THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 5 #4 March-April, 1984

* * * * * * * * *

This Newsletter is published by the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). Although efforts will be made to present accurate, factual information, the NCGSTDS, as a volunteer, nonprofit organization, or its officers, members, friends, or agents, cannot assume liability for articles published or advice rendered. The Newsletter provides a forum for communication among the nation's gay STD services & providers, and encourages literary contributions, letters, reviews, etc. The Editor/Chairperson reserves the right to edit as needed, unless specific requests to the contrary are received. Articles for the Newsletter, or inquiries about membership in the Coalition may be addressed to Mark P. Behar, PA-C, NCGSTDS, PO Box 239, Milwaukee, WI 53201-0239 (414/277-7671). Please credit the NCGSTDS when reprinting items from the Newsletter. We're eager to hear from you! We will try to answer all correspondence! The NCGSTDS is the proud recipient of the National Gay Health Education Foundation's JANE ADDAMS-HOWARD BROWN AWARD, for outstanding effort and achievement in creating a healthier environment for lesbians and gay men, June 12, 1983.

GPA GAY PRESS ASSOCIATION

****

TABLE OF CONTENTS (ALPHA): STDs

TABLE OF CONTENTS (ALPHA): AIDS

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

CURRENT ASPECTS OF STD SYMPOSIUM--III (CASTDS) SCHEDULED FOR AUGUST IN CHICAGO

The National Coalition of Gay STD Services (NCGSTDS) and the American Association of Physicians for Human Rights (AAPHR) are cosponsoring an educational meeting, August 23-25, 1984, in Chicago. Enclosed with this Newsletter is a preliminary program and registration form and a call for papers. Please send requests for additional brochures to Ms. Laura Coates, Howard Brown Memorial Clinic, 2676 N. Halstead St., Chicago, IL 60614 (312/871-5777), NCGSTDS /CASTDS, PO Box 239, Milwaukee, WI 53201, or AAPHR, PO Box 14366, San Francisco, CA 94114.

Three major educational objectives will be addressed in the symposium: 1) To provide practicing physicians and other health workers with increased awareness of new medical and psychological developments related to the Acquired Immune Deficiency Syndrome (AIDS). The emphasis will be on developing skills for meeting the challenges of AIDS. 2) To provide a two day "Homosexual Health Update" for leaders in the field of gay & lesbian health care to increase their knowledge and skills in the areas of research and educational programs in their own communities. This will include updated material on the diagnosis and management of common health problems in the gay nad lesbian community with an emphasis on fertile areas for research and education. 3) To further educate NCGSTDS and AAPHR members regarding the societal problems affecting themselves and their patients. The keynote address, "Psychological and Political Barriers to Quality Health Care for Gay and Lesbian People," will focus on increasing the awareness of participants and providing them with specific skills to cope with the political and societal forces impinging on the health of lesbians and gays.

On Wednesday, August 22, CASTDS will feature a clinical update for the diagnosis and treatment of STDs. The standard reference for this part of the program will be Sexually Transmitted Diseases in Homosexual Men--Diagnosis, Treatment, and Research, edited by David G. Ostrow, Terry Alan Sandholzer and Yehudi M. Felman (Plenum, 1983). Thursday and Friday, August 23-24, will feature critical gay and lesbian health problems. In addition, there will be sessions in the afternoons for contributed poster & videotape presentations. The Annual Business Meetings for both the NCGSTDS and AAPHR will take place during the Conference. The NCGSTDS will charter an elevated train from the Chicago Transit Authority for an evening of "railing" around the magnificant Chicago Loop. Refreshments will be served. A separate mailing will be sent to all NCGSTDS & AAPHR members with details about advance ticket sales. AAPHR's Annual Banquet will feature Dr. Richard Krause, Director of the National Institute of Allergy & Infectious Disease. His topic will be the "Sociology of AIDS and Infectious Disease Research." Continuing Medical Education (CME) creditation will be available for participation in the program.

Accomodations have been arranged at the downtown Chicago Marriott Hotel, which will also be the site of all program activities. A special rate of $53/night (single) and $63/night (double) has been arranged. The Marriott is on the "magnificent mile" of Michigan Avenue, near major entertainment and shopping centers. A full health club, pool and gym will be available to persons staying at the Marriott, and a special $10 registration fee reduction will be given to advance registrants staying two or more evenings at the hotel.

Registration fees for NCGSTDS/AAPHR members are $75 ($100 after June 1), nonmembers $125 ($150 after June 1), house staff & students $50 ($75 after June 1); One day registration for the Wednesday CASTDS-III only is $50; the AAPHR banquet on Saturday evening will cost $45; the NCGSTDS Elevated Train Ride is still being planned--tentative date is Thursday evening, August 23rd (a special mailing will be sent out notifying members of the exact details and advance registration). For more information about any aspect of the Conference, contact the NCGSTDS, AAPHR, or the Howard Brown Memorial Clinic (addresses above).

In addition to the invited speakers, there will be presentations of contributed papers, videotapes, and other special educational materials during the meeting. The abstract form should be used for describing your submission. Please note that the deadline for submission of abstracts has been changed to May 26, 1984, due to the lateness of this Newsletter; abstracts selected for presentation/display will be notified by June 30th. For specific questions about submitting your proposal, please contact David Ostrow (312/565-2109), Bob Bolan (415/587-5569), or Mark Behar (414/277-7671). Hope to see you in Chicago in August!! [And please forgive all the typos on the enclosed brochure & abstract form!!]

* * * * *

NEWSLETTER AVAILABLE FROM NATIONAL GAY HEALTH EDUCATION FOUNDATION

The National Gay Health Education Foundation (NGHEF) recently announced the publication of a quarterly newsletter, reporting on news, resources, and research on gay/lesbian health issues from around the country. The first issue, dated January, 1984, has articles by Bernice Goodman, President of the NGHEF, an interview with Ron Vachon, Executive Director, an update on the Federation of AIDS Related Organizations (FARO), an article by Walter Lear on the National Gay Health Coalition, and an article on Lesbian Health Issues by Margie Nichols. Newsletter editors Margie Nichols and Dean Pierce promise to feature a balance of lesbian and gay health issue topics in the newsletter. If you'd like to submit an article, write: M. Nichols, 281 Pavonia Av., Jersey City, NY 07302 (201/798-5926). If you'd like to subscribe, send a tax-deductible contribution of $25, $50, $100, or more to: NGHEF, PO Box 784, New York, NY 10036. Lesbian health, third-world gay health issues, and non-AIDS related gay men's health issues will be featured in the three remaining issues of the newsletter in 1984.

* * *

REQUEST FOR PROPOSALS: GAY/LESBIAN HEALTH PROJECTS
reprinted with thanks from Lesbian & Gay Health, NGHEF

The National Gay Health Education Foundation, Inc. (NGHEF), a not-for-profit, public charity, is calling for persons with proposals in the area of lesbian/gay health to submit these for consideration. Although funding sources for such proposals are difficult to locate, NGHEF has had some success in this area and can provide two services: 1) Technical assistance in program development, locating funding sources, and grant writing; and 2) Administration of the grant through NGHEF's office. Interested persons may contact Ron Vachon, Executive Director, PO Box 784, New York, NY 10036, or call 212/563-6313 Monday-Friday, noon to 5 pm Eastern Time.

* * *

BOOK: HOMOSEXUALITY & SOCIAL SEX ROLES

Haworth Press of New York recently has announced the publication of Homosexuality & Social Sex Roles, by Michael W. Ross, PhD, Dept. of Psyciatry, Flinders University of South Australia Medical School. This is the seventh edition to Haworth's Research on Homosexuality series, and studies the relationship of social sex roles to homosexuality and reevaluates the psychological, familial, and societal factors involved. A brochure (paid advertisement) is enclosed with this Newsletter.

* * *

LATE AGAIN!!

Apologies are once again offered to NCGSTDS readers for the late publication of this issue of the Newsletter. Late breaking stories, most noteably about the NIAID workshop on AIDS, were partially responsible. As has been noted many times before, the volume of correspondence and mail has dramatically increased over the last few months; this has resulted in delayed Newsletters. Coalition plans for the acquisition of a word processor this fall will greatly facilitate Newsletter production, as well as membership renewals. Your comments are always welcome. Please send to: NCGSTDS, PO Box 239, Milwaukee, WI 53201 or call 414/277-7671.

DUE TO THIS DELAY, THE DEADLINE FOR SUBMISSION OF PROGRAM ABSTRACTS FOR THE CASTDS/NCGSTDS/ AAPHR MEETING, AUGUST 23-25 IN CHICAGO HAS BEEN CHANGED TO: MAY 26; ABSTRACTS SELECTED FOR PRESENTATION WILL BE NOTIFIED BY JUNE 30! SORRY FOR THIS CHANGE!

* * * * *

JOURNAL OF HOMOSEXUALITY OFFERED BY HAWORTH PRESS

Included with this Newsletter is a paid advertising supplement from the Haworth Press describing their famed Journal of Homosexuality, now in its 9th year of publication, along with several other journals and books. Write to The Haworth Press, 28 East 22nd St., New York, NY 10010 for additional information.

* * * * *

HEPATITIS AD IN BOSTON

[ED NOTE: The following is an ad that frequently is published in Boston's Gay Community News. GCN is one of the nation's best examples of responsible gay/lesbian journalism!!]
"WE WON'T USE A HARD SELL...but GCN wants to remind its readers that gay men are at particular risk of contracting hepatitis B, a liver infection which kills 5000 people each year. That's five times as many fatalities each year as have ever been caused by AIDS. As of yet, there is no specific preventative or cure for AIDS. But we do have a vaccine for hepatitis B. If you have already had hepatitis B, you may not need the vaccine. It's even possible that you may have contracted a mild form of the disease without knowing it. A simple and relatively inexpensive screening can determine whether you already have the hepatitis B antibody, or if you should consider getting the vaccine. So visit your doctor, your local gay clinic, or a community health center and ask about the hepatitis B screening and vaccine. And if you can, consider making a donation so that those who can't afford the expensive treatment can stay healthy too. In Boston, the hepatitis B screening and vaccine is available from the Fenway Community Health Center, which maintains a fund to provide grants and loans to those who cannot afford the vaccine. For more information, or to make a contribution to the fund, call the Fenway Community Health Center at (617) 267-7573."

* * *

AMERICAN HEPATITIS B ASSOCIATION FORMS IN NEW YORK

with thanks to the New York Native, 2/27-3/11/84

A group of concerned gay men who are hepatitis B carriers have organized the American Hepatitis B Association with the intention of creating support in the form of outreach discussion groups. The Association will also promote public information on hepatitis B and all surrounding issues. Regular discussion groups meet every Thursday at 7:15 pm at the Lesbian & Gay Community Service Center, 208 West 13th Street, New York (212/541-6099).

* * * * *

BOSTON'S FENWAY SEEKS PERSONNEL

Fenway Community Health Center of Boston is looking for a half-time family practitioner (MD) to start July 1, 1984. As the only openly gay/lesbian health practice in the Boston metropolitan area we tend to see a larger number of gay men for primary care and sexually transmitted diseases. In addition, we see many students and elderly from the surrounding community. We have a medical staff of 15 including nurse practitioners, physician assistants, and physicians with specialties in internal medicine, infectious diseases, dermatology, gynecology, and surgery. Physicians have admitting privileges at the Beth Israel Hospital. For more information, call or write: Jerry Feuer, PA-C, Fenway Community Health Center, 16 Haviland St., Boston, MA 12115 (617/267-7573).

There is also an immediate opening for executive director of the Fenway. MPH, MBA, or equivalent is required. If interested, send resume/CV to Search Committee, 16 Haviland St., Boston, MA 02115.

* * * *

NEW VD PREVENTION FOR EVERYONE--10th EDITION AVAILABLE

The 10th revised edition of The New Venereal Disease Prevention for Everyone is now available from the American Foundation for the Prevention of Venereal Disease, Inc. (527 Madison Av., Suite 1415, New York, NY 10022), for $1 each. The 14 page prochure emphasizes the role of washing and hygiene in the prevention of many sexually transmitted diseases, and also discusses the role of germicidal preparations (such as the "pro-kit" and "Sanitube" germicidal creams). Over 1 million copies of the brochure has been distributed worldwide in several languages, since the first edition in 1969.

* * *

HEPATITIS--POSTERS FROM AMERICAN LIVER FOUNDATION

A series of 5 black & white 11 x 17 inch sized posters suitable for hanging in gay establishments is now available from the American Liver Foundation. Each of the posters is illustrated with presumably healthy gay men in neutral situations: "Help stop the spread...Hepatitis B infection can now be prevented for most people" has two white young men standing against a wall; "Some things are better not shared...Hepatitis B infection is one of them" is illustrated with two young white men, fashionably dressed with a full length mirror; "Chain reaction--The fallout is hepatitis B infection" shows three young men, presumably anglo, black, and latin, wearing dark clothing, looking in different directions; and "After the party's over... are you left with hepatitis B infection?" showing two men at a piano; one poster has two whites; another poster illustrates two blacks. These posters represent a distinct improvement in the American Liver Foundation's attempt to involve the gay community in education about hepatitis B. The Foundation also has published a glossy heavy stock black & white brochure providing important information about the disease. Although the origin of this particular marketing idea is not known by the NCGSTDS, it is noteworthy to recall that the Coalition recommended this very approach several years ago. [Finally is someone listening to the gay health provider community?!] For more information, contact the American Liver Foundation, 800/223-0179 (toll-free), or write ALF, Cedar Grove, NJ 07009. And if you're seeking a worthy organization to donate money to, think about the ALF; and remember to share your constructive criticisms with them and the NCGSTDS. STD CLINIC MEMBERS HAVE RECEIVED A SAMPLE OF THE POSTER WITH THIS NEWSLETTER.

* * * * *

DETROIT'S VD ACTION COALITION'S STD GUIDE

The VD Action Coalition's long-awaited information and resource guide is now available. This new 52 page document entitled "STD: A Community Information and Resource Guide," contains a collection of medical and prevention information on STDs as well as resources for services, program planning and education. It can be useful in a variety of settings to enhance prevention and education efforts of professionals who come in contact with persons who are at risk of contracting STDs. Some of the contents include: a local/national overview on the impact of STDs, a summary of 13 important STDs in chart form, a comprehensive section on prevention and an STD glossary. Send $3 for a copy to: VDAC, UCS, 51 W. Warren Av., Detroit, MI 48201 (checks payable to "United Community Services") or call Gerry Williams (313/833-0622 x 29).

* * *

"DIRECTIONS IN LESBIAN AND GAY HEALTH"--4TH BAPHR SYMPOSIUM

The 4th Annual Bay Area Physicians for Human Rights (BAPHR) Symposium, "Directions in Lesbian and Gay Health" is scheduled for June 22-23, 1984, at the San Francisco Medical Society Auditorium, and is cosponsored by the American Association of Physicians for Human Rights (AAPHR). Five sessions are planned: 1) Attitudes Towards Homosexuality; 2) Parenting Options; 3) Update on STDs and AIDS; 4) Focus on Aging; and 5) Health Issues. Eleven hours of category I continuing medical education (CME) credits are available to physicians. Cost of the Symposium ranges from $60 to $200 (after June 1, $75-225). For more information, contact BAPHR, PO Box 14546, San Francisco, CA 94114 (415/673-3189).

* * * * *

INTERNATIONAL LESBIAN/GAY HEALTH CONFERENCE & THIRD AIDS FORUM

Enclosed with this Newsletter is registration information about the First International (and 6th National) Lesbian/Gay Health Conference and the Third AIDS Forum, cosponsored by the National Gay Health Education Foundation (NGHEF) and the Federation of AIDS Related Organizations (FARO). The Conference will take place June 16-19 at Loeb Student Center at New York University on Washington Square and is expected to attract gay & lesbian health workers from around the world. For more information, contact: Michael Shernoff or Fern Schwaber, NGHEF, 80 Eighth Av., Suite 1305, New York, NY 10011, or by calling 212/206-1009.

* * * * *

ALCOHOLISM & SUBSTANCE ABUSE AMONG GAY/LESBIAN CLIENTELE: ISSUES FOR STD WORKERS

The NCGSTDS is cooperating with members of the National Association of Gay Alcoholism Professionals (NAGAP) to provide ongoing articles about alcoholism and substance abuse problems in gay people, and how STD workers (who frequently are the first contacts with health professional that gay/lesbian clients may have) may learn how to recognize the problem and learn how to intervene. These articles provide only a framework that requires additional and direct assistance of preferably local NAGAP and gay/lesbian Alcoholics Anonymous/Alanon members for guidance, consultation, and staff sensitivity training and inservices. Although the articles may specify "alcohol/alcoholism," you are free to generalize to all substance abuse and addictive behaviors. Your comments and input are importnat--please share them with us and your local gay STD clinic/service! NAGAP's address is: 204 West 20th Street, New York, NY 10011 (212/807-0634); your membership there will be beneficial! In the last issue of the Newsletter (volume 5:3, January, 1984), we talked about the hazards of alcohol, screening for and referral of alcoholics & other chemically dependent persons, and professional enabling vs. helping. Watch for additional articles in the next issue! *****

*****

*****

SUBTANCE ABUSE, AIDS, & IMMUNITY--WHY SHOULD WE BE CONCERNED?

with thanks to Tom Smith, MD, San Francisco Alcoholism Evaluation & Treatment Center

1) Alcohol and drugs of abuse are considered to be co-factors in AIDS (indirectly, but importantly related)
2) IV drug abusers are in a high risk group for AIDS
3) Homosexually active men, another high risk group for AIDS,. are also at high risk for substance abuse problems
4) Substance abusers can have symptoms that are similar to AIDS symptoms (IV drug abusers occasionally develop lymphadenopathy & enlarged spleens; alcoholics frequently have prolonged fatigue, etc.)
5) Alcohol, volatile nitrites (poppers), and cocaine, among other drugs, lower one's resistance to infection
6) Alcohol abuse can suppress the immune system, especially in alcoholics with hepatic involvement
7) Alcohol is toxic to the bone marrow and spleen
8) Alcohol and many other drugs of abuse interfere with sleep, and increase anxiety and stress levels
9) Chronic alcohol and drug abuse leads to the damage of one's overall good health
10) Alcohol and drug use can interfere with one's judgement in relationship to sexuality and self-care matters
11) Individuals with AIDS are currently being served in alcohol and drug abuse treatment agencies. The incubation period for AIDS is thought to be seven months to 2 or more years. If this incubation time is accurate, then substance abuse agencies currently and treating prediagnosed AIDS individuals.
12) A full spectrum of alcohol and drug services for individuals with AIDS are available in San Francisco and possibly other large communities. *****

*****

*****

WHAT ARE SOME OF THE STRESSES ON LESBIANS & GAY MEN LEADING TO ALCOHOL/SUBSTANCE ABUSE?

by Suzanne Balcer & Tom Smith, SF Alcoholism Evaluation & Treatment Center

Lesbians and gay men are two separate groups with some political and social stressor commonalities, and simultaneously with many individual multileveled differences (intrapsychic, social cultural, etc.). The following stresses are reviewed in outline form:

A. Stresses on the Individual
   1) Social and vocational oppression leading to low self-esteem, depression, anger, etc.
   2) Lesbians have double oppression as women and as lesbians. "Homosexuality" often means gay men and excludes lesbians.
   3) Personality splitting (leading a double life) is emphasized in the alcoholic/drug abuser, leading to compartmentalization, paranoia, alienation.
   4) The lesbian/gay subculture are in a formative stage, producing uncertainty of changing value systems and mores.

(CONTINUED)

ALCOHOLISM--STRESSES, Continued

5) Alcoholism and homosexuality are stigmatized in our society, often seen as sinful, sick, and criminal.
6) Many lesbians/gays harbor homophobic thoughts and feelings resulting in "second rate" feelings about the self and distrust and alienation towards other lesbians/gays.
7) Gay men are stressed by the emergence of a new epidemic AIDS resulting in panic, denial, alienation, and paranoia.
8) Compound symptoms--many symptoms of alcoholism are the same as symtoms of homosexuals suffering from social oppression (e.g., depression, low self-esteem, paranoia, etc.)
9) Aging lesbians & gay men may experience depression, fear of loneliness, anger, and homophobia. Many older homosexuals suffer from myths about alone-ness and loneliness. Many older homosexuals do not wish to be open about their sexual orientation leading to alienation from their peers (both hetero- and homosexual) and from the lesbian/gay subcultures.
10) Young lesbians/gays, in addition to the confusion and various stresses of adolescence, face uncertainty about their sexual identity. Positive & supportive role models are often not visible and available to lesbian/gay youth. Often youth don't know that it's okay to not drink and use drugs. These youth also have the stress of the "coming out" process, and peer pressure is also an important factor (frequently negative).
11) "Youth & beauty" issues oppress both gay men and lesbians that are not part of the feminist movement. Alcoholism accelerates the aging process.
12) Prior psychiatric "help" has labeled many lesbian alcoholics with psychiatric labels instead of alcoholism. Thus they have been misdiagnosed and mistreated. Lesbians may erroneously conclude that she is mentally ill because she is lesbian, and may identify with an erroneous diagnosis.
13) The coming out process is often stressful and may continue for years, on many levels.

B. Group and Family Related Stresses
1) Drinking milieus (bars, parties, etc.) are very prominent in lesbian/gay community functions. For many, alcohol drinking settings were the only places where gay people can "be themselves" without having to act a "socially defined" heterosexual role. Studies show that approximately 1/3 of urban lesbians/gays have alcohol abuse problems; most are also polydrug abusers.
2) Alcohol settings and drinking are often associated with "coming out."
3) Many negative myths about gay/lesbian couples cause a belief that coupling and bonding is temporary, superficial, unsatisfying, and "second rate." Approximately 1/3 of gay men and ½ of lesbians in San Francisco are in stable, ongoing relationships.
4) Older lesbians/gays have difficulty socializing.
5) Lesbians/gays often move away from their family of origin and face the uncertainty and stress of forming new social groups, new families.
6) As lesbians/gays, their oppression is not shared with their family of origin, as is the case of ethnic or religious oppression. Lesbians/gays must split off from the family to find support. Sometimes the family of origin is hostile. Coming out for the individual may also include the family's coming out experience.
7) Masculine role traits (e.g., independence, suppression of emotions) often make male-to-male bonding difficult.
8) Feminine role traits (e.g., passivity, merging, dependence) often make lesbian bonding difficult. Drinking might ensue as an escape from closeness and to avoid anger responses.
9) Lesbian mothers (approximately 1/3 of lesbians are also mothers) have the stress of having to be "super & perfect mothers." This unrealistic attitude is often internalized in the lesbian and may lead to alcoholism.
10) Lesbians, as are women in general, protected from the legal system, however "identifiable" lesbians are arrested more frequently and receive worse treatment in the criminal justice system.
11) Sexual activity among gays/lesbians are often associated with alcohol & drug use.

C. Cultural Stresses
1) Lesbians/gays are found in all socio-economic and racial groups, and a representative sample cannot be found. This cultural richness provides challenges and stresses (racism, sexism, etc.).

(CONTINUED)

ALCOHOLISM--STRESSES, Continued

2) Lesbians/gays have formed individual subcultures with a special language, customs, emerging qualities, ghettoization, etc., that provides support and simultaneously stresses of conformity. Many lesbians/gays are not part of these subcultures. [ED NOTE: Perhaps this is what distinguishes those of us who are merely "homosexually active" from those of us who consider ourselves "gay/lesbian."]
3) Many progressive, newly formed gay/lesbian institutions (e.g., political clubs, religious & athletic groups, etc.) promote drinking.
4) Many alcoholism treatment programs provide fewer services for lesbian/gay alcoholics. Some alcoholic treatment programs have homophobic milieus and homophobic staff.
5) Lesbians/gays are at greater risk for violence and rape. Often gay/lesbian bars & hangouts are located in unsafe sections of town. Lesbian/gay ghettos are often targets for street violence.
6) The health & holism movement has promoted many positive changes, however has not reached many groups of lesbians/gays.
7) Many lesbians/gays are visibly identified and discriminated against.

D. Lifestyle Stresses
1) Many diverse lifestyles exist in the gay/lesbian community. Most gays/lesbians are ordinary people that work, play, contribute to the community & lead productive lives.
2) Athletically active lesbians are socially encouraged to drink.
3) "Royal Court" and transvestite groups are strongly related to bar activities.
4) S&M individuals have social and sexual pressures to abuse alcohol and drugs.
5) "Youth & beauty" attitudes negatively affect both the young and physically attractive and individuals that feel they are no part of these categories.
6) Nearly all social events (discos, parties, athletics, etc.) promote drinking.
7) Some sexual milieus in the gay community promote alcohol & drug abuse.

E. Specific Lesbian Alcoholism Issues
1) The lesbian's family of origin has a high incidence of alcoholism which may include both parents and siblings. She will unconsciously seek out partnerships and social systems which replicate the dynamics in her family.
2) If her family was violent whe may find herself in relationships where she is battered or is a batterer herself.
3) Alcoholic women report a high incidence of sexual abuse as children. The lesbian continues as an adult at high risk for sexual abuse if she drinks in public places and is visibly intoxicated on the streets.
4) "Identifiable" lesbians have different consequences to their alcohol problems then heterosexual women. "Identifiable" lesbians report job difficulties and alcohol related arrests.
5) Younger lesbians, lacking drug/alcohol-free role models, often idolize the older, "wiser," more experienced, and often alcoholic lesbian and attempt to emulate and pair off with her.
6) Older lesbians may seek younger women to socialize with to cope with their own "loss of youth & beauty" issues.
7) Older lesbians are often in competition with each other for younger "more desirable" women.
8) Many lesbians who "come out" in mid-life after raising a family often find themselves with few peers to relate to.
9) Many lesbian mothers report difficulty finding partners willing to co-parent.
10) Lesbians have higher rates of suicide attempts than gay men or heterosexual women.
11) Lesbians often have to contend with counter transference issues in treatment.
12) Mental health professions who are not gay-sensitive or knowledgeable in alcoholism treatment often interpret the symptoms of alcoholism as symptoms of lesbianism and seek to change the woman's sexual orientation.
13) Many mental health professionals have difficulty working with "bonded" lesbian couples and inadvertently encourage separation.

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

(CONTINUED)

WHAT ARE SOME PRACTICAL TOOLS FOR GENERAL APPRAISAL OF ALCOHOLISM/DRUG ABUSE?

There are several easy-format, short-answer questionnaires available for STD workers (and others) in initially assessing a client about alcohol/substance abuse. If you are interested in assessment, then you should have a plan for intervention (see next issue!) and follow-up. Please!! Seek the services of experienced and knowledgeable gay/lesbian alcoholism professionals to help develop and supervise a workable program. We have a responsibility to our clientele to do so. Following is one set of questions that can be used:

Now I'd like to learn about your use of alcohol (or other drugs). How much do you drink, on the average? Has anyone ever said that drinking might be causing a problem for you? Has your partner/lover/spouse or someone close to you ever complained about your drinking? Have you ever had to consider cutting down on your drinking?

Yes/no questions usually elicit abrupt answers. Open-ended questions usually encourage longer responses. Both techniques may be useful. The CAGE Questionnaire asks four yes/no questions and is scored with 2 or 3 yeses strongly suggesting a problem with alcohol. 1) Have you ever felt you should CUT down on your drinking? 2) Have people ANNOYED you by criticizing your drinking? 3) Have you ever felt bad or GUILTY about your drinking? 4) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hang over (EYE-opener)?

The Short Michigan Alcoholism Screening Test is another yes/no question format with 13 inquiries. The answer noted parenthetically suggests an alcoholism-indicating response. 1) Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.) [NO.] 2) Does your spouse, parent, or other near relative ever worry or complain about your drinking? [YES.] 3) Do you ever feel guilty about your drinking/ [YES.] 4) Do friends or relatives think you are a normal drinker? [NO.] 5) Are you able to stop drinking when you want to? [NO.] 6) Have you ever attended a meeting of Alcoholic's Anonymous? [YES.] 7) Has drinking ever created problems between you and your spouse/partner, a parent, or other near relative? [YES.] 8) Have you ever gotten into trouble at work because of drinking? [YES.] 9) Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? [YES.] 10) Have you ever gone to anyone for help about your drinking? [YES.] 11) Have you ever been in a hospital because of drinking? [YES.] 12) Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages? [YES.] 13) Have you ever been arrested, even for a few hours, because of other drunken behavior? [YES.] Scoring: 0-1 points--nonalcoholic; 2 points--possible alcoholic; 3 or more points--alcoholic.

[ED NOTE: These assessment questionnaires were reproduced with thanks to the authors.]

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

FUTURE TOPICS ON GAY/LESBIAN ALCOHOLISM & SUBSTANCE ABUSE

In future issues of the NCGSTDS newsletter, contributors will write about intervention techniques--how to convince a person that they need help. Other topics are being considered. We invite your comments and reactions, and once again encourage your establishing close ties with local and national alcoholism/substance abuse personnel & agencies. Only togehter can we begin to effectively deal with the gay & lesbian community's (and America's!) reluctance to deal with this best kept secret and deception--alcophobia (the fear & willingness to confront alcoholism, etc.).

* * *

BERKELEY'S GAY MEN'S HEALTH COLLECTIVE--CORRECTED PHONE NUMBER

In the last issue of the Newsletter, the phone number for Gay Men's Health Collective in Berkeley was incorrect and should have read: 415/644-0425. Sorry for the error!

* * *

PROVINCETOWN/CAPE COD NEEDS PHYSICIANS

Health Associates of Provincetown, Inc., a licensed community health center is seeking applications for primary care physicians to fill immediate openings. Temporary and year round positions are available; family practice physicians preferred; Massachusetts license required. Competitive wage, liberal fringe benefits. If interested, submit curriculum vita to Administrator, Box 613, Provincetown, MA 02657, or call 617/487-9395. Health Associates is an equal opportunity employer.

* * *

PROJECT GRANTS FOR VD RESEARCH, DEMONSTRATIONS, & PUBLIC INFORMATION & EDUCATION

The announcement and deadline for receipt of applications to the Centers for Disease Control for "Project Grants for VD Research, Demonstrations, and Public Information and Education" has passed (March 1), much to the dismay of the NCGSTDS. The announcement arrived in mid-February, not enough time to notify NCGSTDS clinics and members. The remaining information is provided to encourage your application for the next fiscal year, and to notify the right officials so that you'll be on the mailing list for the request for funding proposals (RFP). Between $2-3 million will be available in fiscal year 1984 for continuation grants and new grants. The priority areas for funding include: 1) STD epidemiological and/or clinical research, including mathematical modeling; 2) demonstration activities in the areas of chlamydia control efforts, medical school faculty development, and surveillance efforts; and 3) public information and education efforts such as clinic-based patient education populations. For further information about the procedures and deadlines for 318(b) grant applications, call Leo Sanders (404/236-6575). [ED NOTE: The NCGSTDS has already expressed dismay at not being notified earlier about the availability of these funds; the CDC promised (when did we hear that word!) to get notices out earlier, and apologized for overlooking our members. It is still best for individual clinic administrators to contact Leo Sanders immediately, to ensure that you'll be notified in a more timely manner.]

* * *

VD CONTROL DIVISION CHANGES NAME

Effective immediately, the VD Control Division of the Centers for Disease Control will be known as the Division of Sexually Transmitted Diseases (DSTD), because of the greater scope of the term "STDs" over "VD." "Venereal disease" refers to the classic five diseases whereas "STD" refers to a matrix of over 50 different organisms and syndromes.

* * * *

STD NATIONAL CONFERENCE

The 1984 STD National Conference is scheduled for Kansas City, Missouri, May 29-June 1. In addition to the program content emphasizing practical demonstrations and discussion workshops on specific subjects, there will be a softball game among program staff of the Division of STDs (formerly VD Control Division). For more information, contact the DSTD, CDC, Atlanta, GA 30333, or call 404/329-2552.

* * *

SURVEY OF RESEARCH ON STD

The 1983 edition of Survey of Research on Sexually Transmitted Diseases from the Centers for Disease Control (publication #99-1834) is available from the Division of STD. Write: DSTD, CDC, Atlanta, GA 30333, or call 404/329-2552. The Survey contains 104 pages of abstracts and bibliographies on gonorrhea, syphilis, herpes, other STDs including AIDS, epidemiology and pharmacology.

* * *

MONTREAL HEALTH PRESS: 66,000 COPIES OF "A BOOK ABOUT STDs"

Montreal Health Press recently announced that 66,000 copies of their popular "A Book About Sexually Transmitted Diseases have been distributed since September, with the French edition now also available. Individual copies are available for $2.50 (US funds) each, for a maximum of 10 copies. In addition to the Book About STDs, two other booklets are available--A Book About Birth Control and A Book About Sexual Assault. For additional information, write or call: Montreal Health Press, P.O. Box 1000, Station G, Montreal, Quebec H2W 2N1 (514/272-5441).

* * *

AN OUNCE OF PREVENTION: STD AIDS RISK REDUCTION GUIDELINES

by New York Physicians for Human Rights & Gay Men's Health Crisis

A new brochure written by the New York Physicians for Human Rights is being distributed by New York's Gay Men's Health Crisis: "An Ounce of Prevention--STD/AIDS Risk Reduction Guidelines for Healthier Sex as Recommended by New York Physicians for Human RIghts." Copies of the brochure or a large format heavy stock poster are available without charge from GMHC: Box 274, 132 W. 24th Street, New York, NY 10011 (212/807-6655). Eleven points are presented: 1) Know your partner, his state of health, his lifestyle and how many different sexual partners he has. If you enjoy being with a partner, see him again. The fewer different partners, the less your risk of acquiring disease. 2) Engage in sex in a setting which is conducive to good hygiene. Be certain to wash any part of the boy contacting the rectal area before contact with the mouth. 3) Both partners should shower together as part of foreplay to check for sores, lymph glands, etc... which might not have been noticed by the other partner. 4) Kissing, cuddling, massaging and mutual masterbation have a very low risk of transmitting disease. 5) Exchanging certain body fluids has a higher risk of transmitting diseases. Swallowing semen, urine or feces increases your risk of acquiring a STD. Oral sex when sores or cuts are present within the mouth has a high risk. 6) Rimming has an extremely high risk of transmitting disease except in a totally monogamous couple after examination by their health care provider. 7) Anal intercourse causes tiny tears in the anus through which germs from both partners can enter the body. Use of a water soluble lubricant helps reduce friction and tears and should be used even with a condom. Wearing a condom may reduce the risk of transmitting diseases between partners. Anal douching before or after sex increases the risk of acquiring an infection because it removes normal barriers to infections. 8) Fisting is extremely dangerous no matter what precautions are taken. 9) Urinating after sex may reduce your risk of acquiring some infections. 10) Reduce or eliminate the use of all street drugs, alcohol and marijuana as studies have shown these may impair the body's immune system and your judgement. 11) Maintain your body's immune system by eating well, excercising and getting adequate rest. Cope with stress by learning relaxation techniques (yoga, self-hypnosis, etc.). See your physician on a regular schedule to be checked routinely for inapparent diseases. The brochure concludes with the following message: SEX IS AN IMPORTANT PART OF OUR LIVES. WE OWE IT TO OURSELVES AND TO OUR PARTNERS TO KEEP IT AS HEALTHY (LOW RISK) AS WE CAN.

[ED NOTE: It's good to see how the NCGSTDS's very own "Guidelines & Recommendations for Healthful Gay Sexual Activity" provided the impetus for other groups to write risk reduction guidelines. Since the Coalition's ongoing project, first started in 1979 (and copywrited initially in 1981), Bay Area-, American Association-, and New York Physicians for Human Rights are just a few groups that have issued such guidelines. Others include: Can We Talk? (San Francisco's Harvey Milk Gay Democratic Club), Play Fair! (San Francisco's Sisters of Perpetual Indulgence), and others. Can you help us remember other efforts? Write: NCGSTDS, PO Box 239, Milwaukee, WI 53201. Special kudos to those groups that have wisely combined STDs with AIDS, instead of treating them as separate entities.]

* * * * * *

LETTER TO THE EDITOR

Dear Friends: I appreciate the reprinting of my article from AID Atlanta Newsletter. It, in turn, was reprinted from WOMANEWS, New York City's feminist newspaper (PO Box 220, Village Station, New York, NY 10014) the July-August, 1983 issue. I would appreciate your printing a correction about my institutional affiliation. I'm associated with the St. Mark's Women's Health Collective, 9 Second Av., New York, NY 10009 (212/228-7482). We are formerly the Lesbian Nignt of the St. Mark's Clinic, but became independent of that group and assumed our present name several years before the formation of the Community Health Project. After 10½ years of continual service, we are the nation's oldest all-lesbian clinic. We have recently moved and are actively seeking new health workers and patients. Thanks for your Newsletters--as informative and useful as ever. Hope to see you in New York in June! [The Third National AIDS Forum/First International (& 6th National) Lesbian/Gay Health Conference.]

--H. Joan Waitkevicz, MD

* * * *

FILM FESTIVAL FOR GAYS/LESBIANS IN SAN FRANCISCO

Entries are now being accepted for the 8th San Francisco International Lesbian & Gay Film Festival, June 18-24, 1984. Held each year during that city's Lesbian/Gay Freedom Celebration, the Festival brings together the best in feature, documentary, shorts, and video by and about lesbians and gay men. The Festival has been established by Frameline, a non-profit media organization, to develop an audience for lesbian & gay cinema and to promote a demand for quality productions and wider exhibition both within and outside the lesbian/gay community. Over 60 entries were screen to audiences numbering over 7000 in 1983. Awards will be presented to outstanding films in the categories of feature, documentary, short and super-8 films. The deadline for entries is May 1, 1984. Formats accepted are 35mm, 16mm, super-8, 3/4" and ½" VHS video cassette. For entry forms (please specify film or video) and more information contact: Frameline, PO Box 14792, San Francisco, CA 94114 (415/861-5245). [ED NOTE: Isn't there anyone out there interested in developing gay/lesbian health promotion, risk reduction, and related films/videos, eroticizing condoms & other "healthy/safe-sex" issues?? Not enough time to develop such a project for this year's deadline? Think about next year now! And let the NCGSTDS know!!]

* * *

TULSA, OKLAHOMA STD CLINIC

The University of Oklahoma-Tulsa Medical College has established a sexually transmitted disease clinic that is staffed by a physician who is interested in providing services for gay patients. The Clinic also has a list of private practitioners in the Tulsa metropolitan area who are sensitive to the needs of gay patients which is used for specialty referral. Please feel free to refer individuals seeking medical care in the Tulsa area to this clinic. For additional information, contact: Dr. Jeff Beal, MD, Tulsa Community Internal Medicine Center STD Clinic, 2815 S. Sheridan Rd., Tulsa, OK 74129 (918/838-7331).

* * * *

LIFE WITH AN AIDS PATIENT, Continued from page 32

I lost a good friend to AIDS. If just one person changes his habits to try and give themself a better quality of life and possibly avoid the AIDS scene, then the purpose of this article has been accomplished.

It is apparent to me that Wisconsin — not only the gay community, but the community at large — is trying very hard to ignore this menace. Don't worry though, the price will be paid later. The threat of AIDS is much worse today then it was two years ago, although the media has not been giving much attention to the ongoing problem lately. When Scott was first diagnosed in July of 1982, there were only about 500 cases known. Today that number is well over 3,600.

I hope you live to a healthy old age as I intend on doing.◀

AIDS EPIDEMIOLOGY & SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity

As of April 2, 1984, the Centers for Disease Control AIDS Activity reports a total of 3954 cases of AIDS in the United States (CDC definition). Homosexually active men account for 71.3% of all cases; 17.6% from IV drug abusers; 4.2% from Haitians; 0.7% from Hemophiliacs; and 6.2% from those in no apparent risk/unknown risk group. 22.4% are from individuals aged 29 or less; 46.8% from ages 30-39; 21.4% from ages 40-49; and 8.8% from ages 50 or greater; the remainder are in unknown age groups. 57.5% of the individuals are white; 25.7% are black; 14.5% are hispanic; 2.4% are other racial/ethnic groups or unknown. 46 states (including Puerto Rico and the District of Columbia) have reported cases to the CDC; New York and California have the most cases, with 43.1% and 22.8%, respectively; Florida has 6.9%; New Jersey, 6.6%; Texas, 3.3%; Illinois, 1.9%; Pennsylvania and Massachusetts, 1.6% each; Georgia, 1.2%; Connecticut and Maryland, 1% each; all other areas/states have less than 1% each. Overall case-mortality is 44%. AIDS cases per million of population for the entire US is 17.5, ranging from 174.4 cases per million in New York City, 144.9 in San Francisco, 99.6 in Miami, 57 in Newark, 44.3 in Los Angeles, to "elsewhere" where it is 6.3 cases per million. These cases represent only those meeting the CDC's strict criteria of case definition.

* * * * * *

CAUSE OF AIDS ANNOUNCEMENT "FORTHCOMING" BY CDC

with thanks to Thomas Steele and the New York Native, April 9-22, 1984

Centers for Disease Control (CDC) Director Dr. James Mason and other CDC officials met with staff of the New York Native and Christopher Street, March 28th to discuss work on the purported etiologic agent of AIDS. Mason said that the work in progress at the CDC on the French retrovirus, Lymphadenopathy-Associated Virus (LAV), and related viral strains looked very exciting and that within weeks he hoped to be able to make announcements that LAV has been associated with AIDS as a causative agent. Mason said the work on LAV was still not sufficiently thorough to make the announcement at this time but that CDC had decided to "go after the gold"--put all their eggs in the LAV retrovirus basket. LAV was isolated by French researchers at the Pasteur Institute in Paris over a year ago (Science, May 20, 1983, p. 868), however, the CDC did not begin working on LAV until February, 1984. When Mason was questioned about the standing of CDC research on the association between AIDS and Haitian-strain African Swine Fever Virus (ASFV), Mason replied that based on serological tests performed in June, 1983 (Haitian strains were not tested), ASFV did not seem like a promising lead. He defended CDC's position about not proceeding on all AIDS leads because the agency has limited personnel, laboratory space, and funds, and that all emphasis on research would be placed on retroviruses.

* * *

TREATMENT FOR SHINGLES: CIMETIDINE

by James E. D'Eramo, PhD, with thanks to the New York Native, 2/27-3/11/84

Shingles (herpes zoster) is a severe skin rash characterized by itching and pain, caused by the herpes varicell-zoster virus, which causes chickenpox upon initial infection. Shingles occurs when this virus is reactivated, often during a period of severe nervous stress. Shingles may also develop in those whose immune systems appear to be profoundly suppressed (e.g., cancer & AIDS patients). Although shingles is a self-limiting infection (going away by itself), the itching and pain often drive the afflicted to seek treatment for relief of the symptoms. Antiviral drugs like interferon and acyclovir have been used to treat shingles with some success. In a letter to the February 2 New England Journal of Medicine, Mavligit and Talpaz of the University of Texas System Cancer Center report on the successful use of cimetidine (the ulcer drug) for treatment of shingles. These physicians were using cimetidine to try to restore the immune response of cancer patients and discovered that it was effective in resolving shingles. Two days after one kidney cancer patient with shingles was placed on the drug, there was not only a dramatic improvement in the symptoms and a healing of the lesions, but there was an improvement from a state immune system incompetence to a state of competence within a week. The researchers note that in addition to the possible antiviral effects of cimetidine, its immune-restorative effects might be due to its inhibitive effects on suppressor T-cells. The researchers onclude, "If confirmed by larger controlled trials our small experience in four patients would offer not only a practical rapid relief of symptoms in herpes zoster, but perhaps also in other herpetic infections, such as herpes genitalis." These observations suggest that the postulated immune-restorative effects of cimetidine on people with AIDS and AIDS-related complex should be thoroughly investigated.

* * *

WISCONSIN GOVERNOR ISSUES AIDS MONTH PROCLAMATION

Wisconsin's Governor Anthony S. Earl recently proclaimed February as AIDS Awareness Month and issued the following statement:

"Whereas, the Acquired Immune Deficiency Syndrome, commonly known as AIDS, is a mysterious, potentially fatal disease which has become a national public health crisis; and Whereas, as of January, 1984 the Centers for Disease Control had reported over 3000 cases of which 43% have resulted in death; and Whereas, in Wisconsin, the Division of Health has confirmed 4 cases with 20 suspect cases additionally under surveillance; and Whereas, knowledge of the causes of AIDS and proper treatment will assist in efforts to curb the disease particularly among specially effected populations of gay males, intravenous drug users and Haitians; and Whereas, the Brady East STD Clinic-Milwaukee, the Blue Bus Clinic and the Wisconsin Lesbian/Gay Network-Madison, have worked with the gay community and public health officials to deal with individuals at risk for AIDS; and Whereas, the Medical Society of Wisconsin has undertaken special efforts to ensure access to medical treatment for AIDS on a non-discriminatory basis and to foster education about AIDS; and Whereas the Medical College of Wisconsin has assisted in the medical education and research on AIDS; and Whereas, the Blood Center of Southeastern Wisconsin and other voluntary blood centers have cooperated to secure adequate blood supplies in lieu of donations from individuals at risk who have voluntarily withdrawn from blood donation; and Whereas, the Governor's Council on Lesbian and Gay Issues; Brady East STD Clinic, Milwaukee; the Howard Brown Memorial Clinic, Chicago; and the Cream City Association Foundation, Milwaukee; are cosponsoring the Great Lakes Lesbian/Gay Health Conference on "Abuse, AIDS, Alcoholism" in Milwaukee on February 17 through 19, 1984; Now, therefore, I, Anthony S. Earl, Governor of the State of Wisconsin, do hereby proclaim February, 1984 as AIDS AWARENESS MONTH in Wisconsin in recognition of the many efforts already undertaken to address the problem of AIDS in Wisconsin, and I urge further efforts by the medical community, public health agencies and citizens generally to be aware of the AIDS public health crisis and assist in efforts to combat AIDS. In testimony whereof, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this twenty-seventh day of January in the year of Our Lord, one thousand nine hundred eighty-four. [SEAL & SIGNATURE.]"

[ED NOTE: This speaks for itself!]

* * * *

BATH HOUSE UPDATE

reprinted with thanks, Can We Talk?, San Francisco AIDS Foundation

The San Francisco AIDS Foundation and the Northern California Bathowners Association are pleased to announce the result of a series of meetings held over two months, resulting in an extensive plan for the dissemination of AIDS risk reduction information within the bath houses. The staff of the bath houses will be offering a condom and the "Can We Talk?" risk reduction brochure to each patron as he enters the facility, and will make additional free condoms available within the bath house. In addition, the baths have posted the now (in)famous "You Can Have Fun, And Be Safe Too" poster, and will be posting sexual hygiene signs in the near future. Many of the baths will also be stocking a variety of AIDS related brochures and newsletters for patrons interested in more information. At a meeting held on February 8th, the owners of San Francisco sex clubs agreed to institute a similar program in their establishments. These new agreements are part of the San Francisco AIDS Foundation's continuing efforts to promote "self-sex" sex, in which the possibility of transmitting any disease, including AIDS, is diminished. By providing patrons at baths and sex clubs with accurate information about AIDS, the Foundation and bath house management feel that people will be able to make more informed choices about their sexual activities. By providing free condoms it is hoped patrons will will feel more comfortable in directly dealing with the issue of reducing AIDS risk. It is hoped that through these and other educational activities, gay and bisexual men can learn to make long lasting changes in sexual behavior which will reduce risk during this health epidemic. If you patronize baths or sex clubs, be sure to let the amnagement know that you appreciate their efforts and concern in instituting this program! If a particular bath or club which you frequent hasn't instituted the program, let the management know that you think it's important that they help to educate their patrons about AIDS. For more information, write or call: SF AIDS Foundation, 54 Tenth St., San FRancisco, CA 94103, 415/864-4376.

* * * * *

* *

"GETTING YOUR AFFAIRS IN ORDER"--NEW BROCHURE FOR PEOPLE WITH AIDS

The San Francisco AIDS Foundation recently announced the availability of a new brochure for people with AIDS, "Getting Your Affairs in Order." Since noone can predict when an accident or illness can befall a person, it is important for healthy persons as well to attend to these details. The brochure has a worksheet where important phone numbers & names, insurance documents, financial information, and other related details can be recorded for future reference. The brochure was written by Michael Helquist. Contact the AIDS Foundation for a sample copy: 54 10th Street, San Francisco, CA 94103, 415/863-AIDS.

* * *

NIAID SPONSORS AIDS WORKSHOP ON COMMUNITY ORGANIZING

For the first time in history, an agency of the US federal government, the National Institute of Allergy & Infectious Diseases (NIAID) of the National Institutes of Health (NIH) has called together a workshop of 13 gay health providers as consultants to address the issues of educational outreach to the gay community regarding AIDS. NIAID plans to offer program planning resources to gay leaders in communities that express interest. Although NIAID director Dr. Richard Krause and Assistant Secretary for Health Dr. Edward Brandt will soon be resigning their positions (which may signify policy changes and realignment of agency priorities), sufficient momentum of offering such programs to gay community leaders is hoped to ensure the continuation of commitment of NIAID to the area of gay community education about AIDS. Communities with or without existing AIDS foundations, gay health organizations or similar groups are encouraged to contact JoAnn Kramer, T.J. Schmidt & Associates, 1302 18th Street, NW, Suite 303, Washington, DC 20036 (202/463-8556), for additional information. Although NIAID's primary focus is reseach, these outreach activities fall under the category of "technology transfer," and signify an expansion into a new area of research, educational outreach. The Washington, DC, Los Angeles, Dallas, and Boston gay communities have already cosponsored programs with NIAID. The 13 participants in the workshop included several psychologists and physicians, a physician assistant, and a consultant to NIAID. They were: Walter Batchelor (American Psychological Association, Washington, DC); Mark Behar, PA-C (NCGSTDS, Milwaukee); Brett Cassens, MD (American Association of Physicians for Human Rights [AAPHR], Philadelphia); Don Clark, PhD (San Francisco); Harold Kooden, PhD (New York); German Maisonet, MD (Los Angeles); Alan Malyon, PhD (Los Angeles); Stuart Nichols, MD (New York); Larry Puchell, PhD (Washington, DC); Neil Schram, MD (AAPHR, Los Angeles); Jack Whitescarver, PhD (NIAID, Bethesda); Richard Krause, MD (NIAID, Bethesda), and JoAnn Kramer (consultant, T.J. Schmidt & Associates, Washington, DC).

Although specific recommendations will be forthcoming from the advisory group and printed in the next issue of the Newsletter, several impressive observations may summarize the meeting. 1) The lack of consensus of definitions among gay health workers for common terms such as: gay men vs. homosexually active men vs. multiple partners vs. secretion sharing, in terms of targeting risk reduction information to, mandates that we always clearly define our terms and never assume anything, even among our peers and colleagues--regional variations and influences help account for the lack of such common understandings. 2) The importance of the association of chemical abuse (especially alcohol) in AIDS and other gay health problems. 3) The identification and reinforcement of all positive aspects of "community" and "gay family" are integral to our physical and mental health. An emphasis of getting people involved in some gay/lesbian identified social group will help facilitate positive growth, self-esteem, & personal respect for self and others. Existing gay organizations must be encouraged to promote outreach to the "isolated" gay. 4) NIAID's interest in helping the organized gay commu- governments, fire/paramedic departments, etc.) for AIDS education & awareness programs could have positive, long range ramifications. 5) The importance of seeking out other health care models and learning from the experience of others--for example, the Alcoholics Anonymous/Alanon model for "sex compulsives;" and the Planned Parenthood teen peer-counselor and peer-theatre social modeling programs for AIDS education and "social skills/safe sex reconstruction." 6) The importance of associating anxiety and stress with "compulsive" sex (as with eating, gambling, alcohol/drug use, tobacco use, etc.) in addressing and understanding underlying motivations of people doing high-risk sexual activities.

(CONTINUED)

NIAID SPONSORS AIDS WORKSHOP, Continued

On the basis of these preliminary conclusions, several long range goals may also be considered: 1) The encouragement of using gay professional task forces to advise the federal government on all aspects of health & welfare. Members of these advisory councils should constantly be changing, with gay leaders priming new leaders to take these positions. 2) The development of networks that will continue to foster open communication and dialog among gay health workers and government & private officials. 3) The collection and tabulation of workable ideas & programs for implementation of AIDS & healthier sex outreach programs and to make this information readily available. The format could be a simple check list. The development of an information-sharing nationwide computer network among gay health clinics is underway through the National AIDS Prospective Epidemiology Network (NAPEN) or other organizations. 4) Utilization of existing meetings (AAPHR/CASTDS/NCGSTDS, APHA, NL/GHC, NAGAP, etc.) to bring together gay health workers for regular reassessments of these and other projects, and to offer recommendations to NIAID and other federal officials as necessary. 5) Finding ways to help gay/lesbian organizations enlist more members of the community to their groups and encouraging greater reliance upon those groups for support of healthy sexual activities and stress reduction.

The next issue of the Newsletter will offer specific recommendations. [The opinions & summaries in this article are that of Mark Behar, and are not of the thirteen workshop participants.]

* * *

CHICAGO CLINIC PARTICIPATES IN FEDERALLY FUNDED STUDY

The Howard Brown Memorial Clinic of Chicago, with Dr. David Ostrow as principal investigator, recently received a $2.97 million contract to participate in a study to identify the natural history of AIDS in homosexually active men. This research will be conducted as part of a multi-center effort which includes researchers at the Johns Hopkins University (Baltimore), the University of Pittsburgh, the University of California at Berkeley, and the University of California at Los Angeles. Research sites were selected to include populations at both low and high risk of AIDS. The focus of the research at HBMC will be a four year prospective study of over 1000 homosexually active men. Recruited individuals will be given a detailed questionnaire, physical examination, and various immunologic tests twice a year. The study will follow three different groups of men--800 initially healthy men who will form a core "control" group, another group of men who have "prodromal" (precursor) symptoms possibly related to AIDS, and men who are sexual contacts to individuals in the latter groups or to persons with diagnosed AIDS. Information about these three groups will be compared to determine the natural course of immune functioning and deficiency, the outcome of various "prodromal" symptoms, and possible risk factors for contracting AIDS. Enrollment in the study will be limited to homosexually active men between the ages of 18 and 60. In order to insure that study participants are representative of the at-risk gay male community, there may also be some quotas on age and race. Detailed recruitment information and applications are now available from the Clinic. Of the $2.97 million that HBMC will receive over the next 4 years, about 60% will be paid to Northwestern University Medical School as a subcontractor for immunologic testing and statistical analysis. The remainder of the funding will be used by HBMC for recruitment, testing and examinations, and overall administration of the study. As with any federal contract, use of the monies is restricted to the specified research and there are no funds available within the contract to fund regular clinic operations, including the AIDS Action Project. Funding for these programs must continue to be supported through patient fees, donations, and other fund-raising efforts. HBMC brings many years of clinical experience and high quality research to bear on a project of this scope. The clinic was instrumental in the research of hepatitis B, including the prevalence and efficacy trials that led to the development and approval of the hepatitis B vaccine. Other HBMC research has focused on the use of interferon in the treatment of recurrent genital herpes, in-depth studies of Neisseria gonorrheae and N. meningitidis, evaluations of gonorrhea plating media and the immunologic evaluation of hepatitis B vaccine nonresponders.

* * *

CANADIAN AUDIO-VISUAL MATERIALS ON AIDS

with thanks to Toronto's The Body Politic, April, 1984 and Ken Popert

A videotape made to combat hysteria and misinformation about AIDS is ready for use, according to Toronto free-lance producer Michael Riordon. AIDS: After the Fear is the second AIDS piece put together by Riodon. A videotape for health-care workers is already in circulation. The making of both videotapes was funded by the Ontario government, the City of Toronto, the AIDS Committee of Toronto, and several other organizations. Another video production, The Facts on AIDS, produced by Vancouver's Gayblevision, is already being shown across Canada. For additional information, contact the AIDS Committee of Toronto, Box 55, Station F, Toronto, Ontario M4Y 2L4 (416/926-1626), or AIDS Vancouver, 355 Burrard St., 19th Floor, Vancouver, British Columbia V6C 2J3 (604/687-AIDS.

* * * *

CANADIAN AIDS UPDATE

with thanks to Toronto's The Body Politic, April, 1984, and Ken Popert

New government funding for AIDS research has been made available. On February 3, federal health minister Monique Begin said that an additional $1.5 million is to be spent during the next three years. In Toronto, University of Toronto epidemiologist Colin Soskolne announced a 4 year, $1.3 million study financed by the Ontario government. The study will monitor the health of more than 400 selected homosexually active men. According the Canadian Laboratory Centre for Disease Control, an apparent large increase in AIDS cases in February is merely the result of a change in the methods used to track the national total. The actual rate of increase appears to be smaller than originally suspected. As of February 29, ACT reports 69 cases of AIDS, of which 37 have so far been fatal. Known gay men account for 54% of all cases, while women make up 12% (heterosexual or lesbian).

* * *

CRACKDOWN ON GAY BATHS & CLUBS PLANNED IN VANCOUVER

with thanks to Toronto's The Body Politic, April, 1984, and Gillian Rodgerson

The Vancouver (British Columbia) police and the health department hope to regulate gay clubs and baths more closely, according to a report submitted to Vancouver's city council's community service committee, March 8. The spread of sexually transmitted diseases by "casual sexual contact" and the supposed presence of juveniles at the clubs are cited as reasons for a planned crackdown. The report says that "a number of premises have opened in the city which cater specifically to members of the gay community," and that police lack "proper access" to the clubs and baths and are therefore unable to "control" sexual encounters, according to an article in the Vancouver Sun. The report complains about possible juvenile prostitution, drug use, and the production of pornographic films on the club's premises. The report says, "The Health Department recognizes that casual sexual contact cannot be eliminated and that a programme of health education and better contact tracing, treatment and follow-up is necessary to minimize the spread of disease."

* * * * *

RISK REDUCTION GUIDELINES BEING COLLECTED

Almost 50 samples of patient education brochures and pamphlets geared to risk reduction for STDs and/or AIDS in the gay/lesbian community has been collected by the NCGSTDS. We are seeking additions of all such available materials in preparation for a catelog of brochures. If your group hasn't sent the Coalition a sample of your educational & risk reduction brochures & materials, please send us a copy, NCGSTDS, PO Box 239, Milwaukee, WI 53201. In the next issue of the Newsletter, we will print a listing of materials by city. Thanks!

* * * *

MEDIA AS SOURCE OF INFORMATION ABOUT AIDS

reprinted with thanks from the AIDS Action Project Newsletter (Howard Brown Mem. Clinic)

Our perceptions of AIDS are frequently formed by what we see, hear, or read in the media. In fact, few people have either access or the inclination to scan the medical journals or rigorously question researchers to obtain information about AIDS. As a result, we rely on the media--newspapers, television, radio, popular magazines--to investigate information about the syndrome and report on new developments which may affect us. We rely on the media for clear and accurate information to use as the basis for personal decision-making about AIDS. However, for several important reasons, the media may not be our best source of information. The following will attempt to briefly explore some of the limitations of information gained through the media and a few of the alternatives available for those wishing to obtain more complete information about the syndrome, who it affects, and the current status of our knowledge. One of the problems the media faces in its reporting of AIDS is that the syndrome is not a simple, easily understood medical problem. AIDS is so complex a phenomenon that many medical personnel do not fully understand it, let alone the non-medically trained individual. Thus, we have a complex medical situation that is often being interpreted for us by non-medical people whose primary goal is to tell a story in the shortest amount of time (or space) and still attract our attention. It becomes very difficult to cover AIDS accurately in one or two paragraphs or one or two minutes [of air time]. And while many journalists are expert in their profession, they may not be expert at interpreting relatively esoteric medical information or in accurately judging the impact of incorrect or partial information. As the public's concern about AIDS has increased, so has the extent of media coverage. Much of this expanded coverage has ahd beneficial effects. However, this increased coverage is frequently accompanied by a lack of balance or proper perspective. For example, extensive coverage is often provided inconclusive research reports or personal opinions as opposed to really new or significant information about AIDS. In addition, AIDS feature articles frequently receive banner headlines designed to attract our attention. These headlines are successful in attracting our attention, but we sometimes don't bother to read the rest of the story. There are several problems with headlines. One is that they may not accurately reflect story content or focus, and usually are not even written by the reporter writing the story. Secondly, headlines reduce the complex information even further, thus increasing distortion. Television coverage of AIDS can be equally problematic. It is generally impossible to relate complex medical information adequately in two minutes or less. Physicians, researchers and service providers may spend hours with a reporter only to find several seconds of their interview aired. So called "in depth" reports on AIDS often take factual information out of context both to fit the time constraints of the broadcast and the intended message. This type of coverage may leave more questions than answers in the minds of most viewers. There are obvious lessons to be learned from this examination. We cannot completely rely on the media for all of our information about AIDS. But if we choose to, it becomes incumbent on us to recognize the limitations of this information and not accept it as gospel. We can depend on the media to alert us to new developments concerning AIDS and use this limited information as the basis for more fact-finding. If a topic is important to you, seek out additional information from reliable sources (a reputable medical journal or organization, for instance). And, pay close attention to the whole story, not just the headlines or TV lead-in. Bemember, information is an important and useful tool in a time of uncertainty and crisis. But this tool is only useful if it is accurate. Don't believe everything you read or hear. Check it out before you pass it on and you will have contributed something very valuable to a confusing and frustrating situation.

[ED NOTE: One addendum--few journalists, no matter how well intentioned, can provide a sensitive approach to AIDS or any other gay/lesbian event. The material may be factually correct, but otherwise insulting, demeaning, insensitive, inappropriate. The gay press is our best answer to this problem.]

* * *

WASHINGTON, DC: AIDS NEWS

with thanks to The Washington Blade, 3/6/84

The AIDS Education Fund of the Whitman-Walker Clinic has consolidated contributions made in the memory of Jim McElwain, Don Jackson, Dirk Dieffenbach, and Gilfredo Angueira into an AIDS Foundation, which will provide direct financial assistance to persons with AIDS and their family members. The Foundation, which currently has over $18,000, has set up guidelines which include confidentiality and nondiscrimination on the basis of race, sex, or sexual orientation. Grants will be limited to $300 per person for any six-month period. The Foundation is also considering providing loans to those in need of assistance. For more information contact: 202/332-5939. The AIDS Infoline, operated by the AIDS Education Fund of the Whitman-Walker Clinic in cooperation with the Gay Hotline, Gay & Lesbian Switchboard, and the DC Commission on Public Health, has expanded its hours of service to 4-10 pm every day. To help keep the line open, the Fund has hired Luis Bothwell as program assistant. Bothwell will answer the phone during the day and coordinate eveing staffing. The AIDS Infoline is 202/332-AIDS.

* * * * *

WASHINGTON, DC: AIDS Evaluation Unit Established

with thanks, AIDS Education Fund Newsletter, Whitman-Walker Clinic (Vol. 1:3)

Have you ever had sexual contact with someone who has contracted AIDS? If so, [and you live in metropolitan Washington, DC] sound medical advice suggests you may want to visit the Whitman-Walker Clinic's newly established AIDS Evaluation Unit, funded by a $10,000 grant from the Eugene & Agnes E. Meyer Foundation. Taking advantage of the Unit's services will require five visits to the Clinic. The Evaluation Unit is not a diagnostic or testing service in the typical medical sense. There is no test for AIDS. What the Unit can tell you is only the extent to which your immune system is weakened. This is done by ruling out a series of ailments, disorders, or diseases which display symptoms similar to patients who have contracted AIDS. The first visit is the standard STD visit, with appropriate gonorrhea & syphilis tests and STD history. On the second visit a comprehensive blood analysis is made. The third visit begins with the completion of a 25 page patient history, and includes a series of skin tests to determine whether the body will react to exposure to certain common antigens. Past exposure to candida (yeast), tuberculosis, mononucleosis, and cytomegalovirus are determined. A fourth visit is then scheduled to evaluate the extent of one's reaction to the skin tests. The fifth visit is designed to inform one of the results of the tests, with volunteer physicians and other health workers available for counseling. At this point a person will find out the extent of immunosuppression. [ED NOTE: A questionable conclusion based on laboratory tests? Exactly how many different variables can transiently affect immune system functioning as identified by skin and blood testing?] Again, this does not mean one does or doesn't have AIDS. It simply tells you what potential problems you need to be aware of and what corrective action you could take to try to improve your immune system. Follow-up calls are made to determine how a person is heeding advice given. The services of the Unit are not inexpensive. While the professional staff are all volunteers, the medical testing is still costly--well over $500. The grant from the Meyer Foundation covers only part of these expenses. As a consequence, clients will be asked about medical coverage to help defray the costs of the program. For more information, call 202/332-5295.

* * *

WASHINGTON, DC HIRING AIDS STAFF

with thanks to The Washington Blade, 3/30/84

The District of Columbia announced that it will hire two full-time persons to fill positions to its Bureau of Epidemiology and Disease Control to work on the reporting of AIDS cases in the District. The positions, made possible by a $50,000 grant from the Centers for Disease Control, will include a Public Health Advisor who will serve as a field epidemiologist and a Statistical Clerk. According to the position announcements, the Public Health Advisor will perform surveillance activities "directed at improving the reporting" of AIDS cases in the metropolitan Washington area. The salary range is listed as $25,777 to 33,499 per year. The Statistical Clerk will compile and compute statistical data and prepare reports to the CDC. The salary range is listed as $12,565 to 16,336. Interested persons should contact: DC Office of Personnel, Human Services Cluster No. 1, 801 North Capitol St., NE, 2nd Floor, Washington, DC 20002.

* * *

REFLECTIONS FROM A BATHGOER

[ED NOTE: The following letter was received by Dr. Neil Schram, MD, President of the American Association of Physicians for Human Rights, by one of his patients. Anonymity was requested.] Some reflections on the current gay scene--through the eye of a recovering gay alcoholic/addict. (Do you know that one out of three gay men have a serious drinking problem (Fifield study, LA County, 1975)? My perspective may not be so unique!) I think men who go to the baths, backroom sex places, and, to a lesser extent, the bars, have problems with relationships, especially with other gay men. There is a compulsive aspect to the kind of sex that presents the highest risk, week after week. (I see the same men over and over at the baths I go to...and they see me!) The baths and backroom places are non-verbal, and that is part of their appeal, their draw. Men who go there are acting out (dealing with) their won conflicts over love, sex, and especially self-acceptance. "Sex" in these settings is often a cover for other issues--especially self-esteem, self-acceptance, the expression of love, and power relationships between gay men. I think men who may feel unable or unwilling to continue to frequent their old haunts may suffer increased depression, increased isolation, and guilt. And in some cases an increase in drug & alcohol use. I think part of the answer is not in providing alternative sexual situations, but in providing alternative social, expressive, and loving settings. Gay men need a place(s) to meet, talk, be caring, without sex as a primary issue. The current social outlets involve only a small number of gay men. I have seen an alternative for 3½ years, at work in Gay Alcoholics' Anonymous, where sex is rarely a major issue. Can new alternatives that really involve the community be found? Would a series of workshops, raps, and support groups for gays who are not involved be set up, in conjunction with the community? I think the community has to take a strong role in any search for the solution--one imposed from any "authority" is likely to be met with resentment and anger, and non-participation. This kind of involvement is not easy for most gay men, I believe. The numbers in current organizations probably doesn't amount to 10% of those in the concentrated gay areas (though this figure is just an impression, and could be wrong). The guilt over sex that is now seen as dangerous throws gay men back 20 years, to the time when any gay sex was dangerous because of the police and community condemnation. The question (for me, and many others, I think) is how to retain a sense of freedom as a gay person without the necessity for promiscuity and multiple partners. Some of the sexual patterns currently seen are compulsive, not entirely within the realm of free choice, and a cover for lots of other fears and anxiety. Getting through this old pattern to something better can ultimately be a good thing for the community, but there is already a high price to be paid during the transition--in fear, depression, and psychosomatic symptoms. You are, no doubt, seeing some of this in your practice. The answer, it seems to me, must be along the lines of increased opportunity to ventilate, to reduce anxiety...Finally, I want to reemphasize my strong belief that any attempts at providing new alternatives for gay men must involve these men in their planning stages, as well as in implementation. Something dictated from what will be perceived as the "outside" will be rejected. Best regards.

* * * *

POLL SUPPORTS SEX BAN IN SF BATHS PROPOSAL

reprinted from the San Francisco Examiner (4/8/84), by David M. Cole with thanks

An overwhelming majority of San Franciscans want to ban sex in gay bathhouses or to close them altogether as a method to help stop the spread of AIDS, according to a San Francisco Examiner poll. Some 80% of those polled April 5-6, 1984 favored such action in the face of increasing cases of AIDS. In an exclusive poll of adult San Franciso residents conducted for The Examiner by the public-opinion research firm of Fairbank, Canapary & Maullin, 44% said that sex should be banned in the baths, and 36% of those surveyed suggested that the bathhouses be closed altogther. Fourteen percent believed that neither proposal would work, and 6% said they didn't know. But the gay community seemed almost evenly split on whether the government should take some action at the baths. Among people identifying themselves as gay, 18% said the baths should be closed, 34% said sex should be banned at the baths, and 45% said neither proposal would work. The question of whether the city's baths should be closed or whether sex should be banned in them has been brewing for months. Gay activist & deputy sheriff Larry Littlejohn took the first step in qualifying a proposition for the November ballot that would ban sex in the baths. Soon after that, Public Health Director Dr. Mervyn Silverman told health professionals, city hall regulars, and members of the gay community that he had decided to close the baths. In the face of gay opposition and after reevaluating the evidence, he announced that he had made no decision and has spent the last week talking to members of the gay

(CONTINUED)

POLL SUPPORTS SEX BAN, Continued

community in an attempt to get a consensus on what action to take. [See related article for details.] One of the first questions the pollsters asked was if the bathhouses should be closed. This question, without background, found that 60% of those surveyed felt that the bathhouses should be closed, 28% disagreed, and 15% didn't know. The next question gave those surveyed some background on a proposal that would allow the bathhouses to remain open but would take measures to ban sex in the establishments. Fifty-three percent felt that these measures would be effective in combating AIDS, while 37% felt that the measures would not be effective. Ed Canapary, a principal of the research firm, suggested that the apparent flip-flop of results--at first 60% of those surveyed felt the bathhouses should be shut down, then after receiving the background information, 37% felt that they should be shut down--was because of the public's lack of understanding about the options open to Silverman and the health department. This was reflected in the reasons given by those who said the bathhouses should be shut down: 28% said closing the baths would prevent or stop the spread of AIDS, and 16% said baths were the source of AIDS. Only 11% said they had moral objections to the bathhouses, where it has been reported that a gay man can have between 10-15 sexual liaisons in a visit. Of those who wished to see the baths kept open, 25% said that closing them would deny the individuals freedom of choice. Nineteen percent said that it won't stop random gay sex, and 12% said closing the establishments won't solve the problem. Presented with both proposals--banning sex or closing the baths, 45% of the gay community surveyed felt that neither proposal was right; 18% said that baths should be closed, and 34% said that sex should be banned. In the general survey, of those who initially said the baths should be closed, 52% of the males and 62% of the females felt that the bathhouses should be shut down; 31.3% of the males and 25% of the females felt that the bathhouses should stay open. Of those who identified themselves as Hispanic, 77% felt that the baths should be close, compared to 55% of the whites and 59% of the blacks.

Examiner Poll: Closing the gay bathhouses

The first column reflects the views of the 554 persons in the general survey. The second and third columns reflect the views of those who initially said they favored or were against closures. The last column reflects the views of a special survey of 132 persons in the gay community. All figures are in percentages.

	General populace	Favor closure	Against closure	Gays
Measures to ban sex	43.5	35.6	59.0	34.1
Close the bathhouses	36.5	57.8	5.1	18.2
Neither	13.7	2.8	31.4	45.4
Don't know	6.3	3.8	4.5	2.3
Do you feel that this matter is something that should be decided by the city Health Department, put before the voters or handled by the gay community itself?				
Mention of health dept.	53.6	63.8	37.8	50.8
Mention of voters	22.0	24.1	17.3	7.5
Mention of gay comm.	28.5	17.5	47.4	56.1
Do you feel that AIDS can be contracted by . . .				
Eating food prepared by an AIDS victim				
Yes	3.4	4.8	—	—
No	64.5	62.5	78.2	89.4
Possibly	6.3	6.7	3.2	1.5
Don't know	25.8	26.0	18.6	9.1
Shaking hands or touching a person with AIDS				
Yes	5.4	7.3	1.9	—
No	72.2	69.5	86.5	93.9
Possibly	5.1	6.4	1.3	—
Don't know	17.3	16.8	10.3	6.1
Kissing				
Yes	28.0	30.8	21.1	10.6
No	28.1	23.8	40.4	48.5
Possibly	26.4	29.5	23.1	24.2
Don't know	17.5	15.9	15.4	16.7
Bathing in waters used by an AIDS victim				
Yes	24.9	31.8	11.5	4.6
No	28.0	23.2	43.0	69.7
Possibly	23.6	24.1	23.7	9.8
Don't know	23.5	20.9	21.8	15.9
Blood transfusion				
Yes	85.9	89.8	80.8	87.1
No	3.6	3.8	2.6	.8
Possibly	6.0	3.8	10.2	9.8
Don't know	4.5	2.6	6.4	2.3
Sexual intercourse				
Yes	90.8	94.0	87.2	88.7
No	2.4	2.5	.6	2.3
Possibly	3.2	1.3	7.1	4.5
Don't know	3.6	2.2	5.1	4.5

Examiner chart

Examiner Poll: Gays and the bathhouses

In the general survey of 554 persons, 51 identified themselves as members of the gay community. An additional 81 members of the gay community were identified by calling areas with a high concentration of gays and asking to speak with someone who was a member of the gay community. These figures are based on those 132 persons. All figures are in percentages.

	Total	Favor closure	Against closure
Initiate measures to ban sex	34.1	36.6	32.5
Close the bathhouses	18.2	48.8	3.6
Neither	45.4	7.3	63.9
Don't know	2.3	7.3	—
Do you feel that this matter is something that should be decided by the city Health Department, put before the voters or handled by the gay community itself?			
Mention of the health dept.	50.8	70.7	42.2
Mention of voters	7.5	12.2	4.8
Mention of gay community	56.1	34.1	67.5
Have you had occasion to frequent the gay bathhouses or not?			
Have	54.5	43.9	59.0
Have not	44.7	53.7	41.0
Refused	.8	2.4	—
Of those who have frequented gay bathhouses: Since the AIDS scare, have you visited the bathhouses less frequently, about the same as you did before, or have you stopped going completely?			
Less frequently	12.5	—	16.3
About the same	12.5	11.1	12.2
Stopped completely	56.9	61.1	57.2
Stopped before AIDS scare	18.1	27.7	14.3

Examiner chart

* * * *

SEX BETWEEN MEN BANNED IN SAN FRANCISCO BATHS

excerpted from articles in the San Francisco Chronicle & the San Francisco Examiner (thanks to authors Evelyn Hsu from the Chronicle & Seth Rosenfeld & Dave Farrell from the Examiner)

Public health director Dr. Mervyn Silverman announced a ban on sex in San Francisco's gay bathhouses and private clubs in an effort to stem the spread of AIDS. Silverman stopped short of shutting the bathhouses, and said that health inspectors would make periodic visits to the establishments--much as they now inspect restaurants for cleanliness--and those allowing sexual activity would lose their licenses. "We will be taking steps, with the support of many members of the community, to eliminated the bathhouses, sex clubs, bookstores, as places of sexual encounters between individuals or as a place where multiple sexual contacts take place," Silverman said. The order divided gays and confused Mayor Dianne Feinstein, who favored closing the bathhouses entirely. "Frankly, his written statement is very confusing," the Mayor said after reading it. "It does not deal with specifics or state what, if anything he is prepared to do." [ED NOTE: more on that below!] She added, however, "As I have said before, Dr. Silverman must act only for sound medical reasons. He has assured me that is the way he is proceeding." Her press secretary, Tom Eastham, said she cannot order health director Silverman to close baths, because he is an independent officer. Silverman's only boss in city government, Chief Administrator Officer Roger Boas, concurred. Silverman, flanked by about 20 gay leaders and physicians as he made the announcement, said his order "doen't necessarily mean the elimination of these places. It's what you do, no where you do it." But if baths and sex clubs and bookstores which have cubilces in the back where patrons engage in sex persist in allowing sexual activity on their premises, "they will be closed," he said. "We want these places to continue to operate, to be places for social gatherings, for exercise, for a number of things. They just won't serve the purpose served that they have served in the past. What we're trying to do is not have sex between individuals." Bathhouses frequented by heterosexuals will not be affected since AIDS is "not likely to occur among heterosexuals," he said. Changes in the police and health codes will be needed to give health inspectors the enforcement power to halt sex in the bathhouses, and the Board of Supervisors may be asked to bring sex clubs under city jurisdiction. The city attorney is still drafting the wording of these changes. Only owners of the facilities would be cited if sexual activity between two people is found to be taking place at a bath or club. No actions would be taken against the individuals involved, he said. Silverman's announcement follows two weeks of controversy in which the health director vacillated over whether to close the establishments. Since city officials and the gay community launched their campaign a year ago to promote changes in gay sexual practices, rectal gonorrhea has dropped 50%, indicating gays are being more cautious with their sexual contacts. The incidence of AIDS however, continues to rise. Silverman met with medical experts and said they were "unanimous" that sex in the baths should be stopped. He added that stopping sex is not the complete solution, since "there's always a number of people wou to kill themselves." But the controversy doesn't seem to be settled with Silverman's decision. At least one bathhouse owner said he would be put out of business and is considering legal action. And gay supervisor Harry Britt, who has backed medical experts who want the baths closed, said he found Silverman's plans "confusing and frustrating." He said he was concerned that Silverman's intentions could erode laws protecting the privacy of sexula activity between consenting adults that have given legal protection to homosexual activity. "I would be much more sympathetic to legislation that is specifically directed at the AIDS crisis rather than general legislation" that may extend "legal intrusions into the relationships between consenting adults," he said. "In the long run I don't want one set of rules for straight people and another set of rules for gay people." Supervisor Wendy Nelder, the president of the board, said, "It doesn't sound to me like he's taking any steps at all." Supervisor Richard Hongisto said Silverman's plan "doesn't sound like the ideal approach to me," adding that he isn't interested in instituting "bathhouse police" to crack down on certain sexual activities. Several events have brought the bathhouse issue to the fore recently, said one gay leader, including the nearing Democratic National Convention. Some gay leaders supported the plan. "I think there is a need for the baths but the function of the baths will be changed to provide a social setting for gay men to meet and interact," said Ron Huberman, a vice-president of the Harvey Milk Gay Democratic Club. Gay activist and deputy sheriff Larry Littlejohn, who proposed a November initiative asking voters to endorse a policy statement banning sex acts in the bathhouses, said it appears Silverman's decision removes the need for such a ballot measure. Announcement of Littlejohn's initiative set off a flurry of activity in the gay community. Alarmed by the growing incidence of AIDS and possible anti-homosexual reaction, a panel of gay

(CONTINUED)

SEX BETWEEN MEN BANNED, Continued

doctors and leaders met with Silverman and asked him to close the baths. Bathhouse owners and other gays then met with the health director in opposition to closure. Littlejohn, who helped found the Pride Foundation in San Francisco several years ago, said, " This is a necessary recognition of the seriousness of the problem, and I hope it shocks the gay community into realizing if we want to save our lives, we have to be realisitic and realize multiple sex acts expose us to the danger of AIDS." Others, including several men who have AIDS, were not so sure. "We feel this has been a shotgun approach," said person with AIDS Dan Turner of the People with AIDS Alliance. "We do not believe all sexual activity (at the baths) should be stopped." Turner said sexual activity should be allowed to continue provided participants take precautions such as using condoms. "I've had AIDS for two years. I have a lover. We practice safe sex. He's not at risk." Bill Jones, owner of the Sutro Baths, said Silverman's move in effect will shut down his business. "There will be an uprising about this. It has nothing to do with health. It's over politics. In effect it closes us down," he said. Glen Gerber, gay owner of the bathhouse Club San Francisco, said he doubts that a ban of the sort proposed could be effectively enforced. "Are they going to run around with a flashlight looking for people or knocking on closed doors during inspections? he queried. Although the specifics of public health inspection had yet to be settled upon, Silverman said he did not expect the task to be any more difficult than surprise visits to restaurants or hotels. Establishments would lose their licenses if they violated the regulations. Health officials acknowledge that activities that don't involve the exchange of blood and semen are not implicated in the spread of AIDS. But Silverman said it would be unreasonable to ask health inspectors to distinguish between "safe" and "unsafe" sexual practices in a bathhouse. Support from some people in the gay community hinges on the precise language of the new regulations, particularly the definition of Silverman's phrase, "sex between individuals." "Banning all sex, including 'safe' practices, is a mistake," said Bobbi Campbell, a spokesman for people with AIDS. "If (the new regulation) includes total banning, I will not support it." Turner agreed, stating "We don't feel it's necessary to go that far." "He said there could be no sex between individuals, but he did not say there could be no sex at the bathhouses," said Dr. Richard Andrews, who served on the advisory committee that Silverman convened to settle the issue. "There are many kinds of sexual outlets that do not necessitate contact between two people. I think the gay community is on the threshold of a new sexual revolution. I look forward to telling my patients they can go to the bathhouses as safe places,"Andrews said. "My sense is he has unilaterally moved to implement the Littlejohn initiative," said Paul Boneberg, president of the Stonewall Gay Democratic Club. "I'm not supportive of that. But I think it's better than closing the baths. I simply do not favor government intervention, except as an extreme effort," Boneberg said. He argued the community and bathhouses should have first been given a chance to institute voluntary reforms. "The question is are we getting the most bang for the buck? and I would argue no." Silverman said closing the baths under general health code provisions designed to protect public health is not the best way to deal with the AIDS problem: "If I want to abuse my powers, I could declare a health emergency any time I want. The fact that I've had the power in the past isn't the issue. The point is dealing effectively with the problem. That is what I am attempting to do right now." San Francisco health department inspectors who will be assigned to enforce proposed rules banning sexual activity in gay baths foresee no problems in carrying out these duties. Inspectors already enter gay bathhouses to check on sanitation and maintenance. There are approximately 45 inspectors in the department and two of them regularly monitor the city's gay and heterosexual bathhouses. They do such things as monitor pools and jacuzzis for proper chlorination and take water samples for bacterial analyses. Inspections would not be done by the police department. The sex ban will be enforced "the way we go in and monitor hotels and restaurants now; we go in generally unannounced. Only owners, not individuals involved, will be cited if a sex violation is found," Silverman said. Silverman also hopes to accomplish a sex ban by mandating structural changes in the bathhouses and sex clubs so they will no longer facilitate sexual encounters. Some of the changes being considered include requiring lighting to be turned up and boarding up "glory holes"--cutouts in the walls of closet-like cubicles and bathroom walls where anonymous sexual contacts take place--or tearing down the cubicles or removing their doors. Mattresses in "orgy rooms" may also be removed. Once new regulations are in place, baths & clubs that don't conform will be closed down. Although other establishments such as discos have been able to stay open for years sometimes pending an appeal, Silverman said this would not be the case with the baths because his broad powers as public health director will allow him to close a facility pending an appeal. He exercises that power now with restaurants accused of poor sanitation.

* * * * * *

CLOSURE OF BATHHOUSES DURING AIDS CRISIS--AAPHR STATEMENT

The following statement from the American Association of Physicians for Human Rights (AAPHR) was issued by president Dr. Neil Schram, MD, in March, 1984: "There is no definite evidence, at this time, that closing bath houses would reduce the risk or incidence of AIDS. We strongly state, however, that multiple, anonymous sexual contacts, occuring in any location, increases the risk of all sexually transmitted diseases, including AIDS. Attempts at legislating sexual behavior have only changed locations of that behavior, not curtailed it. We strongly favor, and request assistance for, educational efforts to reduce risks in the light of current knowledge; and indeed such efforts are facilitated at locations such as bath houses, bars, etc. We are prepared to work with bath house owners as well as the gay community to discuss risk reduction." For more information, contact AAPHR, PO Box 14366, San Francisco, CA 94114 (415/673-3189).

* * *

OPEN LETTER TO SAN FRANCISCO HEALTH DIRECTOR MERVYN SILVERMAN FROM AAPHR

[The following letter was written by AAPHR's president Dr. Neil Schram, MD. He urges others to write similar letters, and send copies to AAPHR, PO Box 14366, San Francisco, CA 94114.] Mervyn Silverman, MD, Director of Health, 101 Grove St., San Francisco, CA 94102; Dear Dr. Silverman: The American Association of Physicians for Human Rights is the national organization of gay and lesbian physicians and medical students. We are deeply disturbed by, and must strongly protest the consideration being given to closing the gay bath houses in San Francisco. As I'm certain you have heard, there are many other public health issues not being addressed--smoking, alcohol, overeating, and cyclists not being required [in California] to hear helmets. Why are these other areas not being addressed? Because each of these deals with personal freedom. Unfortunately, the bath house issue has become a civil rights issue, as well as a political one, not a medical one. It is clearly the responsibility of the medical community to educate people against high risk behavior. But in our society it is neither the place nor the responsibility of the medical community to try to force behavioral changes. Further, the San Francisco study [by Leon McKusick, William Horstman, & Arthur Carfagni, 1984, "Reaction to the AIDS Epidemic in Four Groups of San Francisco Gay Men."] shows that such behavior would simply move elsewhere. The closing of businesses to protect people from themselves can not be accepted. We must try to educate people there as well as elsewhere (and indeed it may be easier in bath houses), but ultimately each individual is responsible for himself. The gay community has finally found places where it is safe to meet other gay people without fear of arrest or harrassment. We can not accept what could be the beginning of the end of that major advance. Why could people not argue next that since "gay sex causes AIDS," prevent gay people from meeting each other, so close the bars. And finally, outlaw sex in the bedroom again. The gay community can not allow the return of repression that we have only so recently left--at least in California. It is still too prevalent in other states. There should be no misunderstanding, AAPHR strongly discourages sexual contact with multiple anonymous partners. But we can not and will not support any efforts tl enforce that viewpoint. I know that you have heard a lot of discussion of this issue and I know you have been very supportive of the civil rights of the gay community. We hope you will continue to resist efforts to change that support, and urge you not to. Sincerely yours, Neil R. Schram, MD."

* * *

BACTERIA IMPLICATED IN KAPOSI'S SARCOMA

with thanks to James D'Eramo and the New York Native, April 9-22, 1984

According to Los Angeles dermatologist A.R. Cantwell, Kaposi's sarcoma, one of the "marker" diseases of AIDS may be linked to a "variably acid-fast" bacteria similar to the causative agents of tuberculosis and leprosy, *Mycobacterium*. These bacteria are primarily identified by their ability to retain a specific stain described as "acid fast," a very specific microbiological staining procedure used to identify certain organisms. Certain Danish reseachers have had limited success in treating KS with dapsone, a drug used to treat leprosy and several other chronic skin diseases of unkown cause. Dapsone may act as an antimicrobial agent, however further studies are needed before the medication can be recommended for treatment of KS.

* * *

FUNDAMENTALISTS EXPLOIT PEOPLE WITH AIDS

excerpted from Bay Area Reporter (3/29/84) with thanks to Allen White

People with AIDS (PWA) are being exploited by fundamentalist evangelical Christian organizations. The exploits of these radical Christian groups surfaced with reports of "invasions" at the AIDS ward at San Francisco General Hospital and through a letter from the S.O.S. (Save Our Souls) group on the death of an AIDS patient whom they "salvaged." Augie O'Connor, the coordinator of chaplains at San Francisco General, related instances of what she called "a zealousness to convert." In one situation, a team of missionaries entered the AIDS ward under the guise of delivering toothbrushes, toothpaste and other personal items. Once inside the patient's room, O'Connor said they started to "witness" to people with AIDS. "Witness" is their word for proselytize. She said that fortunately for the patients, "we have built up our own kind of immune system, and we reject these types of foreign bodies." The people were ejected from the ward and the hospital within minutes.

* * *

QUARANTINE PROCEDURES READIED IN CALIFORNIA FOR PEOPLE WITH AIDS

excerpted from Bay Area Reporter (4/5/84) with thanks to Paul Lorch

Dr. James Chin, California's Chief of Infectious Disease, has begun the initial procedure of setting up a quarantine protocol for people with AIDS (PWA). Of special concern to Chin is what to do or what can be done to PWAs "who do not follow the recommendations for the health department." Chin was concerned over the AIDS patient who would have sexual relations with partners who did not know of his condition. First, the PWA would be contacted by the local health department, and informed in writing and by word of the "need to adhere to public health recommendations such as abstaining from sexual activities that could transmit a possible AIDS agent to sexual contacts who are unaware he has AIDS." Next, if the patient either denies he has AIDS or is "openly hostile and refuses to adhere to medical recommendations" that the local health department refer the patient to an AIDS support group who would counsel the patient. The idea is to help change his behavior by talking with peers. If this step failed, the public health official would go further and issue orders for a "modified isolation." The health department orders would detail the need to adhere to policies. It would also outline quarantine procedures that would be implemented. Again, if this warning failed and the PWA ignored the order to modify behavior, the local health department would take severe measures. They would quarantine the patient's residence by posting a sign at the person's address. The sign would indicate that a person "with a communicable disease which can be transmitted by intimate contact resides in the household." California's state attorneys were asked if the plan would encounter any significant legal problems for either the local health departments or the state. Health officers have broad authority to take such measures as may be necessary to prevent the spread of disease. In cases of contagious infections or communicable disease, the community's health may be protected through "isolation" (strict or modified) or through quarantine. Any violations of either stricture are reportable to the district attorney and, as they are misdemeanors, are punishable. In addition, if a person violates the isolation or quarantine, they abandon their right to confidentiality and privacy. Although a person's rights are guaranteed in the state's constitution, these rights are not absolute and "must be weighed against the necessity of protecting public health." State attorney Sharon Mosley commented, "There appears to be no need for a quarantine of a place." No statutes or regulations existed authorizing posting signs. The last law that permitted sign hanging was repealed in 1957. "In many cases, public exposure of this information would serve no productive purpose and would result in unwarranted invasion of privacy," she concluded.

In a related article reported by George DeStefano of the New York Native (April 9-22, 1984), the Judiciary Committee of the General Assembly of the state of Connecticut has voted to submit a bill mandating the quarantine of persons having an"infectious disease or condition" to a vote by the full legislature. The law would cover "individuals unable or unwilling to conduct themselves in such a manner so as not to expose other persons to the danger of infection," according to sponsor Richard Tulisano. Although the legislation makes no specific mention of AIDS, Rep. Tulisano admitted to Boston's Gay Community News that it was drafted in response to the widely publicized case of a New Haven prostitute said to have AIDS. CBS-TV's Sixty Minutes recently focused on the issue. Although Tulisano attempted to downplay the possibility that the proposed measure could be used to confine people with AIDS, a representative of the state's Department of Health Services testified that if a doctor certified that an AIDS patient was contagious, that person would be subject to quarantine under the provisions of the legislation.

* * * *

BOOK: THE AIDS ANTHOLOGY

Lon G. Nungesser is the author of a book to be published by the Gay Sunshine Press of San Francisco. The AIDS Anthology portrays the emotional impact of AIDS and presents valuable resource information to persons concerned about AIDS. Anthology is based on the individual life stories of events that really happened, and provides the emotional coping strategies and resources necessary to determine one's own history in the face of the AIDS crisis. Some of the issues the book plans on dealing with include: How does it feel to wonder about catching AIDS? To experience AIDS when it touches your own life directly, or indirectly as a friend, lover or spouse, family member, employer, neighbor or landlord to a person with AIDS? To give direct care services to persons with AIDS? To be openly gay during the AIDS crisis? If you are interested in being interviewed for this anthology, please indicate your intent in writing, sending any statement of your feelings about AIDS or description of some event that has made you more aware about AIDS. Also send your age, occupation, city, and health status. Address statements to: Lon G. Nungesser, PO Box 5389, Stanford, CA 94305.

* * * *

BALTIMORE HERO PUBLISHES AIDS BROCHURES FOR PUBLIC & NURSING

Baltimore HERO, the Health Education Resource Organization, recently published two useful educational materials: a brochure on "Good Nursing Care and the AIDS Patient," and a single card "The General Public Is Not at Risk." HERO is a tax exempt, non-profit organization staffed by volunteers, working in cooperation with the City of Baltimore Mayor's Task Force on AIDS; and the Division of Communicable Diseases, Maryland Department of Health and Mental Hygiene. For additional information, contact HERO/AIDS, 301/685-1180, or write: HERO, Suite 819, Medical Arts Building, Cathedral & Read Streets, Baltimore, MD 21201. The general counseling number is 301/947-AIDS.

* * *

SIDA/AIDS BROCHURE IN SPANISH AVAILABLE FROM NEW YORK

New York's Gay Men's Health Crisis recently announced another fine addition to community education materials on AIDS. SIDA/AIDS (Sindrome de Inmunodeficiencia Adquirida) provides information about AIDS to Spanish speakers (and readers). GMHC also has counselors available who can speak in Spanish. For free copies, send you request to: Federico Gonzalez, Director of Education, GMHC, Box 274, 132 West 24th St., New York, NY 10011 or call 212/807-6655.

* * *

SPANISH VERSION OF AIDS BROCHURE AVAILABLE FROM WASHINGTON, DC

The AIDS Task Force of the District of Columbia Commission of Public Health has released two brochures on AIDS: The More We Know About It, the Less We Have to Fear (Mientras Mejor Informados Estemos Menos Sera el Miedo), in English and Spanish. For more information, call 202/332-AIDS. [Sorry, no address given.--ED]

* * *

RISK REDUCTION BROCHURE FROM CHICAGO

Chicago's Howard Brown Memorial Clinic's AIDS Action Project announced the availability of a new brochure, "Taking the Odds Out of AIDS: Risk Reduction Recommendations for Gay and Bisexual Men." Contact the Clinic for a copy: HBMC/AAP, 2676 N. Halsted St., Chicago, IL 60614, 312/871-5777.

* * *

AIDS: SPEEDUP OF THE AGING CLOCK?

by Harvey Thompson, MD, with thanks to Cruise (3/2/84) & Tony Rome Enterprises

There are many parallels between AIDS and the process of aging. AIDS is "acquired immune deficiency syndroms." Aging may be the same process. This has led some to conjecture that the plague of the gay community may be just a speeded-up phenomenon of aging. As you know, one of the theories about AIDS is that numerous infections to which gay men, hemophiliacs, and drug abusers expose themselves may be overloading, or "using up" the immune system at an accelerated rate, leaving it depleted. If the immune system is like a punchboard with only so many possible responses, and you use all your chances early in life, you die young; some people may have larger punchboards than others and age more slowly because they have more immune responses to spend. Or so goes this theory. In fact, why people should age at all is not really understood; answers such as "we wear out" are simply not good enough. In a book on genetic approaches to aging, one author speculates that some strategic organ orchestrates the entire phenomenon of senescence. He thinks that organ is the thymus. In his words, aging is "progressive weakening of immunologic surveillance" which allows somatic mutations (or body changes). The mass of the thymus gland begins to decline shortly after sexual maturity, and by age 50 has only 15% of its original maximum size. The thymus seems essential to making "educated" T-lymphocytes from the cells of the bone marrow which pass through it on the way to the peripheral lymph nodes. As we age, the immune system has less and less ability to respond to antigens or foreign substances such as viruses, bacteria, etc. T-cells in particular, seem to lack this ability; as you know, T-cells are consistently low in AIDS persons. Researchers have found that with age, T-lymphocytes lose their ability to multiply (B-lymphocytes do not). T-lymphocytes especially (as opposed to B-lyphocytes) get their "education" from the thymus, more and more recognized as "where T-cells go to college." That's especially interesting in view of reports from pathologists which frequently observe that the thymuses from AIDS persons were wiped out. Did "planned" senescence occur earlier? The immune system may have a built-in lifespan controlled by something genetically unique to the individual. Inbred strains of mice have been known to have genetic control of their lifespans found in the same portion of the genome, or chromosome map, that controls immune function. Despite the common impression that the triumphs of modern medicine have lengthened human lifespan, neither vital statistics nor biologic evidence supports the belief. In fact, the disease-oriented approach to medicine so common in our country may have had little actual effect on increasing lifespan. The fundamental causes of death are not diseases, but physiologic decriments (weakenings) that make their occurence more likely. If the two leading causes of death in Western countries (heart disease and stroke) are eliminated, only about 18 years of additional life could be added. Eliminating cancer adds only about two more years. Human lifespans have remained virtually unchanged since recorded history; only life expectancy has increased. Medical achievements have simply allowed more people to reach the limit of what seems to be a fixed lifespan which appears to be somewhere in the ninth decade. One theory of aging relates lifespan to the number of cell divisions possible. These seem peculiar to each species. For example, Galapagos tortoises have a mean lifespan of 175 years, and their fibroblasts (type of connective tissue cell) are capable of about 100 doublings. Human fibroblasts can double only 50 times, and we therefore live about half as long. Chickens can live about 30 years, and their fibroblasts can only double 20 times, as might be expected. (New England Journal of Medicine, 12/2/76.) Another striking change that regularly occurs in the aging immune system is an increase in the incidence of auto-antibodies, a kind of attack on self. There is a 6-8 fold increase in the appearance of "anti-human" antibodies in 80 compared to 40 year olds. There is also a comparative rise in the prevalence of high titers of circulating immune complex. These factors may cause slowly progressing low-grade tissue damage and some of the degenerative physical changes of aging. Some researchers suggest that this sort of auto-immune phenomena have been seen in AIDS persons, expressed as idiopathic thrombocytopenic purpura, where platelets (the cells largely responsible for blood clotting) are eliminated. High titers of circulating immune complexes or anti-platelet antibodies could be responsible. Older people are more susceptible to infectious diseases than younger ones. For example, the reactivity to the TB skin test declines in people over 70. Also, amounts of antibodies to AB blood group antigens are lower in the older. Along with impaired reactivity to old antigens, there is impairment of the ability to develop new hypersensitivity skin responses. Individuals are usually sensitized to the chemical dinitrocholobenzene [sic] on first contact; 95% of subjects younger than 70 show reactivity on subsequent exposure. Only about 70% of people older than 70 react after reimmunization.

(Continued)

AIDS: SPEEDUP OF THE AGING CLOCK? Continued

I personally, failed the Heptavax vaccine (hepatitis B vaccination); after the first 2 doses, there was no antibody formation, a not uncommon response for those over 40. A higher dose of antigen in requried in older animals to bring about the response found in younger ones. In cancer control, natural "killer" cells sound great, and they are especially important in destroying tumor cells. Older people have lower numbers of natural killer cells, and this may be why they often show a rare form of cancer, Kaposi's sarcoma. No final conclusions can be drawn. However, it is interesting that high titers of auto-antibodies, low T-cell helper and suppressor lymphocyte activity and severe impairment of cutaneous hypersensitivity are associated with increased mortality and aging--and they may also correlate with AIDS.

* * *

GAY BATHHOUSES & HEALTH CLUBS HOLD FIRST CONVENTION

reprinted with thanks: Cruise Magazine (Tony Rome Enterprises, Detroit), 2/10/84

Owners of gay health clubs and bathhouses form across the country met in New Orleans January 15-19, 1984, for the first annual convention of the Association of Independent Gay Health Clubs (IGHC). Representatives from 28 different clubs participated, including 18 member clubs and 10 observer clubs, in the 5 day convention that covered topics ranging from national advertising to dealing with AIDS. The IGHC was formed in mid-1983 by Stan Berg of Indianapolis' Body Works, with the idea that independently owned gay health clubs had much to gain by working together in areas of common concern. Perhaps one of the most important, as well as politicized topics of discussion had to do with coping with AIDS. Many of the owners expressed concern and even anger about some calls for the closing of gay health clubs. The owners felt that these calls amounted to self-righteous finger pointing and scapegoating. "We have to take an enlightened, responsible, rational position about AIDS as it relates to our businesses and our community," stated Sal Accardi, an owner of San Jose's (California) The Watergarden. With this statement in mind, the IGHC unanimously passed a resolution "Regarding an Objective Response to AIDS." Individuals or clubs interested in more information about the IGHC can write to the organization at 303 N. Senate Av., Indianapolis, IN 46204, or call Stan Berg (317/632-2457). There are currently 31 member clubs in the organization, with several clubs from Canada.

* * *

AIDS PANIC IN FRENCH HOSPITAL

with thanks to Toronto's The Body Politic, March 1984

Bruno-Pascal C., a 20 year old hairdressor, had lived in Paris only a few months when, last June, he got sick. He had a severe outbreak of herpes, a 40 degree C. fever, fatigue and weight loss. In October he was diagnosed as having AIDS and was admitted to Laribosiere hospital. His experience shows that AIDS panic among medical personnel is not restricted to certain institutions in the US. Masks, gowns, gloves, and a large disinfecting device were placed outside his room and a large red dot was affixed to the door. Nurses and orderlie refused to enter his room, and all meals were left in the hall. He was instructed to leave all food leftovers in a large garbage can which hospital staff refused to empty. He went on a hunger strike for a week, refusing all food, drink, and medication. When radio station Frequence Gaie aired Bruno's request that listeners visit him, hospital staff noted the large number or people who weren't afraid to enter the room. Attitudes relaxed slightly, and the staff stepped through the doorway from time to time, although medication was left in large quantities to cut down on the number of visits, and his meals were still left in the hallway. Ironically, in December Bruno discovered that he had been misdiagnosed, and never had AIDS.

* * * * *

EARLY DETECTION TEST FOR AIDS SAUGHT

reprinted with thanks from Boston's Gay Community News (4/7/84)

The federal government has alloted $1.1 million for research seeking an early detection test for AIDS and a process that would permit screening to eliminate blood donations that may transmit AIDS, according to the Associated Press.

* * *

OHIO HIRES GAY HEALTH CONSULTANT

On January 2, 1984, the Ohio Department of Health hired Buck Harris as Gay Health Consultant to serve as a liaison to the medical and gay communities. This position was created to respond to the marked increase in requests for information about gay & lesbian health issues, especially AIDS, from physicians and other medical personnel, and gay men and women throughout the state. Buck has worked in the health field for the last five years as a training specialist and consultant for Planned Parenthoods in northeastern Ohio. In addition, he completed the CDC's STD Technician training program and worked in an STD clinic for two years. Buck's major responsibilities for the next year include producing the bi-monthly Ohio AIDS Newsletter, producing brochures, expanding and maintaining a statewide physicians and support services referral directory, representing the Ohio Health Department at local task force meetings, overseeing the toll-free AIDS hotline, and speaking to professional and community organizations about gay/lesbian health issues. Says Buck of his new position, "Clearly, much attention needs to be given to AIDS, but I am as concerned about gay health in general, especially prevention." For more information, contact Buck (Ohio 1/800/282-0546) at Ohio Department of Health, PO Box 118, Columbus, OH 43216.

* * * * *

SALT LAKE CITY CONFERENCE ON AIDS

with thanks to the NY Native, 2/27-3/11/84

A 6 day symposium on AIDS was held in Salt Lake City, Utah, February 5-10, sponsored by Schering Pharmaceutical Corporation and the University of California at Los Angeles. Over 47 speakers addressed the large gathering of health professionals and researchers that attended the meeting. Dr. Roger Enlow, MD, from the New York City Health Department's Office of Gay & Lesbian Health Concerns, participated in the meeting and reported the proceedings to the Native. One of the most interesting presentations was given by CDC researchers, who reported on their recent studies on AIDS in Zaire, where they recently returned from Kinshasha, the nation's capital. The research team saw 37 new cases of AIDS during their 3 week vist at 2 hospitals, and estimated the number of cases to be 25/100,000 per year (compared to 1.63/100,000 in the US). 57% of the AIDS cases in Zaire are males (93.4% in the US), the median age of the males is 42, of females is 30; AIDS in Zaire does not seem to be a function of homosexuality (no reported cases) or intravenous drug abuse/ The epidemiology of AIDS in Zaire suggests a heterosexual mode of transmission from females to males. The immunologic picture of AIDS patients there resembles that of AIDS cases in the US--including reversed T-cell ratios. 15% of all AIDS cases in Zaire have been diagnosed with KS. They reported that clinicians in Zaire have noted a "wasting syndrome" similar to AIDS since the mid-1970s. They also noted that between 5-10,000 Haitians worked in Zaire in the early to mid-1970s. REcently, a case of AIDS was reported in a female nurse from Haiti. Dr. Jim Curran, head of the CDC AIDS Activity Task Force told attendees that the sexual revolution in the US may have set the stage for the development of AIDS. The average incubation period seems to be between 2-3 years. The lymphadenopathy syndrome which has been noted in gay men may not represent only a prodrome of AIDS, but also a milder form of the disease itself. There is no evidence that this kind of unexplained generalized lymphadenopathy is a new occurence (perhaps related to the new French retrovirus, lymphadenopathy-associated virus [LAV]). Dr. Curran reported that the variability of reporting AIDS cases may be due to different surveillance techniques in different US cities (in NYC, there is hospital-based surveillance), but 100% of all diagnosed AIDS cases are reported to the CDC after 6 months, and 95% of these after 3 months. Absolute numbers of AIDS cases are still increasing, with 46 cases of AIDS in children in the US. Curran believes that the increasing number of cases among heterosexuals suggests the syndrome is changing and may "blossom" in that population. There are 46 blood-transfusion-related AIDS cases in the US (38 adults, 8 children). He predicted that transfusion-related AIDS cases will decrease as the new guidelines for blood donors are implemented. In speaking on theories of etiology, Curran remarked, "African Swine Fever Virus (ASFV) is one of the better theories." There is still no known increased risk for developing AIDS among health care providers. Curran also stressed the importance of understanding and defining the natural history of AIDS.

Dr. P. Ebbesen of Denmark reported that there are 268 cases of AIDS in Europe, all in the West. Most of the French and Belgian cases are from Zaire and Central Africa. In a study of AIDS patients carried out by Dr. Ebbesen, 22% had sexual contact with citizens of the US, 95% participated in both penetrative and receptive anal intercourse, and 62% had engaged in anonymous sexual activity. Dr. M.B. Gardner of California discussed AIDS in monkeys, from

(CONTINUED)

SALT LAKE CITY CONFERENCE ON AIDS, Continued

which his research team has isolated a monkey retrovirus. The group believes that simian AIDS (SAIDS) has occured spontaneously and may have occureed for the last 10-15 years among monkey colonies throughout the US. The team also thinks that there are carriers of SAIDS in the monkey research colonies, and that these carriers are female monkeys. They believe that SAIDS is transmitted by bodily secretions. Although SAIDS may not be the same as AIDS, it may provide a good animal model for the syndrome in humans. Drs. R. Gallo and M. Essex discussed their research on the human retrovirus, Human T-cell Leukemia Virus (HTLV), which has a predilection for attacking helper T-4 cells, which are depleted in AIDS patients. These researchers are working on isolating and characterizing several types of HTLV, and although HTLV has been isolated from a number of AIDS patients, there is still no evidence that HTLV causes AIDS. Dr. Galla proposed that the French retrovirus, Lymphadenopathy Virus (LAV), be renamed HTLV-3. Dr. J.C. Chermann, of the Pasteur Institute of Paris, gave an update on his impressive work with LAV. A team of French researchers has isolated LAV from AIDS patients and patients with lymphadenopathy syndrome. LAV also has a predilection for the helper T-4 cells. The French team reports that LAV is easily grown in laboratory cell cultures. Promising and significant reports on the immunomodulator interleukin-2 (IL-2) indicated that the substance--which is produced by helper T-4 cells--has had positive effects on several AIDS patients. In trials, IL-2 improved several of hte immune abnormalities of AIDS patients. Further research and clinical trials are now underway. Dr. W. Current reported on the parasite Cryptosporidium, which has a devastating effect--severe diarrhea--on AIDS patients. Dr. Current said the parasite is ubiquitous and infects virtually every animal, causing only a mild diarrhea, unless the animal is concurrently ill with another infection, in which case they would have a severe diarrhea. There is still no satisfactory therapy for cryptosporidiosis.

* * * *

AFRICAN SWINE FEVER VIRUS INVESTIGATED AT PLUM ISLAND

with thanks to the NY Native, 2/27-3/11/84, and James D'Eramo

Scientists at the Plum Island Animal Disease Center (PIADC) are discussing research protocols for investigating the theory that African Swine Fever Virus (ASFV) may be causally related to AIDS. Plum Island, which is located just off the coast on nothern Long Island, New York, has done research on ASFV since the early 1960s. Dr. Jane Teas, a pathobiologist from Harvard, observed that AIDS in Haiti and Zaire emerged during the epidemics of ASFV in the pig populations of those two countries.

* * *

BOWL-A-THON FUNDRAISER GENERATES $50,000 FOR AIDS IN CHICAGO

thanks to Chicago's Gaylife (3/8/84)

Over $56,000 was generated for Chicago's AIDS Action Project of the Howard Brown Memorial Clinic by over 65 bowlers in the "Strike Against AIDS Celebrity Bowl." Money was raised through pledges for every pin knocked down during one game by each bowler. Although the minimum pledge was 10¢ per pin, some bowlers have collected as much as $25 per pin. Businesses, groups, individuals, and politicians were represented in the bowl-a-thon, and area brewers--Miller, Budweiser, Old Style, and Schlitz donated $3800 to offset expenses.

* * * * *

HOUSTON AIDS BROCHURES AVAILABLE

Two brochures and one newsletter are now available in limited quantities (up to 10 per request) from the KS/AIDS Foundation of Houston, 1001 Westheimer, Suite 193, Houston, TX 77006. "AIDS--Acquired Immune Deficiency Syndrome" is geared to the general public; "AIDS Play Safe Information" is geared to the sexually active gay man; and the "KSA Lifeline Newsletter" is geared to both the general public and the gay community. Call 713/524-AIDS for more information. "The Guide for Persons with AIDS" (hospitalized or out-patients with AIDS) is available from the University of Texas M.D. Anderson Hospital Patient Education Clearinghouse for 35¢ per copy. Call 713/792-7375, or write to the hospital at Box 21, 6723 Bertner Av., Houston, TX 77030.

* * *

* *

NO WAY TO DIE

by Harvey Thompson, MD, reprinted with thanks from Cruise Magazine (Volume 6:3, 1/27/84)
[Dedicated to Mr. X, who agreed to having his story told.]

He hadn't told the doctors when he was first admitted that he was Gay. At the age of 71, he probably didn't consider it important.

When he came to the hospital, his doctor asked about his past history, but was politely told by the patient that he would "rather not go into that because it's not important anyway." So, it became a silent contract between them to ignore the past history portion of the interview, and just stick to physical findings and laboratory tests.

He was cultured from every oriface, his heart was ultrasounded, his blood studied, and he was treated for presumed endocarditis when his fevers continued. The doctors called in to consult on the case had thought of AIDS, but since the patient denied being at risk for this, they dropped the possibility.

He kept hoping that they would find the right antibiotic to cure his self-diagnosed "bronchitis", and that this "flu" would just run its course. But it didn't, and he became more and more frightened. He was ready to open up to the right person.

Ten days into his hospitalization, the "Gay doctor" was asked to consult. It's unusual for non-Gay doctors to ask help from their openly Gay colleagues; I remember feeling like the priest in "The Exorcist."

After the initial formalities and the usual medical questions, I sat down, graspedhis hand, and said, "There's something important we have to talk about. I'm Gay, many of my patients are, and it's important to know if that is a possibility in your case . . ."

Then he poured out his story. He had left his midwest family in the 1930's when he realized he was "different." He headed for California, and never saw his family again. He worked in a box factory for most of his life; he and his lover kept quietly to themselves. It was dangerous to get together with other homosexuals. That was the way he learned to live his life—in secrecy.

When he retired from being a security guard in Reno, he moved to Sacramento and lived in a high-rise apartment downtown. He tried to socialize at a senior citizens' center, but had little in common, and besides, "they wouldn't talk to me." He was lonely, and went to San Francisco most every week—his little secret. He said he hadn't had sex since his open-heart surgery three years before. Though he went to bathhouses, he "didn't do anything." He didn't consider being the passive partner in anal sex with numerous partners "doing anything." After all, they had sex, not him.

He worried about AIDS, and was careful not to kiss or go down on anyone. He always went to the same bathhouse, thinking it was less risky than frequenting different bars or backrooms.

Once, he was treated for syphilis at the county clinic, and just for reassurance, he checked with three private dermatologists for retreatments. He always asked, "Do I have AIDS? Even the internist he visited in San Francisco told him, "Seventy year-old men don't get AIDS." Remember--he wasn't Gay, and didn't ever have sex, anyway.

But then he started losing weight, despite vitamins and food supplements from health food stores. He never liked to cook, and usually ate out. Then he lost his appetite for that and stayed home more and more in his apartment with all the things accumulated from his past. He started getting dizzy and couldn't sleep, had night sweats and even fainting spells.

His eyes brimmed with tears when he looked up and asked me if he had AIDS. He didn't really want to know; you could tell from the way he said "I don't have AIDS, do I?"

His shortness of breath, his fifty-pound weight loss, and fevers to 104 spelled out pneumonia, but the proof wasn't ready until the following day. He a lung biopsy which showed pneumocystis carnii organisms, confirming the impression of AIDS. The day of the biopsy was the last one that enabled him to ask anymore questions; he was intubated and unable to talk with the endotracheal tube in place.

There were more tubes: IV's, arterial lines, CVP's, bladder catheters, suction, and oxygen. The endotracheal tube burned, the needles hurt, and his skin was raw from stool that he couldn't control. He couldn't have asked for it all to be stopped if he wanted. He may never have been asked if he wanted someone notified or if he needed anything from his apartment.

It was hard to tell who was who when everyone came through the door in identical caps, masks, gowns and gloves. He couldn't even see out of the window very well; it was covered with signs that said "CMV precautions: no pregnant women," or "Strict Isolation! AIDS."

No friends came to visit. He hadn't any. There was that lover of a decade before somewhere in Arizona, but he didn't want him tracked down anyhow.

It was no way to die, isolated, alone, and unloved.

© Stonewall Features Syndicate, 1983

LIFE WITH AN AIDS PATIENT

by David Paul, reprinted with thanks from WisconsIn Step (3/22-4/4/84)

It's been almost a year since Scott died. It seems like a bad dream when I think about it all today, but it wasn't.

I'll never forget the July afternoon when Scott entered the room where David (my lover) and I were watching television. He had a somber look on his face and quietly looked at us and said, "I've been to the doctor today." There was was seemed like an incredibly long pause followed by a burst of tears and "I've been diagnosed as having AIDS."

We had a large flat in the Castro district of San Francisco. Scott shared the flat with David and I for about two years. God, I remember what that place looked like when we first moved into it. We even had Evan White (a newscaster on KRON-TV in San Francisco) living directly across the street. That building was, without a doubt, the ugliest building on the entire block. It had a certain charm to it, though. Over the last couple of years the three of us had turned that ugly duckling into a home we were all proud of. Our friendship had elevated to that of three brothers, not just roommates and lovers. Scott was 29 years old, unemployed and receiving unemployment benefits which were about to run out. His entire family lived back in Minnesota.

For some odd reason, neither David nor I were particularly shocked by the news. I can't explain why. Possibly it was the look in his eyes when he walked into the room that afternoon. It was the most helpless look I've ever seen in someones eyes — it was obvious that Scott knew a lot more than we did.

After we quieted him down, my first reaction was to pull him into the kitchen and start talking about financial aid from various local and federal groups. Everything I had heard about AIDS up until then said the same thing: "It gets real expensive, real quick." (I was just reading in the paper recently that the average medical bills for an AIDS patient are exceeding $80,000.) Common sense told me that if we at least got the paperwork rolling before he became severely ill, it would be to his benefit. There weren't too many success stories on treating the disease. That probably was the smartest move we made.

Simply put, the months that followed were pure hell — for all three of us.

Scott did go to every possible agency he could think of. In having AIDS, his doctors verified that he was incapacitated and therefore was eligible for social security disability payments. That was great for getting him some cash to live on, but what about the medicals?

Shortly after he was diagnosed, I read an article in the *San Francisco Chronicle* about an experimental interferon program at U.C. San Francisco Medical Center. At that point, there really weren't (and still aren't) any other alternatives. Scott went to the university the following day to see if he could get in that program. The three of us talked about the alternatives available and we figured his level of medical care would be better getting involved in this kind of program. I found out later that it was the drug manufacturer who made interferon and some grant money that made the program possible. As it were, they had already selected the ten participants in the program, but one dropped out that morning and they needed just one more person. Scott happened to be in the right place at the right time.

The group of ten were divided into two. One group would receive mega-doses of the drug, and the other a lesser amount and/or placebo. Scott was in the high dosage group. The after effects of

(CONTINUED)

LIFE WITH AN AIDS PATIENT, Continued

these treatments were probably as bad as standard chemotherapy. His fever would spike up to 103-104° and he would get extremely nauseous. After six or seven hours, the fever would come back down and he could eventually get something into his stomach. This went on for weeks. If I ever clean up vomit again, it will be all too soon.

Scott enlisted the help of Shanti, which is a non-profit group that helps not only to educate the public on the concerns of AIDS, but provides needed assistance to those who are diagnosed. If anything positive managed to surface during these difficult times, it was Scott's counselor Drew. I don't feel too ashamed to admit this, but there were times when David and I just couldn't deal with his illness. Drew was always there — without fail. Scott, David and I were pretty close, but not close enough to give him that shoulder he needed or a warm hug. There were times when Scott would be in the hospital and Drew would come over to pick up some of Scott's things. We would end up talking for hours on end. Even if it didn't remove the hurt, anger and frustration I was feeling, nor cure Scott, it sure made me feel better after one of our talks. Drew usually got called whenever it was necessary for a trip to the hospital because they would not allow David and I into the emergency room or in tests with Scott. The hospital staff would allow Shanti counselors into these rooms. What a true saint Drew was!

One day, Scott came home in better spirits than he had been in previous weeks. He told us that his doctors thought he was possibly going into some kind of remission as one of his purplish spots caused by the Karposis Sarcoma was beginning to fade away. Scott was just beaming when he showed us the disappearing spot. We were all so happy that day. I don't ever remember a time when the three of us felt that kind of camraderie after that afternoon.

Within just a matter of days, the spots started growing at a rate that was much faster than we had seen previous. All of our excitement vanished within a week as it was obvious that he was growing worse each day. He had originally been diagnosed with six of the spots and now, just a short time later, had over 20. Other changes in his body became more evident as each day passed.

He developed this awful cough that would stay with him until he died. It was a hacking kind of cough where the coughing fits would last for several minutes at a time, and sounded like he would cough his lungs right out of his body. As I reflect back on all of that, it was that damned cough that really bothered me the most. It wasn't the pneumonia that often accompanied Karposis, but more of a bronchial condition that his doctors just couldn't seem to control.

For the next several months, Scott was in and out of the hospital regularly. It was necessary for him to go for blood transfusions about every other week. He would come home from the hospital after a transfusion looking and acting like he just put his batteries on the charger for three days. Just prior to a transfusion he looked deathly white and was totally lethargic.

His doctors would run series of tests regularly and always found several things wrong with him (infections, odd blood counts, etc.). It was obvious that his body was totally out of control to his doctors because they took him off the interferon program and concentrated more on controlling the onslaught that was rapidly taking over a man's life. The medications his doctors prescribed would work great for a week or two until he would come down with another whole series of infections. Some of them were so bizarre.

The one infection that really made me take considerable notice was one he had in his mouth — a yeast infection growing on his tongue. The treatment for this required him to suck on a woman's vaginal suppository. It used to make me sick to my stomach to watch him taking these suppositories. Try and imagine how Scott felt — I couldn't.

By now the entire medicine cabinet was stuffed with various medications for all these different infections. The spots had grown to around 50 — and the ones he had for some time were getting much larger, about the size of a quarter and much darker in color. Instead of just noticing spots, I thought of them as real tumors now.

David and I both had the same medical coverage in an excellent health plan. Regular visits to our doctors to get ourselves checked over were the only way to have any kind of peace of mind. We had been taking certain biohazard precautions since the day Scott was diagnosed, but you just have no way of assuring yourself that you're healthy unless you pay your own doctor a visit.

Somehow we did manage to keep a pretty cool head about it all, and took necessary precautions around Scott. It probably wouldn't have bothered me too much to move out at this point, but David's friendship with Scott went back considerably further than mine and David was reluctant to just throw in the towel and walk away from it. We had never thought of asking Scott to move out until one Sunday afternoon.

We were eating and watching the TV when I heard a gasp. I turned around to see Scott having what I first thought was a heart attack. I grabbed him, and knew then that he was having a seizure — and a real bad one. David had worked that night and I literally screamed at him to get his ass in the living room. Waking someone up out of a sound sleep to assist in the control of a seizure is probably not the wisest thing to do. When David just froze, I yelled at him to call an ambulance, which he did. Scott was just totally out of it. He didn't know who David nor I were, where he was, what day of the week it was. Nothing! It wasn't until several hours later in the emergency room that he even recognized who I was. (That was the only time the hospital allowed me in the emergency room because they needed me to play forty questions with the emergency room staff to find out all the neat little diseases Scott had.) They never did find out what the actual cause of the seizure was. We were told it could have been from any one of a number of things like his medications, the disease, an infection, etc.

That was when David and I started thinking about alternative arrangements for Scott.

The last thing we wanted to do was purposely ask Scott to move out. After the seizure we realized that with our working hours we couldn't possibly be there with him all the time and certainly could not afford an attendant for him. If he were to have another attack, it would probably be hours before Scott would even realize what had happened to him. I was convinced that if another seizure would happen that he would seriously hurt himself by hitting the piano some other piece of furniture, or the floor. We decided that the best approach was to announce that David and I were going to take an apartment on our own and move out.

That painful decision was made a little easier by Scott's announcement that he was trying to move into a hospice that was being set up. It was truly an odd scene as we both made our announcements almost simultaneously. The date was unsure, but it seemed to coincide with our moving plans. All three of us realized that our friendship was coming to a slow end and there was nothing any of us could do about it. It had to be done.

Shortly before he was to move into this hospice Scott decided to go back to Minnesota to visit his family. I think now that he knew he was dying and wanted to be on his own turf when "it" happened. After he got back to Minnesota, he became very ill and was put into the hospital. His mother decided that the doctors had done all they were going to do for Scott and demanded his release. The hospital complied and while driving back to their country home, he went into respiratory arrest and died. He was 30. That was last May, only ten months after he was originally diagnosed. It wasn't so much Scott's death that bothered me much — we all knew death was inevitable with this disease. Feelings of deep pity for his mother were all that I could feel when I learned of Scott's death. I shed no tears over his death. David and I both knew that his quality of life was next to nothing and both know that there is an afterlife. Scott was much better off dead than alive with AIDS.

Yeah, it sure changed my outlook on living a healthy gay lifestyle. Throughout his illness, I always made a point to be as well educated on the subject as possible. The research teams really are no closer to a solution today than they were two years ago. The medical community generally is ecstatic about AIDS because they think that if they can find the cause of the disease that it would lead to an almost certain cure for cancer. I knew quite a few people in the medical community personally, and it was awful hard to share that enthusiasm while a close friend was wasting away right in front of my eyes.

Thinking back, Scott was a partier. He loved to go out until all hours and then work on two or three hours sleep, participated in a lot of anal sex (receiving end), did a lot of drugs, and didn't eat right — everything that they've been saying are high risk factors.

(Continued on page 12)

WHEN DEATH IS TOO MUCH WITH US

by Michael Lassell, reprinted with thanks from Toronto's The Body Politic

It's a beautiful, *cool*, Friday in Los Angeles — the weather as much like San Francisco as an adult might reasonably expect. I've been passing the day with no cash in my pocket, praying the sort of prayers I've been trained to forego: "Dear God: Send Money. Love, Michael." By late afternoon, an adorable pink cheque has found its way into my hands, and, dressed in my best Gay summer shorts I head to the Gay bank to cash/deposit my newfound Gay wealth. An acqaintance happens to drive up, and we do Gay chit-chat for a minute: "How-are-you-what-are-you-doing-so-and-so-says-hi-are-you-still-with-your-lover, etc." Then he lets me have it:

"Do you know anyone who died from AIDS?" Oh, no, I say to myself, but, trying to be responsible I reply: "Yes," hoping a terse answer will divert him from further inquiry. Fat chance!

"How many?"

I say: "Four. Is this a contest?" (That should shame his mouth shut, I think.) But he is undaunted: "Do you know anybody who has it now?"

"Yes," I say, squirming, but the subject is once again on the floor. Mortality is once again too much with me, and once again on an all-too-rare idyllic LA day, I am talking about Gay death and Gay dying and The Meaning Of It All. Only this time I'm trying to do it without dying a little myself, and this time you get to listen.

When my political friend Ken died, it was still GRID, "gay-related immune deficiency." He died from a series of "opportunistic infections": hepatitis, pneumonia, amoebic dysentery, shingles. He wasted away to nothing in the days before we knew *it* was often fatal. Ken maintained a cheerful optimism; then he was dead. Our political club planted a tree in his memory. It was a nice gesture; I did not attend the ceremony.

Then a former boss of mine died. By this time it was already AIDS. One, two, three, zip: felt like shit, was diagnosed and died. Three weeks.

Yeah, I know all too many people, men, friends, acquaintances. I know three people who were diagnosed as having AIDS *by mistake*! It seems they had CMV. Oops, sorry, guys, our mistake. The straight doctors were... well, "insensitive" to be charitable, "incompetent butchers" when I'm in a bad mood. But if someone tells me I have AIDS, he better be right if he wants to see sunrise.

Yet men like me are dying. And I'm in a high-risk group, as they say: Gay white male, thirty-six, resident of LA and a fan of frequent if not unlimited sex (sorry, honey: remember it's you I love). I've cut my sex life down, but I may be carrying a disease I caught two years ago from a stranger or a friend, even from my lover, who may be infectious without knowing it. A year from now I could be among the Gay dead, and my parents are still actively avoiding coming to terms with my homosexuality. It's the end of their second decade trying, bless their resistant Republican hearts.

Now, I've never been dead and have no after-death experiences to relate. I'm just an urban Gay male trying to get through the day the best I can. But there's been a lot of death in my life, and I guess it's time to look at it.

The first wave of deaths was family. It was the '60s and I was a teenager and those deaths marked the end of innocence for me. Family members died. The family died. My family was not rich, not artistic: just loving, vital, human, full of life. We sang and danced and drank and told jokes around a Christmas groaning board, showing off our shirts and ties and sweaters and toys. And then they started dying. The worst was my Aunt Helen, my godmother, protector, friend: she never witheld her love to manipulate my behaviour, she faced my every caprice with unconditional acceptance. Like the death of the father in Bergman's *Fanny and Alexander*, that death shattered reality for me. Only little pieces of reality made sense after that. Family was over. I ate. I drank. I was not merry.

The '70s came along and I was "out." By this time the second wave of deaths hit: the Vietnam deaths. My friend Ralph, the first person I ever told I was gay, was missing in action and presumed dead. The church we grew up in erected a flagpole in honour of "Lieutenant" somebody — the same person I called Ralph, the man who accepted my sexuality while my parents were busy rejecting it. Before he died we had a conversation one summer night in the outfield of the local little-league park. First there was the mindless belief in the religion of your parents, Ralph surmised; then there was a period of doubt, agnosticism, atheism; then there was the discovery of a personal relationship with a God, a divinity, a spiritual power. But Ralph slammed his jet fighter into the Southeast Asian jungle and, as far as I was concerned, God died with him.

●

I drank some more, got into drugs. By this time I hated everything about myself, most particularly my sexuality, having for some reason believed all the lies everyone had ever told me. I was obsessed with suicide, I wanted to be dead. After two rounds of deaths, that's how I was dealing with it: "Fuck Life!"

And there were other deaths: suicides, motorcycle and automobile accidents, bone-splitting cancers, a drowning. Deaths near and far. I participated in them all; and each man's death diminished my life, but no man's life enriched it. I went to a memorial service at Grace Cathedral in San Francisco for a stranger who had been fag-bashed to death. Like Brecht, I felt that if all humanity were jammed into the hold of a ship, each man and woman would freeze to death from loneliness.

By 1976 I was as tired as I could get. I stopped drinking, stopped taking drugs, lost weight, started feeling good. Encouraged by others who were trying sobriety as a way of life, I started talking about God, tentatively at first, thinking Ralph's third-stage "personal relationship" was beginning to happen in my life. I had friends — good, loving, supportive, positive, endorsing friends. I was included. I was in good health. I was relatively unscathed by my self-destruction, my obsession with death. I met Ben in 1978 and have been increasingly in love with him on a daily basis ever since. The first two years he did the relationship part of the relationship alone. All I could do was show up. He waited until I knew what love was. I felt good about being Gay for the first time in my life. I felt good about being alive. I was a productive member of Society, a contributing member of the Gay Community.

And then they started dying again, from AIDS, from alcoholism, whatever. Ken and I got hepatitis at the same time. I got mine instead of going to law school. He never recovered. I wanted to think like the spiritual positivists, that I could choose to live, I could want to live so badly that nothing need affect me adversely. Then my best friend's T-cell ratio inverted and we gave serious (and silly) consideration that he might die. That I might die.

We joked about it, Gay humour being our forte. We cried about it, Gay drama running a close second. We talked about dead friends whose deaths were sad or inspirational. We hoped if it came to it, we could die with grace, even though we'd often lived as bumbling fools. I prayed that, no matter what, I would die sober. It was a by-product of my own new love of life, caring about people. I cared about people. I was surprised. A man I call a "spiritual adviser" (really just a friendly former drunk with a direct line to a power that keeps him happy all the time) tried to get me to redefine my attitudes toward death: Death as graduation, passing over,

(CONTINUED)

WHEN DEATH IS TOO MUCH WITH US, Continued

there is no death, there is only moving to another plane of spirituality, a new level, and so on.

In "Fanny and Alexander," which I saw with same spiritual friend in San Francisco, the people who die do not go away. "I lived my whole life with you. Where else should I go in death?" one character asks. I want to believe that. It would make it so easy to accept loss, death. Another friend in San Francisco is rotting piece by piece. He has half a hip left, he's missing several spinal vertebrae, has a blood disease and is considered terminal, but clean for now. His reaction is: "I've done everything and everything pretty much I wanted to do. I had great friends and had great times with them. If I die tomorrow, it's okay with me."

You know what my reaction is? "Holy shit, I haven't done a Goddamned thing." I haven't won a Nobel Peace Prize or an Olympic Gold Medal. I haven't written a best-selling book like my friend Clark or sold a screenplay, stolen a piece of the Acropolis, prayed in a Buddhist temple in Kyoto, walked the Taj Mahal by moonlight, or even returned my library books!

Most interesting to me about that list is that there's no sex in it. Here I am, a homosexual, and the things I would die regretting have nothing whatever to do with sex. I mean, I have *done* sex. Sex with dignity and sex-as-humiliation. I've done sex in a field at dawn and in the backrooms of Forty-Second Street. The things I want to do before I die that I have not yet done involve the experience of the beauty of life, the joy of life, and the communication of that beauty and joy to friends and strangers, to "those who come after."

All this death, all this impending middle-age, is changing me. It's moving, shifting me away from the centre of a hedonistic universe and toward some spiritual pantheism in which we all take part. It's matriarchal, healing, Yin, flowing, intuitive, female, water, all that stuff. It's round and circular and cyclical and complete in and of itself, and we are all a part of it, and we all get to feel it if we want. All we need to do is choose it.

All this thinking about death made me think what a powerful people we are, we faggots and dykes. They called us sinful and we make monuments to the beauty of God. They called us sick and we healed ourselves and go merrily along feeling well. They make us illegal and we change the laws. They beat us; encamp us; murder us, one at a time and in groups; they lie about us with impunity and without conscience; but we keep surviving as a people. Because for everyone who died, there are gay people somewhere determined to live.

People loving each other, or three or four, however haltingly, however hesitantly — that is Community in the making. It is survival. It is perseverence. It is the beginning of... well, immortality of a kind, a step on a spiritual path we may not even know exists.

You see, I don't quite yet believe that after I leave here, I'm going to go somewhere else, some other level or spiritual plane. I don't believe that I have a soul that is going to outlive my body. I'd like to believe it, but I don't. So I'm just going to have to make it from one day to the next with some sort of principles that make sense to me, even though I am not rich and famous, my mother is not marching with Parents and Friends of Gays, my lover and I can never agree on a restaurant, and my friends still die from time to time. Even though the gay and lesbian community is facing its latest greatest crisis. And that principle is easy and simple. I'm going to be myself: happy, joyous, free and gay. I'm going to make myself available to help the living and the dying anyway I can.

●

There is a scene in the movie *Gandhi* when Gandhi starts out on the salt march declaring, "A journey of a thousand miles begins with the first step." He is marching to the sea in a symbolic gesture of reclaiming the right of free access to salt, to reclaim control of India for the Indian people. A young boy climbs a dead tree for a better view; and what he sees makes him smile. This scrawny little cherub has just had an experience that would change his life, etched on his consciousness in the guise of a small smile: the first revelation that he is Indian, proud to be Indian, and happy to participate in the making and shaping of his country.

And that's my principle. One step at a time on a journey of a thousand miles, as one among many, so that no gay or lesbian child, no teenager, youth, adolescent, young adult, middle-aged parent or senior citizen need ever again feel what I felt when I was ashamed and alone and embarrassed, when I hated life and was trying my damnedest to obliterate myself. I'm going to be sober for the millions who are still drinking. I'm going to be as fully alive today as I can because many are dying. I'm going to be happy today so the unhappy can see it's possible, that it's a matter of choice. I don't need any credit for it. I probably won't do it at large public gatherings, but I'm going to do it. And whenever I can I'm going to make every other person's experience with me a moment of joy, whenever our paths cross, whether for an instant or for many years.

When all is said and done, if I find out I have "*it*" (or any of the other "its" out there), I guess I could forgo the piece of the Acropolis, the temple at Kyoto, the Taj Mahal in the moonlight to go as gentle into the night as I can, because I will know that the love I have engendered will survive me. I am just now thinking the least original possible thought, that love is God, God is love. And that's just fine with me.□

Michael Lassell is a Los Angeles freelance writer "with too many college degrees," who has been involved in the gay movement since the mid-'60s.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

February 17, 1984/Vol. 33/No. 6

Epidemiologic Notes and Reports

Severe Neutropenia during Pentamidine Treatment of *Pneumocystis carinii* Pneumonia in Patients with Acquired Immunodeficiency Syndrome — New York City

During November 1983, three patients at one New York City hospital who had the acquired immunodeficiency syndrome (AIDS) and *Pneumocystis carinii* pneumonia (PCP) developed severe neutropenia while being treated with pentamidine isethionate. Since August 1981, 23 other patients with AIDS and PCP had been treated with pentamidine at this institution. None developed neutropenia that could not be explained by the simultaneous administration of another drug.

Case 1: A 43-year-old male with recently diagnosed Kaposi's sarcoma (KS) was suspected of having PCP in late October 1983, based on symptoms of cough, dyspnea on exertion, a chest roentgenogram showing bilateral interstitial pulmonary infiltrates, and pulmonary-function tests showing a drop in arterial pO_2 with exercise. He was begun on sulfamethoxazole/trimethoprim (SXT) (20 mg trimethoprim/kg/day orally) as an outpatient. Before treatment, his white blood cell count (WBC) was 5,700/mm^3 (4,560 neutrophils/mm^3). After 9 days of SXT, he developed a maculopapular rash, an elevated serum glutamic-oxaloacetic transaminase (SGOT), an elevated serum creatinine, and neutropenia (WBC = 1,700/mm^3 with 816 neutrophils/mm^3). SXT was discontinued. The patient was admitted to the hospital 4 days later. Toluidine-blue and Gram-Weigert stains of a bronchoalveolar lavage showed *P. carinii* cysts, and the patient was started on pentamidine isethionate 4 mg/kg/day intravenously.* Two days before pentamidine was started, his WBC was 2,700/mm^3 (1,377 neutrophils/mm^3) but rose to 4,000/mm^3 at initiation of pentamidine. All other manifestations of SXT toxicity had resolved. The patient's WBC ranged between 3,200/mm^3 and 5,600 mm^3 during the first 5 days of treatment. He experienced transient flushing during the treatment infusion, which disappeared when the infusion time was increased from 45 to 90 minutes. On day 6 of pentamidine, he developed a fever but no thrombocytopenia or anemia. His WBC was 1,900/mm^3 and dropped to 300/mm^3 (36 neutrophils/mm^3) on day 7. The drug was discontinued, and gentamicin plus moxalactam were begun. During the 10 days after discontinuation of pentamidine, his WBC rose gradually to 2,800/mm^3 (868 neutrophils/mm^3), and a bone-marrow aspirate showed an increased myeloid to erythroid stem-cell ratio.

*Since intravenous administration of pentamidine can be hazardous, CDC recommends that it be given intramuscularly whenever possible.

Neutropenia — Continued

The patient received no further therapy for PCP, and a repeat bronchoalveolar lavage revealed no *P. carinii*. His respiratory symptoms improved markedly. However, *Mycobacterium avium-intracellulare* was found in a blood culture that had been taken in late October, and the patient was treated with ansamycin. During the first 4 days of ansamycin, his WBC ranged from 2,800/mm^3 to 4,300/mm^3 (neutrophils 868 mm^3 to 1,785/mm^3) but fell to 1,900/mm^3 on day 5 when the drug was discontinued. The following day, his WBC was 1,500/mm^3, with 405 neutrophils/mm^3. Five days later, the patient was discharged with a WBC of 1,500/mm^3. Thereafter, he remained well, and during the 25 days after discharge, his WBC rose gradually to 2,200 mm^3.

Case 2: A 30-year-old male, referred for diarrhea and started on tetracycline as an outpatient, was admitted with fever, dyspnea, abnormal chest roentgenogram, and abnormal pulmonary-function tests. *P. carinii* cysts were seen on toluidine-blue and Gram-Weigert stains of a bronchoalveolar lavage, as well as on a methenamine-silver stain of a transbronchial biopsy and a Gram-Weigert stain of bronchial brushings. *Vibrio parahemolyticus* and *Giardia lamblia* were found in his stool. He was begun on SXT (20 mg trimethoprim/kg/day intravenously) and tetracycline. After 8 days of SXT, he developed a rash, and his WBC fell from a pretreatment level of 5,400/mm^3 (3,888 neutrophils/mm^3) to 1,900/mm^3. SXT and tetracycline were discontinued. The following day, his WBC was 1,800/mm^3, with 1,026 neutrophils/mm^3. Over the next 4 days, the rash disappeared, and his WBC rose to 2,900/mm^3 (2,175 neutrophils/mm^3). The patient was then started on pentamidine isethionate 2 mg/kg/day intravenously, which was increased to 4 mg/kg/day after 2 days. During the first 6 days of pentamidine, his WBC rose to 4,300/mm^3 but then gradually fell to 1,700/mm^3 (980 neutrophils/mm^3) by the 11th day of therapy. Pentamidine was discontinued, and his WBC fell to 1,600/mm^3 2 days later. He did not develop anemia or thrombocytopenia. However, his respiratory status had improved markedly, and he was discharged from the hospital. Quinacrine was begun for his *Giardia* infection as an outpatient. After 7 days, his WBC rose to 2,800/mm^3. He remained clinically well 2 weeks after all therapy was discontinued.

Case 3: A 29-year-old male was admitted with a history of fever and dyspnea for 2 weeks. *P. carinii* cysts were seen on a Gram-Weigert stain of a bronchoalveolar lavage. Since the patient gave a history of a diffuse pruritic rash when treated with SXT in August 1983 for an upper respiratory infection, he was started on pentamidine isethionate 4 mg/kg/day intravenously at the outset. With each infusion of the drug, he developed hypotension, flushing, and chills, which were controlled by increasing the infusion time from 1 to 3 hours and by pretreatment with meperidine and diphenhydramine. His WBC before pentamidine administration was 1,300/mm^3 with 910 neutrophils/mm^3. His WBC initially was stable but fell from 1,400/mm^3 on day 6 to 500/mm^3 (55 neutrophils/mm^3) on day 7. He developed a fever and was placed on gentamicin and ticarcillin. The following day, with a WBC of 400/mm^3 (8 neutrophils/mm^3), pentamidine was discontinued. Throughout this period, the patient did not develop anemia or thrombocytopenia. He was begun on SXT (15 mg trimethoprim/kg/day intravenously); the drug was continued for 11 days, during which his WBC rose to 1,700/mm^3. SXT was well tolerated, except for mild pruritis and an erythematous rash that disappeared when the drug was stopped. His chest film and respiratory symptomatology had improved markedly. The patient was discharged 12 days later and remained well at a follow-up appointment 7 days thereafter.

Reported by B Polsky, MD, J Dryjanski, MD, E Whimbey, MD, B Wong, MD, JWM Gold, MD, D Armstrong, MD, Infectious Disease Svc, Dept of Medicine, Memorial Sloan-Kettering Cancer Center, New York; Parasitic Diseases Drug Svc, Div of Parasitic Diseases, Center for Infectious Diseases, CDC.

THE OFFICIAL NEWSLETTER OF THE NCSSTDS - VOLUME 5, NO. 4 - MARCH/APRIL, 1984 - PAGE 35.

Editorial Note: For each patient, this was the first admission for PCP, and each showed clinical recovery. In two, recovery occurred while on pentamidine therapy. Folinic acid, topical antifungal agents, benzodiazepines, and in one patient, meperidine and diphenhydramine, were administered during the period in which the pentamidine-associated neutropenia developed. Furthermore, despite intensive screening, only a few other infectious agents (*G. lamblia, V. parahemolyticus, M. avium-intracellulare,* and superficial *Candida*) complicated these cases. In two of these, neutropenia developed or worsened during the administration of other anti-infective drugs. Thus, despite the close temporal relationship between neutropenia and the administration of pentamidine and the gradual improvement of the neutropenia after withdrawal of the drug, it should not be presumed that these reactions were specifically related to pentamidine.

CDC's Parasitic Diseases Drug Service has received standard report forms for 179 patients with AIDS and PCP treated with pentamidine from January 1982 to September 1983. Of these, 26 (14.5%) developed leukopenia, with decreases in leukocyte counts from pre-therapy to mid- or post-therapy of 50% or more. In 12 instances, the physician discontinued pentamidine because of leukopenia, and in six of these 12, neutropenia or granuocytopenia was specifically mentioned as a complication. However, standard report forms ask only for WBC and are otherwise not sufficient to further characterize this phenomenon. CDC has sent a questionnaire to physicians for 114 randomly selected patients for whom pentamidine was released from October 1, to December 16, 1983, to obtain a more complete characterization and incidence estimate. In addition, physicians using pentamidine are encouraged to provide more detailed information on hematologic changes occurring during pentamidine treatment on the standard patient report form for pentamidine therapy.

Epidemiologic Notes and Reports

Fulminant Hepatitis B among Parenteral Drug Abusers — Kentucky, California

During the first 10 months of 1983, unrelated clusters of fulminant hepatitis B (HB) deaths occurred in Madisonville, Kentucky, and Porterville, California. Both outbreaks were limited to circles of parenteral drug abusers and their sexual contacts. Thirty-six cases occurred, with five deaths, for a case-fatality ratio (CFR) over 10 times the expected ratio.

Investigations involved active HB case finding, identification of possible risk factors for fulminant HB, and serotesting for HB and the Delta agent (a dependent virus recently implicated as a co-factor in fulminant HB infection). In both outbreaks, a case was defined as: (1) acute clinical symptoms compatible with hepatitis B; (2) acute elevation of serum glutamic-oxaloacetic transaminase (SGOT) or serum glutamic-pyruvic transaminase (SGPT) two or more times greater than the upper limit of normal; and (3) positive hepatitis B surface antigen (HBsAg) serology.

Fulminant Hepatitis — Continued

In Kentucky, 17 outbreak-related cases occurred between January and September 1983. Twelve patients were male, and all 17 were white, non-Hispanic. Ages ranged from 18 to 30 years (median 22 years). Two of the 17 patients (one male, one female) had fulminant disease that resulted in death, for a CFR of 11.8%. Fifteen patients had needle exposures; two were sexual contacts of patients.

In California, 19 HB cases were identified between June and December 1983. Seventeen patients were male; 17 were Hispanic; one, an American Indian; and one, white, non-Hispanic. Ages ranged from 18 to 34 years (median 20.5). Three patients, all male (including two brothers), had fulminant HB that resulted in death, for a CFR of 15.8%. Eighteen patients had needle exposures; one was a sexual contact of a patient.

The combined outbreak-related CFR was 13.9%, as compared with a combined CFR of 4.5% in 22 concurrent nonoutbreak-related cases and a CFR of 1% expected for hospitalized HB patients.

In both outbreaks, the only hepatotoxin identified was alcohol; however, the alcohol intake of patients with fulminant HB did not differ significantly from that of patients with nonfulminant disease. Anti-Delta antibody was detected in one of three patients with fulminant HB from whom serum was still available and in none of 32 patients with nonfulminant HB. This patient had strongly positive IgM-anti-Delta and a biphasic clinical course indicating co-infection with the Delta agent. In addition, at least two hepatitis non-A, non-B (NANB) cases and several previous NANB cases were identified among intravenous-drug users in both outbreaks.

Reported by RL Schaefer, MS, Regional Medical Center, RL Wolfe, MD, CM Steinfeld, MD, EE Kawas, MD, DA Martin, MD, Hopkins County Health Dept, Madisonville, MW Hinds, MD, State Epidemiologist, Kentucky Dept of Health Svcs; RH Johnson, MD, Kern County Medical Center, Bakersfield, JR Hayes, MD, J Jacobs, MD, Porterville, J Pendleton, Jr, MD, Tulare County Health Dept, AG Redeker, MD, Los Angeles, RR Roberto, MD, J Chin, MD, State Epidemiologist, California Dept of Health Svcs; Hepatitis Br, Div of Hepatitis and Viral Enteritis, Center for Infectious Diseases, CDC.

Editorial Note: Hepatitis B is generally a mild disease with a CFR of only 1% in patients ill enough to require hospitalization. In one large, drug-related military outbreak, no deaths occurred among several thousand patients with clinical HB (*1*). The severity of the current outbreaks might be explained by any of several factors, including an unusually virulent strain of HB, simultaneous infection with other hepatotrophic viruses (NANB virus or the Delta agent) or the action of hepatotoxic chemicals. Although the existence of virulent strains of HB virus have not been clearly documented, each of the other factors has been implicated as a cause of at least one severe hepatitis outbreak.

One previously reported cluster of fulminant HB deaths among parenteral drug users, in which six of nine patients died, occurred in New Bern, North Carolina, in 1979 (*2*). An extensive investigation implicated the injection of 3,4 methylene diamphetamine (MDA) as a possible co-factor to account for the severity of the outbreak. Follow-up studies in chimpanzees exposed to MDA and HB virus were inconclusive. Two cases of NANB hepatitis in drug users were also associated with the outbreak.

There was no MDA use in either of the two current outbreaks. Although "crank," a locally-produced, amphetamine-like substance, was available in California, it was used to a far lesser extent than heroin, and none of the patients with fulminant HB were known to have used it.

As in the New Bern outbreak, a few cases of NANB hepatitis were associated with both recent outbreaks. NANB hepatitis virus has been implicated, along with HB, in an exceptionally virulent outbreak of hepatitis (11 deaths/42 patients) among hemodialysis patients and staff in Edinburgh, Scotland, in 1969-1970, when stored sera were recently retested using modern serodiagnostic techniques for hepatitis A and B (*3*). However, until a reliable serologic

PAGE 36 - THE OFFICIAL NEWSLETTER OF THE NOSOTOS - VOLUME 5, NO. 4 - MARCH/APRIL 1984

Fulminant Hepatitis – Continued

test for NANB virus(es) is developed, the role of concurrent NANB hepatitis infection in outbreaks of severe HB cannot be clearly defined.

Infection with the Delta agent was recently implicated as the cause of an exceptionally severe hepatitis epidemic among Venezuelan Indians (in which 34 of 149 patients died) (*4*). The Delta agent is an HB-dependent virus composed of a protein antigen (Delta antigen) and a ribonucleic acid (RNA) of low molecular weight, coated with hepatitis B surface antigen. It is transmissible as an independent infectious agent but may only replicate in the presence of active hepatitis B virus infection (*5*). Coprimary infection with HB/Delta, or Delta virus superinfection of an HB carrier may cause acute and/or chronic hepatitis; both types of infection have been associated with fulminant hepatitis B in Europe (*6*). Delta agent infection is endemic in southern Italy and in certain parts of South America and western Africa, but has been limited to hemophilia patients and drug-addict populations in the rest of Western Europe, North America, and Australia (*7,8*).

Evidence of infection with the Delta agent was found in one of three patients with fulminant HB in whom serum was available for testing (1/1 from California, 0/2 from Kentucky). Although Delta was not clearly defined as the cause of these outbreaks, testing for markers of Delta infection is indicated in any outbreak of fulminant hepatitis.

Control of hepatitis B outbreaks in parenteral-drug-using populations is difficult. Efforts in these outbreaks were focused on physician education with respect to diagnosis of HB by appropriate serotesting and prophylaxis of needle and sexual contacts of patients. Seronegative needle contacts should be offered HB vaccine in addition to standard passive prophylaxis. The Delta agent is transmitted similarly to HB and requires no special precautions other than those recommended for HB.

References

1. Cates W Jr, Warner JW. Hepatitis B in Nuremberg, Germany. Epidemiology of a drug-associated epidemic among US Army soldiers. JAMA 1975;234:930-4.
2. CDC. Hepatitis B—New Bern, North Carolina. MMWR 1979;28:373-4.
3. Marmion BP, Burrell CJ, Tonkin RW, Dickson J. Dialysis-associated hepatitis in Edinburgh; 1969-1978. Rev Infect Dis 1982;4:619-37.
4. Hadler S, Monzon M, Ponzetto A, et al. Delta virus infection and severe hepatitis: an epidemic in the Yucpa Indians of Venezuela. Ann Intern Med (in press).
5. Rizzetto M, Canese MG, Gerin JL, London WT, Sly DL, Purcell RH. Transmission of the hepatitis B virus-associated Delta antigen to chimpanzees. J Infect Dis 1980;141:590-602.
6. Smedile A, Farci P, Verme G et al. Influence of Delta infection on severity of hepatitis B. Lancet 1982;II:945-7.
7. Rizzetto M, Shih JW-K, Gocke DJ, Purcell RH, Verme G, Gerin JL. Incidence and significance of antibodies to Delta antigen in hepatitis B virus infection. Lancet 1979;II:986-90.
8. WHO. Hepatitis surveillance: Delta agent. Wkly Epidem Rec 1983;58:391-2.

CENTERS FOR DISEASE CONTROL

March 9, 1984 / Vol. 33 / No. 9

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Update: Treatment of Cryptosporidiosis in Patients with Acquired Immunodeficiency Syndrome (AIDS)

In November 1982, 21 patients with acquired immunodeficiency syndrome (AIDS) and severe, protracted diarrhea caused by cryptosporidiosis were reported; the report concluded that no effective treatment for cryptosporidiosis was known at that time (*1*). Since then, 91 additional AIDS patients with chronic cryptosporidiosis have been reported to CDC. Although no therapy has been consistently effective in treating them, preliminary reports suggest that a few may have responded to treatment with spiramycin (Rovamycine,* Rhône-Poulenc Pharma, Montreal) or the combination of quinine and clindamycin.

Since December 1982, physicians at the University of Miami, Florida, have used spiramycin to treat seven AIDS patients with chronic cryptosporidiosis; six other AIDS patients with cryptosporidiosis have been treated with spiramycin at five other institutions; and one non-AIDS patient with chronic cryptosporidiosis associated with a bone marrow transplant has received the drug. Thirteen of the 14 patients were adults; they received 1 g of spiramycin orally three or four times a day. The 14th patient, a 2-year-old child, received 500 mg orally twice a day. No adverse effects were attributed to the drug.

Three of the 13 AIDS patients were apparently cured after 3-4 weeks of spiramycin therapy (i.e., all three improved symptomatically, and intestinal biopsies and three successive stool examinations after therapy were negative). Follow-up 6-7 months after discontinuation of spiramycin revealed that all three remained asymptomatic. Two have subsequently died from causes related to their underlying immunodeficiency—one with Kaposi's sarcoma, the other with *Pneumocystis carinii* pneumonia.

In an additional three AIDS patients, gastrointestinal symptoms improved rapidly with spiramycin (in two cases, within 48 hours of starting the drug), but these patients continued to have *Cryptosporidium* in their stools. Spiramycin was continued for variable periods of time, but when therapy was stopped, diarrhea in each patient promptly recurred. On reinitiation of spiramycin, two of the three again improved, but the third continued to have severe diarrhea and has since died. One of the two surviving patients had *Cryptosporidium* detected in his stool at weekly intervals for the first 3½ months of therapy. The patient recently had three negative stools, and spiramycin was stopped; he now has been off therapy for 2 weeks and remains asymptomatic.

The remaining seven AIDS patients did not respond symptomatically or parasitologically to spiramycin. Three, however, died within 2-7 days after starting spiramycin. None of the deaths was attributed to spiramycin.

A non-AIDS patient with chronic cryptosporidiosis, acquired after receiving a bone marrow transplant, also improved with spiramycin therapy. She began spiramycin after suf-

*Use of trade names is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

THE OFFICIAL NEWSLETTER OF THE NOOSTDS - VOLUME 5, NO. 4 - MARCH/APRIL, 1984 - PAGE 37.

Cryptosporidiosis — Continued

fering from severe, watery diarrhea and abdominal cramps for 6 weeks; within 24 hours, her cramps had resolved and her diarrhea had improved, and 2 weeks later, she was having one bowel movement a day. After 3 weeks of therapy, a stool examination was negative for *Cryptosporidium*.

CDC has also received six reports of AIDS patients and one bone marrow transplant patient with cryptosporidiosis who were treated with a combination of quinine and clindamycin, both given orally. Two patients did not respond after 7-14 days of therapy. In three others, the drugs were discontinued because of adverse effects; one developed a severe rash; another, severe vomiting; the third, thrombocytopenia. Symptoms improved in two of these three patients during the first few days of therapy. The sixth patient had acute cholecystitis and diarrhea associated with *Cryptosporidium* of the cystic duct and intestines. He received 300 mg of clindamycin and 250 mg of quinine, given orally four times a day. Within 2 days of initiating therapy, the patient's diarrhea resolved, but stool examinations after therapy continued to show occasional *Cryptosporidium*. A seventh patient, who developed chronic cryptosporidiosis after receiving a bone marrow transplant, also received oral quinine and clindamycin; the patient showed no clinical improvement despite 2 weeks of therapy.

Reported by M Whiteside, MD, C MacLeod, MD, M Fischl, MD, G Scott, MD, Miami, Florida; J Cain, MD, M Wolfe, MD, Washington, DC; T Brasitus, MD, Chicago, Illinois; B Blazar, MD, Minneapolis, Minnesota; R Glickman, MD, New York City, R Soave, MD, D Kaufman, MD, New York; E Buckley, MD, Durham, North Carolina; G Poporad, MD, Elkins Park, S Gluckman, MD, W Lipshutz, MD, R Kaplan, MD, Philadelphia, Pennsylvania; D Portnoy, MD, M Zaklos, MD, Montreal, Quebec, Canada; AIDS Activity, Div of Host Factors, Protozoal Diseases Br, Div of Parasitic Diseases, Center for Infectious Diseases, CDC.

Editorial Note: *Cryptosporidium* is a protozoan parasite that causes severe, protracted diarrhea in immune suppressed patients. The first patient with human cryptosporidiosis was reported in 1976, and before 1982, only seven cases of human cryptosporidiosis had been published. During 1982 and 1983, however, the number of reported cases has increased steadily (*2*).

The case reports described here are the first to offer encouragement in the treatment of cryptosporidiosis in immune suppressed patients. However, these reports must be viewed cautiously for several reasons. Most of the patients have had no response to spiramycin or the combination of clindamycin and quinine, and many of the patients who have responded symptomatically have not had parasitologic cures. Furthermore, treatment with clindamycin and quinine was associated frequently with adverse effects. Little is known about spiramycin's antiprotozoal activity. There are no published reports evaluating the efficacy of spiramycin against cryptosporidiosis in animals, and preliminary results by investigators at Auburn University, Alabama, suggest that spiramycin does not inhibit *Cryptosporidium* growth in tissue culture (*3*). Spiramycin is used in Europe and Canada to treat infections caused by another protozoan parasite, *Toxoplasma gondii*, but studies of spiramycin's efficacy for human toxoplasmosis have not included appropriate control groups, and animal studies have produced equivocal results (*4-7*).

Spiramycin is a macrolide antibiotic with an antimicrobial activity similar to erythromycin and clindamycin. It has been used in Europe and Canada for over 20 years to treat bacterial infections. Serious adverse effects from spiramycin are apparently rare, and no drug-associated deaths have been reported. Two patients have been reported who complained of nausea, sweating, giddiness, and paresthesia 1 hour after a single oral dose of 3 g; the symptoms subsided spontaneously within an hour (*8*). Mild to moderate diarrhea, including bloody diarrhea in two cases, has been reported in patients receiving various doses of spiramycin (*8-12*). Other reports of adverse reactions include one patient who developed a mild rash and others who developed contact dermatitis after handling spiramycin in animal feed (*13-16*).

The U.S. Food and Drug Administration (FDA) has not approved spiramycin for routine use, and therefore, the drug is not commercially available in the United States. Physicians in the United States who wish to obtain spiramycin should contact the FDA's Division of Anti-infective Drug Products, telephone (301) 443-4310.

References

1. CDC. Cryptosporidiosis: assessment of chemotherapy of males with acquired immune deficiency syndrome (AIDS). MMWR 1982;31:589-92.
2. Navin TR, Juranek DD. Cryptosporidiosis: clinical, epidemiologic and parasitologic review. Rev Infect Dis (in press).
3. Current WL. Auburn University. Unpublished data.
4. Beverley JKA, Freeman AP, Henry L, Whelan JPF. Prevention of pathologic changes in experimental congenital toxoplasma infections. Lyon Medical 1973;230:491-8.
5. Thiermann E, Apt W, Atias A, Lorca M, Olguin J. A comparative study of some combined treatment regimens in acute toxoplasmosis in mice. Am J Trop Med Hyg 1978;27:747-50.
6. Coradello H, Kretschmer S. Vergleichende Untersuchung der Wirksamkeit von Ultrax, Diazil, Baktrim und Spiramycin auf die experimentelle Toxoplasmose der Maus. Wien Klin Wochenschr 1978;90:25-9.
7. Desmonts G, Couvreur J. Congenital toxoplasmosis. A prospective study of 378 pregnancies. N Engl J Med 1974;290:1110-6.
8. Kamme C, Kahlmeter G, Melander A. Evaluation of spiramycin as a therapeutic agent for elimination of nasopharyngeal pathogens. Possible use of spiramycin for middle ear infections and for gonococcal and meningococcal nasopharyngeal carriage. Scand J Infect Dis 1978;10:135-42.
9. Hudson DG, Yoshihara GM, Kirby WM. Spiramycin: clinical and laboratory studies. AMA Arch Intern Med 1956;97:57-61.
10. Kamme C, Kahlmeter G. Evaluation of spiramycin in meningococcal carriage. Scand J Infect Dis 1979;11:229-32.
11. Di Febo G, Milazzo G, Gizzi G, Biasco G, Miglioli M. Antibiotic-associated colitis: always pseudomembranous? Endoscopy 1982;14:128-30.
12. Decaux GM, Devroede C. Acute colitis related to spiramycin. Lancet [letter] 1978;II:993.
13. Macfarlane JA, Mitchell AA, Walsh JM, Robertson JJ. Spiramycin in the prevention of postoperative staphylococcal infection. Lancet 1968;I:1-4.
14. Paggiaro PL, Loi AM, Toma G. Bronchial asthma and dermatitis due to spiramycin in a chick breeder. Clin Allergy 1979;9:571-4.
15. Hjorth N, Roed-Petersen J. Allergic contact dermatitis in veterinary surgeons. Contact Dermatitis 1980;6:27-9.
16. Veien NK, Hattel T, Justesen O, Norholm A. Occupational contact dermatitis due to spiramycin and/or tylosin among farmers. Contact Dermatitis 1980;6:410-3.

CENTERS FOR DISEASE CONTROL

March 30, 1984 / Vol. 33 / No. 12

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Disseminated Gonococcal Infections and Meningitis — Pennsylvania

Between January 9, and January 31, 1984, two cases of disseminated gonococcal infection (DGI) associated with meningitis occurred in the Philadelphia, Pennsylvania, area. The patients did not have a common sexual contact. One patient died.

Case 1: A 15-year-old female, previously well, was admitted to a Philadelphia-area hospital on January 9, with less than 1 day of malaise, sore throat, and progressive mental confusion. Her previous medical history was unremarkable for repeated or unusual infections. During July 1983, she had been treated for a culture-proven *Neisseria gonorrhoeae* cervical

PAGE 38 - THE OFFICIAL NEWSLETTER OF THE NCGSTDS - VOLUME 5, NO. 4 - MARCH/APRIL 1984

Disseminated Gonococcal Infections — Continued

infection with oral ampicillin 3.5 g/probenicid 1 g; her test-of-cure was negative. The patient was seen again at an area clinic during November 1983 as a suspected contact of gonorrhea and was treated with oral ampicillin 3.5 g/probenicid 1 g; the cervical culture submitted was negative for *N. gonorrhoeae*. No sexual partners were identified at these visits or at the current admission.

Clinical and laboratory findings on admission supported a diagnosis of hypovolemic shock and sepsis, with acute renal failure, disseminated intravascular coagulation, and meningitis. Intravenous ampicillin and chloramphenicol were administered, along with other supportive measures. Two blood cultures and a cervical culture obtained on admission were positive for *N. gonorrhoeae*. Although cerebrospinal fluid (CSF) cultures were negative for bacterial pathogens, large numbers of polymorphonuclear leukocytes were present. Despite intense supportive measures, including intubation with ventilator support, the patient succumbed to overwhelming sepsis, shock, and noncardiogenic pulmonary edema on January 13.

Case 2: A 19-year-old female, previously well, was admitted to a second area hospital on January 24, with a 2-day history of nausea, vomiting, headache, and neck stiffness. Following admission, she was treated with intravenous penicillin, to which she gradually responded. Specimens obtained from the cervix and CSF were culture-positive for *N. gonorrhoeae*. She was discharged following an uneventful recovery. Two male sexual contacts were identified, with symptoms localized to the genitourinary tract.

Laboratory investigation: Isolates were submitted to CDC for further confirmation and evaluation. The identities of the isolates were confirmed by carbohydrate utilization and commercial coagglutination; each isolate was tested for production of β-lactamase (penicillinase). Serogrouping based on major outer membrane proteins was determined using experimental monoclonal antibodies (*1*). Nutritional requirements were identified by auxotyping (*2*). Antibiotic susceptibilities were determined by agar dilution, and plasmid content was identified for each gonococcal isolate. Gonococci were incubated with normal human sera and the patients' sera to determine serum bactericidal activity. Major complement component levels were determined for each patient.

Isolates from the blood and cervix of the first patient were *N. gonorrhoeae*, nonpenicillinase-producing, serogroup IA, proline auxotype, plasmid content of 2.6 megadaltons, with susceptibility to penicillin, tetracycline, chloramphenicol, erythromycin, trimethoprim/sulfamethoxazole, spectinomycin, and cefoxitin. Incubation of gonococci with normal human serum (NHS) showed resistance to killing, but there was bactericidal activity with the patient's serum (PS). Quantitation of complement components for the first patient revealed a moderate depression of C-3 and C-4 components.

Isolates from the CSF and cervix of the second patient were confirmed as *N. gonorrhoeae*, nonpenicillinase-producing, serogroup IA, proline auxotype, plasmid content of 2.6 megadaltons, with a similar antibiotic susceptibility pattern to the isolates from the first patient. Incubation of gonococci with NHS and PS demonstrated resistance to NHS and bactericidal activity with PS. No serum complement deficiencies were demonstrated.

Reported by S Plotkin, MD, C Pasquareillo, MD, E Charney, MD, J Campos, PhD, The Children's Hospital of Philadelphia, R Swenson, MD, N Pullman, MD, E Burkhardt, Temple University Hospitals, S Shapiro, MD, L Polk, MD, R Sharrar, MD, B Cassens, MD, M Goldberg, City of Philadelphia Dept of Health, CW Hays, MD, State Epidemiologist, Pennsylvania State Dept of Health; Sexually Transmitted Diseases Laboratory Program, Center for Infectious Diseases, Div of Sexually Transmitted Diseases, Center for Prevention Svcs, CDC.

Editorial Note: The occurrence of two cases of DGI associated with meningitis within a 1-month period in the same area is extremely unusual. Both patients were similar by age group (15-19 years), sex, race, and geographic area. The isolates from the patients were identical with regard to serogrouping, auxotyping, and plasmid content. There were no complement deficiencies, except a moderate depression of C-3 and C-4 components in the first patient, which may have been attributable to overwhelming sepsis. However, C-3 deficiency has been associated with recurrent infections caused by other pyogenic organisms (*3,4*).

DGI is most commonly associated with clinically diagnosed arthritis or tenosynovitis and typical skin lesions. However, a microbiologic diagnosis based on positive blood, synovial fluid, or skin-lesion cultures may be difficult to confirm.

DGI causing meningitis, septic shock, and death is very rare to virtually unknown. Only 20 gonococcal meningitis cases were reported between 1922 and 1972 (*5,6*). Among 49 DGI patients from a recent report, none had meningitis; most of these organisms were serogroup IA (*7*).

The unusual clinical presentation of DGI with meningitis supports the necessity for the differentiation of *N. gonorrhoeae* from *N. meningitidis* among patients with Gram-negative diplococcal bacteremia and meningitis.

There have been no additional cases of DGI with meningitis reported from the Philadelphia area. Recommendations have been made to increase surveillance for DGI and complications of gonococcal infection, particularly among hospitalized patients. A survey is being conducted to sample representative *N. gonorrhoeae* among the Philadelphia population.

References

1. Sandstrom EG, Chen KCS, Buchanan TM. Serology of *Neisseria gonorrhoeae*: Coagglutination serogroup WI and WII/III correspond to different outer membrane protein molecules. Infect Immunity 1982;38:462-70.
2. Knapp JS, Holmes KK. Disseminated gonococcal infections caused by *Neisseria gonorrhoeae* with unique nutritional requirements. J Infect Dis 1975;132:204-8.
3. Alper CA, Abramson N, Johnson RB, Jr, Jandi JH, Rosen FS. Increased susceptibility to infection associated with abnormalities of complement-mediated functions and of the third component of complement (C3). N Engl J Med 1970;282:349-53.
4. Ballow M, Shira JE, Harden L, Yang SY, Day NK. Complete absence of the third component of complement in man. J Clin Invest 1975;56:703-10.
5. Sayeed ZA, Bharudi U, Howell E, Meyers HL, Jr. Gonococcal meningitis. JAMA 1972;219:1730-1.
6. Holmes KK, Counts GW, Beaty HN. Disseminated gonococcal infection. Ann Intern Med 1971;74:979-93.
7. O'Brien JP, Goldberg DL, Rice PA. Disseminated gonococcal infection: a prospective analysis of 49 patients and a review of pathophysiology and immune mechanisms. Medicine 1983;62:395-406.

CENTERS FOR DISEASE CONTROL

April 6, 1984 / Vol. 33 / No. 13

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Prospective Evaluation of Health-Care Workers Exposed via Parenteral or Mucous-Membrane Routes to Blood and Body Fluids of Patients with Acquired Immunodeficiency Syndrome

In August 1983, CDC initiated prospective surveillance of health-care workers with documented parenteral or mucous-membrane exposures to potentially infectious body fluids from patients with definite or suspected acquired immunodeficiency syndrome (AIDS). By December 31, 1983, 51 health-care workers with such exposures were enrolled in CDC's surveillance registry through the auspices of participating hospitals, other health-care institutions, and health departments in the United States.* None of these workers has developed signs or symptoms suggestive of AIDS. All but one of these workers had been followed for less than 12 months (see below).

Among the 51 exposed health-care workers studied, 19 (37%) have been reported from New York; nine (18%), from Texas; seven (14%), from Pennsylvania; five (10%) from New Jersey; and 11 (21%), from seven other states. Exposures occurred between April 1981 and November 1983. Length of follow-up of exposed health-care workers ranged from 1 month to 32 months by December 31, 1983 (mean 5.5 months). Twenty-four (47%) of the exposed workers were nurses; nine (18%) were physicians; five (10%) were phlebotomists; three (6%) were respiratory therapists; and the remaining 10 (20%) were health-care workers with less direct patient contact, such as laboratory and maintenance personnel. Eighty percent were white, and 75% were female. Ages ranged from 18 years to 51 years (mean 29 years).

The majority of exposures occurred in direct patient-care areas. Twenty-seven (53%) exposures occurred in patients' rooms or on wards, and 12 (24%) occurred in intensive-care units. Seven incidents (14%) took place in laboratories, and five (10%) occurred in operating rooms or morgues. The types of exposures were: needlestick injuries (65%); cuts with sharp instruments (16%); mucosal exposure (14%); and contamination of open skin lesions with potentially infective body fluids (6%). Post-exposure treatment consisted of local care only in 41%; administration of hepatitis B immune globulin (HBIG) alone or in combination with immune globulin (IG) or tetanus (Td) prophylaxis in 24%; IG alone or with Td in 31%; and Td only in 4%. Among the 12 exposed health-care workers receiving HBIG, three were exposed to AIDS patients reported positive for hepatitis B surface antigen (HBsAg).

Reported by GA Thomas, MD, MD Anderson Hospital, Houston, Texas; G Talbot, MD, Hospital of the University of Pennsylvania, Philadelphia, J Jahre, MD, St. Luke's Hospital, Bethlehem, C Legaspi, MD, Veterans Administration Medical Center, Lebanon, Pennsylvania; D Silverman, MD, Bellevue Hospital Medical Center, W McKinley, Beth Israel Medical Center, J Gold, MD, Memorial Hospital for Cancer, M Grieco, MD, M Lange, MD, St. Luke's-Roosevelt Hospital Center, J Vieira, MD, Brooklyn Hospital, New York City, C Matkovic, MD, St. John's Episcopal Hospital, Smithtown, A Laporta, MD, Astoria General Hospital, Long Island City, R Stricof, New York State Dept of Health; JA Jacobson, MD, LDS Hospital, Salt Lake City, Utah; MA Sanchez, MD, Englewood Hospital, Englewood, HD Luce, MD, New Jersey State Dept of Health; JA McCutchan, MD, University of California Medical Center, San Diego, L Thrupp, MD, University of California Medical Center, Irvine, California; N Jacobson, MD, Coral Reef General Hospital, Miami, Florida; BP Buggy, St. Luke's Hospital, Milwaukee, Wisconsin; M Eberenz, Mt. Carmel East Hospital, Columbus, Ohio; P Dennehy, MD, Rhode Island Hospital, Providence; AH Everhart, Doctors Hospital, Tucker, Georgia; Div of Immunization, Center for Prevention Svcs, AIDS Activity, Div of Host Factors, Div of Viral Diseases, Hospital Infections Program, Center for Infectious Diseases, CDC.

Editorial Note: The principal goal of this surveillance project is to evaluate the risk, if any, to health-care workers exposed to potentially infectious materials from AIDS patients. Epidemiologic evidence is consistent with the hypothesis that AIDS is caused by a transmissible infectious agent (*1,2*). AIDS appears to be transmitted by intimate sexual contact or by percutaneous inoculation of blood or blood products. There is no evidence of transmission through casual contact with affected individuals or by airborne spread, and there are no cases of AIDS among health-care workers that can definitely be ascribed to specific occupational exposures. The risk of AIDS transmission to health-care workers through percutaneous or mucosal inoculation of blood or body fluids from AIDS patients remains undefined, although currently available epidemiologic data suggest that the risk of transmission, if any, is small.

Recommended precautions for preventing AIDS in health-care workers have been published (*3-5*). These recommendations are designed to minimize the risk of mucosal or parenteral exposure to potentially infectious materials from AIDS patients. Based on descriptions of the incidents supplied to CDC, over one-third of the exposures among these 51 health-care workers might have been prevented by following recommended precautions. Health-care workers are urged to become familiar with and adhere to these recommendations.

No single form of post-exposure care appears to predominate among personnel reported to CDC, although local wound care only was the largest individual treatment category. Since AIDS patients are often in groups at high risk for hepatitis B, post-exposure prophylaxis should follow guidelines for immunoprophylaxis for viral hepatitis (*6*).

The enrollment phase of this surveillance project is designed to last 3 years. Institutions and investigators wanting information on participation in the project should contact CDC's Hospital Infections Program at (404) 329-3406.

References

1. CDC. Update on acquired immune deficiency syndrome (AIDS)—United States. MMWR 1982;31:507-8, 513-4.
2. Francis DP, Curran JW, Essex M. Epidemic acquired immune deficiency syndrome: epidemiologic evidence of a transmissible agent. J Natl Cancer Inst 1983;71:1-4.
3. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
4. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.
5. Williams WW. Guideline for infection control in hospital personnel. Infect Control 1983;4:326-49.
6. ACIP. Immune globulins for protection against viral hepatitis. MMWR 1981;30:423-8, 433-5.

*Since December 31, 1983, preliminary reports have been received on an additional 50 exposed health-care workers.

THE OFFICIAL NEWSLETTER OF THE NCGSTDS
VOLUME 5, NO. 4
MARCH/APRIL 1984