's medical symposium, a three day program covering gay & lesbian health issues chaired by Roger Enlow, David Ostrow, and Brett Cassens, presented new and informed information for the mostly medical audience.

[ED NOTE: Please see Volume 5:1, pp. 26-29 and pp. 10-11 and elsewhere for detailed reports of the Denver meetings.]

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THE DENVER CONFERENCE--ANOTHER PERSPECTIVE

by Fern Schwaber & Michael Shernoff, 1984 Conference Co-chairs

Lary Abramson's article in the July BAPHRON about the Fifth National Lesbian/Gay Health Conference is important and merits a reply. The Denver Conference was a unique and provacative professional event in so far as it was an interdisciplinary meeting that included physicians, other health professionals as well as consumers of medical care. This in itself must have felt strange to many physicians who are not used to meeting with other health care providers as well as potential patients all at the same time as peers. The purpose of meeting in such a manner is to learn from each other regarding medical and psychosocial issues. Hopefully this results in an increase of sensitivity towards the broad range of needs of all patients. Traditionally, physicians are used to being viewed as the ultimate authority in health matters. At this Conference this assumption was challenged. To hear their views challenged must have seemed odd, at the very least. The patient/consumer advocate model for improved health care services was often expressed throughout the Conference. Thus many doctors unused to this view felt threatened, shocked, and unsettled by the newness of the environment they found themselves in. Yet numerous other physicians spoken with during and after Denver found the four days "provocative, challenging, and refreshing."

The 1980s pose many challenges for all of us in the health sciences. The medical profession has a history of failing to provide sufficient training to sensitize medical students to the fears and concerns of the people who will be in their care. Often individual attitudes and aloofness cloaked in the guise of "professionalism," help perpetuate feelings of distrust, especially from those with a history of being traumatized and victimized by the traditional medical profession. Like all other attitudes and behaviors, these can change if individuals are open to honest and critical self-examination. Openly gay MDs have the opportunity to really be on the vanguard of humanizing medical care. The goal for all who attended the Denver Conference was to improve the quality of health care for lesbians and gay men. Next year's lesbian/gay health conference will be an international event to be held in New York with the theme, "Toward Diversity." It would be a serious loss for all of us, if physicians chose not to attend and present at the 1984 Conference.

The courageousness and risks taken by openly gay/lesbian physicians must not be minimized. By being able to weather attacks of distrust, and being sensitive to possible causes of this, physicians are in the crucially important position of helping foster a better environment for improved doctor-patient relations. In striving to create a climate where MDs will feel valued and welcomed at the 1984 Conference, we are open to your suggestions about how doctors can best fit in, contribute their special expertise and feel comfortable at the international Conference in June. Perhaps one answer might be a forum or workshop held by physicians and other health workers on helping people traumatized by homophobic, sexist, or simply insensitive medical practitioners to work through and resolve these feelings. The immediate and ultimate challenge is to learn to work together in providing quality health care services as openly lesbian/gay professionals to our own communities. To do otherwise would be playing right into the hands of the homophobes. Hope to see as many of you as possible in New York City, June 16-19, 1984 at OUR health conference.

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APOLOGIES TO BILL OWEN!

In the last issue of the NCGSTDS Official Newsletter (Volume 5:1, August, 1983, p. 9) we failed to acknowledge that Dr. William Owen authored the review of Sexually Transmitted Diseases in Homosexual Men: Diagnosis, Treatment, and Research, edited by David Ostrow, Terry Sandholzer and Yehudi Felman. Sorry for the oversight!

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GUIDELINES & RECOMMENDATIONS FOR HEALTHFUL GAY SEXUAL ACTIVITY

The NCGSTDS' Guidelines & Recommendations for Healthful Gay Sexual Activity widely acclaimed brochure is now in its 3rd edition, and is also one of many risk reduction brochures now available throughout the country. Some of the brochure's shortcomings, an absence of information about risk reduction information directed to lesbians, or enthusiasts of S & M practices, was pointed out in Denver, at the Fifth National Lesbian/Gay Health Conference. A 4th revised edition is under consideration for release in June, 1984. Any suggestions or comments about potential revisions must be addressed to the NCGSTDS immediately. Some individuals are suggesting that the Coalition defer the publication of the brochure to other groups such as the National Gay Health Education Foundation, or American Association of Physicians for Human Rights. One thing is clear--requests for single and bulk orders of the brochure are sharply down from last year, which is affecting the amount of income normally coming in to the NCGSTDS. Any other suggestions or comments should be addressed to the NCGSTDS, PO Box 239 Milwaukee, WI 53201. Thanks for your interest in this valuable project!

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NEWS FROM CHICAGO'S HOWARD BROWN MEMORIAL CLINIC

excerpts from the Clinic Courier (summer, 1983)

Chicago's Howard Brown Memorial Clinic recorded over 14,000 patient visits in 1982 from three bathhouses, the mobile STD van, and the main facility. Major reasons of visits in 1982 were for routine testing (21% of the patient visits), gonorrhea (13%), venereal warts (10%), and non-gonococcal urethritis (9%). Approximately 300 volunteers contributed almost 23,000 hours of service to the clinic. The majority of their time, over 20,000 hours, was devoted to clinic operations, including more than 13,000 hours for administrative duties, almost 5,000 for lab & nursing functions, and 1,800 hours for physicians' services. In addition, testing at other locations (bathhouses & van) totaled almost 900 hours. Volunteers spent more than 1000 hours on fundraising; the Board of Directors' meetings involved over 200 volunteer hours and about 500 hours were spent by volunteers in training.

The Brown Elephant resale shop of the Clinic has been open for more than 6 months, and is open daily from 9-5pm. It now features sales on antiques, clothing & shoes for man, women, & children, cameras, jewelry, books, records, housewares, & furniture; although most of the items are donated by the gay & lesbian community, most of the sales are from the neighborhood residents.

"It is disturbing and distressing that only 175 patients have begun receiving the hepatitis B vaccine at the Clinic during the eleven months it has been available," reported Executive Director Harley McMillen. Sexually active gay men are among those who are at high risk of being infected with hepatitis B. About 60% of men tested at the Clinic either have it currently or have indications that they had it in the past. Those who are sexually active and do not yet have immunity to the virus have about a one-in-five chance of developing hepatitis B during the next year. About 10% of persons who develop hepatitis B never fully recover and become chronic carriers. Total cost is now $176 and includes the pre-test, three injections, post-test, and administrative fees for five visits over eight months.

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NEW HERPES BOOKLET

The Washington Center for Cognitive Therapy has published a new self-management booklet for those who have contracted herpes and the professional staffs and clinics that treat them. The booklet is specifically written to address the psychological consequences of the disease and is based on extensive patient interviews, clinical observation, and the treatment program developed and employed by the WCCT. It has been prepared in cooperation with the American Social Health Association, which houses the nationally known Herpes Resource Center. The 27 page booklet contains many ideas and strategies that can be easily understood and put into practice. For a single copy, send $2.95 plus $1 postage & handling to WCCT, PO Box 39119, Washington, DC 20016. Please inquire about quantity/bulk ordering. Tear sheets, requests, questions, please direct to Public Affairs Office.

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"MAN-TO-MAN" CONDOMS BEING MARKETED FOR STD/AIDS PREVENTION

Enclosed with this Newsletter is information from the manufacturer and distributer of a new type of aid in prevention of transmission & acquisition of infectious diseases during sexual intimacies between men--the condom. "Doc" Johnson Enterprises, maker & distributer of numerous "marital aids" is now marketing a "doubly lubricated" latex condom. Although there are many different brands of condoms now available for contraception, none have been exclusively tested to withstand the rigors of anal intercourse, to the best of this Editor's knowledge. If any readers know of such studies, please share the information! In experiments recently reported at the 5th International Meeting of the Society for STD Research in Seattle this last August, Frank Judson, MD, of Denver reported that condoms sheathed to a "standard" sized dildoe and subjected to repeated simulations of intercourse in a glass cylinder, showed no leakage of either herpes simplex virus or chlamydia trachomatis. (The dildoe was 25 cm, simulating the "average" size human organ (fantasy?!), the cylinder was 5 x 16 cm!) [Ed note: The October, 1979 issue of Consumer Reports was allegedly devoted to comparisons of condoms.]

For more information about the new "Man-to-Man" rubbers, contact: Doc Johnson Enterprises, 11933 Vose Street, North Hollywood, CA 91605 (213/764-1543 or 800/423-3665). Suggested retail price is 3 condoms for $2.95. Any recognized health or social agency involved in STD care may request a sample 3 pak; please write to the Public Relations Director.

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ASSOCIATION OF FREE AND COMMUNITY CLINICS EXPANDS IN LOS ANGELES

The Association of Free and Community Clinics of Los Angeles County announced that it has received a grant from the California Community Foundation for the purpose of staffing an office. Since being organized in 1977, the Association has been a voluntary consortium without paid staff and without funding other than membership dues. This grant has allowed staffing for the first time in the Association's history. Executive Director Thomas M. Nylund, past president and a founding member of the Association, was asked to write the proposal which led to the grant after leaving the post of Health Services Administrator for the Gay and Lesbian Community Services Center where he had operated a clinic for more than five years. The grant consists of $26,400 in cash and a $10,000 "challenge" grant to be matched with other cash which the Association may raise from any source.

Plans are underway to develop a group purchasing program by which member clinics may buy needed drugs and supplies at discount rates, thus passing the savings on to their clients. Of the 78 licensed primary care clinics in Los Angeles County, only 9 are licensed free clinics. The rest, although they may offer some of all services free of charge, are licensed community clinics which means they have the legal right to charge but only on a sliding scale based on the client's income. Many are small, staffed largely by volunteers and offer low-cost, but still excellent health care to what amounts to about 10% of the number of persons seeking the services of a physician or other health care provider in the county.

Membership in the Association is open to any non-profit, tax-exempt (501(c)(3)) licensed free or community clinic in Los Angeles County. Meetings are held the first Thursday of the month at 8:30 am at the Association headquarters, 514 W. Adams Blvd., LA, CA 90007. Additional information may be obtained by calling 213/749-9734 or writing.

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GAY ACADEMIC UNION HONORS 13 AT NATIONAL CONFERENCE

The Gay Academic Union, Inc. (GAU) will present special awards to 11 individuals and 2 organizations at an awards dinner in San Diego, November 26, 1983. The fund-raising dinner helps to sponsor the GAU's National Scholarship Program, and is part of the Ninth National Conference of the GAU on the campus of the University of California at San Diego. This is the fifth presentation of annual awards by GAU, an organization of lesbian and gay academics and professionals with chapters and members nationwide. The awards are designed to recognize and honor the achievements of individuals in various fields who have made significant contributions to gay scholarship and understanding and the enhancement of the gay experience. Previous recipients have included subh individuals as Abigail Van Buren of "Dear Abby" fame, former presidential advisor Midge Costanza, Wisconsin State Representative David Clarenbach, the Rev. Robert Arthur, Adele Starr, founder of Parents and Friends of Lesbians & Gays, writers Jane Rule, Dennis Altman, Lillian Faderman and Christopher Isherwood, poet May Sarton, artists Paul Cadmus, Lily Lakich, and the Great American Lesbian Art Show Collective, attorney Donald Knutson, librarian Barbara Gittings, journalist Randy Shilts, publisher Barbara Grier, performer Meg Christian, producers Martin Sherman and John Glines, researchers Stephen O. Murray, Raymond M. Berger, John Boswell, Anne Peplau, Barry Adams, Vivienne Cass, John DeCecco, and Wayne R. Dynes, and former California Governor Edmund G. Brown, Jr.

The 1983 recipients represent an equally wide spectrum. The Humanitarian Award for demonstrating exceptional understanding, compassion, courage, and committment to human rights in work that had direct benefit to the gay community this year will be presented to Paul Popham and the Gay Men's Health Crisis, Inc., of New York, for the extraordinary effort to raise funds and galvanize the gay and lesbian communitiy's support in meeting the major health crisis of the decade. The Evelyn C. Hooker Research Award for gay-related research that demonstrates in its design and implementation the standards of excellence that have characterized Dr. Hooker's own work will be presented to Rhonda R. Rivera, Esq., Associate Dean for Clinical Programs in Ohio State University College of Law, for her monumental analysis in Hastings Law Journal of nearly every gay-related court case. Her 200 page article was cited in the decisions which invalidated the sodomy laws of New York and Texas and provides the basic legal position for civil litigation on behalf of gay and lesbian clients. The Theory Development Award is for work-in-progress on the development of social theroy promising to contribute significantly to an understanding of gay-related issues. This year's recipient is the team of Dr. David P. McWhirter, MD, and Andrew M. Mattison, PhD, of the Clinical Institute for Human Relationships in Dan Diego, for their exhaustive study of gay male couples to be published soon. The Performing Arts Award is for outstanding achievement in a theatrical medium that serves to inform and enlighten the public's view of lesbians and gay men. This year it salutes the unique contribution made by Harvey Fierstein to the growing field of gay theater and its crossover into wider acceptance by a non-gay audience as exemplified by his Tony Award-winning play "Torch Song Trilogy" and his book for the current Broadway musical hit "La Cage Aux Folles." Ironically, last year's award was to John Glines, producer of "Torch Song Trilogy" which had just made the transition to Broadway from Greenwich Village. This year's Literature Award for the published work with a gay-related theme that articulates with unusual beauty issues of importance to lesbians and gaymen is being presented to Alice Bloch, author of "Lifetime Guarantee" (Persephone Press, 1981). Her new novel, "The Law of Return," being published this fall by Alyson Publications, is described as "the rich sensual story of a woman claiming her voice as a Jew, a lesbian, and a women" which is winning praise for "its vibrancy and sense of revelation." The 1983 Fine Arts Award for achievement that illuminates in an exceptional way the quality of the gay experience goes to David Hockney, a distinguished artist whose career has embraced not only painting but theater and opera design. The Journalism Award is designed to recognize the unique contribution which reportage about gay men and women and their lifestyles makes toward greater knowledge and understanding of the gay condition. This year it is being presented to The Body Politic Collective in Toronto which has made a valiant effort to publish despite the concerted efforts of Canadian authorities to shut doen the paper. The President's Award for unusual diligence in overcoming anti-gay prejudices and increasing understanding and acceptance of gay people in the community at large will be presented to two individuals this year. Virginia Apuzzo, as Executive Director of the National Gay Task Force, has become one of the most effective spokespersons for gay men and lesbians, their concerns and their lifestyles, before

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GAU HONORS, Continued

Congressional committees, with White House aids, and in the media. Emery Hetrick, MD, who helped develop the Caucus of Gay, Lesbian and Bisexual Members of the American Psychiatric Association and is a founder of Gay Psychiatrists of New York and New York Physicians for Human Rights, has also been a frequent spokesperson on television and in print for the gay community. In addition to these honors, two Special Recognition Awards for actions significantly contributing to the advancement of the lesbian and gay rights movement will be given to Jeanne Cordova of Los Angeles and Don Baker of Dallas. During the decade she published The Lesbian Tide, Cordova provided a sorely-needed voice for the lesbian community. She was a political force successfully pushing for a lesbian platform at the international Women's Year Conference in Houston. More recently, she has written for a variety of publications including Gay Community News, The Advocate, Update, Frontiers and Off Our Backs. Baker is the former Dallas school teacher who was plaintiff in the successful suit to strike down the Texas sodomy law. He headed the Dallas Gay Alliance for three terms. The awards to Cordova and Baker recognize their long standing commitment to gay and lesbian rights and their willingness to put themselves on the line to achieve those rights.

The Awards Dinner will be held at the La Jolla Village Inn in San Diego, Saturday, November 26, 7:30 pm. Tickets are $25, with all proceeds earmarked for the GAU National Scholarship program. Reservations must be made in advance; tickets will not be available at the door. For more information: GAU Awards Dinner, PO Box 82123, San Diego, CA 92138.

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HOUSTON'S DRYDEN CLINIC OPENS

One of Houston's first privately, physician owned screeding & diagnostic clinics, The Dryden Clinic, Inc., designed to address the growing health problem of AIDS, and what is thought to be related, sexually transmitted diseases, has opened its new facility September 1, 1983. In addition to being a full service clinic for STDs, The Dryden Clinic performs complete clinical examinations and laboratory testing for the early detection of AIDS. The Clinic, under the supervision of Dr. Maria A. Scouros, MD, Medical Director, feels that early detection of AIDS, and appropriate measures taken for those persons diagnosed with AIDS, may reduce the morbidity and mortality of this deadly disease constellation. As an immunologist and oncologist, Dr. Scouros is presently assistant professor of internal medicine at the University ofTexas Medical Center. She was previously associated with MD Anderson Hospital in the Departments of Clinical Immunology and Biological Therapy and is experienced in treating AIDS patients in conjunction with the Cancer Prevention Department of Anderson. Additionally, Dr. Scouros is a member of the Houston Health Department's AIDS Working Group. Mr. Frank J. Berrier has also assumed the position of Administrative Director and STD clinician. He was previously Executive Director of The Montrose Clinic, and is especially knowledgeable about STDs and the concerns of the Montrose community. The Dryden Clinic will be able to provide AIDS screening at very reasonable rates, most of which is insurance reimburseable, due to a relationship with Immu-Test Laboratories, Inc. Those persons concerned with STDs or AIDS can make an appointment by phoning the Clinic at 713/795-0385. For more information, contact Frank Berrier, Jr., The Dryden Clinic, 1709 Dryden, Suite 1002, Houston, TX 77030.

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ANTI-GAY/LESBIAN VIOLENCE MONITORED BY NGTF

The National Gay Task Force (NGTF) reports that in the first eight months of 1983, 1682 incidents of harassment, threats, and attacks against lesbians and gay men were reported to its Violence Project. Documented by the NGTF Crisisline and twelve local vilence projects from across the country, these incidents will be included in NGTF's first annual audit of anti-gay/lesbian vilence, scheduled for publication early in 1984. During this same period, the gay community was hit by the first wave of vilence attributed to "AIDS backlash." According to San Francisco's Community United Against Violence (CUAV), fear and hatred associated with AIDS was a motivating factor in nearly 20% of all incidents reported this year. Seattle's Dorian Group also reports that gangs of youths seeking to beat up "plague-carrying faggots" were responsible for 22 brutal attacks this summer. In Northampton, in centeral Massachusetts, homophobic assailants have laid siege to the town's sizable lesbian community. According to Northampton's Gay and Lesbian Activists (GALA), over the past year lesbians were singled out for sexual assaulets and other physical attacks; lesbian-identified establishments were vandalized, and hundreds of phone threats and other verbal harassment against lesbians were reported. Ginny Apuzzo, Executive Director of the NGTF commented, "As our communities havebecome more visible, so have the numbers of those who ant to bludgeon us back into the closet. NGTF's Violence Project and other local efforts are working to make being openly gay or lesbian safe--by documenting homophobic crimes, by demanding that the criminal justice system hold perpetrators accountable, and by responding to the needs of survivors." Of the incidents reported to NGTF thus far, 57% are verbal harassment /intimidation, 28% are physical assaults (including sexual assaults and attacks with weapons), and 1% are homicides. 4% are incidents of arson or vandalism against the property of lesbian/ gay people, and 10% are other types of crimes not yet classified. Of all incidents reported, 7% involved police harassment or brutality. According to Kevin Berrill, Director of the Violence Project, "These figures represent oly a small fraction of the total number of incidents that actually occured during this period. The great majority of lesbian and gay victims do not report attacks against them, and far too many still suffer the aftermath in silence and isolation. Nevertheless, these statistics are an important step forward in our effort to document the extent of anti-lesbian/gay violence. They are the product of close ties and increased cooperation between local anti-violence projects and the NGTF, and will enable us to educate the police, the criminal justice system, victim service agencies, legislators, and the public about this problem and how to address it." NGTF's audit of anti-gay/lesbian vilence will provide a detailed breakdown of all incidents reported in 1983, and will include incidents reported in the press, as well as those documented by the Crisisline and local anti-violence projects. Anyone who sees articles about incidents of homophobic violence are encouraged to clip and send them to NGTF.

NGTF urges all victims of anti-gay/lesbian harassment or violence to make a report to their local violence projects. Those without a violence project in their community, or those wanting to learn of the nearest project, should contact the NGTF's toll-free Crisisline at 800/221-7044 (in New York, Alaska, and Hawaii only, call 212/807-6016). The Crisisline is open Monday-Friday, 3-9 pm, Eastern time. Specially trained Crisisline staffers will take a confidential report and refer callers to local support services.

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UPDATE: FEDERATION OF AIDS RELATED ORGANIZATIONS MEETS IN NEW YORK

by John Kopchak and Caitlin Ryan, AID Atlanta

The Steering Committee of the Federation of AIDS Related Organizations (FARO) met in New York City, August 13-14 to follow-through on plans initiated at the Second National AIDS Forum in Denver, June, 1983. The Federation, which has now grown to 54 members, was represented by 14 local and national organizations, to outline structure, purpose and implementation of the two agreed upon tasks: formation of a Lobby Project and a Resource Clearinghouse for storage and dissemination of information. It was decided that no additional projects would be undertaken at this time. In response to concerns over establishing yet another megaorganization, and thus duplicating efforts, the Steering Committee affirmed its original concerpt of interacting as a federation, of loosely connected national and local organizations who will share information, resources and skills and whenever possible, link up with existing organizations to accomplish our mutual goals. It was further decided that the Federation would not attempt to speak for its members, and would issue no policy statements other than on issues of federal funding. Regional representation by members of the Steering Committee, which was a factor in the selection of that Committee, was examined with a view to including the entire country and making certain that each representative on the Steering Committee network within their regions for input and information sharing. With that in mind, the composition of the Steering Committee wil be reconsidered by a task force charged with preparing a study of regional distribution of AIDS cases, AIDS organizations and specific needs. Results of this study will be presented at the next meeting of the Steering Committee and voted on accordingly.

The Lobby Project reported that health lobbyist Gerald Connor had been hired on a consultant basis to act on behalf of the Federation and its member organizations in lobbying Congress for substantial increases in funding for AIDS research. It was decided that it would be more economical to hire Mr. Connor as a consultant rather than hiring a full-time lobbyist and staff at this time, especially since we would have minimal impact on the appropriations for fiscal year 1984. Mr. Connor will work closely toward our goal of raising $100 million for AIDS research with representatives from the National Gay Task Force and Gay Rights National Lobby. The Resource Clearinghouse, staffed by Ron Vachon, Executive Director of the National Gay Health Education Foundation in New York, presented a report on proposed structure, budget and rapid exchange of information. It was decided to continue with Mr. Vachon as director and to re-involve the original resource committee (established at the Denver AIDS Forum) in developing concepts for the structure, budgeting, and implementation of the Resource Clearinghouse. A national resource directory will be available, in draft for the next Steering Committee meeting, along with further ideas on how the Clearinghouse can best meet our needs. Representatives from the National Gay Health Education Foundation, the National Gay Task Force, and volunteers at the Gay Men's Health Crisis of New York will participate in developing this project. The Directory will include but not be limited to, educational materials, research, legislation, people with AIDS/networking, funding & fundraising, and will be updated quarterly. If your agency/organization is interested in being listed in the Resource Directory, write to Ron for copies of the organization information & project abstract sheets: Ron Vachon, FARO/RCH, 506 W. 42nd St., #E5, New York, NY 10036 (212/563-6313).

Original goals of gender parity (equal representation of women and men) as well as a consideration of providing financial support for members on the Steering Committee from People With AIDS and a representative from the Women's AIDS Network, were re-evaluated and supported by a majority of all members. A concept for coordinating FARO's Steering Committee evolved from election of Co-chairpersons Matt Redman (Los Angeles) and Bernice Goodman (New York), to development of a five-member Coordinating Committee with representatives from the two projects and from People With AIDS. This five member committee will meet in addition to general meetings of the Steering Committee and will facilitate development of ideas and accomplishment of tasks. In accordance with this concept, Paul Popham (New York) was elected Lobby Project Committee Chair and Caitlin Ryan (Atlanta) was elected Resource Clearinghouse Committee Chair. A representative from People With AIDS will also be elected to this Committee from that organization. The next scheduled meeting of the full Steering Committee is November 11-13 in San Francisco. We would like to encourage your participation by providing us with your suggestions/feedback/ideas. We will be sending informational updates whenever new developments occur. Please let us know of other individuals or organizations who would like to be added to our mailing list, and please let us hear form you. Write: Caitlin Ryan or John Kopchak, AIDS Atlanta, 1801 Piedmont Rd., Atlanta, GA 30324 (404/892-2459. ***** ***** *****

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NGTF DISCUSSES MEDICAID ELIGIBILITY RULES WITH ADMINISTRATION OFFICIALS

National Gay Task Force Executive Director Virginia M. Apuzzo, in a meeting October 18th with top federal Medicare and Medicaid officials, called on the Reagan Administration to address "some of the systemic problems with out nation's health care programs that our experience with the AIDS crisis has underscored so dramatically." Apuzzo, joined by Jay Lipner, special counsel to the Gay Men's Health Crisis, and Jeffrey Levi, Washington representative of NGTF, met with Dr. Carolyne Davis, Administrator of the Health Care Financing Administration (HCFA), Dr. Donald Young, Deputy Director of HCFA's Policy Bureau, and Dennis Siebert from the HCFA Office of Public Affairs. The representatives of the gay/lesbian community identified three major areas of concern relating to Medicare and Medicaid and the AIDS crisis. They were problems in entitlement education--letting individuals know what federal and state health assistance benefits are available to them; coverage of experimental treatments for AIDS under Medicare and Medicaid; and the huge fiscal burden placed on public hospitals in cities with large numbers of AIDS cases.

Lipner told the HCFA officials that there is a "massive sense of confusion" regarding what benefits people with AIDS are entitled to. For example, applicants for disability under Social Security are not told that they may be eligible for Medicaid immediately, and thus wait unnecessarily long periods of time before becoming part of that program. Because AIDS can be a fast-moving illness, speedy access to programs is necessary or important treatments might be postponed. "We cannot grant health retroactively," Lipner declared. Davis committed herself to discussions on this issue with the Social Security Administration and the state directors of Medicaid, who actually implement the Medicaid program. Apuzzo stressed that "we are not asking for special treatment or special benefits; we are asking that a mechanism be put in place that improves communication for all potential beneficiaries." Recipients of Supplemental Security are entitled, after two years, to benefits under the Medicare program. Not all medical expenses are automatically covered under Medicare, particularly experimental methods. Medicare coverage standards are often used as the basis for Medicaid regulations in the various states as well. One of the questions raised was whether Medicare, and ultimately Medicaid programs, would cover some of the new methods being used to treat AIDS. Young committed HCFA to reviewing on an expedited basis any experimental treatments related to AIDS, such as plasmapharesis, which are not currently covered by Medicare. The fiscal burden that the AIDS crisis has placed on public hospitals "begs for attention from the federal government," Apuzzo said. She and the other community representatives urged the Administration to give favorable consideration to Congressman Ted Weiss' Public Health Emergency Prevention and Treatment Fund proposal, which would set aside funds to be granted to states and localities faced with unexpected costs related to a public health emergency such as AIDS.

Apuzzo described the meeting "as an opening round in bringing to the government's attention our concerns regarding health care costs. We hope this Administration's interest in all aspects of the AIDS crisis will result in some fundamental changes in how our health care system deals with ehalth emergencies and educates the public about programs to which they are entitled."

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AIDS EPIDEMIOLOGY & SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of October 24, 1983, the Centers for Disease Control AIDS Activity reports a total of 2577 United States cases of AIDS (CDC definition), and 156 foreign cases from 21 different countries voluntarily reported to the CDC. Homosexually active men account for 71.6% of the cases; 16.9% from IV drug users; 4.9% from Haitians; 0.6% from hemophiliacs; and 6.0% in no apparent risk group or unknown/unidentified.22.2% are from individuals aged 20-29; 46.4% from ages 30-39; 21.7% from ages 40-49; 8.9% from ages 50 and over, and the remainder are in all other age groups. 57.7% of the individuals are white; 26.0% are black; 14.1% are hispanic; 2.2% are others/ unknown. 44 states (including Washington, DC and Puerto Rico) have reported cases; New York state has 45.2%, California--22.3%; Florida--7.0%, New Jersey--6.2%; Texas--3.1%; Illinois & Pennsylvania--1.8% each; all other states account for less than 1.5% 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.)

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LAMBDA LEGAL DEFENSE TACKLES AIDS DISCRIMINATION

Lambda Legal Defense and Education Fund, Inc., Professor Arthur Leonard of New York Law School (representing the complainant), the New York City Commission on Human Rights and a major New York City employer have resolved a case in which an anonymous complainant had charged the employer with discrimination on account of AIDS in violation of the City's Human Rights Law.

The complainant, a young man with some symptoms which have been linked to the Acquired Immune Deficiency Syndrome, was initially denied employment. The employer reviewed the current state of medical knowledge about AIDS and the medical history of the job applicant as a result of the charge being filed, and determined that his employment would be appropriate. As a result of its study of the problem, the employer has determined that job applicants or current employees with symptoms of AIDS will be dealt with on a case by case basis, with the factor of AIDS considered only as relevant to the ability of the individual to perform his or her hob consistent with the health and safety of the employer's workforce. The complainant, who has now been hired by the employer, has withdrawn the charges and the matter has been closed to the satisfaction of all parties. Related charges filed by Lambda Legal Defense Fund on behalf of the complainant with the Department of Labor's office of Federal Contract Compliance Programs will also be withdrawn as part of the settlement of the case.

Lambda Legal Defense and Education Fund is expressly concerned with fighting discrimination against lesbians and gay men through litigation and public education. For more information, contact: 132 W. 43 St., New York, NY 10036 (212/944-9488).

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NATIONAL CANCER INSTITUTE SEEKS AIDS RESEARCH COLLABORATORS

In an August 22, 1983 letter to Neil Schram, MD, President of the American Association of Physicians for Human Rights (AAPHR), Dr. James Goedert, MD, Environmental Epidemiology Branch of the National Cancer Institute proposes two collaborative AIDS studies. The first would be a case-control study of gay men with AIDS and matched gay controls; the second would be a national study of a large cohort of gay men (perhaps 10,000 subjects) that would be followed up in 1-2 years. In this large cohort study, the serum will be banked pending development of an "AIDS antibody" test. When such a test is available, we will be able to determine risk factors and rates for seroconversion and for clinical illness, as well as incubation periods, carrier states, and the like. Given that many gay men in New York City, San Francisco, and Los Angeles may already be seropositive, collaborating physicians would be particularly needed from the rest of the country. We are hoping that 100 physicians will each contribute 100 patients. The feasibility of these studies, which would try to avoid the biases of earlier studies, depends on the cooperation of these collaborating physicians, particularly those in clinical practice with predominately gay patients. As a first step, I would like to poll prospective collaborators on the following 4 questions:

1) How many of your gay patients have had CDC-definition AIDS (KS, PCP, or other life-threatening opportunistic infections?
2) Would you give us permission to interview and draw blood from all new AIDS cases* [see note below] and matched healthy gay control patients* from your practice? You would have to notify us of the case via an "800" toll-free number. [ED NOTE: Perhaps more importantly, does the patient give his permission to be interviewed by someone from NCI?]
3) Would you distribute questionnaires to and draw blood (serum) from 100 basically healthy gay patients*, if we supplied all the materials and postage?
4) What city are you in?

*NOTE: We would need the identities of the subjects in the case-control study (question 2) and in the cohort study (question 3). In the case-control study, each subject would have a face-to-face standardized interview with an experienced interviewer trained specifically for this study. In the cohort study, the person's identity is the only way to be certain of locating him for follow-up after 1-2 years. These identities would be held in strictest confidence. They are protected by the Federal Privacy Act and are not susceptible to investigations by other Federal agencies. [ED NOTE: How many of you really believe that?] In spite of

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NATIONAL CANCER INSTITUTE SEEKS COLLABORATORS, Continued

these protections, some patients will not want to participate. Given the excellent cooperation of gay men to out earlier studies, however, I expect that many patients will be eager to participate.

The most direct way to poll potential collaborators is to request that anyone wishing to participate should call Pat White at 800/638-8985, 9 am-11 pm (EST) weekdays, 10 am-6 pm Saturdays, and 2-10 pm Sundays and record answers to the above 4 questions. In addition, I would be happy to discus our AIDS research with any potential collaborator. My number is 301/496-4375 [for Dr. James Goedert, MD]. Thank you for your interest and help, and please let me know if you have any insights or suggestions on AIDS research. Astute clinicians often provide us with valuable etiologic clues.

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NIH AWARDS FUNDS FOR STUDY OF EPIDEMIOLOGY & NATURAL HISTORY OF AIDS

The National Institutes of Health announced the recipients of much coveted grant monies for the 4 year longitudinal study of the epidemiology and natural history of AIDS in gay men. Over 210 requests for proposals (RFPs) were sent by the NIH; 25 proposals were received, and 5 grants were awarded: University of California--Los Angeles ($2,692,812), University of Pittsburgh ($4,362,906), Chicago's Howard Brown Memorial Clinic ($2,971,652), Baltimore's Johns Hopkins Medical Center ($2,323,461) and University of California--Berkeley ($2,979,870). Proposals from the Wisconsin Division of Health, Yale University, Boston's Fenway Clinic, the University of Washington in Seattle, University of Toronto, and the National Jewish Hospital in Denver were rated highly, but were not funded due to the lack of funding.

Howard Brown's Executive Director Harley McMillen noted that gay men have "a life and death stake" in AIDS research, and commented that the award would help place the Clinic "at the very forefront of AIDS research." The award is the largest grant ever made to a gay organization by a government institution. The study in Chicago will focus on some 1000 homosexually active men who fall into four risk groups for AIDS: those who have no AIDS-related symptoms (low risk); those who have one or more such symptoms (high risk); those who have actually been diagnosed as having one of the opportunistic infections associated with AIDS (patients); and those who are sexual partners of or live with AIDS patients. All 1000 men will be tested every four months, said HBMC Research Director Dr. David G. Ostrow, MD, PhD, and detailed medical histories of the men will be kept. The research will be done in conjunction with the Northwestern University Medical School, which will provide immunologic testing and statistical and data management support.

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"BENEFIT FOR AIDS"--EXACTLY WHERE IS YOUR MONEY GOING?

from Florida Keys Memorial Hospital AIDS Newsletter

Benefit for AIDS? Great! But where are the funds going? You may have ssen posters advertising numerous benefits for AIDS. Frequently however, they fail to tell you where the funds are going. Be sure to ask: Are they going for screenings? Education & Information? Direct patient use? Research? Other support services? Will the money collected be used for local or state or national projects, or will it be used elsewhere? You have a right to know how and where those funds will be used. And by all means, support the benefit!

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SEATTLE AIDS PROJECT UNDERWAY

by John Gliessman, excerpted from Staff Notes, Seattle Gay Clinic

A program of major importance for the Seattle gay community was inaugurated in August, 1983. The AIDS Assessment, Education, and Surveillance Project was mandated by the Seattle City and King County councils as part of their combined fiscal provision for AIDS research, relief, and education. The staff include Dr. Steve Helgerson (formerly of the CDC, where he worked on Toxic Shock Syndrome and Legionnaires Disease) who has been receiving an intensive education in gay sensitivities and sensibilities, and Will Jones, a gay health activist who has been involved in the Seattle Gay Men's Health Group, and who prior to the setup of the AIDS Project, was a volunteer helping to coordinate an unofficial and somewhat chaotic information bank on the local AIDS situation. What makes this particular AIDS program especially important is that it will be the one single place in Seattle which is completely devoted to providing AIDS information, serving as a crisis line, performing physical examinations & evaluations, and making medical referrals (including those of psychological counseling) for anyone, gay or otherwise, who is curious, concerned, or scared a deep shade of pistachio about AIDS (other shades ok too!). The Project will also perform a research function. The Project is open from 8am-5pm weekdays. Its information services are free, but the physical assessment, because of time and material costs, will bear a charge of approximately $24. This fee will be assessed on a sliding scale based on ability to pay--no one will be refused services because of finances. For more information, contact: The AIDS Project, 14th Floor, 1200 Public Safety Bldg., Seattle, WA 98104, 206/587-4999.

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AIDS PATIENTS SEEKING ALTERNATIVE TREATMENTS

excerpted with thanks from Medical World News (8/22/83)

As researchers continue searching for the cause and effective treatment for AIDS, some anxious patients have begun turning to alternate therapies. These patients have found a growing marketplace of unconventional--and sometimes questionable--treatments.

*Acupuncture and/or Oriental herbs are being used in several cities to relieve AIDS-related symptoms, and at least one practitioner claims he may be capable of bringing the disease into remission. San Diego acupuncturist K.C. Chan offers free treatment to AIDS patients. He suggested in a recent press release that acupuncture might cause remission, citing findings of a New York physician/acupuncturist as evidence. But that physician, Dr. Michael O. Smith, denies claiming the technique could cause AIDS remission. "I've treated about 20 AIDS patients with acupuncture. Symptoms like night sweats, fatigue, diarrhea, and moderate shortness of breath are often helped quite a bit. Most of our AIDS patients feel more energy and feel more comfortable. But I'd be the last to say that, in an unknown, serious condition that is so highly unpredeictable, you could ever claim remission. Smith is head of the Acupuncture Research Division at New York's Lincoln Hospital. Chan, who says he was trained as a physician in China, said that a misunderstanding led him to use Smith's name. But he added, "Acupuncture has been very successful in treating immune disorders like asthma, allergic rhinitis, and lupus. So theoretically, I think we should be able to bring remission to AIDS. But we won't know until we test it." Acupuncture is being used for symptomatic relief in Chicago, Boston, Birmingham, and New York, and probably in other major cities.

*Nutritional therapy--probably the most popular alternative treatment for AIDS--is being offered by some holistic physicians and chiropractors, and most often includes megadoses of vitamins. Ads in gay-oriented newspapers promote expensive, mail-order vitamin supplements, purportedly designed to strengthen the immune system. A number of people with AIDS have sought vitamin therapy at holistic health centers. Dr. Richard Kunin, a board-certified San Francisco psychiatrist who describes himself as an "orthomolecular physician," says he is "researching very carefully" the potential use of vitamins in AIDS. "Recent medical literature indicates that many nutrients support the immune function. Chief among them are vitamins A, B-12, folic acid, and zinc. But specifically for AIDS, it is too soon to know." Dr. Bruce Osher, co-chairman of the medical advisory committee of the AIDS Project/Los Angeles, noted that some AIDS patients are foresaking orthodox treatment entirely in favor of nutritional therapies. "There is an apparent risk of teh disease's worsening if it is not being treated conventionally."

*Some people with AIDS have traveled to Mexico and Central America for unconventional drug treatments, including Laetrile. Others are being treated with Mexican folk remedies. One patient went to Guatemala for a series of polyvalent vaccines with no results whatsoever.

(CONTINUED)

AIDS PATIENTS SEEKING ALTERNATIVE TREATMENTS, Continued

*Stress-reduction techniques, hair analysis, visualization, and cytotoxic testing have been advertised in gay-oriented newspapers as AIDS treatments or preventive measures.

*A federal court injunction has temporarily halted mail solicitation for a vaccine purported to cure or prevent AIDS. Ads in gay-oriented newspapers by the promoters of the "Reticuloendothelial Vaccine (REV Treatment)" appear to have capitalized on the current hysteria over AIDS, according to assistant US attorney Roger E. West. A $1900 fee was being charged for the series of immunizations, administered at unidentified sites in La Paz, Mexico, and in West Germany. Literature produced by David Blanco and Gene Parcesepe, whose company promoted the treatment, describes the serum vaccine as human antibodies drawn from the spleen, bone marrow, and thymus. These antibodies, according the the company's handouts, are injected into rabbits until the animal's immune system responds by producing a high level of its own antibodies to combat the invading antigens. Several weeks later, blood is drawn from the animal and only the antibodies developed by the animal against the degeneration of the human tissue and which are able to stimulate and normalize the human reticulo-endothelial system are preserved and later injected into the patient. Dr. William Klaustermeyer, chief of allergy & immunology at UCLA, contends that many of the claims about the vaccine have no validity and are "impossible at our present state of knowledge." In a statement submitted to the federal court, he called the therapy hazardous and said it could result in an anaphylactic or serum-sickness reaction.

"The entrepreneurs are certainly out there," warns Dr. Martin D. Finn, medical director of public health programs for the Los Angeles County Department of Health Services. Most AIDS patients continue to rely on traditional treatments, according to Bill Cunningham, coordinator of the AIDS Project at the San Francisco Department of Public Health. The San Francisco Health Department has published a list of alternative therapies available in the city, as part of the booklet "AIDS: A Screening Protocol and Resource and Referral List." The 47 page handbook, designed primarily for health professionals, lists Bay Area practitioners offering acupuncture, vitamin and nutritional therapy, amino-acid therapy, and psychic healing. Dr. Neil Schram, president of the American Association of Physicians for Human Rights, is disturbed but not really surprised by the emergence of these alternative therapies. "It seems to happen with every disease that is perceived as incurable. Some people are out there capitalizin on the situation, while others are lookinf for hope that they haven't found anywhere else."

* * *

BLOOD FROM AIDS DONORS NOT TO BE RECALLED

excerpted with thanks from Medical World News (8/22/83)

A federal advisory committee meeting here has recommended against setting guidelines for a mandatory recall of blood products found to contain components from an AIDS victim. The FDA's Blood Products Advisory Committee took its action despite the National Hemophilia Foundation's strong plea for recall guidelines. Calling a special meeting, the committee had requested recommendations from representatives of clotting factor manufacturers, the NHF, the CDC, and the NIH. In the deliberations that followed, committee members generally agreed that any government action now would cause unnecessary fear and jeopardize the supply of clotting factor that 15,000 hemophiliacs in the US need to survive. Dr. Stephen Ojala from Cutter Labs of Emeryville, CA noted, "We must keep the life-sustaining properties of this product in mind, not just the uncertain dangers." The manufacturer representatives reported that as many as 20,000 donations make up the plasma pools that are teh starting point for isolating factor VIII and that several hundred hemophiliacs may receive the factor from each pool. And, because commercial plasma donors tend to give blood repeatedly, one AIDS patient's blood could show up in as many as 50 pools. If this worst case happened just once to each of the four US manufacturers of clotting factor, the equivalent of one year's production of factor would be lost. Instead of establishing recall guidelines, the manufacturers recommended continuing donor education and screening programs they instituted this past winter. These programs have forced the rejection of very few donors and have kept most high-risk individuals away from the donor clinics. The companies are in the process of adding cervical lymph node palpation for lymphadenopathy, a possible precursor of AIDS, to their donor screening criteria.

* * * * *

FLORIDA ALLEGEDLY "DUMPS" AIDS PATIENT

from press clippings

An outraged San Francisco Mayor Dianne Feinstein fired off an angry telegram to Florida Governor Bob Graham demanding an ivestigation of what San Francisco officials believe is a "blatant case" of "dumping" a critically-ill AIDS victim. The Florida Health Department reported that fear among medical personnel of getting AIDS may have caused the curious transfer of an AIDS patient from Gainesville to San Francisco. The patient who was hospitalized for almost three months in Florida for AIDS, was flown on a privately chartered Learjet and taken to the AIDS/KS Foundation, too weak to move his head; the patient was then taken to San Francisco General Hospital in poor, but stable condition. Representatives from Shands Hospital, which is a teaching facility of the University of Florida at Gainesville, vigorously denied charges that it "dumped" the patient, and were stunned at charges of "outrageous and inhumane" treatment. They sited "humanitarian" motives to make sure the patient received the best possible out-patient care, who they claimed did not need acute hospital care. Shands' social workers failed to locate a nursing home in Florida who would accept the victim. Florida's state health officer, Dr. Stephen King stated that the situation does merit an investigation, but added, "I would hope it's all a misunderstanding."

* * * *

MYSTERY GLYCOPROTEIN MAY BE LINKED TO AIDS

from Medical World News (10/10/83)

While looking for a potential disease marker in plasma proteins of AIDS patients, researchers at Newark's (NJ) St. Michael's Medical Center found elevated levels of a basic, but as yet unidentified glycoprotein in 16 patients. Elevated levels of the glycoprotein also appeared in one patient with prodromal symptoms of AIDS and in 18 hemophilia-A patients. The elevations weren't seen in plasma cyroprecipitates of normal controls or of patients with liver disease, cancer, or hemophilia B. Dr. Veena K. Dayal, director of St. Mike's thrombosis research laboratory, hasn't characterised the glycoprotein, but she and her associates have made progress in learning what the substance is not. They've rulled out fibrinogen, microglobulins, thymosin alpha-1, IgG, albumin, and proteins involved in coagulation. The researchers theorize that AIDS-induced biochemical changes are reflected in blood plasma and could constitute a marker for the disease.

* * *

DIGNITY MINISTERS TO PEOPLE WITH AIDS

Dignity/New York seeks your help in informing persons with AIDS, who may also be gay and Catholic, that an outreach group exists whixh is uniquely tailored to meet their spiritual and emotional needs. We feel that part of this ministry should be to encourage Catholics with AIDS to participate fully in the life of their church and their community. We will also refer those of other faiths to religious gays and lesbians of their own religions whenever possible. We believe that hospital and parish clergy generally tend to avoid visiting gay & lesbian patients in hospitals, especially those that have AIDS. We further believe that when pastoral visits are made, reservations on the part of the clergy, whether consciously or unconsciously expressed, contribute to the sense of absolute abandonment often experienced by persons with AIDS. We hope to help them overcome this sense of isolation with our spiritual support group. For more information, please contact us: Dignity/NY, Box 1554 FDR Station, New York, NY 10150.

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WOMEN AND AIDS

by Michael Helquist, excerpted with thanks, from the San Francisco Bay Guardian

As the epidemic of AIDS spreads, concern is growing aobut the incidence of the condition among women and whether women can spread it to men or other women through intimate contact. Although the federal Centers for Disease Control (CDC) has consistently maintained that AIDS is not casually contagious, little attention has thus far been focused on women who have contracted it or are at risk of contracting the immune system-disabling disease. Why has it taken so long for AIDS researchers to focus on women, almost 200 of which having already been diagnosed as having contracted AIDS? One obvious reason is the predominance of men among the first high risk groups to be identified. But Pat Norman, coordinator of lesbian/gay health concerns for San Francisco's Department of Public Health, believes much of the fault lies with the federal government for not providing adequate research funding to explore wider issues of AIDS transmissibility. "One result of the lack of federal funding has been insufficient research into how these women have contracted AIDS," she said. "Women don't know their risk factors are...." Concerns about the spread of AIDS to women has reached the point where a forum on the topic--the first in the nation--was held September 15th at the Women's Building in San Francisco. Sponsored by the Women's Building, the Women's AIDS Network, the Lyon-Martin Clinic, and the AIDS/KS Foundation, the forum attracted a standing-room-only crowd of 250 women and a handful of men to hear discussions of the disease itself, the politics of AIDS, donor insemination and the needs of people who have contracted AIDS.

The risks of possible donor insemination concerned a number of women at the forum, since, according to Diane Jones, staff nurse in the AIDS Special Care Unit at San Francisco General Hospital, there are hundreds of women in the Bay Area who have children or want to have children by donor insemination. Jones herself is a lesbian mother with a four-year-old child conceived by donor insemination. "There is a risk of contracting AIDS through donor insemination. Each woman has to consider the risk involved," she concluded.

In the Bay Area, many health and women's community and lesbian activists have organized to provide information, referrals and support to women concerned about AIDS. The AIDS/KS Foundation and the Women's AIDS Network (415/864-4376) will provide medical reports, news updates, referrals and general AIDS-related information. The Shanti Project (415/558-9644) and the Lyons-Martin Clinic (415/921-1234) offer counseling and medical services, as well as volunteer opportunities.

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"AIDS PLAY SAFE WEEK" IN HOUSTON

by Michael Wilson

The KS/AIDS Foundation of Houston has just finished "AIDS Play Safe Week," eight days of education, entertainment, and fund-raising. A packet of information sharing the concept, activities, brochures, and press coverage relating to the event, is available to fellow AIDS workers. Fliers, posters, and press kits were distributed. General information about AIDS, a special "AIDS Play Safe Week" brochure on "safe" sex, buttons, rubbers, and other items were distributed at event during the week and at area bars and businesses. The cooperation from the community was great and the acceptance of the concept was overwhelming. Each day's event was a success: Montrose Jam; People With AIDS Day; "Can We Talk?" production at a local disco; the philosophical psychology of "sex--the times, they are a-changin'," six city council members gave speeches at the "Politics of AIDS" meeting; laser education (safe sex advice flashed across the disco floor to the beat of "so many men..."); a private social for People With AIDS and their guests; a high-camp water ballet; box lunch auction; bartenders' swim relay race, and a candlelight prayer vigil. Something for everyone, and learning about AIDS was not so painful this time. Please write or call for further information:
1001 Westheimer, Suite 193, Houston, TX 77006, 713/524-2437.

* * *

STD/AIDS ANXIETY

by Wayne Dodge, MD, MPH, with thanks to Seattle Gay Clinic Staff Notes

SUBMITTED FOR YOUR APPROVAL...Gene C., age 28, a newly successful trial lawyer in our city, is getting ready to go to dinner with his lover of the past year, Mark M. As Gene straightens Mark's collar, he notices a prominent lump on the back of the young man's neck... Henry S., 36, the owner of the only known Pacific Northwest Gay Health Food Cruise Bar (happy hour--Perrier and carrot juice, ½ price) has just finished his daily 15 mile run. While drying himself off, he notices a slightly purplish spot on the side of his big toe.... These men are each about to enter an uncharted territory--"The Twilight Zone of an AIDS Attack."

What is an AIDS attack? It consists of the sudden fear and panic as you become certain that you or a loved one has AIDS. The attack usually occurs at 2 am of a Sunday morning the week that your doctor has gone on vacation. Some newly noticed symptom or sign that you know can be associated with AIDS--a cough, swollen glands, malaise, an odd-looking mark on your skin--triggers a throbbing uncertainty. Is THIS??? Could it BE??!?? This uncertainty quickly crystallizes--often thanks to some underlying, unresolved guilt ("I'm such a slut I deserve to get sick."), into a dread certainty that the unthinkable has happened ("I just KNOW I have IT.") This is the start of a full-blown AIDS Attack.

What are the symptoms of an AIDS attack? The heart rate increases dramatically, the palms start to sweat, breathing becomes rapid and shallow. Often there is nausea and tingling of the hands, feet, and lips, which may progress to major spasms. Overshadowing all of these physical symptoms, however, is the existential angst of the direct and acute threat of one's own mortality.

How is an AIDS attack treated? Liberal doses of understanding and knowledge are needed immediatedly. The person suffering an AIDS attack will be unable to function properly until his fear and anxiety can be diminished. An AIDS attack is, in fact, a medical emergency. Although the help of a knowledgeable physician or other practitioner may finally be required in some cases, attacks can often be handled by a well-informed lay-person. Just having someone around to listen to his fears can be extremely therapeutic for the anxiety victim. An AIDS attack often can be cured by simply answering the fearful questions that plague the sufferer. Ending the encounter with offers of further help is also important as AIDS attacks may recur. Unfortunately, not all medical providers know how to treat this kind of anxiety. In fact, physicians can cause an attack with unguarded statements ("How long have you had this unusual bluish spot in the middle of your back? Oh? Hmmmmmmmm.") or their own ignorance ("You have lymphadenopathy, which is a pre-AIDS condition. [period!]") Choose your source of medical care and information carefully, and do not be bashful about questioning your clinician's statements.

How can AIDS attacks be prevented? The best preventative is knowledge. Having the facts as currently known about AIDS and spreading that knowledge will be helpful both to you and your friends. Be careful, thouth, not to spread gossip & rumor ("Only those who use poppers get AIDS.") Good sources of up-to-date information include your local gay STD clinic or AIDS organization, and proven media sources such as The New York Native. Medical publications may be recommended for those with a technical bent. Specifically not recommended are most local newspapers, most weekly newsmagazines (since they have consistently played on the hysterical aspects of the problem and have not infrequently been factually incorrect in their reporting). The second best AIDS attack preventative is the knowledge that all AIDS symptoms are, by definition, persistent, and unexplained by other causes (e.g., smoking, diet, stomach flu, etc.). The cough you've had for the past week, the bluish spot you found on your foot after the soccer match, the diarrhea you've had since your return from Mexico, are overwhelmingly likely to be a viral or strep throat, a bruise, and turista. Concern need not be felt until these symptoms have persisted for an unusual length of time. Also recommended for AIDS attack prevention (or at least early treatment) is development of a strong support network between you and your friends. We all need at least one person whom we would feel comfortable calling at 3 am if we really needed to talk. Conversely each of us should be on tap for at least one other person. Such support and mutual caring can do more to prevent the ravages of AIDS anxiety than a hundred forums. * * * * *

SUGGESTIONS FOR BATHHOUSES: RISK REDUCTION & AWARENESS FOR AIDS

special thanks to AID Atlanta with apologies for "Ed Notes"

Display AIDS prevention materials in prominent places
Informational brochures on gay health, STDs, AIDS
Gay/lesbian health newsletters
"Can We Talk?" brochure from San Francisco or other similar brochures
Posters listing risk reduction information (AIDS/KS Foundation is printing colorful, erotic posters with this info: PO Box 14227, SF, CA 94114), including such information as:
Reduce your number of sexual partners
Shower between partners
Use condoms
Limit your use of recreational drugs
Don't share lubricants, douches, or toys

Have AIDS information hotline numbers clearly posted, local and national

Make condoms readily available for your patrons
It's best to give them away free, since more people will use them. The best condoms to use are Fourex since they're stronger and more sensitive [ED NOTE: Any "research" to verify that claim?!]. Buying in bulk cuts costs.

Have lots of clean towels & make clean sheets available

Have individual soap dispensoers in all bathrooms and showering areas. Shared soap may transmit diseases

Don't sell poppers. There is some indication that there may be a correlation between the inhalent nitrites and AIDS. This correlation has not been ruled out. [ED NOTE: Please see elsewhere in Newsletter, report of CDC study that does rule out poppers as a significant agent in the etiology of AIDS.]

Stock safer lubricants, such as water-based, [non-perfumed] lubricants. "Probe" and "Foreplay" are sold in individual packets throught the Pleasure Chest in New York City. (Pleasure Chest, 20 W. 20th St., New York, NY 10011, (212/242-4185).

Light up orgy rooms

Encourage socialization and social events
For example, some Atlanta baths used to host free cookouts one evening per week.
Experiment with new programs for group activities, such as:

condom night	jack off night
safe sex night	massage night
jock strap night	aerobic dance night

Give away "SAFE SEX" buttons with purchases or entrance fees [ED NOTE: false advertising?]

Sponsor VD Testing one evening per week

Have match books available in prominent places and cubicles, with AIDS prevention information on the outside and a place inside for patrons to write their partner's name & number [ED NOTE: promoting smoking, another unhealthy activity? Double message?]
Leave pencils or pens on a string in the cubicles.

Frequent cleaning of floors is highly recommended with strong germicide. Carpet can harbor germs--tile is much safer. Limit carpet to entrance area. [ED NOTE: what type of cleaner? Things that smell strong aren't necessarily better; also, there may be false assurance here; whatabout something that is viricidal? etc.]

(CONTINUED)

AN EVALUATION OF "AIDS APPREHENSION" AMONG NURSES & ITS EFFECTS ON PATIENT CARE

by Genevieve M. Clavreul, MS, MPA

[ED NOTE: The following is an abstract of a program presented at a National Clinical Nursing Conference on AIDS sponsored by the National Institutes of Health in Bethesda. The author is interested in finding other medical professionals working with people with AIDS who may be willing to help her distribute survey questionnaires. Please contact: Genevieve M. Clavreul, CCM Consultants, 4119 Los Feliz Blvd., #9, Los Angeles, CA 90027, or call 213/661-3936.]

Studies using survey and direct observation methods have revealed that nurses within all age groups and religious backgrounds feel some level of discomfort when treating openly gay patients (Nursing Life, 1983). Further research has suggested that nurses feel especially uncomfortable when administering care to identified AIDS patients--regardless of their sexual orientation (Clavreul, 1983). We propose that a) nurses at all levels of homophobia will express equal discomfort in administering care to identified AIDS patients; b) that the actual level of care given patients decreases proportionately with the discomfort level of the caregiver; and c) that patients themselves accurately subjectively perceive lowered care treatment. One hundred twenty nurses in the greater Los Angeles area constituted the sample; theme consisted of individuals of varying economic backgrounds, levels of education and sexual orientations. The sample was given a questionnaire providing for an index of homophobia. The same sample was then administered a questionnaire providing for an AIDS Apprehension level. For a two-month period, blind confederates observed the number of "non-required" visits nurses gave to both non-identified and identified AIDS patients. Finally, all the patients within the unit were given a questionnaire designed to produce a subjective measure of perceived quality of care given. The results suggest that there is a low correlation between level of homophobia and quality of care given; nurses at all homophobia levels reported an increased apprehension when working with AIDS-identified patients. Nurses with a higher level of AIDS apprehension tended to pay fewer "non-required" visits to identified AIDS patients. AIDS patients were more likely to report a subjective perception of decreased quality of care given than non-AIDS identified patients in a unit. Through the open-ended portions of the questionnaires given to nurses, factors such as "over-heard negative talk among health professionals regarding AIDS patients" and "adverse publicity generated by the news media" were linked to the decreased quality of patient care by apprehensive nursing personnel. No experiemntal manipulation was performed to test the validity of these potential explanations for the problem.

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HAITIAN AMBASSADOR RESPONDS TO AIDS CRISIS

with special thanks to James D'Eramo and the New York Native

The following letter appeared in the September 15, 1983 issue of the New England Journal of Medicine from the Haitian Ambassador to the United States, Fritz N. Cineas.

To the Editor: The Republic of Haiti has suffered a severe injustice over the past year in the American press. Countless broadcast and print journalists have related stories attributing the origins of the acquired immunodeficiency syndrome (AIDS) to Haitians, without sufficient factual data to support this theory. Recently, press reports have refelcted a shift in opinion about the origins of the disease. Unfortunately the new evidence often has been hidden on the inner pages, while damaging information about the alleged Haiti-AIDS connection has appeared in front-page stories of American newspapers and journals.

Haiti is already the victim of a negative image in the United States, exacerbated by the tendency of the media to ignore coverage of positive steps taken in Haiti toward liberalization and democratization. The volume of media stories relating Haitians and AIDS has cast a pall of gloom over the country, deterring potential business investors and tourists from venturing too near. The negative impact on our already distraught economy has been tremendous.

It is puzzling to contemplate the reasons for selecting Haiti as a target for origination of the dreaded AIDS problem. We sympathize with all AIDS sufferers and hope a cure will be found before hundreds more fall prey to this deadly menace. Haiti, however, has sufficient problems without being selected as a scapegoat for a mysterious ailment that has, sadly, descended largely upon the American homosexual community.

We, as a black nation, well understand the pains of world discrimination and trust that a free, democratic system like the United States would be particularly careful to ensure that its medical conclusions are based on objective, thoroughly researched conclusions and not on biased conjecture.

The time is well overdue for the record to be set straight regarding AIDS and the Haitian connection. I am sure responsible institutions like yours will uphold your admirable American tradition of unveiling the truth.

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SUGGESTIONS FOR BATHOUSES, Continued

Clean your pools and jacuzzis daily. Pools can breed bacteria. [ED NOTE: more chlorine?]
No sex in pools or jacuzzis. Hot, bubbly (aerated) water is a prime breeding ground for parasites

Hang display signs near pools and jacuzzis stating: Shower Beofre Entering

Thank you for your participation in helping to reduce the risk of AIDS [and other STDs!]
[ED NOTE: Many of the recommendations are taken from the Guidelines & Recommendations for Healthful Gay Sexual Activity brochure. See elsewhere in this Newsletter for more about the brochure.]

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STATEMENT FROM NORTHERN CALIFORNIA BATHHOUSE OWNERS--MAY 27, 1983

The "Baths" are a traditional social institution for the gay community. In response to the recent concern of possible new communicable diseases, we have begun a process of self-education in order to best serve ourselves and our patrons. We are now in dialog with medical/health professionals, and gay, lesbian & bi-sexual community leaders to learn the most effective ways to positively deal with this highly charged situation. With this information, we hope to address the psychological, physical and emotional needs of ourselves and our patrons. We call upon other business, social and political groups to be active and concerned in looking after their respective members. We call upon the media to act responsibly in this sensitive and complex issue; and ask that the media become aware of the possible dire consequences that irresponsible reporting can have on our community. Only through responsible concerted and cooperative action from all segments of our community can we best combat and eventually defeat this most serious threat. [ED NOTE: curious that "AIDS" isn't mentioned by name!]

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CLUB MILWAUKEE BATHS ACTIVELY SUPPORTS GAY HEALTH

Change is certainly a part of life, and Club Milwaukee is integrating change as part of its profile. Health issues and social responsibilities have caused us to reevaluate the Club and its responsibilities to the community and you. We are attuned to the issues of health and sexuality, and feel it is time to address these issues and not skirt them as something that will go away. This fall, the Club will be offering new programs designed to increase the fitness and health awareness of its members. We hope that you will join with us as we begin to develop a greater sense of self-discipline in ourselves. Aerobic dance classes will be offered three times weekly; anaerobic workouts, i.e., workout with equipment, is encouraged with the addition of new equipment and expanded space; talk nights with a discussion topic--reduced rates if you hold a membership card for any gay/lesbian non-profit organization; VD testing continues to be offered several times monthly (as it has since 1974 at the Club and its predecessors). The rental fee that you pay for a room or locker will be donated to the gay clinic for each person tested at the Club; in addition, the patron will receive a free pass for a future visit to the Club whenever tested. The Club supports the institutions serving our community and encourages its members to take responsibility for their own health. A new overtime policy will be in effect soon. For each hour that members stay beyond the initial 8 hour period, there will be an additional $1/hour charge that will be donated to the gay clinic. In addition, for each hour overtime, the patron will receive a ticket good for a weekly prize drawing.

[If your community has novel ways of dealing with the AIDS crisis, or with dealing with the generic problem of STD/gay health education, awareness, risk reduction, etc., please send them in: NCGSTDS, PO Box 239, Milwaukee, WI 53201.]

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CONFIDENTIALITY AGREEMENT

In consideration of the furnishing of the requested information by _____ [insert name of participant] (hereinafter referred to as the participant) and the voluntary participation of the participant in this program, the undersigned (if a corporation insert "or any of its employees, agents, officers, or directors") _____ [insert name of the undersigned] hereby convenants and agrees that it will not distribute, release, or otherwise disclose the name, address, telephone number, Social Security number, or any other information (hereinafter referred to as "identifying information") which could specifically identify the participant to any other individual, institution, organization, association, governmental agency, or other entity without prior written notice to the participant at your last known address without first obtaining written consent of the participant.

In the event the undersigned is compelled under penalty of law to release any such identifying data to a third party for whatever reason, written notice will be given to the participant at least sixty (60) days prior to the release of that information. In such event, the participant will be entitled to exercise whatever rights the undersigned has to the identifying information so as to prevent the dissemination of that identifying information to any third party, including but not limited to the right to demand that the information be returned to the participant as well as the right to seek legal redress to contest the release of that information to a third party.

This agreement does not in any way inhibit or abridge the rights of the undersigned to disseminate purely scientific and/or research data which is not otherwise specifically identified with the participant to interested third parties. This agreement will continue in full force and effect so long as all identifying information is in the possession, custody, or control of the undersigned.

_____

[Signature of Participant]

_____

[Signature of Researcher or Institution]

Witness:

_____

or

Acknowledgement:

On the _____ day of _____, 19____, before me came _____, to me personally known, who, being by me duly sworn did depose and say that he resides at _____ in the City of _____, County of _____, State of _____; that he is the _____ of _____, the corporation described herein and which executed the foregoing instrument; that he knows the seal of said corporation; that the seal affixed to the foregoing instrument is such corporate seal; that it was so affixed by order of the board of directors of such corporation, and that he signed his name thereto by like order.

Sworn to before me this _____ day of _____, 19____.

_____

Notary Public

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HOUSTON'S KS/AIDS FOUNDATION PRODUCES ILLUSTRATED AIDS BROCHURE

As part of their "AIDS Play Safe Week," September 18-25, 1983, the KS/AIDS Foundation of Houston, Inc., distributed two brochures. The first, in standard (3½ x 8½ inch) format, deals with "AIDS--A Realistic Discussion of a Serious Health Problem" in a straight-forward way. The second carries the "sexually explicit material" warning and features a cast of animal caricatures engaged in various safe physical and sexual intimacies with written advice on risk reduction. Some may not appreciate the animal analogies, but the point seems clear--you can do something about AIDS. For more information, contact: KS/AIDS Foundation of Houston, 1001 Westheimer, Suite 193, Houston, TX 77006, or call 713/524-AIDS.

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Who Knows What About Us?

by Chris Collins, Tim Sweeney, John Boring, Michael Callen, Dave Nimmons and Keith Lawrence

"Active surveillance." Before AIDS, these two words would have struck terror into the heart of the gay community. Yet after years of maintaining that government has no place in our bedrooms, some gay people are now demanding that the federal government undertake a massive epidemiologic examination of urban gay male lifestyles. Never before have so many gay men so willingly offered so much information about themselves and their lifestyles to government and private researchers.

What is happening to this information? What is the potential for its misuse? Should we allow government agents (rather than private institutions) to conduct these epidemiologic surveys? Is it really necessary for the advancement of research that subjects provide their name, address, phone number, and Social Security number? And if so, what can be done to ensure the confidentiality of this personal identifying information?

We must always remain aware of the political context in which AIDS research is occurring. We are inviting into our lives a government which does not recognize our fundamental rights to be free from discrimination on the job or in housing or our right to love whom we choose. The spectre of quarantine continually raises its ugly head. Already the federal government, through the Department of Health and Human Services, is, in effect, quarantining blood donated by most of the male homosexual population. And conservatives such as Patrick Buchanan are now demanding that all gay persons who handle food, work in health care, or work around children be fired—simply for being members of a group which is at higher risk for acquired immune deficiency syndrome.

While it is clear that research into the causes of AIDS must proceed quickly, we cannot forget the long history in this country of the misuse of information gathered by governmental agencies. We must recognize that the Reagan administration has instituted what may be the largest single campaign of centralized computer monitoring of private citizens in America's history.

Despite this ominous context, the federal Centers for Disease Control and the New York City Department of Health—with the encouragement of some gay people—are presently attempting to reinstitute "active surveillance" for all reported AIDS cases in New York City.

Unfortunately, it is not difficult to imagine scenarios in which a conflict of interest might exist between their role as researchers and their role as government agents. For example, the CDC has devised a lengthy and detailed questionnaire for AIDS patients which, in addition to asking patients to admit to sexual practices which are illegal in a number of states, also asks subjects to admit to the use of illegal drugs.

Suppose the FBI or the Drug Enforcement Administration were investigating drug trafficking and demanded information from the Centers for Disease Control on drug use by gay men, Haitians, and intravenous drug abusers. Can we be certain that the CDC would not share this information? Would subjects even be notified that the FBI had requested this information? If so, would the subjects be able to stop one agency of the federal government from providing information to another?

Consider a case recently confronted by the newly formed Confidentiality Sub-committee of the New York City AIDS Network. Over the past five years, with the cooperation of New York's gay community, the New York Blood Center conducted screening trials which eventually led to the development of the hepatitis B vaccine. Although this study has been completed, it appears that the Blood Center has retained the computerized information which it amassed on over 11,000 participants.

The CDC recently requested that the Blood Center turn over these files so that the federal agency could determine how many of these gay men have gone on to develop AIDS. In the end, the CDC instead turned over its list of AIDS patients to the Blood Center. Although this action may be a violation of federal law, the apparent justification for this astounding breach of confidentiality was that a comparison of lists would be useful in determining any possible correlation between hepatitis B and AIDS. Whether or not this is so, the case raises a number of important questions. If the CDC is willing to turn over confidential information to a *non-governmental* agency, can we safely assume that it will not do so with other agencies within the government? And although, in this instance, the Blood Center chose not to turn over its files, what is to prevent it from doing so in the future? Has it already done so in the past?

Do participants in any scientific study have the right to say what becomes of the information they provided? It does not appear that either the CDC or the New York Blood Center consulted any representatives of the gay community—much less the subjects themselves—when deciding what would be done with the information from the Blood Center study. And even if the subjects had known that the lists had been requested, it is doubtful that they would have been able to prevent either institution from turning over this information.

It is clear that we as a community can no longer trust that the good intentions of others will adequately safeguard the confidentiality of information volunteered in good faith for research. So what can be done?

The most absolute protection, of course, is not to provide personal identifying information (name, address, etc.) in the first place. In many instances such information is not necessary for the research; if this is so, don't volunteer it.

But in other instances, it may be necessary for researchers to be able to contact subjects. Although there are laws which govern confidentiality, and although there are computerized methods of protecting confidentiality ("scrambling," "double-blind" studies, identifying subjects by initials and birthday only), we must create measures which will better protect our confidentiality and privacy.

We feel that the single best safeguard for research participants is a formal agreement of confidentiality (such as the one which appears below), signed by the participant and the researcher conducting the study. Such a form serves as a legally binding contract and gives the volunteer legal standing to bring a lawsuit to prevent researchers or institutions from disseminating information against his wishes.

The bottom line is simple: although gay people support and encourage research, it is apparent that we cannot rely on others to protect our privacy for us. The time has come to do that for ourselves.

NGTF RELEASES WORKING DOCUMENT ON A COMPILATION OF AIDS SERVICES & RESOURCES

The following outline represents the National Gay Task Force's working document for compiling services & resources on AIDS. Please send comments to: NGTF, 80 Fifth Av., New York, NY 10011.

A. Psychological
   1. Support Groups
      a. AIDS support group
      b. KS support group
      c. PCP support group
      d. AIDS "prodome" support group (AIDS symptoms, no diagnosis)
      e. Support groups for health care providers & social service providers of people with AIDS
      f. General support group for people facing any life-threatening diseases
      g. Support group for lovers and care partners of people with AIDS
      h. Support group for paraprofessionals and volunteers working with people with AIDS or in AIDS-related activity
      i. Worried-well support group (AIDS anxieties and concerns in people who are generally healthy)

B. Patient Support Services (Non-Medical)
   1. Transportation pools: providing transportation (or public transportation subsidy) to and from places for those physically or economically incapable
   2. Housing
      a. Emergency housing
      b. Hospice
      c. Tenant advocacy (non-legal)
   3. Legal Aid
      a. Providing legal assistance to people with AIDS in whatever area necessary
      b. Tenant advocacy
      c. Medical advocacy
      d. Social service advocacy
      e. SSI & government assistance counselling
   4. Buddies (Chicken Soup Brigade)
      a. In-home/hospital visitation/befriending
      b. Errands
      c. Bureaucratic troubleshooting (SSI, welfare, food stamps, applications, etc.)
      d. Social accompaniment/group activities
   5. Paraprofessional contributions
      a. Crisis intervention counselors
      b. Hospice-trained home companions
   6. Eats Department
      a. Collection and distribution of canned goods and non-perishable items for long-term distribution, perishables for short-term
      b. Weekly food allowance.
   7. Medical
      a. Patient advocacy program, medical monitoring committee
      b. AIDS medical network
      c. Pheresis project: securing of plasmapharesis services or purchasing of separate pheresis equipment
      d. Hospital visitation program

C. Education
   1. Hotline
   2. Media monitoring & spokespeople
   3. Bibliography
   4. Archives
   5. Resource Directory

(CONTINUED)

NGTF WORKING DOCUMENT, Continued

6. Publications
   a. Gay & lesbian community (basic facts, risk reduction, guidelines for people with AIDS)
   b. Straight community
   c. Medical community
   d. Legislators

D. Government
   1. Liaison
   2. Lobbying & watchdogging
   3. Protests, gatherings, public memorials

E. AIDS Groups
   1. Patient services coordination
   2. Education
   3. Fundraising
   4. Volunteer coordination
   5. Communication sharing, national networking, conferences

F. Miscellaneous
   1. Association for health care providers
      a. Gay & lesbian
      b. Involved in AIDS treatment & research

* * *

CHARACTERISTIC LYMPH NODE LESIONS MAY BE RELATED TO AIDS

abstracted with thanks from Medical World News, 9/12/83

According to Dr. Harry Ioachim, MD, director of pathology at Lenox Hill Hospital in New York, the lymph nodes may be the first targets of attack by the suspected AIDS agent. Though it has been known for about 2 years that enlarged lymph nodes generally precede the full-blown AIDS syndrome by anywhere from 2 to 20 months, this is the first time the lesions have been so completely characterized. They consist of marked cellular distruction within the germinal center and of an accumulation of nuclear debris, scattered hemorrhages, and neutrophils. They are similar to the virus-related lymph node lesions seen in patients with infectious mono, herpes, and vaccinial infections. As the lesions were observed microscopically in biopsies from cervical, inguinal, and axillary nodes, they may serve as a marker for persons at high risk for developing AIDS. The presence of the "vesicular rosettes" reported by the CDC and others has also been noted. The CDC's Edwin Ewing Jr., confirms that lymphadenitis--rather than reactive hyperplasia, as some researchers have called it, is a particularly apt description for what he too, has found in AIDS patients. The chemotactic response of neutrophils is particularly noteworthy. Dr. Ewing underscores the importance of performing biopsies on enlarged lymph nodes to rule out treatable diseases, such as tuberculosis and lymphoma, and because the changes in early AIDS are "fairly characteristic although not specific."

* * * * *

PHILADELPHIA PRODUCES AIDS BROCHURES FOR HEALTH WORKERS

Philadelphia's AIDS Task Force, a project of the Philadelphia Community Health Alternatives and Philadelphia Health Professionals for Human Rights are distributing two brochures designed for health workers. The first, "A Nurses Guide to AIDS Task Force Services" provides a concise summary of the services offered--education, counseling, and support. The second, "Infection Control Guidelines for Health Care and Related Workers" summarizes recent Public Health Service recommendations about infection control and providing care to people with AIDS. For more information, contact: Philadelphia AIDS Task Force, PO Box 7259, Philadelphia, PA 19101 or call 215/232-8055.

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Patient-Source Scabies among Hospital Personnel — Pennsylvania

In early January 1982, a 60-year-old woman with severe diabetes mellitus and multiple end-organ complications was admitted to a Pennsylvania hospital with bacterial sepsis and shock; she had previously been a custodial nursing home patient. The patient died 5 days after admission. During her hospitalization, she was comatose and required total nursing care, including repeated physical contact by the floor nursing and support staffs. On admission, the patient had an excoriated, crusted rash covering her entire body that had been present for many weeks; retrospectively, it was believed to be crusted or Norweigan scabies. No other patients requiring extensive care contact had dermatologic problems on this unit during the same period.

Approximately 3 weeks after the patient's death, unit staff members began to report to the employee-health service with itching and red, scaly, skin lesions primarily on the anterior trunk and volar side of the arms. Epidemiologic investigation revealed that all the ill individuals had had frequent, close contact with the deceased. Staff members at risk of physical contact were identified, and on examination, 10 had skin rashes clinically compatable with scabies. Some of these individuals had already been treated with a scabicide by their private physicians. All had onset of rash about 2 weeks after the death of the index patient; the remaining 20 at-risk individuals without rash had considerably fewer intense physical contacts with her. There were no cleaning or food service personnel or orderlies, transporters, or other nonnursing-care staff in either the skin-rash or at-risk groups.

All individuals with rash were examined. Four had been previously treated, and their lesions were resolving. Five had lesions suitable for scrapings to detect mites; three of these had positive scrapings.

All 10 individuals were treated with lindane lotion and noted prompt relief of symptoms and resolution of rash. Surveillance over the next 8 weeks identified one possibly late primary case with the same clinical features as the original 10 and one suspected secondary case with hand-dominant localization. Both patients were treated by private physicians, with immediate symptom resolution.

After a year of total follow-up, no additional cases were reported.

Reported by SJ Pancoast, MD, JJ Kishel, Mercy Hospital, Scranton, Pennsylvania; Div of Vector-Borne Viral Diseases, Center for Infectious Diseases, CDC.

Editorial Note: Each patient in this outbreak had a rash distribution that included mainly the anterior trunk, upper legs, and volar arms. Classic hand involvement was conspicuously absent. The predominance of trunk and arm distribution reflects the mode of probable acquisition (body contact acquired by lifting and positioning the index patient). All affected staff members had repeated, close body contact without protective outerwear, frequently with bare arms and forearms. The lack of hand involvement can be partly attributed to frequent post-patient handwashing.

In many custodial, close-confinement situations with disabled patients, scabies is an endemic problem. When skin-rash outbreaks are reported among hospital personnel, even with an atypical distribution of skin lesions as in this case, scabies should be considered. The usual mode of transmission in such instances may be predominantly body-to-body contact.

All persons admitted to patient-care institutions should be examined for skin lesions. Those positive for scabies should be managed as having an infectious disease and isolated until cured to prevent spread among staff and other patients. This includes the use of gloves and, if indicated, gowns, while actually in contact with suspected or positive cases.

CENTERS FOR DISEASE CONTROL

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MORBIDITY AND MORTALITY WEEKLY REPORT

Neonatal Gonococcal Ophthalmia — California

A case of neonatal gonococcal ophthalmia has been reported to CDC from San Diego, California. The ophthalmia occurred even though the neonate received ocular prophylaxis with erythromycin.

In late June, a male infant, of normal weight for gestational age, was born to a primiparous mother after a full-term, uncomplicated pregnancy. The mother had received prenatal care at a local health center since the end of the first trimester. She had been seen nine times during the pregnancy. Specimens for VDRL and gonorrhea cultures had been obtained in February 1983; both tests were reported as negative. The father had been seen at the clinic of a naval air station, diagnosed as having gonorrhea, and treated 9 days before the infant's birth. The mother was not contacted for either evaluation or treatment at that time.

One day before delivery, the mother visited the health center with uterine contractions but was not considered to be in active labor. A yellow-green, slightly odorous discharge was noted at the vaginal introitus. Cultures were taken, and she was referred to the affiliated hospital, with a diagnosis of possible rupture of membranes. No antibiotics were administered.

She was admitted on the following day to the obstetric ward in active labor, with spontaneous rupture of membranes and a copious green vaginal discharge. Two hours later, an internal fetal monitor was applied. Six hours and 35 minutes later, a lightly meconium-stained infant was delivered vaginally, vertex posterior presentation. Apgar scores were 6 at 1 minute and 9 at 5 minutes. The infant's eyes were treated with erythromycin ophthalmic ointment about 5 minutes after delivery. The newborn examination was described as normal.

Approximately 24 hours after birth, the results of the cultures obtained from the mother the day before delivery were reported as positive for a gram-negative, oxidase-positive organism, eventually confirmed as *Neisseria gonorrhoeae*. The mother was treated with procaine penicillin, 4.8 million units intramuscularly (IM) and probenecid 1 g orally. Blood and cerebrospinal fluid for culture were obtained from the infant, and he was treated with 200,000 units of benzathine penicillin (50,000 units/kg). Both cultures were subsequently negative. At 2 days of age, the infant developed a copious yellowish discharge from both eyes, along with ocular swelling and redness. Gram-stain smear of the exudate revealed gram-negative diplococci, subsequently confirmed as *N. gonorrhoeae*, β-lactamase negative. He

Ophthalmia – Continued

was treated with aqueous penicillin, 50,000 units/kg intravenously (IV), for 7 days. In addition, his eyes were washed with saline every 30 minutes to 1 hour, and tetracycline eye ointment was instilled after each saline irrigation. The infant's eyes gradually improved over the next 2-3 days. Topical therapy was maintained for 5 days. Examination by an ophthalmologist revealed no corneal damage. The infant was subsequently seen as an outpatient; he had no apparent eye damage. One week after delivery, the mother was readmitted for endometritis culture-positive for *N. gonorrhoeae*, β-lactamase negative, demonstrating the severity of her infection. She responded to treatment with IV antibiotics.

Reported by R Coen, MD, Dept of Pediatrics, University of California at San Diego, Venereal Disease Control Unit, Infectious Disease Section, California Dept of Health Svcs; Operational Research Br, Div of Venereal Disease Control, Center for Prevention Svcs, CDC.

Editorial Note: This is the first case brought to the attention of CDC of gonococcal ophthalmia caused by nonpenicillinase-producing *N. gonorrhoeae* that occurred despite the use of erythromycin ophthalmic ointment. Recent reports have shown that penicillinase-producing *N. gonorrhoeae* can cause gonococcal ophthalmia despite prophylaxis with erythromycin or with silver nitrate (*1*).

Several risk factors associated with this case may have reduced the efficacy of prophylactic use of erythromycin ointment. Prolonged rupture of membranes is more frequently associated with gonococcal ophthalmia than with other forms of ophthalmia (*2*). The interval between rupture of membranes and delivery may have been anywhere from 7 to 24 hours. The description of "yellow-green, slightly odorous discharge" on the day before the delivery is compatible with an established infection. The lower 1 minute Apgar score and light meconium staining noted after birth may have indicated mild distress before delivery, suggesting that an infection was already present. The incubation period of gonorrhea in neonates is 1-5 days. Therefore, the newborn examination within 24 hours after birth would not normally be expected to detect an early infection. In fact, documented cases of gonococcal eye infection have occurred even with minimal inflammatory responses (*3*).

Prophylaxis against ophthalmia with either silver nitrate or erythromycin ointment is not adequate for treatment of an already established gonococcal infection. In one study (*2*), 44 of 46 cases of gonococcal ophthalmia occurred despite silver nitrate prophylaxis. Investigators in this study also found that chlamydia ophthalmia was the most common specific type of ophthalmia neonatorum in their study, occurring in 86 of 302 cases. Silver nitrate is not effective prophylaxis for chlamydia ophthalmia, but erythromycin ophthalmic ointment has been proven to prevent that disease (*4*).

In this case, gonococcal ophthalmia developed despite the use of topical erythromycin ointment and IM benzathine penicillin. Current CDC recommendations are to treat infants born to mothers with gonococcal infection with aqueous crystalline penicillin G (*5*): 50,000 units IM or IV for full-term infants, or 20,000 units IM or IV for low-birth-weight infants. Documentation of prenatal care, cultures done during pregnancy, circumstances around labor and delivery, knowledge of the incidence of gonococcal infection in the local population, and other factors may help to delineate the choice of agents to be used under high-risk circumstances. The Division of Venereal Disease Control, CDC, encourages reporting of any known cases of neonatal gonococcal ophthalmia for further evaluation of the efficacy of the current recommendations for prophylaxis.

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Notice to Readers

Relocation of CDC's Division of Hepatitis and Viral Enteritis

CDC's Division of Hepatitis and Viral Enteritis, Center for Infectious Diseases, has moved its operation from Phoenix, Arizona, to Atlanta, Georgia. Epidemiologic assistance and consultation were transferred to Atlanta on August 29, 1983. The new telephone number is (404) 321-2342 (FTS 236-2342).

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health-Care Workers and Allied Professionals

Acquired immunodeficiency syndrome (AIDS) was first recognized in 1981. The epidemiology of AIDS is consistent with the hypothesis that it is caused by a transmissible infectious agent (*1-3*). AIDS appears to be transmitted by intimate sexual contact or by percutaneous inoculation of blood or blood products. There has been no evidence of transmission by casual contact or airborne spread, nor have there been cases of AIDS in health-care or laboratory personnel that can be definitely ascribed to specific occupational exposures (*4*).

CDC has published recommended precautions for clinical and laboratory personnel who work with AIDS patients (*5*). Precautions for these and allied professionals are designed to minimize the risk of mucosal or parenteral exposure to potentially infective materials. Such exposure can occur during direct patient care or while working with clinical or laboratory specimens and from inadvertent or unknowing exposure to equipment, such as needles, contaminated with potentially infective materials. Caution should be exercised in handling secretions or excretions, particularly blood and body fluids, from the following: (1) patients who meet the existing surveillance definition of AIDS (*1*); (2) patients with chronic, generalized lymphadenopathy, unexplained weight loss, and/or prolonged unexplained fever when the patient's history suggests an epidemiologic risk for AIDS (*1,2*); and (3) all hospitalized patients with possible AIDS.

These principles for preventing AIDS transmission also need to be adopted by allied professionals not specifically addressed in the previous publications but whose work may bring them into contact with potentially infective material from patients with the illnesses described in the above three groups.

The following precautions are recommended for those who provide dental care, perform postmortem examinations, and perform work as morticians when working with persons with histories of illnesses described in the above three groups.

DENTAL-CARE PERSONNEL

1. Personnel should wear gloves, masks, and protective eyewear when performing dental or oral surgical procedures.
2. Instruments used in the mouths of patients should be sterilized after use (*5-9*).

PERSONS PERFORMING NECROPSIES OR PROVIDING MORTICIANS' SERVICES

1. As part of immediate postmortem care, deceased persons should be identified as belonging to one of the above three groups, and that identification should remain with the body.
2. The procedures followed before, during, and after the postmortem examination are similar to those for hepatitis B. All personnel involved in performing an autopsy should wear double gloves, masks, protective eyewear, gowns, waterproof aprons, and waterproof shoe coverings. Instruments and surfaces contaminated during the postmortem examination should be handled as potentially infective items (*5-7*).
3. Morticians should evaluate specific procedures used in providing mortuary care and take appropriate precautions to prevent the parenteral or mucous-membrane exposure of personnel to body fluids.

These and earlier recommendations outline good infection control and laboratory practices and are similar to the recommendations for prevention of hepatitis B. As new information becomes available on the cause and transmission of AIDS, these precautions will be revised as necessary.

Reported by AIDS Activity, Div of Host Factors, Div of Viral Diseases, Hospital Infections Program, Center for Infectious Diseases, Office of Biosafety, CDC

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

An Evaluation of the Immunotoxic Potential of Isobutyl Nitrite

Initial epidemiologic studies indicated that the use of inhalant drugs, such as amyl nitrite, isobutyl nitrite (IBN), and butyl nitrite, may be a risk factor for acquired immunodeficiency syndrome (AIDS) (*1,2*). Because the immunotoxic potential of these drugs was unknown, CDC undertook an immunotoxicologic evaluation of one of the most commercially available inhalants—IBN.

Isobutyl Nitrite — Continued

Balb/c mice were exposed to IBN at vapor concentrations of 20, 50, and 300 parts per million (ppm) for 6.5 hours a day, 5 days a week, for 3, 7, 13, or 18 weeks. At selected intervals, mice exposed to either 50 or 300 ppm of IBN were removed from the exposure chambers and tested for immunocompetency by the following assays: 1) antibody-producing cells were counted by localized hemolysis in gel assay (Jerne Plaque Assay) (*3*) 4 days after the mice had been immunized intraperitoneally with sheep erythrocytes; 2) radiometric skin testing with PPD (purified protein derivative) was performed 21 days after immunization with Freund's complete adjuvant (*4*); 3) the lymphocyte blast transformation (LBT) assay was performed by using splenic lymphocytes stimulated at several concentrations of the following mitogens: phytohemagglutinin, concanavalin A, pokeweed mitogen, or lipopolysaccharide. Each assay was performed on at least 10 (five male, five female) exposed animals and 10 control animals each time, and, except for the skin testing, assays for each animal were done in replicates of three (plaque assay) or four (LBT).

In addition to the immunocompetency testing, all animals were weighed weekly; their spleens, thymuses, and livers were weighed at necropsy, when hematologic measurements, including white-cell counts, red-cell counts, differential white-cell counts, and methemaglobin levels, were also determined. Fifteen major organs were removed and processed for histologic and pathologic analysis.

None of the animals exposed to IBN showed any evidence of immunotoxic reactions. Methemaglobinemia was noted in animals exposed to 300 ppm of IBN, and some evidence of thymic atrophy, possibly stress-related, was found in this group. All detailed histologic examinations have not been completed.

Reported by Immunology Section, Laboratory Investigations Br, Div of Respiratory Disease Studies; Chronic Toxicology Section, Experimental Toxicology Br, Div of Biomedical and Behavioral Sciences, National Institute of Occupational Safety and Health; AIDS Activity and Div of Host Factors, Center for Infectious Diseases; Office of the Director, Center for Environmental Health, CDC.

Editorial Note: Aliphatic nitrites, such as IBN, are commercially available as room odorizers but are commonly used as inhalant "street" drugs. The results of the present study, as well as the occurrence of AIDS among populations not commonly using inhalant nitrites, suggests that these drugs are not responsible for the basic immune defects characteristic of AIDS.

Although the data obtained in this study indicate that IBN was not immunotoxic for mice, these drugs do have toxic effects. They have been shown to be mutagenic in vitro (*5*) and are highly flammable. Reported side effects include: dizziness, headache, tachycardia, syncope, hypotension, and increased intraocular pressure; nitrites have also been associated with methemoglobinemia and, rarely, sudden death (*6*). Nitrite inhalants do not appear to be implicated as a cause of the immunosuppression seen in AIDS, but their role as a cofactor in some of the illnesses found in this syndrome has not been ruled out.

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Current Trends

Update: Acquired Immunodeficiency Syndrome (AIDS) — United States

As of September 2, 1983, physicians and health departments in the United States and Puerto Rico had reported 2,259 persons with acquired immunodeficiency syndrome (AIDS) who met the surveillance case definition.* Of these, 917 (41%) are known to have died. Fifty-eight (3%) cases were diagnosed before 1981; 231 (10%) in 1981; 883 (39%) in 1982; and 1,087 (48%) to date in 1983. *Pneumocystis carinii* pneumonia (PCP) is the most common life-threatening opportunistic infection in AIDS patients, accounting for 52% of primary diagnoses; 26% of patients have Kaposi's sarcoma (KS) without PCP, and 7% 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. The proportion of patients with each of these primary diagnoses has remained relatively constant during the last 12 months, although the proportion with KS has decreased slightly, and the proportion with opportunistic infections other than PCP has increased from approximately 10% of all cases a year ago. Cases have occurred in all primary racial/ethnic groups in the United States: 57% of those reported have been white, 26% black, 14% Hispanic, and 3% other or unknown. One hundred forty-seven (7%) cases have been reported in women.

Eighty-nine percent of patients with AIDS can be placed in groups† that suggest a possible means of disease acquisition: 71% are men with homosexual or bisexual orientations; 17% (including 51% of the women) have used intravenous (IV) drugs; and 1% are hemophiliacs. Of the other 11% of cases, means of disease acquisition is less clear, but in none of these cases does casual contact appear to be involved. This group of 11% includes cases for whom information about risk factors is either absent or incomplete (3% of total), and others whose risk and exposure factors are under investigation. The latter includes patients who were born in Haiti but are now living in the United States (5% of total). Also under investigation are heterosexual partners of persons with AIDS or persons at increased risk of AIDS (1% of total), and those exposed to blood transfusions (1% of total). Finally, some thoroughly investigated cases belong to none of the above groups (1% of total).

Almost 47% of AIDS patients are 30-39 years old at diagnosis; an additional 22% are 20-29 and 40-49 years old, respectively. The age of drug-abuse patients clusters more tightly, with 81% being 20-39 years old. Compared with the average for all AIDS patients, Haitian entrants with AIDS tend to be younger (47% are 20-29 years old); the patients who received blood transfusions before developing AIDS tend to be older (median age more than 50 years old); and those with hemophilia tend to have a broader age range without clustering.

Most cases continue to be reported among residents of large cities. The New York City standard metropolitan statistical area (SMSA) has reported 42% of all cases meeting the surveillance definition; the San Francisco SMSA, 11% of cases; the Los Angeles SMSA, 7% of cases; and the Miami SMSA, 5% of cases. Cases have been reported from 41 states, the District of Columbia, and Puerto Rico (Figure 4).

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

*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 and no other cause of reduced resistance reported to be associated with that disease.

AIDS INFECTION CONTROL & GENERAL INFO PACKET AVAILABLE

The San Francisco Bay Area Chapters of the AIDS/KS Foundation and the Association for Practitioners in Infection Control, are pleased to announce the availability of "AIDS: An Infection Control and General Information Packet for Health Care Providers," for the nominal charge of $10, which includes postage & handling. As caregivers for patients with AIDS since the summer of 1981, the AIDS/KS Foundation and the Association for Practitioners in Infection Control believe it useful to share some of the infection control policies in use throughout the Bay Area.

The packet contains: 1) general information on AIDS; 2) statements from the San Francisco Department of Public Health; 3) copies of the Morbidity & Mortality Weekly Report which are pertinent to AIDS and infection control; 4) care of AIDS patients in the community; 5) representative examples of inpatient and outpatient infection control policies and procedures from several Bay Area acute-care hospitals; 6) educational handouts for distribution to employees; 7) examples of nonstandard precaution signs from three Bay Area hospitals; and 8) guidelines on sterilization of instruments and equipment. The information contained in the packet can be used as guidelines for formulating your own policies and procedures. As frequent continuing education on AIDS is often necessary, this packet may also be used as a basis for in-service educational programs.

* * *

The AIDS/KS Foundation also has further information available on many subjects related to AIDS, as well as an up-to-date Clinical Bibliography on AIDS. Call the AIDS/KS Foundation, San Francisco, at 415/864-4376, or write to: AIDS/KS Foundation, PO Box 14227, San Francisco, CA 94114.

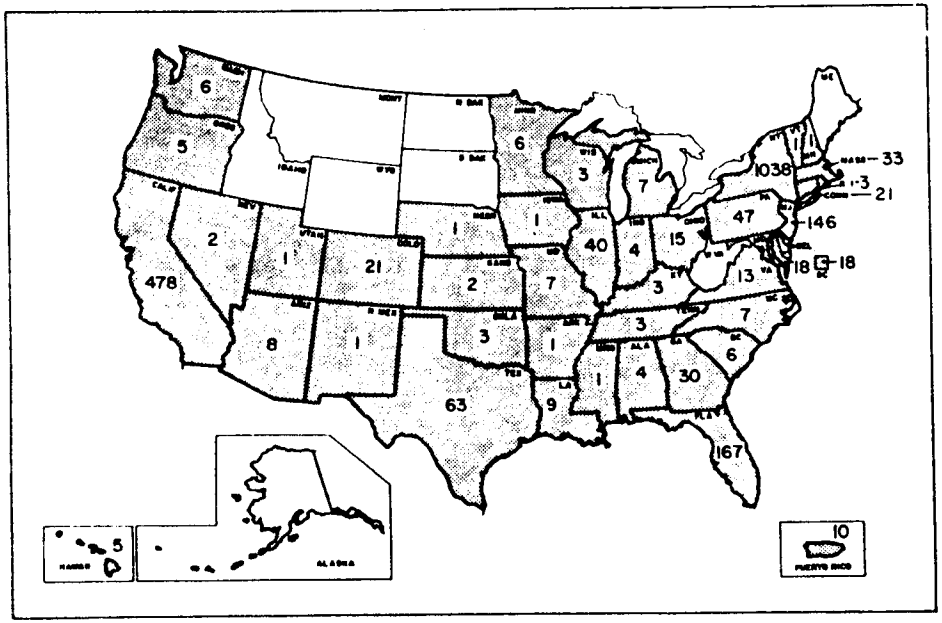
AIDS — Continued

Editorial Note: AIDS cases have been classified into groups at greatest risk of acquiring the disease. Classification is an essential element of any epidemiologic investigation and serves such purposes as formulating prevention recommendations, providing direction for research, and identifying medical needs. However, the classification of certain groups as being more closely associated with the disease has been misconstrued by some to mean these groups are likely to transmit the disease through non-intimate interactions. This view is not justified by available data. Nonetheless, it has been used unfairly as a basis for social and economic discrimination.

The occurrence of AIDS cases among homosexual men, IV drug abusers, persons with hemophilia, sexual partners of members of these groups, and recipients of blood transfusions is consistent with the hypothesis that AIDS is caused by an agent that is transmitted sexually or, less commonly, through contaminated needles or blood. About 91% percent of reported cases have occurred in these patient groups. Among the remaining cases, there has been no evidence that the disease was acquired through casual contact with AIDS patients or with persons in population groups with an increased incidence of AIDS. AIDS is not known to be transmitted through food, water, air, or environmental surfaces.

The great majority of persons in population groups with increased incidences of AIDS have not been affected by the disease. Until epidemiologic studies identify the subgroups within these populations that are truly at increased risk for acquiring AIDS, the classification system will lack precision. However, such classifications should not be construed to imply that usual social contact with such groups is involved in the transmission of AIDS.

FIGURE 4. Acquired immunodeficiency syndrome (AIDS) cases meeting the surveillance definition reported to CDC, by state — United States, as of September 2, 1983



†The groups listed are hierarchically ordered; cases with characteristics of more than one group are tabulated only in the group listed first.

LATE BREAKERS: ARTICLES RECEIVED IMMEDIATELY BEFORE PUBLICATION!
with special thanks to the New York Native (October 24-November 6)

*****GAY MEN'S HEALTH CRISIS GRANTS $100,000 FOR AIDS

New York's Gay Men's Health Crisis has announced the distribution of more than $100,000 in grants for medical research on AIDS, for equipment at diagnostic facilities, and for information agencies. $30,000 in research grants has been distributed to Dr. Simon Karapatkin of New York University Medical Center, and to Drs. Michael Grieco and Michael Lange of St. Luke's to better understand the effects of AIDS and to evaluate the efficacy of pharmaceutical agents for treatment. $25,000 will go for the purchase of medical equipment for the newly established Community Health Project (the recently merged St. Mark's Clinic and Gay Men's Health Project). $12,000 will go to the National Gay Task Force Crisisline in order to enable the AIDS information service to increase its referral service, technical assistance, and volunteer efforts. $40,000 will go to the Federation of AIDS Related Organizations (FARO), which lobbies to promote appropriations of federal research money for AIDS research. The Lesbian and Gay Community Council of Greater New York and the National AIDS Vigil Commission have each received $1000. The "Fair Share" pledge to the Community Council is intended to ensure networking with other member organizations for social service referrals, patient advocacy programs, and the like. The AIDS Vigil Commission pledge was for seed money for fundraising for the October 8th march on Washington. *****

*****"MEDICAL ADVERTISING" AND "AIDS 'SCREENING'"
by Steven C. Arvanette, NY Native

Noting that gay people are visiting physicians like never before, several gay leaders associated with medical issues have taken notice of a recnet proliferation of clinics offering what they claim are tests for the diagnosis of immune suppression. In particular, objections have been raised to the phrase "AIDS screening," which has been included in some medical ads in gay publications and which these gay leaders believe offers a definitive conclusion of whether a patient suffers form AIDS. "There is no screening for AIDS," said Dr. Roger Enlow, immunologist, of New York City's Health Department's Office of Gay and Lesbian Health. The term "screening" implies a "quick and simple answer," he added, and present medical knowledge does not accept a definitive test. A New York City physician who advertises that he specializes in the testing and treating of gay men disputes the claim of Mel Rosen, that many of the current ads from physicians and medical clinics are "somewhat misleading," and "undesirable." Rosen is the former executive director of New York's Gay Men's Health Crisis. Harold S. Ross, MD, said the tests he performs for AIDS are the same as those used by physicians at the hospitals in the city that are doing most of the research and treatment of AIDS. He said that the testing he does is certainly a check of the patient's immune system. "Of course, other viruses will cause abnormalities" and lead to indications of immune suppression that may not be AIDS, he conceded, but he said the tests give a definitive measure of immune response at a given time. Advertising which specifies the types of sexually transmitted diseases which a physician treats is beneficial for gay people who want to consult a doctor, Ross asserted. Far from being a means of capitalizing on the epidemic, he said, listing the availability of AIDS evaluation or diagnosis "is as important as putting syphilis and amebiasis" testing and treatment information in an ad. Both Rosen and Enlow expressed concern that many healthy gay men, in a state of panic over the epidemic, are needlessly requesting expensive series of tests in an attempt to determine whether they might have AIDS. "There's entirely too much running to the doctor," said Enlow. If a gay man feels ill and has certain symptoms, then he should consult a physician for possible testing. Ross contended that sexually active gay men who regularly get tested for STDs should request the most basic tests associated with immune suppression [presumably complete blood counts & differentials?]. The more expensive and detailed tests, such as checks of T-cell subsets, would not be needed, Rosen stated, unless preliminary test results or examinations suggested otherwise. Rosen and Enlow agree that ultimate supervision rests with the state health department and with professional peer-review organizations. *****

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