THE OFFICIAL NEWSLETTER OF THE

# NATIONAL COALITION OF GAY STD SERVICES

VOLUME 6 #4 March-April, 1985

 Articles for the Newsletter, or inquiries about membership or subscriptions may be addressed to Mark P. Behar, PA-C, Chairperson, NCGSTDS, PO Box 239, Milwaukee, WI 53201-0239 (414/277-7671). Please credit the NCGSTDS when reprinting items from the Newsletter. We're eager to hear from you, and will try to answer all correspondence! The NCGSTDS is the proud recipient of the National Lesbian/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.

GAY PRESS ASSOCIATION

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## WORKSHOP AT INTERNATIONAL AIDS CONFERENCE: DEVELOPING AIDS CONTROL GUIDELINES

A Workshop on Developing State-of-the-Art AIDS Control Guidelines and Educational Programs is being held in conjunction with the International AIDS Conference, Sunday, April 14, 1-5 pm, at the Georgia World Congress Center. The tentative agenda includes a review of current knowledge base for AIDS risk reduction, including epidemiologic information, HTLV-III transmission data, role of co-factors, and nonsexual risk factors; critique of current AIDS risk reduction guidelines, which will review the common elements of available guidelines and their differences, and specific suggestions about additions or changes; practical considerations, including measuring behavioral change, methods for getting knowledge to persons at risk, motivating behavioral change in persons at risk, and how we can assess the efficacy of those efforts; and specific concrete proposals, including guidelines content, format & media, and how to integrate guidelines into a national AIDS educational effort, STD programs, community outreach programs, and education of medical professionals. All are invited to participate in this workshop, which is being cosponsored by: American Association of Physicians for Human Rights, Emory University School of Medicine, the International Conference on AIDS, National Coalition of Gay STD Services, and the National Lesbian & Gay Health Foundation. If you are interested in presenting on a specific topic, contact Mark Behar (414/277-7671) or David Ostrow, MD (312/565-2109); formal presentations should be no longer than 5 minutes in length, however a written outline or summary (at least 50-100 copies) would be appreciated. There is no registration fee for this satellite workshop! A written report will be forthcoming after the Workshop, and specific recommendations will be incorporated into future editions of guidelinelines brochures.

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## INTERNATIONAL AIDS CONFERENCE RELATED ACTIVITIES SPONSORED BY AID ATLANTA

Scientists and gay health workers from around the world will be attending the International Conference on AIDS in Atlanta, April 14-17, at the World Congress Center to share their most recent research in the battle against AIDS. AID Atlanta will be very active during the Conference. AIDA will be sponsoring a performance of Warren, an original play written and produced by a close friend of Warren, a person with AIDS, and first performed at The Seven Stages Theatre in Atlanta. Warren is scheduled for a Monday evening performance as part of the official program. AIDA will host a hospitality suite at the Omni International Hotel as a gathering place for the other community-based AIDS service organizations to meet and share their programs and experiences. AIDA will sponsor a display space for all interested AIDS Service organizations to display their educational material. AIDA will host a cocktail party at the home of one of its board members on Sunday evening for all AIDS Service organizations delegates and friends. Finally, volunteers from AIDA will open their homes and provide housing for any delegates to the Conference from AIDS Service organizations from around the country. We look forward to showing some true "southern hospitality" to our brothers and sisters working as we are to respond to this epidemic. For additional information, contact: AID Atlanta, 1132 W. Peachtree St., NW, Suite 112, Atlanta, GA 30309 (404/872-0600).

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## INTERNATIONAL AIDS CONFERENCE: SUNDAY DINNER SPONSORED BY GAY HEALTH GROUPS

Gay and lesbian participants of the International AIDS Conference are invited to a special dinner, Sunday, April 14, 8:30 pm, at the Maison Gourmet, 2581 Piedmont Rd., NE, Atlanta 30324 in the Lindbergh Plaza (a ten minute Marta ride (the subway) from the World Congress Center). The dinner is cosponsored by the American Association of Physicians for Human Rights, Georgia Association of Physicians for Human Rights, National Lesbian & Gay Health Foundation, AID Atlanta, National Coalition of Gay STD Services, Inter-National AIDS Prospective Epidemiology Network, and the Gay & Lesbian Caucus of the American Public Health Association. The dinner includes a choice of appetizer (Norwegian Shrimp cocktail, pate & imported cheese), salad, choice of three entrees (catch of the day, boneless chicken in wine, or minced veal in pasty shell), desert, and beverage for $18. Reservations MUST be made by calling restaurant owner Dirk Ten Bosch (404/231-8553) or by writing to the above address. This will be a most enjoyable occasion--indeed a special occasion for those of us attending the meetings! Hope to see you there!

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## LESBIAN & GAY HEALTH ISSUES AGENDA DISCUSSED AT MEETING

The National Lesbian & Gay Health Foundation is sponsoring a working meeting of representatives from nine national organizations to improve and/or initiate communication among various groups dealing with lesbian and gay health issues, to provide a perspective to the organizations, to the lesbian/gay community, to the federal government, and to the country in general, regarding health issues both within and outside the context of AIDS, and to discuss cooperative plans to improve gay and lesbian health through research, legislation, and/or improved funding by various sources. One potential goal of the meeting would be to create an ongoing, constructive, and cooperative way to continue to meet our objectives and problems as they arise. A second goal would be to articulate a 3-5 year plan to identify and address health concerns. A third goal is to formulate a consensus statement which could be disseminated and discussed further at the Seventh National Lesbian/Gay Health Conference this June in Washington, DC. Representatives from the following organizations were invited to participate: American Association of Physicians for Human Rights, American Psychological Association, Federation of AIDS-Related Organizations AIDS Action Council, Gay Rights National Lobby, National Association of Gay & Lesbian Alcoholism Professionals, National Association of Social Workers, National Coalition of Black Gays, National Gay Task Force, and the NCGSTDS. The NCGSTDS will be represented by Jim Graham of Whitman-Walker Clinic (Washington, DC). After an introduction to organizations represented and a review of goals and objectives, there will be a delineation of health problems and issues including such items as research, prevention, screening, etc., for each of the following: AIDS, STDs, hepatitis B, alcoholism/drug addiction, mental health issues, lesbian health issues, third world gay/lesbian health issues, homophobia in the health professions, lesbian/gay disabled, lesbian/gay elderly, and other issues. An attempt to set achievable goals for 1985-86 will be made, setting priorities, coordination of overlapping issues, and activities, and serious efforts to achieve continued and improved communication and interaction will be made. Finally, a consensus statement will be developed, disseminated, with the hope of further discussing and developing the statement by the time of the Health Conference in June. The NCGSTDS Newsletter will print additional information and official statements and reports as they are issued.

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## SIXTH INTERNATIONAL MEETING OF THE INTERNATIONAL SOCIETY FOR STD RESEARCH--CALL FOR PAPERS

The Sixth International Meeting of the International Society for STD Research will be held at teh Metropole Hotel, Brighton, Enland, July 31-August 2, 1985. The Society was established May, 1975. At the last meeting in Seattle in 1983, over 200 scientific papers were presented. The aims of the Society are to encourage young researchers and to enable workers in different countries to meet in a common forum to discuss freely research interests. Three major plenary sessions will address: AIDS--Laboratory Diagnosis and Therapy; Herpes Infections; and Sexually Transmitted Diseases and Cervical Pathology. In addition to the plenary sessions, there will be opportunity for papers to be submitted within the following subject areas: AIDS epidemiology, laboratory, clinical and therapy; Recent advances in treatment of herpes, gonorrhea, chlamydia, H. ducreyi, syphilis, and other STDs; interferon therapy; hepatitis; gastrointestinal-tract infections; genito-urinary tract infections; vaginitis; cervical pathology; pelvic inflammatory disease and infertility; maternal/fetal/neonatal disease; new diagnostic techniques; immunologic advances; and recent developments in epidemiology of herpes, gonorrhea, chlamydia, H. ducreyi, and other STDs. Abstracts should be typed as camera-ready copy to be contained within a form provided by the program staff; as the deadline for receipt is March 31st, you should contact program staff immediately: 6th International Meeting, Concorde Services Ltd., 10 Wendell Road, London W12 9RT, United Kingdom. Advance conference registration fees are 140 British Sterling Pounds before May 31; thereafter, the cost is 195 Pounds. For additional information, contact: Sarah Storie-Pugh, Conference Organizer or Sarah Frost-Wellings, Exhibition Organizer at the above address, or by phoning 01-743 3106 (telex: 946240 ref: ELN 19003590). Any NCGSTDS members or newsletter readers planning to attend are asked to contact the Coalition, so that we may refer additional inquiries to you. Thanks!

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## SEVENTH NATIONAL LESBIAN/GAY HEALTH CONFERENCE & FOURTH NATIONAL AIDS FORUM

The National Lesbian and Gay Health Foundation, Inc. (formerly National Gay Health Education Foundation, Inc.) announces the presentation of the Seventh National Lesbian/Gay Health Conference and the Fourth National AIDS Forum, June 28 through July 1, 1985, in Washington, DC. This major event is cosponsored by the National Institute of Allergy and Infectious Diseases, Division of STD Control of the Centers for Disease Control, the AIDS Center, and the Addiction Recovery Corporation. Centering on the theme of "Mainstreameing Lesbian and Gay Health Care," this year's conference will address pertinent scientific, social, emotional and organizational issues within the following areas: lesbian and gay health care; delivery, treatment, and epidemiology of STDs; current developments with AIDS; addiction--etiology and treatment. The initial results from the first National Lesbian Health Care Survey will be presented. The agenda will be set by Peter Laqueur, Conference General Manager, along with Federico Gonzalez of New York's Gay Men's Health Crisis, Elaine Noble of Noble Associates, and other members of the national planning committee. CMEs and CEUs are planned. Workshop proposals are now being solicited for papers and workshops within the above areas. Each proposal will be reviewed by a scientific advisory committee comprised of individuals representing the nation's major health organizations and agencies. All proposals must be submitted in the form of a typed abstract, no longer than one page, together with a recent copy of the presentor's curriculum vitae. Four copies of the proposal must reach the conference office by April 10, 1985. All correspondence should be addressed to NLGHF, Conference '85, PO Box 65472, Washington, DC, 20035. For additional information, please contact: Peter Laqueur, 301/547-0303.

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## CONFERENCE OF MAYORS & CDC OFFER GRANTSMENSHIP/PROPOSAL WRITING WORKSHOP AT GAY CONFERENCE

Officials from the U.S. Conference of Mayors (USCOM) and the Centers for Disease Control (CDC) are planning to offer a workshop on writing grant proposals geared to gay/lesbian health & social service, non-profit agencies at the 7th Annual Lesbian & Gay Health Conference/4th National AIDS Forum, planned for June 28-July 1 in Washington, DC. The suggestion to offer such a workshop came from the AIDS Program Advisory Board of USCOM, at the conclusion of their two-day meeting March 18 & 19 designed to review scores of proposals submitted and offer recommendations for funding of a request for funding proposals (RFP) for developing community oriented health education & AIDS risk reduction programs for the gay community. USCOM was especially interested in programs that targeted hard to reach groups, such as blacks & hispanics, youth, and closeted men who don't necessarily identify with the "gay community." It was apparent that certain deficiencies characterized several of the proposals. "These deficiencies are probably related to a lack of experience in submitting grant proposals," said Mark Behar, Chairperson of the NCGSTDS and one of the Advisory Board Members. "We want this to be a learning experience for those agencies who had novel ideas or important project proposals but just didn't clearly write their proposal." Members of the USCOM's AIDS Program Advisory Board included Katherine McCarter (American Public Health Association), Shellie Lengel (Office of Public Affairs, Department of Health & Human Services), Jeff Levi (National Gay Task Force), Jack Jones (AIDS Health Education Activities, Center for Health Promotion & Education, CDC), and Behar. Fred Kroger, Deputy Director of the CDC's Division of Health Education in the Center for Health Promotion & Education was the program officer sitting in with the Board, and Elise Ward, Debbie Lamm, Richard Johnson and Alan Gambrell from USCOM, also participated. Official notice of awards will be made by the Conference, and reported in the next NCGSTDS Newsletter. Summaries of some of the grant proposals will also be published in a future Newsletter. "Most of [Advisory Board Members] were impressed with the vast public education effort already underway by gay health groups. Most of those organizations are accomplishing their efforts with minimal financial support by local governments, and with essentially volunteer staffs," Behar said. The workshop will hopefully help these groups be able to fairly compete in seeking funding through public and private agencies. One idea was to establish an agency "buddy" system, with a seasoned agency, having been previously successful in getting grants, being teamed up with an inexperienced "buddy," to help with the mechanics of writing the proposal. Peter Laqueur, coordinator of the Conference, welcomed the idea of the workshop, saying that it would be one of many important and useful workshops that would benefit individuals and organizations working in gay & lesbian health issues.

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## RFP ON WARTS & ANORECTAL DISEASE RESEARCH FROM NIH

The National Institute of Allergy and Infectious Diseases (NIAID) invites applications for regular research grants on the biology and molecular virology of human papilloma viruses (HPV) in association with the pathogenesis, epidemiology and natural history of human warts and laryngeal papillomas. Additional information may be obtained from: William P. Allen, PhD, Westwood Bldg., Room 736, National Institutes of Health, Bethesda, MD 20205, 301/496-7453. Application receipt dates are March 1, July 1, and November 1. Please reference: P.T. 34; K.W. 0714125, 1002047, 0715220, 1002008. The National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases (NIADDK) and the National Institute on Aging (NIA) announce a continuing interest in basic and clinical research and research training in anorectal diseases and disorders. The diseases and disorders represented include hemorroids, fissures, fistulas, rectal prolapse, constipation, anorectal pain, fecal incontinence, and congenital anomalies. Also included are those basic studies of anorectal structure and function, and relationship of the anorectum to the more proximal digestive tract. Applications for research and research training in all areas of anorectal disorders, diseases, and related basic structure and function exclusive of neoplastic and infectious diseases are encouraged through this announcement. For more information contact: For digestive diseases & disorders--Donald Murphy, PhD, Special Emphasis Areas Program Director, Westwood Bldg., Room 3A15, NIADDK/NIH, Bethesda, MD 20205 (301/496-7455); For aging and incontinence--Evan C. Hadley, MD, Acting Chief, Geriatrics Branch, Biomedical Research and Clinical Medicine Program, NIA/NIH, Bethesda, MD 20205 (301/496-1033).

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## SOUTHEASTERN CONFERENCE FOR LESBIANS & GAY MEN

The Tenth Southeastern Conference for Lesbians and Gay men will be hosted April 11-14, 1985 by the Carolina Gay Association on the campus of the University of North Carolina at Chapel Hill, where it began in 1976. With a theme of "Here Today and Here to Stay," the Conference will retrospect on the last decade of lesbian and gay organizing in the Southeast as well as focus on getting us through the conservative '80s. The theme reflects both our southern pride and our determination to continue working for progress. Workshops will cover a wide area of interests to lesbians and gay men, including: aging, AIDS, arts & literature, businesses, drug and alcohol abuse, civil rights and responsibilities, legal issues, libraries and archives, media and media impact, men's issues, networking, parenting, relationships, religion, separatism and separate space, sexism and sexual issues, sports, student and youth groups, women's issues, and video and film. For more information, contact: SECLGM, PO Box 73062, Birmingham, AL 35235, or P.O. Box 344, Chapel Hill, NC 27514.

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## AAPHR MEDICAL SYMPOSIUM: GAY/LESBIAN HEALTH CARE IN THE 1980s IN VANCOUVER, AUGUST 7-10

The American Association of Physicians for Human Rights (AAPHR) is happy to announce their annual meeting and medical symposium, "Gay/Lesbian Health Care in the 1980s," August 7-10, 1985, in Vancouver, British Columbia. Three major objectives will be addressed in the 1985 Symposium. To achieve these goals, national and international speakers have been selected to contribute presentations for the Symposium. 1) To provide practicing physicians with increased knowledge of the new medical, psychological and sociological developments related to AIDS. 2) To provide a two day "Gay/Lesbian Health Care" update around critical gay and lesbian health problems in the 1980s. This update will focus on the diagnosis and management of current health care concerns of the gay/lesbian population; and also on education and further research in these areas. Emphasis will be on increasing the knowledge and skills of physicians in areas of gay/lesbian health care. 3) To further educate AAPHR members and other physicians regarding the psychogical and sociologic problems affecting themselves and their interactions with patients. Topics on sexual assault, AIDS counseling, impairment, aging, ethics, socializing patters, sexual abuse and others will focus on increasing the understanding of participants, and providing them with skills to confront the psychological and sociological forces impinging on the health of gay and lesbian individuals. Registration fees before June 1 range from $25 for students to $275 for AAPHR non-members. For more information, contact: AAPHR, PO Box 14366, San Francisco, CA 94114, or Brian Willoughby, MD, Conference Coordinator, 404-1160 Burrard St., Vancouver, BC V6Z 2E8 Canada.

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## GAY MEN'S HEALTH CRISIS SELECTS NEW DIRECTOR TO REPLACE MCFARLANE

Rodger McFarlane announced that the Board of Directors of Gay Men's Health Crisis, Inc. has selected a new Executive Director to assume responsibility for the organization when McFarlane's resignation becomes effective in June. The new director will be Richard Dunne, who joined GMHC in January, 1982 as a Crisis Intervention Worker, and now works as a supervisor of other volunteers working with clients. Dunne is also a Revson Fellow at Columbia University, where he is studying public health issues. McFarlane, who has held the post since July, 1983, said his resignation was a difficult decision. "GMHC's work is vital and we have an extraordinarily dedicated group of staff and volunteers. Over the four years of our history, we have helped hundreds of thousands of people to cope with and understand AIDS. I'm very proud of my role in that but this work is very tough. After two years on the frontlines of the epidemic, I'm nearing exhaustion."

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## BARTENDERS AS GAY HEALTH EDUCATORS

by Ken Hunt, with thanks to Awareness Jacksonville (Florida), 11:5, February, 1985

Thanks to the cooperative efforts of the Jacksonville (Florida) Business Guild (an association of gay bar owners), St. Luke's Metropolitan Community Church, and the Bold New City Coalition for Human Awareness (BNCC), the local community will have the opportunity to attend educational symposia on AIDS, STDs, and Safe Sex. The primary guest speaker, Buck Harris, gay consultant to the State of Ohio Health Department, is the author of the "Bartender As A Gay Health Educator" program (previously described in NCGSTDS Newsletter, 6:1, August-September, 1984, page 6). According to Harris, "Gay life, especially for single men, revolves around the bar scene. Bars are likely places to meet prospective sexual partners. Bartenders, needless to say, have access to great numbers of men, many of whom are highly sexually active. The idea for this project came to me one night when I was having a cold one in one of Cleveland's watering holes. I overheard the bartender telling a small group of patrons at the end of the bar this absolutely ridiculous story about how AIDS was transmitted. He claimed his source was "Sixty Minutes." The patrons neither questioned him nor appeared to doubt him. That incident set me to thinking. Good bartenders converse extensively with their patrons. They are in a position to disseminate a lot of information. Why not provide them with training to become gay health educators; to provide accurate information about AIDS and other STDs, and to promote safe sex practices?" Those participating in the workshop will be able to identify five of the most common STDs in gay men; describe the disease process of AIDS and suspected modes of transmission; describe seven sexual behaviors that will reduce the risk of contracting AIDS and other STDs, and identify local referral sources for medical, social and other supportive services for gay men. In addition to Harris, local STD Clinic staff, local physicians, and a local Person with AIDS will serve as facilitators. For more information, contact BNCC, PO Box 27061, Jacksonville, FL 32205, or Buck Harris, c/o Alan Ford, Ohio Dept. of Health, Div. of Communicable Diseases, 246 N. High St., Columbus, OH 43215.

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## BULIMIA AMONG GAY MEN

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 3/16/85

The incidence of bulimia among gay men is increasing, according to Clinical Psychiatry News. Bulimia, usually characterized by binging and then vomiting, primarily affects women, an estimated 3.5 million in the U.S. It is perceived as a protective response to stress and as a temporary coping mechanism that serves as an anti-depressant, according to Dr. Peter D. Vash of the University of California School of Medicine, who spoke at a recent symposium on eating disorders at Johns Hopkins University School of Medicine.

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**NEXT NEWSLETTER: MAY/June, 1985**
**DEADLINE FOR ARTICLES: June 1st!**

## AMERICAN PUBLIC HEALTH ASSOCIATION'S 113th ANNUAL MEETING IN WASHINGTON, DC

The newly renamed Lesbian & Gay Caucus of the American Public Health Association (previously, "Gay Public Health Workers Caucus") has announced its plans for their ninth annual program at the 113th Annual Meeting of the American Public Health Association, November 17-21, 1985 in Washington, DC. The theme of the meeting, "In Defense of the Public's Health" emphasizes government's role in public health. The Caucus feels it is only through partnership with government that the Lesbian and Gay community can work to reduce discrimination, decrease morbidity and encourage community wellness. Hence, the Caucus is planning scientific paper sessions, panel discussions, round table discussions and poster sessions on the following topics: L/G aging, youth, & mental health; STD prevention & treatment, lesbian health; substance abuse; AIDS research, prevention, epidemiology, & treatment; reentry of the disabled & people with AIDS; administration and funding; and homophobia in service provision. Other topics can be considered as are submitted for review. The Caucus hopes to be cosponsoring joint sessions with the APHA's Epidemiology Section on "Investigations of Infectious Disease Outbreaks," Studies of Emerging Health Problems;" with Public Health Nursing Section on "Care of At-Risk Population Groups," "Political Activism;" and with Statistics Section possibly on the National Lesbian Health Care Survey. The deadline for abstracts is March 12th, and should be directed to Mitch Bart, c/o San Francisco AIDS Foundation, 54 Tenth St., San Francisco, CA 94103-1360 (415/864-4376). The standard abstract form from the journal, The Nation's Health, should be used.

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## LESBIAN & GAY CAUCUS OF THE APHA ANNOUNCES NEW LEADERSHIP

The Lesbian & Gay Caucus of the American Public Health Association recently announced its slate of new officers, elected at their recent annual meeting in Anaheim during the APHA's 112th Annual Meeting, November 11-15, 1984. Helen Schietinger (San Francisco Shanti Project, 890 Hayes St., SF, CA 94117, 415/558-8611) and Bill Mannion (Chicago's Howard Brown Memorial Clinic, 3640 N. Fremont, Chicago, IL 60613, 312/935-6795) were elected co-chairs; Program cochairs for the 1985 meeting in Washington, DC are Mitch Bart and Hugh Rice (San Francisco & Los Angeles, respectively); Ron Sable (Chicago) was elected secretary & membership coordinator; Don Tarbutton was reelected treasurer (Bainbridge Island, Washington); and Jonathan Goldman, Newsletter Editor (535 Taylor St., #603, San Francisco, CA 94103, 415/776-4251). If you have items for publication in the Caucus' Newsletter, contact Jon before April 25th, the next issue's deadline. Membership dues have been reduced for 1985, to encourage more participation; write to Ron Sable for more information:3719 N. Magnolia, Chicago, IL 60613 (312/929-4439).

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## CHICAGO RESOURCE CENTER ANNOUNCES REQUEST FOR PROPOSALS FOR 1985

In 1985, lesbian and gay organizations continue to be a primary funding area of the Chicago Resource Center. We continue to consider a wide range of programs with emphasis on the following areas: direct services for gay men and lesbians; health care issues and education; civil and legal rights of gay men and lesbians; coalition building; and outreach to educational and community institutions. Priority will be given to organizations which focus exclusively on gay/lesbian issues. All grant awards are for one year's funding only. Programs previously funded may apply again in subsequent years. However, requests from funded organizations will not be considered prior to the one year anniversary of the previous award. Applications for funding must include a summary sheet (obtainable from CRC) and information requested on a proposal guidelines sheet (also available from CRC). Eighty-three grants were awarded in 1984, ranging from $700 to $10,000 (average = $5328, total over $440,000). For more information and for application forms and the 1985 proposal guidelines, write to: Chicago Resource Center, 209 W. Jackson Blvd., Suite 500, Chicago, IL 60606 (312/461-9333). All applicants must be non-profit and tax-exempt (501[c][3]). Applications will be reviewed quarterly, with submission deadlines and applicant notification dates as follows: April 1, June 15; July 1, September 15; September 30, December 15; and December 20, March 15, 1986.

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## JOURNAL OF HOMOSEXUALITY BOOK SERIES OFFERED BY HAWORTH PRESS

Included with this issue of the Newsletter is a one page advertising sheet from Haworth Press, describing many of their excellent Journal of Homosexuality monographs reprinted as books. Topics include: Homosexuality and the law, alcoholism, social sex roles, historical perspectives, nature & causes, psychotherapy, literary visions, homophobia, critical theoretical & clinical issues, bisexualities, lesbianism, and psychopathology & psychotherapy. Please write to: The Haworth Press, Inc., 28 East 22nd Street, New York, NY 10010 for additional information.

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## VACHON SUCCEEDS ENLOW AS NEW YORK DIRECTOR OF GAY & LESBIAN HEALTH CONCERNS

Ron L. Vachon, PA, was recently appointed Director of the New York City Office of Gay and Lesbian Health Concens, succeeding Dr. Roger Enlow. According to Health Commissioner Dr. David J. Sencer, Vachon is currently employed by the health department as a physician assistant, and was the executive director of the National Gay Health Education Foundation, Inc. [now called National Lesbian & Gay Health Foundation, Inc.]. The Office of Gay and Lesbian Health Concerns was established March, 1983, as part of the City's efforts in addressing the AIDS crisis. It also deals with existing programs to better answer the health concerns of the lesbian and gay community. Vachon has served on the Mayor's Inter-Agency Task Force on AIDS, the St. Marks Clinic, and the New York AIDS Network.

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## ROCKY MOUNTAIN GAY & LESBIAN HEALTH CONFERENCE

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/16/85

The first annual Northern Rocky Mountain Lesbian and Gay Health Conference will take place at the University of Montana from April 12-14. The theme is specialized health care needs of lesbians and gay men, including mental health, sexuality and lifestyles, and substance abuse. Proposals for workshops, panel presentations and papers are invited. All topics lesbian and gay health will be considered, non-traditional as well as traditional methods. Send abstracts to: OIM, Inc., PO Box 8896, Missoula, MT 59807, Attn: Health Conference.

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## PHYSICIAN NEEDED AT BOSTON'S FENWAY

Boston's Fenway Community Health Center is seeking an energetic self-starter who is experienced in ambulatory primary care and can work with physician assistants and nurse practitioners. A commitment to women's heatlh issues and gay/lesbian health concerns is required. Fenway is a free-standing non-profit ambulatory health facility in Boston, and is nationally recognized for its services to the gay community, its leadership in advocating and providing quality health care services for people with AIDS, and for its educational efforts with local and state organizations and authorities. The Fenway Community Health Center (FCHC) is the recipient of federal and state funds for AIDS education and research. We are also participating with the Centers for Disease Control in a three-year project. Fenway's patient population is comprised of several communities. Geographically close are the elderly and student neighborhood residents. We operate satellite clinics in two elderly apartment complexes, and act as the official health provider for the students of the New England Conservatory of Music. The Health Center is also the primary medical provider for many women and men in the greater Boston lesbian & gay community. Fenway offers affordable, quality health care to all people, regardless of inclome, in a non-judgemental manner. Last year, FCHC handled over 18,000 patient visits. Back-up relationships with Beth Israel and the New England Deaconess Hospitals for patients requiring hospitalization. Interested candidates should send their resume to Medical Director Eric Hanson. Additional information is available from either Dr. Hanson, or Executive Director Anthony Knopp: FCHC, 16 Haviland St., Boston, MA 02115 (617/267-7573).

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PRECOCIOUS PUBERTY IN PUERTO RICO DUE TO HIGH ESTROGENS IN MEAT

compiled by Stephanie Poggi with thanks to Boston's Gay Community News, 3/9/85

Claridad reports that between 6-7000 children on Puerto Rico are suffering from early sexual development caused by high levels of estrogen in local meat, particularly chicken. Estrogen is given to cattle and chicken in Puerto Rico to speed up growth and reduce feed costs. The children's condition often begins with breast development or thelarche, but can advance to what doctors call "precocious puberty" (sexual development in girls under nine and boys under ten) which often leads to stunted growth. In the U.S., one of 10,000 children is affected; in Puerto Rico at the end of 1983, the rate was estimated at one in 50. According to a study reported in Ms. magazine, most of the children affected are girls, but boys have also developed engorged breasts. Many of the children have pubic and underarm hair. Some girls start menstruating between the ages of 3 and 6--the youngest reported to get her period was 9 months! In children whose conditions were not sufficiently advanced, symptoms disappeared when chicken was removed from the children's diets. The FDA also found elevated levels of estrogen in chicken samples in a preliminary test, but later found nothing, possibly because chicken producers had temporarily stopped using estrogen. The FDA, CDC, and USDA now deny there is any problem at all although cases of thelarche, precocious puberty, and stunted growth continue to climb. Local chicken producers have started a massive campaign with government assistance to reassure consumers. Dr. Carmen Saenz de Rodriguez, director of pediatrics at Hospital de Diego in Santurce, a suburb of San Juan, alerted the Puerto Rico about the alarming health problem in 1975 and again in 1982. When she received no response, Saenz published her own findings in the local press. The ensuing public outcry and dramatic drop in chicken sales--a major problem for the industry--finally prompted government response. Saenz has been threatened with death several times, but continues to monitor the chicken, still a staple primarily for the poorer on the island, and to fight for an estrogen ban.

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CHILD SEXUAL ABUSE CHARGES DISMISSED AGAINST ALASKAN INNUIT

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/2/85

An Innuit man was found not guilty on two counts of child sexual abuse and one count of attempted sexual abuse after a Fairbanks, Alaska trial, according to the Anchorage Daily News. Anthropologists' testimony convinced the court that 57 year old Jack Jones' behavior was within the bounds of traditional Innuit culture and had no erotic intent. Jones was in the habit of trying to pull the pants off his son and grandson. The children were expected to resist and fight back. Anthropologists testified that Jones "was well within a cultural tradition of teasing behavior that has as its root teaching young boys to laugh off adversity, to protect themselves when other people come after them, and to be quick in response," according to Judge Tom Stewart. The accusation and charges arose when Jones attempted the same thing with a child not familiar with the custom. The child told his parents who later informed the Alaska State Troopers.

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SPIDER MAN ABUSED AS A CHILD

edited by Matthew Stadler, with thanks to New York Native, 3/11-24/85

In the February 17 issue of Spider Man, the popular syndicated comic strip, Peter Parker, Spider Man's secret identify, revealed that he had been sexually abused by an older boy named Skip when he was young. Skip took young Peter aside and showed him a sexy magazine and then proposed, "Let's see if we can touch each other like the people in that magazine." The episode was prepared by Marvel Comicx in collaboration with the Chicago-based National Committee for the Prevention of Child Abuse.

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## HOUSTON'S MONTROSE CLINIC HITS 10,000 PATIENTS

Houston's Montrose Clinic reached a new milestone, March 14, when patient number 10,000 registered at the Clinic. During the three years of the facility's existance, these 10,000 have accounted for almost 23,000 patient-visits, making the need for the Clinic in the community quite obvious. Montrose, which is located in the Montrose neighborhood, is in the heart of the gay community. It is operated almost entirely by a dedicated staff of about 100 volunteers, including physicians, nurses, pharmacists, and others who provide the myriad of support services needed. Montrose Clinic is supported by donations from the gay community and by the nominal fees charged for services. The basic fee of $20 for screening for STDs includes screening, treatment, and followup test of cure. Unfortunately, this fee only covers about one-third of the Clinic's costs for providing services. In addition, almost one-third of the patients seen have fees waived because of financial difficulties. A report published by the Texas State Senate in 1982 stated that the average cost of receiving care for an STD episode in the private sector was $200 per patient. In addition to basic screening for STDs, the Clinic also offers testing for hepatitis B and also provides the hepatitis B vaccine. The cost of being screened is $35, and the vaccine, $160. These costs are compared to $300-400 if these services are obtained privately. Another program offered by the Clinic is the Program for AIDS Counseling and Evaluation (PACE). This involves immunological testing and physical examination, and referral to other physicians for additional followup, as needed. Although the Clinic has been successfully operating for three years, there are constant challenges to our financial stability. Operating costs have risen steadily and the Clinic has occasionally been under financial strain. Montrose is a front line defense in the fight against AIDS and it needs the constant and sustained support of the community. We appeal to any organizations or individuals who would like to offer financial assistance! For additional information, contact The Montrose Clinic, 803 Hawthorne, Houston, TX 77006, or call 713/528-5531/5535.

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## NEW HERPES TREATMENT TO RECEIVE PATENT

Exovir, Inc., of Great Neck, New York, has received a patent for a unique new topical anti-herpes product, according to a news release from that company. The product, called Exovir-HZ Gel, combines human leukocyte interferon with an antiviral in a way that in vitro studies suggest will create a two-pronged, synergistic attack on recurrent outbreaks of oral and genital herpes (HSV). Maxwell Powell, chairman of the board and chief executive officer of Exovir, explained that to cause and extend an active herpes infection, viruses must enter new cells and reproduce. "Our research indicates that the product's interferon stimulates an immunological response that disrupts the replication of herpes virus within infected cells; meanwhile, the antiviral ingredient, a surfactant called nonoxynol, appears to strip migrating herpes viruses of their protective covers and ability to spread externally to new cells. Although the ingredients' synergistic relationship is still not fully understood, the nonoxynol also appears to enhance markedly the interferon's ability to penetrate into the individual infected cells," Powell said. "In vitro experiments...indicate that this synergistic effect renders the interferon-nonoxynol combination 18 times more effective in destroying active herpes viruses than might be possible if the ingredients were used independently," he noted. Although clinical studies are now concentrating on the gel form of Exovir's interferon-nonoxynol product, the new patent will also cover foams, suppositories, and other potential topical applications. For more information, contact: David Monagan, Hill & Knowlton, Inc., 212/697-5600, or Exovir, Inc., 111 Great Neck Road, Great Neck, NY 11021, 516/466-2110.

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## DENTISTS & ORAL SURGEONS BEING SAUGHT

The AIDS Education Programs, in affiliation with Florida Keys Memorial Hospital, is searching for dentists and oral surgeons willing to treat people with AIDS. This office would like to prepare a referral list to include all states, but with a focus on Florida. If you know of any dentists or oral surgeons willing to work with PWAs or to receive referrals, please contact Allan O'Hara, Coordinator, AIDS Education Programs, PO Box 4073, Key West, FL 33041.

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AIDS EPIDEMIOLOGY/SURVEILLANCE UPDATE

abstracted from AIDS Weekly Surveillance Report, CDC AIDS Activity & The Body Politic, 4/85

As of March 18, 1985, the Centers for Disease Control AIDS Activity reports a total of 8853 adult and pediatric cases of AIDS in the US (CDC strict case definition). Homosexually active men account for 73% of all cases; 17% from IV drug users; 3% from Haitians; 1% from hemophiliacs; 1% from heterosexual contacts to persons with AIDS or at risk for AIDS; 1% from blood/blood product recipients; and 4% from those in no apparent risk/unknown risk group. [The CDC continues to receive much criticism for this atypical "hierarchical" listing--some of the homosexually active men may also be IV drug users or Haitian or hemophiliac, etc., but are only counted in the top, i.e., "homosexual" category. It is our contention that this confuses and misrepresents the data, which CDC officials themselves have admitted.--ED.] 23% are from individuals aged 29 or less; 47% from ages 30-39; 21% from ages 40-49; and 9% from ages 50 and older. 59% of the individuals are white; 25% are black; 14% are hispanic; and 1% are other/unknown. 48 states including the District of Columbia and the Commonwealth of Puerto Rico have reported cases to the CDC; New York and California have the most cases, with 38% and 23%, respectively; Florida, 7%; New Jersey, 6%; Texas, 5%; Illinois, Pennsylvania, and Massachusetts, 2% each; all other states have less than 2% each (comprising more than 15% of all cases). Overall mortality is 49%, which reflects an increased case-mortality since the last Newsletters. AIDS Cases per million of population for the entire US is 38.9 per million, ranging from 338.9 per million in New York City and 320.6 per million in San Francisco, 206.1 in Miami, 117.0 in Newark, 99.4 in Los Angeles, and 16.7 cases per million Elsewhere (irrespective of standard Metropolitan statistical area).

As of February 21, the Laboratory Center for Disease Control in Ottawa had recorded a total of 183 adult cases of AIDS in Canada; of these 131 (72%) were homosexually active men. Ontario recorded 71 cases; Quebec, 64; British Columbia, 32; Alberta, 9; Nova Scotia, 4; Saskatchewan,1; Manitoba, 1; Newfoundland, 1; neither New Brunswick nor Prince Edward Island had any cases.

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DELTA AIRLINES BACKS DOWN ON AIDS POLICY

by Christine Guilfoy, with thanks to Boston's Gay Community News, 2/23/85

The Atlanta-based Delta Airlines recently filed a tariff with the Department of Transportation saying it would not allow people with AIDS on any of its flights, falsely believing that AIDS can be transmitted by casual contact, such as through coughing or sneezing, or via toilet seats. The airline withdrew the unimplemented policy following prompting by Jim Curran, MD, of the CDC's AIDS Activity, who informed them there was no medical basis on which to exclude passengers who have AIDS. CDC's involvement was prompted by Stosh Ostrow, MD, president of the Georgia Physicians for Human Rights, who asked Curran to intervene after getting word of the policy. Curran said that the CDC has not, and will not abdicated responsibility for informing the public on current knowledge about transmissibility. How did the airlines learn of a passenger's having AIDS? "We have to go by what people tell us," said Delta spokesperson Dick Jones. "It was not our intent to discriminate against any particular group. We sincerely felt [the policy would] protect the preponderance of the public."

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UNITED EMPLOYEE REINSTATED

by Christine Guilfoy, with thanks to Boston's Gay Community News, 2/16/85

A United Airlines flight attendant who was forced form his job because he has AIDS has won the right to reinstatement. Gar Traynor, who was placed on a medical leave of absence in June, 1983, won the right to reinstatement when his case was submitted to binding arbitration. He had been summarily placed on leave when United learned he had AIDS. The arbirator, Martin Wagner, a member of the National Academy of Arbitrators and a professor at the University of Illinois, ruled that the airline was incorrect in characterizing attendants with AIDS as health hazards to themselves and the flying public. When asked if he would return to work, Traynor said, "I was fighting for the right to go back. But a lot of things have changed." Because of his treatment regimen, he indicated it was unlikely he would return to work.

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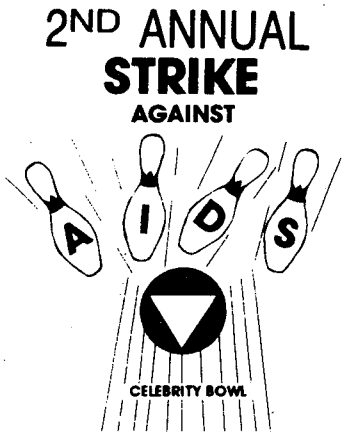
## "STRIKE AGAINST AIDS" TOURNAMENT BENEFITS SET GOAL OF $100,000




With a goal of $100,000 in contributions, the second annual "Stike Against AIDS" Tournament to benefit the AIDS Action Project and Howard Brown Memorial Clinic of Chicago, will be held at Marigold Arcade Bowl, May 18 and 19. Anheuser-Busch, Inc., brewer of Budweiser Beer, is contributing $15,000 to underwrite expenses of the event. The benefit will include a celebrity bowl, a raffle, and a bowling tournament, and is co-sponsored by Marigold Arcade, GayLife Newspaper, Gay Chicago and Howard Brown Memorial Clinic (HBMC). The first such event, held in March, 1984, was the most successful charity fund-raiser in Chicago's gay community and contributed $42,000 to the AIDS project. As many as 50 bowlers are expected to participate in the celebrity bowl, each bowling independently or representing a business or organization. Pledges for each bowler are being solicited from businesses and individuals at a minimum of 10¢ per pin. Each bowler's gaol is to amass $10 a pin in pledges for the one game he or she will bowl on May 18, for a minimum total amount of $1000 in pledges. Raffle prizes will include a new 1985 Honda Accord Hatchback auto, a two-week vacation for two to Hawaii with airfare, hotel room, and rental car, and a $500 shopping spree at Marshall Field's, and a 19 inch color television set. Tickets will cost $1 each or six for $5, and will be sold in various participating businesses and at the Clinic beginning in April. Entry fee for the bowling tournament will be $25, with prizes awarded at Paradise Chicago following the tourney on May 19th. Tax-deductable contributions to the AIDS Project or HBMC may be sent to the Clinic: HBMC, 2676 N. Halsted St., Chicago, IL 60614 (312/871-5777).

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## AIDS VOLUNTEERS OF CINCINNATI CELEBRATE LA CAGE AUX FOLLES WEEK

with thanks to Detroit's Cruise Magazine, March 22, 1985

La Cage Aux Folles Week has arrived in Cincinnati. The AIDS Volunteers of Cincinnati (AVOC) in cooperation with the Cincinnati Gay Bar Owners are presenting a fun filled week of activity in conjunction with "La Cage Aux Folles." The road company of that Broadway musical will be on stage for a one week run in town, and most bars are having an event planned for that week. Some of those activities include: a Male Fantasy Review, an opening night cast party, a "Za-Za" Look Alike Contest and a Grand Finale Benefit Auction with AVOC members and several "gay celebrities" on hand to present their version of La Cage will all help raise funds to directly benefit Cincinnati area persons with AIDS.

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## CONCERTS RAISE MONEY FOR AIDS

with thanks to Chicago's GayLife, 2/21/85

More than $9500 was raised at Chicago Sings Against AIDS concerts at the Park West. At least 1000 people attended the concerts, which featured all three of Chicago's gay and lesbian choruses as well as several individual entertainers. All proceeds from ticket sales went to the Howard Brown Memorial Clinic's AIDS Action Project, into a fund to benefit needy AIDS patients.

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## SWEDISH OFFICIALS RECOMMEND PRISON SENTENCES FOR PWAs HAVING SEX WITH OTHERS

with thanks to The Washington Blade, 2/1/85

The National Public Safety Board of Sweden recommended that AIDS victims who have sexual relations with persons not afflicted with the syndrome be sentenced to two years in prison, reports the New York Times. Eight people have thus far died of AIDS in Sweden, and an additional 200-300 persons have AIDS-related symptoms.

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## NEW YORK BATH OWNERS TO PROMOTE SAFER SEX

by Sue Hyde, with thanks to Boston's Gay Community News, 3/23/85

Acknowledging the potential dangers in government intervention, members of New York City's gay and lesbian community and owners of about half the city's bathhouses are working together to promote "safer" sex in the baths to reduce both the risk of AIDS and the risk of forced closure or police raids. At a meeting in early February, representatives of the Coalition for Sexual Responsibility, a sex-month old group of concerned gay and lesbian activists, and owners of six of the 11 gay bathhouses met to discuss safer sex in the baths. Efforts are underway to hold a second meeting which, it is hoped, will include those owners who failed to attend the first. And one bath owner is attempting to organize a meeting for bathhouse owners only. The Coalition for Sexual Responsibility (CSR) had called the February meeting to present the owners a list of requests, including posting of visible safer sex posters and literature; free condoms and liquid soap; elimination of "glory holes;" increased lighting levels; free on-site VD testing; and permission for CSR representatives to monitor the baths for compliance. At some of the bathhouses, many of the suggestions had already been implemented. At the St. Marks Baths, for instance, staff hung posters offering medical advice on AIDS risk reduction a year ago. In addition, the lighting levels were increased, safer sex literature was made readily available, extra sheets and towels were there for the asking, and pencils and slips of paper were available for partners to exchange names and phone numbers. The staff will soon begin to distribute an envelope to each patron containing a sealed condom and a small card enumerating safer sex guidelines. The cards also have space for recording names and numbers of sex partners. The envelopes bear the inscription, "The contents could save your life." While several of the bathhouse owners earned high praise for their willingness to institute CSR suggestions, the absent owners caused concern. David Nimmons, chair of CSR, suggested that economic pressure could be brought to bear on bathhouse owners who refuse to comply or simply will not participate in the discussions. "Noncompliers have got to understand that there is a cost to noncompliance ....If they continue to not get [the message], there's not much of an excuse for them to continue to be patronized." The bathhouse owners could make quantity purchases of supplies, share information and ideas, and work to solve problems together. Michael Callen, a member of the CSR and a founding member of People With AIDS-New York, has called for governmental involvement in the regulation of the baths. Callen, in a recent Village Voice, asserted that sex clubs are businesses, not gay community organizations, and can be appropriately treated as such. "Three years into this epidemic free condoms and safer sex education matehrials are not routinely handed to each and every patron as he enters. This is, of course, a scandal which justifies threats of license revocation. If both the state and the city say, 'We will never close bathhouses,' then where is the motivation for owners to deal with their negligence?" Both Mayor Ed Koch and City Health Commissioner David Sencer say they oppose forced closure of the baths. But others take a dim view of governmental intervention. "The whole point here is that it's much better for the community to deal with it than having the government stick its nose in. Government intervention opens us up to all kinds of abuses on the civil rights front," Tim Seeney of Lambda Legal Defense and Education Fund said. Sweeney described sex education efforts in the baths as a way "to reach men who don't think of themselves as gay and, therefore, don't perceive any risk for themselves in certain sexual practices." He said bath owners need help and funding to implement the CSR's suggestions. "God knows nobody in this society knows how to go about doing sex education." David Nimmons expressed confidence that the Coalition's 15 members represent a cross-section of opinions on bathhouse sex. "We raised questions ourselves about whether we had the moral and political authority to do this....But I feel comfortable that this is as broad a consensus on this issue as I've ever seen yet."

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## BATH CLOSURES REJECTED BY LOS ANGELES & SAN DIEGO

edited by Matthew Stadler, with thanks to New York Native, 2/25-3/10/85

Mayoral task forces in San Diego and Los Angeles have rejected proposals to close bathhouses as a measure for preventing the spread of AIDS. The San Diego task force, concerned about possible intrusions on civil liberties, concluded, "Informed, consenting adults have, by our national tradition, been allowed to make their own decisions about high-risk behavior--especially when the risk is not to the uninvolved bystander but rather to the individual participant." The chair of the LA task force, Neil Schram, MD, pointed out that educating the gay community about safer-risk practices would do more than bath closures. "It's the activity that is performed, not the place where it happens," Schram told the Philadelphia Gay News.

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## SEX BAN INITIATIVE FOR DC BATHHOUSES DRAWS OPPOSITION

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 3/15/85

Representatives of four Washington, DC gay political groups said an election initiative proposed by gay activist Leonard Matlovich that seeks to ban sex in the city's gay bathhouses could have a "disastrous effect" on the local gay/lesbian community and pledged to do all they can to oppose it. Representatives fo the Gertrude Stein Democratic Club, the Langston Hughes-Eleanor Roosevelt Democratic Club, the DC Coalition of Black Gay Men and Women, and the Gay Activists Alliance, along with officials from the Whitman-Walker Clinic, insisted that an initiative to ban bathhouse sex would do little to curtail the AIDS problem but would enable homophobic groups to wage an inflammatory election campaign that would target gay rights rather than AIDS. Matlovich, a former Air Force sergeant who in 1975 became the first person to challenge the military's ban on gay service members, stunned gay activists when he announced he had submitted two proposed initiatives addressing the AIDS epidemic to the DC Board of Elections and Ethics. One of the initiatives would ban sexual activity in "public bathhouses." The second would require the posting of health warning signs in "all businesses that cater to persons who are in the AIDS high risk group." Matlovich said he introduced his initiatives because he believes the Washington gay community and the District government have failed to take adequate steps to curtail the spread of AIDS. He has introduced similar initiatives in San Francisco.

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## NO SEX SPIES FOR SAN FRANCISCO

edited by Matthew Stadler, with thanks to New York Native, 2/25-3/10/85

San Francisco's new seven-member Health Commisssion ruled that the city's Health Dept. must withdraw its request for $10,000 to hire undercover investigators to report on sexual practices in the city's baths. The ruling leaves the Department free to use its own employees for spying. The decision was welcomed by gay activists and others concerned with the threat to civil liberties posed by bathhouse spying. John Wahl of the Committee for sexual and Civil Liberties and Mobilization Against AIDS suggested that "the money spent by the city on this action [spying] could better be spent on educating gay and bisexual men on safer sex practices." But Commissioner Jim Foster, a longtime gay activist pointed out the decision is not against spying --it is a decision against hiring private investigators. "Our action does not diminish the department's commitment to continue to monitor the sex activities in these businesses--as mandated by the court." The court action came in December, when Superior Court Judge Roy Wonder directed the Health Dept. to regulate "unsafe" sexual activity in sex-related businesses. "The monitoring by the Department does not involve anyone being detained, harrassed, or arrested," Foster told George Mendenhall of the Bay Area Reporter. "No sexual activity is being stopped immediately when it is observed. It is the owner--not the customers--who are confronted."

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## ATLANTA BATHHOUSE BUSTED DUE TO AIDS-PHOBIA

by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/23/85

The Solicitor of Atlanta's Fulton County is seeking to close the two gay bathhouses there under Georgia's public nuisance law, and police have arrested at least nine patrons for "sodomy" in a February raid on the baths. According to Glen McGahee of AID Atlanta (AIDA), the civil suit brought by Solicitor Jim Webb asks that Club Atlanta and Locker Room Health Club be closed to prevent the further spread of AIDS, and that police be granted access to the baths without a warrant in the future. Police had no warrant in the present raids, according to Nick Dana, head of the Lesbian/Gay Rights Chapter of the Georgia branch of the American Civil Liberties Union. Brian Spears, attorney for Club Atlanta, said that Webb claims his goal is to stop the spread of contagious diseases, including AIDS, but didn't elaborate how closing the baths can prevent further cases of AIDS. Spears noted that Georgia's state law expressly prohibits "sodomy" and gives Webb extra ammunition against the baths. Continued police harassment is expected. Gay and lesbian groups in Atlanta are rallying to fight the solicitor's suit. Dana and other gay activists believe Webb is taking advantage of the AIDS epidemic to carry out his anti-gay agenda. He is "using AIDS as an excuse to clobber gays," said Dana. "Police aren't concerned about health [either]," he added.

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## SOCIAL SECURITY ALLOWS BENEFITS FOR "PRESUMPTIVE DISABILITY"

by John Boring, National Gay Task Force AIDS Program

The Social Security Administration (SSA) recently published a new regulation permitting local district offices of the SSA to allow benefits for persons with AIDS on the basis of presumptive disability (PD). If properly utilized, the regulation ought to help some persons with AIDS (PWAs) to gain speedier access to Supplemental Security Income (SSI) benefits. (In some localities where the process has already been expedited through informal agreement with the local district officers this new ruling may not further reduce waiting periods; claimants must still satisfy income and resources limits for SSI; also, AIDS-Related Complex (ARC) claims are not covered under PD.) Up until this time, PWAs could receive benefits for up to 90 days under a ruling of PD only by authority of the state-run disability determination services (DDS), to whom the district office (DO) sends the application for medical evaluation. The advantage of the new regulation is that now benefits can begin on the basis of PD before forwarding the application to the DDS. The DO need only determine that the claimant is not working and, by contacting a treating source provided on the claim, verify the diagnosis and the claimant's inability to work. (However, in order for the claimant to continue to receive benefits on a long-term basis [beyond the interim 90 day period], the DDS will still have to obtain and evaluate the pertinent medical records.) The new regulation was printed in the Federal Register, volume 50:28, February 11, 1985, and went into effect on that date.

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## ANTIBODY BLOOD TEST LABELING ASSURANCES SECURED

The National Gay Task Force and Lambda Legal Defense and Education Fund have received assurances from the Food and Drug Administration that the HTLV-III/LAV antibody blood test will be labeled with language intended to minimize civil rights abuses. The unprecedented, government-required labeling will read: "It is inappropriate to use this test as a screen for AIDS or as a screen for members of groups at increased risk for AIDS in the general population." The labeling will also emphasize that the test is not a diagnostic tool for AIDS. Commenting on the FDA action, NGTF then executive director Virginia Apuzzo said, "The labeling agreement is a step forward in our efforts to ensure that the civil rights of the gay and lesbian community are protected, and that the antibody is as safe and effective as possible. NGTF will monitor the 'phasing-in' process to make certain the government's promises are kept. Much work remains to be done in the areas of confidentiality and education; in addition, we will be looking closely at the evaluation of scientific data. But clearly, we have made some headway in educating the Public Health Service about placing civil rights concerns and medical safety above political expediency."

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## PHILADELPHIA PWAs CUT OFF FROM MEDICAL ASSISTANCE

edited by Matthew Stadler, with thanks to New York Native, 2/25-3/10/85

Under a complicated policy, several PWAs have been denied state medical assistance funds. In three cases cited by Dr. Nick Ifft of the Philadelphia AIDS Task Force, PWAs lost state assistance when they began receiving Social Security Disability, Ifft told Tommi Avicolli of the Philadelphia Gay News. Karen Kaufman of the State Welfare Agency explained that the cutoffs were not specific to AIDS cases. "Medical assistance is tied in with the neediness of persons having the disease." The income levels of patients are balanced against the costs of treatment. For unhospitalized patients, the net income (income minus medical costs) must not exceed $180 per month. When it does, the patient becomes ineligible for state medical assistance. Hospitalized patients are evaluated on a 6 onth basis, with a maximum allowable net income of $2100 for that period. In all three cases, the federal disability payments took the individuals over the allowable income and they were removed from state assistance. Ifft acknowledged that the policy was not directed at AIDS patients, pointing out that cancer patients were losing assistance also. "It's strictly an income thing," he told Avicolli. "But the result is it does nothing but impoverish the patient. It's particularly shocking that this is going on at a time when the Governor is announcing $188 million surplus in the state treasury."

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CONDOMS CATCHING ON AT GAY BARS & BATHHOUSES

by Paul Cotton, with thanks to Chicago's GayLife, 3/7/85

It used to be "Love the One(s) You're With." Then the AIDS crisis changed gay men's tune to either "Can't Get No Satisfaction" or "Ain't Nobody's Business If I Do." Now the music's changing again to (pardon the paraphrase) "If You've Got the Condom Daddy I've Got the Time." Many gay men took to celibacy and monogamy like Aztecs to igloos. The rub-and-hug school of safe sex didn't send shivers down too many spines either. The much-maligned condom unrolled itself to the rescue, stretching the limits of safe sex to more fulfilling parameters. News that nonoxynol-9, a common spermicide used to lubricate many condoms, kills the suspected AIDS virus, sent already rising sales skyrocketing. [ED NOTE: The spermicidal agent nonoxynol-9 is chemically related to the laundry detergent, Oxydol, and has never been scientifically tested on rectal mucosa. Some gay health workers allege that its surface active properties may increase the risk of cancer or other diseases or conditions. We await willing clinicians/researchers to easily test the product's safety. Any takers?!] "Sales have increased drastically," said Sam Dlugatch, vice president for sales of National Sanitary Labs, a leading condom manufacturer. Gay baths and some bars have been providing the little latex wonders free during the past year. Chicago's largest bathhouse, Man's Country, reports going through about two condoms per customer. "It was a fad, something new at the beginning," said Ed Holland of the Unicorn Baths, one of the first clubs to set out open boxes of condoms. "At first, people would take them not knowing what to do with them. Everybody was blowing them up and everything, boys will be boys, you know. But now that the fad's worn off we don't find them lying around unused anymore." "More and more people are accepting them," said Dr. Jerry Soucy, patient support services director for the AIDS Action Project of the Howard Brown Memorial Clinic. "People are realizing that this is one way they can take control." "They sell real well," noted Bob Maddox of Male Hide Leathers. Condom sales were discontinued at the store a few years ago because of poor turnover, but "they're coming back pretty strong. For the last two years, sales have been going up steadily" to match increased awareness of the AIDS situation, he said.

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MINNESOTA'S CAPTAIN CONDOM PASSES OUT RUBBERS & SAFER SEX BOOKLETS

with thanks to The Washington Blade, 2/1/85

The Minnesota AIDS Project has hired a "real outgoing guy" to dress up as "Captain Condom" and distribute condoms and safer sex booklets in the city's gay bars, according to Chicago's GayLife. Capt. Condom is a cartoon character created by Jeff Jacklin and originally published in Minnesota's Equal Time. Jacklin said the blunt and graphic educational cartoon strips are intended to get gays talking about AIDS and safer sex.

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MORE SEX PARTNERS IN ANTI-GAY AREAS

with thanks to The Washington Blade, 2/1/85

Gay men who live in a homophobic environment may have more sexual partners than those living under tolerant conditions, according to the results of an international study reported in the Sexually Transmitted Diseases Bulletin in January. A survey of more than 600 men from Australia, Finland, Sweden, and the Republic of Ireland, conducted by Dr. Michael Ross of Flinders University of South Australia Medical School, showed that "in the more anti-homosexual and sex role-rigid countries of Ireland and Australia, there was a higher percentage of aprtners per man," according to the report. "In addition," the STD Bulleting reported, "the more an individual defined himself as bisexual, and the higher the expectation of a reaction to homosexuality in the society," the more partners were predicted.

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STONEWALLING: BLOOD BANK LEADERSHIP??

by Charles Ortleb, with thanks to New York Native, 3/11-24/85

How come people who have received blood transfusions themselves are not being told to refrain from donating blood? A soon-to-be-published study in Germany indicates that 17% of a group that received multiple transfusions in the last several years were positive for HTLV-III antibodies. One top New York City health official has proudly told other doctors that he has 1) received transfusions in the past, and 2) subsequently donated blood. What a leader!

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JACKSONVILLE SPONSORS "PLAY SAFE" CAMPAIGN

by Chris Addams

Jacksonville, Florida launched a "Play Safe" campaign, March 1, with the visit of Ohio gay health specialist, Buck Harris, who presented talks on AIDS and STDs. One of the main purposes of the talks was to help inform the city's gay bartenders about AIDS and STDs and how to promote the advantages of "playing safe." Others supporting the campaign include the Jacksonville Business Guild, the Bold New City Coalition (BNCC), St. Luke's Metropolitan Community Church, the newly organized AIDS Task Force, and local doctors and STD Clinic workers.

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WILL CONDOMS BLOCK AIDS AGENT?

by Michael Helquist, with thanks to San Francisco's Coming Up!, February, 1985

Safe sex has become the watchword of gay men living in the age of AIDS. One of the mainstays of this new concern is an old preventive tool: the condom. With the probably AIDS virus only identified last spring, doew anyone know if the condom can block this new infectious agent? No, but the word will be out within a few months. [ED NOTE: Research has demonstrated that latex condoms--natural lambskins have never been tested to the best of our knowledge--are effective in preventing the transmission of several bacterial and viral agents, some of which are known to be smaller in size than the HTLV-III virus. Thus, the inference that latex condoms are probably effective in preventing the AIDS agent.] The San Francisco AIDS Foundation will soon authorize laboratory tests to determine whether condoms prevent passage of the probable AIDS virus. Although previous tests with other bacteria and viruses strongly suggest that condoms will block the AIDS agent, a specific study with the AIDS virus may convince more sexually active individuals to use condoms. The scientific study will complement a broad-based AIDS education and prevention campaign being developed to encourage the use of condoms to prevent the transmission of STDs. The laboratory tests will most likely be conducted under the auspices of Marcus Conant, MD, and the University of California San Francisco AIDS Clinical Research Center. Conant previously conducted lab tests with condoms to determine their effectiveness in blocking herpes simplex 2. When condoms are inflated like a balloon, they retain their shape, which means that air molecules, which are much smaller than viruses, cannot escape. [ED NOTE: However, two other factors must be considered--quantity and quality of lubricant (water soluble vs. petroleum, which may degrade latex), and degree of friction if and when that lubrication wears thin.] Few AIDS educators believe that the present lack of a scientific study has kept gay men from using condoms. Instead, many individuals consider using condoms a nuisance and a hindrance to spontaneous sexual activity. While the AIDS epidemic may counter the inconvenience of condoms for many, several sex educators aspire to alter the non-erotic image that condoms now project. In the months ahead, the education department at the AIDS Foundation, in conjunction with the sexologists Sexual Health Project and a professional marketing firm, will develop a campaign to encourage gay and bisexual men to enhance sexual enjoyment whild also protecting themselves and their partners by using condoms.

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HEALTH WORKER GETS HEPATITIS B, BUT NOT AIDS FROM NEEDLESTICK

by Michael Helquist, with thanks to San Francisco's Coming Up!, February, 1985

A technician at San Francisco General Hospital, subject to an accidental needlestick while working with an AIDS patient, failed to develop AIDS symptoms or evidence of exposure to the AIDS-associated retrovirus. However, the hospital worker did contract hepatitis B and showed symptoms of fatigue and jaundice 15 weeks after exposure. Researchers from UCSF suggested that the lack of AIDS symptoms is "reassuring and suggests that the risk of transmission of AIDS may not be great, even with accidental exposures that transmit hepatitis B. Fifteen months after the needlestick, a test for antibodies to AIDS Associated Retrovirus was negative, and the worker's ratio T-helper cells to suppressor cells was normal. The January 3, 1985 issue of the New England Journal of Medicine details the case in a letter to the editor. The case does not preclude the possibility of transmitting AIDS by needlestick, since the potency of the AIDS virus may have been diminished by that stage of the patient's condition. Eighty-five cases of workers exposed to the virus, 30 of them by needlestick were evaluated; after 8 months, none showed any sign of the virus.

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## HPA-23 SHOWN TO INHIBIT RETROVIRUSES FROM REPLICATING

by Charles Ortleb, with thanks to New York Native, 3/25-4/7/85

Researchers at the Pasteur Institute in Paris have reported preliminary results on a substance which may halt the progress of AIDS. Three persons with AIDS and one person with a pre-AIDS condition were treated with HPA-23, a substance known to inhibit the replication of retroviruses. Clinical improvement occured in these four persons, however the treatments did not completely eliminate the virus from the lymphocytes; nor did HPA-23 had no significant effect on T-4 lymphocyte counts or on the T4/T8 ratios. French researchers are cautious: "Inhibition of Lymphadenopathy Associated Virus [LAV, thought to be the same as HTLV-III] replication may not completely correct complex immune dysfunctions." They further warn that "Autoimmune mechanisms that may be involved in AIDS could prove to be self-perpetuating even in the face of inhibition of LAV multiplication." News of the preliminary findings has been circulating among AIDS patients for a number of weeks. The Native has spoken with the lover of one man who flew to Paris to be treated by the research team, and has reportedly not suffered any side effects during his treatment. Another patient, who has been informed by his doctor that he can expect his health to decline rapidly in the next six months, told the Native he is angry that the Food and Drug Administration is not moving rapidly to make HPA-23 available in the US. "Our government obviously doesn't care about us. I plan to go to Paris, one way or the other. Even if I have to go there and sit on the steps [of the Pasteur Institute] until they give it to me, I will."

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## AIDS PREVENTION DRUG DISCOVERED???

editorial comment by Mark Behar, NCGSTDS Chairperson

I am always stricken by apparent inconsistencies -- the gay media's attempt to provide excellent and comprehensive information about all aspects of AIDS, something the mainstream media continues to shy away from (mildly stated). The inconsistency here is the full page ad that has appeared in The Advocate and The New York Native, and possibly other papers & magazines, promoting the inadequately tested spermicide nonoxynol 9 as an "AIDS prevention drug discovery," by entrepreneur Dr. Bruce Voeller and The Mariposa Foundation. In vitro (test-tube) tests have demonstrated that the surfactant nonoxynol-9, which is closely related to the laundry detergent oxydol, does disrupt the HTLV-III virus, thought to be the putative AIDS agent. So does a 10% solution of chlorox bleach! But is the product safe when used on the rectal mucosa? Certainly, the spermicide has been safely used on vaginal tissue (unlike 10% cholorox), but vaginal epithelium is very different then rectal endothelium. Is it premature to promote a product that could be easily tested for at least rectal irritation (as a crude, but objective and noninvasive measure)? Are we not providing a false sense of security to those members of our community who are grasping for easy solutions that do not yet exist by suggesting that the spermicide is a good preventative (considerably easier than relearning habits & behaviors)? Why haven't gay sensitive physicians & researchers been more interested in testing the effects of lubricants for anal intercourse? Or the National Cancer Institute or the Centers for Disease Control? Why hasn't Mariposa's product, ForPlay Sensual Lubricant, excellently packaged in a sanitary push-plunger dispenser, been specifically marketed for use as a rectal lubricant? But most importantly, why don't representatives of Mariposa--Dr. Voeller or others--engage in a dialog with other gay health experts and the media to debate risk reduction guidelines publically? Many gay & lesbian health workers need to be a part of these discussions. Let's hope that the Risk Reduction Workshop scheduled before the International AIDS Conference in Atlanta, April 14, will be a continuation of these discussions started back in 1979, when the NCGSTDS was established, in part to promulgate such guidelines & recommendations. And we hope that Dr. Voeller will accept his invitation and help clear the air about the spermicide. Let us know what you think! NCGSTDS, PO Box 239, Milwaukee, WI 53201.

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"CURES" FOR HERPES & AIDS

[ED NOTE: The following was received and we thought it would be of interest to readers.] "A Bristol Tennessee doctor has discovered a method for the destruction of the AIDS virus in vitro and in vivo, and has produced a method to cure herpes virus infections in vivo and in vitro. The method causes the virus molecule to breakup and become ineffective. At the same time, the body acquires increased immunity to the virus. The increased immunity makes it much more difficult to become reinfected. No medication is used in the process. There are no detrimental side effects. The process is the result of twenty years of biomedical research. Several years more will be required before research is completed. Additional funding for university medical research is sought. For additional information, contact: Dr. C.E. Goulding, PhD, PO Box 3351, Bristol, TN 37620."

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BLACK GAYS ADVISED ON AIDS

by Mark Scott, with thanks to The Washington Blade, 3/15/85

Black gay men with AIDS are often unable to acknowledge their homosexuality and deliberately isolate themselves from their family and friends in their last monsths, according to health-care workers at a forum on AIDS in the Washington, DC black community. The forum, sponsored by the DC Coalition of Black Gay Men and Women and Faith Temple, drew about 30 people. "One of the biggest problems I've encountered is ]patients'] feelings toward their own homosexuality," said Raquel Palmer, a social worker at Howard University Hospital, which has treated 10 black gay men with AIDS. "There's tremendous denial and anger. When other people see ]the anger] they run, isolating the patient even more." One patient insisted his door be locked so his family could not visit him, Palmer said. "Some people blame themselves" for getting AIDS, said Dr. James Tinney, pastor of the Faith Temple, which serves primarily Third World Lesbians and Gays. "This is just a confirmation that they're no good. They believe everything they've been taught" about homosexuality. Others believe "if they will agree to everything they have been taught about [homosexuality], God will forgive and heal them," Tinney said. "It's rather tragic--there are no problems I have seen worked through about one's sexual orientation once a person has been diagnosed. There doesn't seem to be a way to work through it." For patients who leave the hospital and are able to continue treatment on an outpatient basis, there are problems of finding work and paying for medical bills and prescriptions, Palmer said. Of the 10 men treated at Howard so far, only one is a college graduate--the rest are "unskilled workers" with little hope of finding emplyment, she said. "Professional people have more problems dealing with AIDS than people with AIDS," said Cheryl Wilson, a nurse at DC General Hospital, which has treated 11 black gay men with AIDS. "It's a constant battle to get professionals over their fear." Often, Wilson said, doctors shy away from contact with people with AIDS, resulting in incomplete care and isolation of the patient. At Howard, said Dr. Wayne Greaves, "We've had to come down hard on other physicians who immediately want to isolate a patient because he's gay." The Whitman-Walker Clinic's AIDS Education Fund plans to distribute AIDS information for blacks and hispanics in area libraries, shopping centers, and malls later this year, according to David Naylor, who has overseen the Fund's outreach to the black and hispanic communities. The Fund also plans to take out ads in the Howard University and University of District Columbia school newspapers in April. There is already an educational advertisement printed on the back of the city's subway farecards, and is available at subway stations in predominantly black and hispanic neighborhoods.

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MOUTH-TO-MOUTH RESUSCITATION BANNED BY FIRE FIGHTERS IN ENGLAND DUE TO AIDS PHOBIA

UPI--British firefighters are refusing to give mouth-to-mouth resuscitation to victims until they are given proof that the deadly AIDS virus cannot be contracted through saliva. The Fire Brigade Union announced that it would impose the ban on oral resuscitation until a Home Office medical team proved they faced no risk of contracting AIDS by giving the "kiss of life" or by treating cuts. The Home Office said it would give "urgent and sympathetic" attention to the request for special resuscitation devices for treating fire or accident victims who might have AIDS.

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## HAITIAN LIAISON FOR AIDS GROUP IN BOSTON

by Christine Guilfoy, with thanks to Boston's Gay Community News, 3/16/85

Boston's AIDS Action Committee (AAC), together with the Haitian Community Multi-Service Center (HCMSC) have jointly submitted a grant proposal to the U.S. Conference of Mayors AIDS Program to establish a part-time Haitian AIDS worker who will act as a liaison between the AAC and the Haitian community. The proposal details the unique problems the Haitian community has had in dealing with the AIDS crisis, and the repercussions these problems have had in providing direct service to this high-risk community. The liaison position, or clinical coordinator, will be: "Bilingual/bicultural of Haitian ethnicity, [fluent] in Creole/English, experience[d] in the field of human services [and] sensitive to AIDS issues." If funded, the clinical coordinator would be responsibile for helping people with AIDS cope in obtaining hospital care, social service benefits as well as adequate housing and mental health supports. The Haitian coordinator would attempt to disseminate information to the community and in particular to work towards eliminating the isolation experienced by PWAs who are also Haitian. The grant proposal is interesting as it may be the first instance in the US of a community AIDS group establishing a formal relationship with the Haitian community. Although the proposal documents only 18 official cases of Haitians with AIDS in Massachusetts, that number is expected to rise rapidly. AIDS experts believe that the epidemic in Massachusetts has lagged behind the hardest hit areas--New York and San Francisco--but they expect that the commonwealth will soon see a rapidly rising caseload. In Massachusetts, currently, reported cases are doubling every six months. There are now 210 cases reported in the state. It is estimated that 20,000 to 30,000 Haitians live in Massachusetts. In addition to the expected increase, some also feel that the number of AIDS cases among Haitians have been underreported. Anne Silvia, the city AIDS coordinator and one of the grant writers, said she believes some Haitians who become ill go back to Haiti. Some, unfamiliar with and distrustful of US medical practices, simply do not go to the hospital and may thus never show up in official statistics. The problems detailed in the AAC/HCMSC proposal trace economic and cultural differences which affect the Haitian community's thinking about AIDS. Additionally, there are negative attitudes regarding homosexuality which also influence the community's willingness to work with what is perceived as a gay organization. Economically, Haitians are generally low income, and when employed, usually work by the hour without substantial health benefits. HCMSC notes an increase in employment discrimination, particularly in nursing homes, food services, and even in domestic work, resulting from the association of AIDS with the Haitian community. The HCMSC asserts that there is a mistrust of bureaucracies, particularly government bureaucracy which makes it less likely that members of the community will attempt to obtain benefits. There is also a concern that application for benefits may result in an unfavorable change in immigration status. Language is also a problem, as few public welfare agencies have employees fluent in Creole. The language barrier has also created problems in getting accurate information regarding AIDS to Haitians, with some members of the community apparently believing that AIDS can be transmitted through casual contact. A quarter of the community expresses an interest in providing help or support to persons with AIDS only if it does not involve direct contact, according to HCMSC.

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## AIDS PHYSICIAN NEEDED IN CHICAGO

The Division of General Internal Medicine/Primary Care at Cook County Hospital wishes to recruit an attending physician to supervise care of both patients with general medical problems and patients with AIDS. Board eligibility in Internal Medicine is required; subspecialty training in Infectious Disease or Oncology is desirable. General Medicine responsibilities occupy 50% time and include ward attending and supervising the General Medicine Clinic. AIDS service responsibilities include participation in biweekly clinics and regular ward consultations for patients with AIDS and AIDS related conditions (ARC), and involvement in educational and research programs of the AIDS service. Sensitivity to the health care needs of gay men and other AIDS risk group members is needed. Starting salary for Board Certified physicians is $54,228/year. For further information, please contact Renslow Sherer, MD, Coordinator of AIDS Services, Division of General Medicine, Cook County Hospital, 1835 W. Harrison, Chicago, IL 60612. Cook County Hospital is an Equal Opportunity/Affirmative Action Employer.

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## TAXONOMY OVER TREATMENT?

by John Beldekas, PhD, with thanks to Boston's Gay Community News, 2/16/85

In the January 11 issue of Science, an article appeared linking LAV/HTLV-III virus, the reputed cause of AIDS, to a sheep virus, called Visna, and it was liked to AIDS because it causes a slow brain infection in sheep similar to what is occasionally seen in PWAs. The authors, who include Robert Gallo of the National Cancer Institute, compared the genetic material of Visna to HTLV-III and found striking similarities. Visna and a close cousin, Maedi virus, are both retroviruses which infect sheep and goats, causing a series of complicated brain and lung diseases. The disease was first reported in Montana and South Africa in 1915, thought the worst epidemics were reported in Iceland over a 25-year period beginning in 1939. The names are Icelandic for wasting and rapid breathing, and the disease is characterized by severe loss of weight and pneumonia, progressing very slowly through a flock, oftentimes taking years to show signs of infection. In reviewing the literature, I found that Visna/Maedi and other slow brain viruses and progressive pneumonia viruses all appear to be closely related when their physical, morphological and immunological properties are compared. However, differences between Visna/ Maedi and progressive pneumonia viruses have been shown with regard to nucleic acid sequence and immunological cross-reactivity. Both of these retroviruses are morphologically indistinguishable from HTLV-III, at the moment. Before going into the spectrum of the disease and what all this means to our understanding of AIDS, let's pause and take a historical look back to spring, 1983. In the May 1983, Science, American scientists including Gallo and Dr. Max Essex argued for HTLV-I as the cause of AIDS. In the same issue, a French team lead by Dr. Luc Montagnier, described an AIDS-associated virus isolated from a gay man in Paris with swollen glands. They named this retrovirus Lymphadenopathy Associated Virus (LAV). Montagnier chose not to place it in the HTLV family because it did not cause a leukemia. On the contrary, it produced quite the opposite effect--a drastic reduction in the number of T-cells, typical of AIDS. Also in 1983, Montagnier stated that the virus more closely resembled Equine Infectious Anemia Virus (EIAV), a retrovirus that infects horses and produces a syndrome similar to AIDS. In March of 1984, before NCI and Gallo announced their discovery, HTLV-III, Montagnier publishedan elegant study in the Annals of Virology (vol. 135E, pp. 119-134) describing the relatedness of LAV with EIAV. The point of this communication was not to say that they were the same virus but that they had a common evolutionary ancestor. All of this took place long before Gallo ever made his announcement. EIAV infections are persistent and lifelong. Clinical symptoms parallel that of AIDS and Visna. Recently, it has been shown that EIAV is closely related to the Lentinviruses, to which Visna/Maedi belong. When I first read this report in Science implicating this family of viruses as the agent in AIDS, I felt excited by the wealth of knowledge around these two diseases which could help in our understanding of AIDS. What I realized later was that this new embrace by Gallo and his coworkers of the Visna model is just another smokescreen to discredit the French. From the beginning of the health crisis, there has been a race to see who will get credit for discovering the agent in AIDS. When the French discovered the virus, the US ignored the discovery until Gallo and Secretary of Health Margaret Heckler made their announcement. Gallo and co-workers waited 17 months to make their discovery known so they could include in their announcement a very shaky diagnostic blood test. First, it was the race to discover the agent; now it is the race to classify it. As a scientist and a gay man I am getting angry over these childish games. The French have already discovered the virus and called it LAV. Now the Americans must do the same and classify it as closely related, but distinct from, the French virus--just to save face for the National Cancer Institute. All of this comes at a time when the actual genetic sequence of the virus is about to be published and will clearly show that LAV/HTLV-III are the same. To think that at this stage of the epidemic these scientists would pursue a path of taxonomy over treatment is both insulting to the memories of those who have died and clearly indicative of their personal intentions. To date, there is still no effective treatment, no biological molecule or chemical capable of restoring immune fundtion. The best that can be done is to manage the infections until the person succumbs to the disease. How many more cases of AIDS must we endure, live in fear of, until an effective treatment is found? Now that the race to identify and classify is apparently over, maybe these men of science will focus on treatment.

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## INTERFAITH FORUM ON AIDS ATTRACTS 400

by Steven Arvanette, with thanks to New York Native, 3/11-24/85

A New York City physician, prominently identified in treating gay men with AIDS, told a group of Christian and Jewish clergy, "Their spiritual needs become far more important than their medical needs." At a forum on AIDS and religion held February 21, Dr. Stephen Caiazza said, "There's not a lot I can do" for PWAs, but their spiritual needs are "quite profound." Approximately 400 people gathered at the forum, which was cosponsored by New York's Gay Men's Health Crisis and the AIDS Resource Center, to hear medical and religious aspects of AIDS discussed. More personal reflections were offered by Dr. Michael Beck, a gay man with AIDS, who admitted he once "had one foot in the grave," until he drastically changed his outlook on life. "I learned AIDS is not only a disease of the immune system but also a disease of self-esteem," Beck, a psychiatrist, stated. It wasn't until he decided "I'm ready to fight" that his condition improved. "My physical state is a reflection of my mental state," he said. The issue of self-acceptance or esteem was often raised during the forum. Caiazza, president of New York Physicians for Human Rights, said he has found gay men with AIDS often "racked" by guilt, dealing with issues of rejection, and "crying with need for forgiveness because so many believed they have sinned." The Rev. Carl Flemister, executive minister of the American Baptist Churches of Metropolitan New York, said he believes there are three "epidemics" that must be dealt with. Besides AIDS and the fear of AIDS, Flemister said, there is the "unchristian, damnable, judgemental [Jimmy] Swaggart/[Jerry] Falwell epidemic." Part of the reason organized religion has been slow in responding to the AIDS crisis, he said, is because "we haven't gotten our act together on sexuality in the religious community. As religious leaders, we need to go back to our Bibles and follow the examples," Flemister urged his fellow clergy. "All of the ammunition I need is contained there." The Rev. Howard Basler of the Roman Catholic Diocese of Brooklyn acknowledged the conflict that has historically existed between gays and his church. While there may be differences of opinion among Roman Catholics about the issues of homosexuality, Basler said there should be none about ministering to the ill. He compared those who work with AIDS patients to Calcutta's Mother Teresa. Later in the forum, when the topic came up of New York Archbishop John O'Connor's opposition to extending civil rights protection to gays, Basler commented, "Those of you who know ecclesiastic geography, know there is a big river between [Manhattan and] Brooklyn." Brooklyn Bishop Francis Mugavero has long been more sensitive to gay civil rights issues. Other clergy saw little value in confronting O'Connor. "It just wouldn't be productive." noted Flemister. He said it would be much like the archbishop trying to change Flemister's mind. New York Episcopal Bishop Paul Moore Jr. stressed to fellow clergy that they have an "obligation" to fight for the civil rights of PWAs as well as for the entire gay community. Moore, long an outspoken advocate for gays, said he realizes many straight peoplebelieve AIDS is somehow devine retribution for a lifestyle. "I don't believe this is God's judgement, but you have to repeat this again and again and again," he said. Moore acknowledged that two of his clergy have died of AIDS. Rabbi Balfour Brickner of the Stephen Wise Free Synagogue said, "The issue is not one of homosexuality at all, but of those who are reaching out." He too, issued a call for greater clergy involvement, saying, "Social justice is our vocation as much as is prayer. The effects of ignorance and bigotry are terrifying and lethal." Another Episcopal cleric offered more practical information on how his peers might minister to PWAs, a group he said society has "cast as the least of our brothers and sisters." The Rev. William Doubleday outlined his work and offered observations as pastoral care coordinator for PWAs at St. Luke's-Roosevelt Hospital Center. Doubleday cautioned clergy to be ready to receive anger from patients. "These funny collars seem to attract it," he noted. Much of the anger is because the individual has much to be depressed about, Doubleday stated, but there also often exists "longstanding and well-founded anti-religious feelings." The Episcopal priest urged that fellow clergy be involved in the "ethical decision making" of life and death issues. It had been his experience that a cleric is often the best individual "to work with channels, or around channels," when it comes to resolving problems of hospital care and services. A question about the theological role between sin and sickness initially drew a long pause from the forum speakers. Flemister was the first to respond, offering, "If sickness and sin had a connection, we'd see a lot more sickness." Brickner noted that the Jewish tradition has "never made the association" between the two. Physician Caiazza stated, "If sin causes AIDS, then every gay man should have AIDS." He then posited, "What about little children [who get the disease]?" The forum was GMHC's first major program on the religious aspects of the disease. Federico Gonzalez, GMHC's program director, stated after the forum that evaluations from participants

(NEXT)

INTERFAITH FORUM, Continued

were highly favorable. He anticipates more cooperation and a new commitment from religious leaders as a result of the forum. The Rev. Martin Hauser, assisting pastor at St. Peter's Lutheran Church where the forum was held, said he was also pleased at the response. Space for the event was donated, he said, because of its wide community importance. "Like any urban church, we have anumber of gay people in our parish." Hauser acknowledged those who atteded the forum were already likely supportive of gays, but they "wanted to do a better job of what they were doing" in their ministry. "Pastoral care of people with AIDS is such an immediate and essential concern with the church," he added. Hauser had special praise for the Brooklyn Roman Catholic Diocese for sending a representative, terming it an "extremely welcome gesture," and for the New York Episcopal Diocese. "The pastoral care program the Episcopal Church has set up for Father Doubleday is a real application of the Gospel, and I would hope it would become a model for other churches," the Lutheran clergyman said.

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MILWAUKEE ROMAN CATHOLIC ARCHDIOCESE DONATES MONEY FOR AIDS

Gay activist and Milwaukee AIDS Project volunteer Leon Rouse announced a $3000 donation for AIDS patient support services from Milwaukee Archbishop Rembert Weakland and the city's Roman Catholic Archdiocese. Rouse, chairperson of the Committee for Fundamental Judeo-Christian Human Rights, spearheaded the fight for Wisconsin's gay rights ordinance and consenting adults laws several year's ago. The Milwaukee AIDS Project (MAP) is a program of the Brady East STD (BEST) Clinic, which has provided gay health care to the community since 1974. For more information, contact: BEST MAP, 1240 E. Brady St., Milwaukee, WI 53202.

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STONEWALLING: GAY MARRIAGE EQUALS "SAFE" SEX

by Charles Ortleb, with thanks to New York Native, 3/25-4/7/85

The following is from the March 2 issue of The Economist: "The reason AIDS has spread so fast is that many male homosexuals are sexually promiscuous. The best single way of preventing further spread is to persuade them to commit buggery with fewer, and known, sexual partners. Intolerance will not help achieve that. Deliberate tolerance might. So sanction some sort of legal "marriage" for gays in the hope that this will give them more reasons to be less promiscuous? The Christian churches could help by focusing less on St. Paul's hang-ups and more on Christ's compassion. In some countries there is a fearful rate of buggery in all-male prisons; don't turn so blind an eye to rape and unwilling buggery in prisons, but do sanction frequent conjugal visits by wives, girlfriends, and boyfriends so that prisoners are less sexually frustrated."

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OKLAHOMA AIDS AWARENESS MONTH

with thanks to The Gayly Oklahoman, February, 1985

February is a month of Valentines and love. Oklahoma City's Oasis Community Center wants to give you a Valentine to show we care. Our Valentine may seem unorthodox, but you need to know. The front of the card says, "Affection, Not Infection." And inside we are talking about AIDS. "What do you know? What don't you know? What you don't know could kill you, or someone close to you. It does affect women, and children, and straight people. Would you recognize the symptoms if you or someone you know had them? Would you know what to do?" Our Valentine is a four-week series on AIDS from people and sources that will clarify issues and answer questions. There will be up-to-the-minute data, informational pamphlets and slides, and culminate in a planning session to help audience members get involved in AIDS support programs at Oasis. For more information, contact: Mike Curry, Chair, Oasis AIDS Support Program, The Community Center, 2135 N.W. 39th St., Oklahoma City, OK (405/525-2437).

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## PALM SPRINGS AIDS RESIDENCE CLOSES

edited by Matthew Stadler, with thanks to New York Native, 3/11-24/85

The Hardtline Residence Resort Project, a Palm Springs (CA) hotel for PWAs, is for sale after three months business brought only two customers. Fred Hardt, who describes his project as "ahead of its time," put the building up for sale in January. "In the future, when there are 20,000-30,000 cases, a facility of this nature will be needed," he told the Associated Press. The one guest remaining at the facility will stay. "We'll take care of him for as long as he needs, but I'm not accepting any others for the time being," Hardt promised, adding, "I have to survive." The hotel can accommodate 17 guests at a time. The hotel was embroiled in controversy shortly before it openned, due to fears it would be detrimental to Palm Springs' tourist & vacation industry.

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## ONLY 37% OF SAN FRANCISCO MEN EXPOSED TO HTLV-III?

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/16/85

A new study shows far fewer gay men have been exposed to HTLV-III than previously believed, according to the Bay Area Reporter. The $3 million federal study indicates that the local exposure rate is 37%, while earlier studies calculated exposure at 65%. Earlier studies, however have been criticized for recruiting subjects among groups who had contracted venereal disease or hepatitis. The new study, which is still underway, uses "population-based, random sample" survey techniques. Because San Francisco has the highest incidence per capita of AIDS, the fact that more than half of gay men here have not yet been exposed is encouraging. Researchers hope their findings "will inspire additional public education efforts...and encourage homosexual men to...undertake other measures to limit their possible exposure to the AIDS virus."

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## ETHICAL, LEGAL AND SOCIAL CONSIDERATIONS OF AIDS--PRIM&R CONFERENCE

Public Responsibility in Medicine and Research (PRIM&R) and Tufts University School of Medicine are co-sponsoring a two day meeting which will cover a variety of topics relating to AIDS--The Ethical, Legal and Social Considerations. The conference features a distinguished faculty that includes several nationally known, distinguished experts from the fields of ethics, law, the history of science, psychology, and community groups. The Conference is scheduled for April 24-25, 1985, at the Park Plaza Hotel, 64 Arlington St., Boston. Some of the presentations are given below: Overview of the History and Current Clinical Status of AIDS Keynote (Mervyn Silverman, MD); Government Involvement and the Development of Public Policy in AIDS Research and Reporting Keynote (Edward Brandt, Jr., MD); The Rights of Individuals, The Rights of Society --Individual and Public Health Values in Conflict (Sheldon Landesman, Jerome Groopman, William Curran, Johanna Pindyck, Jeff Levi, Michael Callen); Legal Problems of AIDS Patients and Providers (Leonard Glantz, Stephen Ansolabehere, George Annas, Alvin Novick, Michael Callen); The Impact of AIDS on the Patient, Family, Friends, and Community (John Mazzullo, Joseph Interrante, David McWhirter, Marshall Forstein, Joseph Barbuto, Lawrence Kessler); Public Health Policies & Concerns as AIDS Moves Into the Community--The Medical, Ethical, Political, and Legal Aspects of HTLV-III Antibody Screening (Judith Swazey, Max Essex, Mathilde Krim, Peter Page, Ken Mayer, William Dommel); The Ethics of Biomedical Research on AIDS and AIDS Patients (Robert Levine, Martin Hirsch, Carol Levine, John Martin, William Hamilton); Ethical Issues in Social Science Research on AIDS and On Groups At Risk for AIDS (Robert Levine, Barbara Stanley, Gary Melton, Walter Batchelor, Joan Sieber); A Cross-Cultural and Historical Look at AIDS (Sanford Chodosh, Barbara Rosenkrantz, Allan Brandt, Sheldon Landesman). Several workshops will also be offered, some of which follow: Researcher/Physician Responsibility in Treating AIDS Patients; The High Cost of AIDS: Who Will Pay? Dealing With Insurance Companies and Private Hospitals; Gay Culture, Post-AIDS; The Role of the Media in AIDS Reporting: Educating the Public or Creating a New "Typhoid Mary?"; Blaming the Victim: Sexually Transmitted Diseases, Homophobia, Racism, Drug Use. For additional information, contact: PRIM&R, 132 Boylston St., Boston, MA 02116 (617/423-4112, 423-1099).

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CUBAN OFFICIALS HOLDING REFUGEES IN QUARANTINE DUE TO AIDS-PHOBIA

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 3/23/85

Terrified and ill-informed about AIDS, Cuban officials are holding Cuban refugees being sent back to the island from the United States in quarantine, according to the Chicago Tribune. The first 23 of 2746 refugees Cuba agreed to take back were reportedly handcuffed upon arrival in Cuba on February 21, and were chained around the ankles. All 2746 of the returning refugees are to be quarantined indefinitely. Cuban officials say AIDS has not yet been detected in Cuba and they intend to keep it out. The quarantine action is apparently based on the belief that homosexuality is widespread in US prisons where some of the refugees have spent close to five years. The refugees Cuba has agreed to accept for return are described by American officials as the criminals or mental patients among the 125,000 people who sailed for the US from the port of Mariel in 1980. Many gay men were expelled from Cuba at that time. US Immigration and Naturalization Services laws would mandate sending openly gay Cuban refugees back to Cuba.

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PLAINTIFF IN AIDS DISCRIMINATION SUIT DIES

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 3/30/85

A man with AIDS who sued his former employer for $10 million after being fired from his job in April, 1984, died earlier this month, according to the Washington Blade. Leonard Graff, legal director of the National Gay Rights Advocates, said NGRA intends to continue pushing Timothy Trueman's case. "The estate is entitled to benefits and damages," said Graff. "It's a very bad message to send out that an employer only has to wait long enough for a plaintiff to die." Trueman, who was diagnosed in March, 1984, filed suit in Wayne County Circuit Court last May. He charged the Advanced Underwriters Insurance Agency and his boss, Howard Camden, with discrimination against a handicapped person and with violation of Detroit's human rights ordinance which prohibits anti-gay discrimination. The suit also charged that Camden broke a two-year employment contract with Trueman. Trueman was asking $5 million in compensatory damages and $5 million in punitive damages, in addition to back pay and benefits. The case did not reach trial while Trueman was alive, but Graff expects a hearing by late spring.

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MASSACHUSETTS AIDS PLAN UNVEILED

by Sue Hyde, with thanks to Boston's Gay Community News, 3/30/85

High-level officials in Massachusett's Governor Michael Dukakis' administration have unveiled a plan to step up both medical and social services to people with AIDS (PWAs) in the state, as well as to the worried but well (WBW) and the general public. But, at the same time, they made no specific promises to change the zero-funding for AIDS in the 1986 budget proposal, and instead said any budget recommendations put forth by a newly-formed interagency working group would be considered. Three new initiatives were described to launch "a broad state response to AIDS that includes education and support services, as well as quality medical care." The new program proposes: A state-funded toll-free AIDS information hotline operating out of the Boston offices of the AIDS Action Committee; The establishment of an interagency working group to assess current state AIDS programs and recommend others to fill in gaps, as well as identify contact people in state departments and agencies who will act as trouble shooters with regards to AIDS; and The appointment, within one month, of a permanent statewide AIDS coordinator to head up educational efforts and serve as a conduit of AIDS information within state government. The state's commitment to AIDS programming, in quantity as well as quality, is under close scrutiny by AIDS activists. Larry Kessler of the AIDS Action Committee commented, "The big question is how much money are we going to see." Kessler has mentioned a baseline figure of $2.5 million to cover social services and to support current research projects. State Public Health Commissioner Bailus Walker, Jr. noted that the state's efforts to date were "commendable, but the level of [AIDS] requires that we do more." He cited a one-year jump in the state's caseload from 78 to 231 and said, "We will continue to identify more cases of AIDS, and those who become ill will require extraordinary amounts of medical care and other support services."

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FLORIDA FIRES WORKERS WHO HAVE AIDS

by Christine Guilfoy, with thanks to Boston's Gay Community News, 2/9/85

Florida's Broward County has adopted a policy which forbids persons with AIDS from working for the county government. The policy, adopted when a local dermatologist refused to "guarantee 100%" that AIDS could not be spread through social contact, has resulted in the firing of two employees who have AIDS. The employees, Todd Shuttleworth, 31, a junior budget analyst, and Don Fanus, 47, a mail clerk at the public library, have decided to fight the policy. The policy was developed by Floyd Johnson, the county administrator, along with the county's attorney, Noel Pfeffer. Although the county claims it consulted medical authorities in the formulation of the non-employment policy, only Peter Babinski, MD, a dermatologist who has treated approximately 15 men with Kaposi's sarcoma, has been publicly named. Babinski opposes firing people with AIDS, although the county uses Babinski's statements as the underpinning for the policy. Jeffrey Sacks, Florida's chief epidemiologist, was quoted in the Miami Herald as saying, "To fire an employee because he/she has AIDS is in my opinion utterly deplorable and completely unjustifiable medically.... I think the county would be hard pressed to find any reputable AIDS expert in the country who would support such action." Both Shuttleworth and Fanus will exhaust their administrative appeals before going to court. Officials from Lambda Legal Defense and Education Fund, National Gay Task Force, Boston's Gay and Lesbian Advocates and Defenders, and the American Civil Liberties Union are providing professional support.

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FIRED UP ABOUT AIDS

by Gregory McDaniel (Indianapolis), with thanks to Boston's Gay Community News, 3/16/85
(Writen as a letter to the editor.)

Dear Editor: The officials of Broward County can prove to the world that their policy of firing people with AIDS is not monstrous bigotry against the gravely ill, but just an effort to protect the lives of coworkers. All they need do is to apply the same policy to all who pose a life-threatening danger. A study by the Environmental Protection Agency estimates that 500-5000 NON-smokers die each year of lung cancer caused by others' cigarettes. If they are really interested in protecting the lives, they should fire all employees who smoke and resign themselves if they smoke. Even this move would leave them needing an explanation of why they fire those with STDs. If they feel that their co-workers are at risk, I would like to know just what is going on in Broward County that we have not heard about. In a spirit of fairness, [signed].

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LEARNING TO LIVE WITH AIDS--A NOVEL

with thanks to Joseph Interrante, reviewer, and Boston's Gay Community News 3/2/85

FACING IT: A NOVEL OF AIDS, by Paul Reed, Fan Francisco: Gay Sunshine Press, 1984. Facing It is a welcome addition to our struggle to learn to live with AIDS. The novel focuses on the lives of two lovers in New York City, Andy Stone and David Markman, during the nine-month period of Andy's illness. It also ranges broadly into the medical, political, and social aspects of AIDS, both to place these lives in context and to illustrate how the seemingly "private" experience of Andy's illness is embedded in and deeply affected by this "public" world. As the first fictive work of imagination concerned with AIDS, Facing It operates as a historical novel describing the first year of the epidemic; it works as an educational novel providing basic medical and social information about AIDS; and it explores the meaning of gayness by depicting one experience of a gay man with the illness. Even though I found the novel's ending a bit contrived in the interests of gay affirmation, the book was a complex and insightful work, one whose compassion and depth grows with rereading. At the same time, I feel compelled to caution readers not to interpret Facing It as any kind of paradigm for the experience of living with AIDS. What you will find is one particular relationship whose dynamics depend upon a number of factors, not only with the specific complex of medical conditions affecting the individual, but also with the social and economic resources he/she can marshal for living with it. There is no single way to live with AIDS. None of these qualifications are meant to detract from Reed's depiction, but to caution against burdening this novel with too much responsibility, and to call for more accounts by people with AIDS. [ED NOTE: Apologies for a cruel editing job!]

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## NUTRITION AND AIDS: LETTER TO THE EDITOR

"It is true that "medical training has been devoid of intense instruction in nutrition," as is painfully apparent when some physicians recommend megadoses of vitamins, despite ample warnings from the National Research Council and nutrition professionals of the dangers of vitamin and mineral over-supplementation. The macrobiotic diet is another area where the nutritional status of people with AIDS (PWAs) is at stake. Despite the positive press this diet has recieved, it should be remembered that sadly, the man who originally wrote about macrobiotics in the New York Native recently died from AIDS. The Tufts University Diet and Nutrition Newsletter ran an article this January entitled, "The Macrobiotic Diet--No Way to Treat Cancer," which detailed the dangers of following such a diet. Originally developed by Japanese George Oshawa in the 1960s, the Zen macrobiotic diet has been well known for causing death from malnutrition in those who follow it to its ultimate level. Dangerously low in many nutrients, the diet is often promoted as a cure or treatment for cancer, and now AIDS. A group of experts from the Clinical Nutrition Center at the University of Chicago recently conducted a review of the effects of macrobiotic diets on cancer. They concluded that there is no evidence that the diet will prevent cancer and that it not only raises false hopes but can actually interfere with sound medical and nutritional treatment. People with cancer and PWAs, especially those undergoing radiation or chemotherapy, often lose weight and appetite and may have increased nutrient requirements. The macrobiotic diet, however, is low in calories, protein, vitamins D, B6, B12, riboflavin, niacin, folic acid, calcium, and iron. In addition, people fighting disease require high quality protein. Because the macrobiotic diet restricts the intake of animal proteins, this is difficult to achieve, and the diet guidelines don't explain how to combine vegetable proteins to get the proper balance of complete proteins needed. Finally, even healthy followers of a macrobiotic diet frequently experience weight loss. For a person who has already lost a significant amount of weight, this can be a dangerous situation. Where can a PWA turn to for nutrition support? All hospitals are staffed with nutrition professionals called registered dietitians who are available [for] inpatient and usually outpatient [counseling]. Since they are often understaffed, a hospitalized PWA may have to request a nutritional consult. In addition, the American Dietetic Association (800/621-6469) can send you the names of registered dietitians in private practice in your state. While the nutritional needs of PWAs will vary, a well-balanced diet rich in calories and high quality protein is usually the first step in nutritional treatment. If intake is inadequate, a tube feeding or total parenteral nutrition may be necessary. A macrobiotic diet however, is like with cancer, no treatment for AIDS. Sincerely, Peter McKnight, Registered Dietitian, Clinical Nutrition Specialist."

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## COMPREHENSIVE NEWSPAPER FILE OF AIDS INFORMATION BEING DEVELOPED

The AIDS Medical Foundation (AMF) is building a comprehensive file of AIDS information for use by writers and researchers from all over the world, from local newspapers. Volunteers from around the country are needed to build an "intercity network" of newspaper clippers who will send articles from local papers about AIDS to AMF. Volunteers will be sent a supply of stamped self addressed envelopes along with a more detailed letter explaining what kinds of articles are especially being looked for. All volunteers will have to do is to clip the article, put it in the envelope and mail. When combined with the efforts of others from around the country, the results will be a unique, central depository of information on AIDS. If you'd like to participate, drop a note to: Peter Carey, AMF, 43 Greenwich Av., #8, New York, NY 10014. For more information about the AIDS Medical Foundation, a nonprofit tax-exempt organization established to seek funding from foundations, individuals, and corporate donors in order to conduct and support research into the causes, methods of treatment, and prevention of AIDS, write to: AMF, 230 Park Av., #1266, New York, NY 10169 (212/949-7410).

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RECORD COMPANY FAILS TO PAY PROMISED AIDS DONATION

edited by Matthew Stadler, with thanks to New York Native, 2/11-24/85

A recording by the late Patrick Cowley, an accomplished disco artist who died of AIDS in 1982, marketed with a label promising "100% of worldwide profits from this record will be donated to Gay Men's Health Crisis [of New York] to help fight AIDS," has earned at least $20,000, yet only $735 of that money has reached GMHC. Marty Blecman, president of Megatone Records, the company that marketed Cowley's "Menergy Megamedley," has confirmed to Brian Jones of the Bay Area Reporter that Megatone withheld over $19,000 in money due to GMHC and promised that he had "every intention" of honoring the commitment. Megatone informed GMHC that the record grossed only $13,000 and that minus expenses, the profit was $735. Yet the company's own financial records indicate a gross profit in excess of $26,000. The records also indicate a $20,000 donation to GMHC, a donation that was never sent. Jones quotes one source, "close to the project" as saying, "Marty told me 'there must be at least $35,000 I owe AIDS in royalties...I hope they never catch me...I only made token payments."

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RED CROSS HOME ATTENDANT PROGRAM LOSES FUNDING

by Sally Chew, with thanks to New York Native, 2/11-24/85

A New York citywide program designed to provide people with AIDS with in-house services will lose its independent public funding, due to what the city's Human Resources Administration (HRA) calls "underutilization." The American Red Cross AIDS Home Attendant Program, funded (50% federal, 25% state, 25% city) to serve 200 PWAs never had more than an average of 25 clients. While it was only through aggressive overtime outreach that the program's 10 staff members were able to get past the initial eight-client average, according to director Jeannetta Bushey, staff will now be collapsed to three as the program is absorbed into a Red Cross senior citizen's program. Why the gap between the city's projected 200 eligibles and the total 65 actually served? When the program was initiated in February, 1984, there were an estimated 1000 living PWAs in New York City. Many of these were not in need of continueal medial attention, but could have used the kind of help with shores the program's visiting "attendants" provide. The fact that no city agency had been willing to send its employees into the homes of victims of the mysterious illness compelled the establishment of some special service of the kind. Bushey blames a combination of things. For one, the city never made a needs assessment before it set the arbitrary target number. Then, getting through the various interagenciy referral bureaucracies took so long that eligible PWAs were often too advanced in their illness by the time the attendant program got to them. Another obstacle was Medicaid eligibility, particularly in the "community" or nonmedical category specified by this contract. All clients must be Medicaid-eligible. Bushey discovered it to be a very narrow category, and says that many PWAs who could have been served didn't know they were entitled to sign up for Medicaid. While opinions vary on where to place blame for the program's "underutilization" and whether or not it can do as "well" as it did in its larger, independent form, no one doubts the need ofr such a service. PWAs have to go through "lifestyle changes overnight," AIDS Resource Center Director Robert Morgan says, emphasizing their need for nonmedical assistance. On top of sudden physical changes, their "sudden dependence on others" can be "emotionally traumatic."

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BOSTON AIDS COMMITTEE RECEIVES $150,000

by Sue Hyde, with thanks from Boston's Gay Community News, 3/2/85

Boston Mayor Ray Flynn announced that the city has awarded the AIDS Action Council (AAC) a grant for $150,000. The money will be used to pay AAC staff salaries and to pay for educational and counseling programs, patient support services and programs, and direct financial aid to people with AIDS. This is the second city grant awarded to AAC. Last fall, the Neighborhood Development and Employment Agency gave the group $40,000 toward its educational and outreach efforts. Larry Kessler of AAC called the grant "an important step taken to promote cooperation between grassroots groups and the city government." He said the goal of AAC is that no person with AIDS "fall through the safety net we are trying to weave."

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POLICE WITH AIDS NOT OUT

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/2/85

San Francisco's Civil Service Commission and Police Department recently concurred that city employees, including police officers, who refuse to work with other employees who have AIDS may be guilty of "insubordination" and subjected to disciplinary action, according to the Bay Area Reporter. The Police Department was responding to petitions circulating among city sheriff's deputies, one of which reportedly asked that a deputy with AIDS be prevented from working with other deputies and police officers. On January 3, John J. Walsh, personnel manager for the Civil Service Commission, advised John L. Taylor, clerk of the Board of Supervisors, that "The preponderance of current medical opinion indicates that persons with AIDS do not present risk factors in the normal course of their employment environment or work activities.... If other co-workers refuse to work as a result simply because of the presence of an AIDS victim, they are subject to the due-process disciplinary procedures." Noting that many city workers need more accurate information about AIDS, city supervisor John Molinari has requested an educational program on the disease for all city department heads and middle managers.

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BRITISH PRISON QUARANTINED AFTER AIDS DEATH

compiled by Stephanie Poggi and Sarah Schulman, Boston Gay Community News, 3/9/85

According to the Frency newspaper Liberation, a British prison was placed on quarantine after the death of its chaplain from AIDS. The British minister of the interior farbade all transfers in or out of the Chelmsford prison, a facility for young "delinquents" north of London, after the death of Reverend Gregory Richards, at the age of 38. This decision followed a similar proposal by the union of prison guards. The prisons of Wellingborough and Onlye, in northern England, had refused to admit buses carrying guards and prisoners from Chelmsford. A medical team will shortly begin examination of all the prisoners at Chelmsford before normal intraprison activity is resumed.

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BLUEBLOOD'S BOOK EXCLUDES PEOPLE WITH AIDS

compiled by Stephanie Poggi with thanks to Boston's Gay Community News, 3/9/85

Burke's Peerage, the catalogue of Britain's bluebloods, will exclude all people with AIDS and their families, Burke's publishing director announced, according to the Boston Globe. Adding insult to injury, publishing director Harold Brooks-Baker has also made it known that PWAs and "those close to them" will not be considered for membership in Burke's Blood and Gold Club, a marriage guide to the most eligible people by birth and wealth. Said Brooks-Baker, "It may be that some people, because of their genetic make-up, are more likely to get it than others, as is the case with rhematic diseases. We are not taking any chances."

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IV DRUG USE IN SAN FRANCISCO GAY MEN WITH AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/23/85

Twelve percent of the gay and bisexual men with AIDS in San Francisco report a history of IV drug use, according to Coming Up! Researchers have begun considering men, who are both sexually active with other men and who use intravenous drugs as a category at "ultrahigh risk" for AIDS. Harold Ginzburg, the Associate Director of Clinical Medicine for the National Institute on Drug Abuse, presented findings several months ago from his research of the first 2000 AIDS cases that showed 25% had a history of IV drug use. Ginzburg and others advocate that the CDC more accurately classify AIDS statistics and that more research and services be focused on IV drug users.

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MURDER VICTIM GIVEN AIDS TREATMENT BY MORTICIAN

with thanks to Chicago's GayLife, 2/28/85

A murdered gay man's body was handled as a suspected AIDS case, though there was no evidence suggesting the disease, reports Minneapolis-St. Paul's Equal Time. A Ramsey County (Minnesota) Medical Examiners office investigator ordered the special treatment, which adds about $100 to embalming costs, for Algis Garbenis, 51. Garbenis and his lover, Guy Carlisle, 61, were found shot in the back of the head in the home they shared. The mortician who handled the case, Margery Powers of O.E. Larson Mortuary in Minneapolis, said she questioned the need for the AIDS precautions. "The medical examiner's office told us to handle it that way. The staff here was not pleased," she said. Meanwhile, Carlisle's son Tim, 38, a police officer in the Chicago suburb of Lisle, has been charged with two counts of first-degree murder. Lisle police found a .45 caliber pistol and Guy Carlisle's car in the son's possession. Garbenis and Carlisle were both divorced and retired, meeting in Chicago in the 1960s. Garbenis had cared for wheel-chair-bound Carlisle for the past five years.

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DICK GREGORY SAYS AIDS IS GOVERNMENT PLOT AGAINST GAYS

with thanks to Chicago's GayLife, 3/7/85

Black comedian/activist Dick Gregory charged that AIDS is a U.S. government plot to eliminate gays in a February 16th speech at Swarthmore College, reports Philadelphia's Gay News. Gregory said the virus was developed by government researchers testing monkeys six years ago at the University of California at Davis. If AIDS actually "had anything to do with gay sex, there'd be a thousand cases in Rome by now," he said, adding that flamboyant gays are in the most danger. "They're the ones that are dying. You don't hear about the gays in the federal government dying.... My gay friends tell me they want to come out of the closet, and I tell them to get right back inside. Not because I have any problems with homosexual acts, but for their own safety."

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DUELING MARQUEES IN DULUTH & SUPERIOR

with thanks to Chicago's GayLife, 3/7/85

An anti-gay minister in nearby Superior, Wisconsin recently declared, "Stop AIDS Now. Quarantine Gays" on the marquee of the old theater that houses his church, reports the Duluth News-Tribune & Herald. The sign drew pickets and a response on the marquee of another former theatre that houses a book store in Duluth, Minnesota, across the river. Robert Carlson of Chester's Used Books and Records responded to Rev. Craig Hultgren's sign with one saying, "Aid Gays. Quarantine Bigots." "At one time I wouldn't have done something like this," said Carlson. "But now my priority is to speak my mind. If people don't like it, I figure they can buy their books somewhere else."

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BLOOD BILL REJECTED IN NEW HAMPSHIRE

by Christine Guilfoy, with thanks to Boston's Gay Community News, 3/2/85

The New Hampshire House of Representatives has rejected a bill on a voice vote, which would have prevented lesbians and gay men from donating blood. The bill would have made it a felony for "homosexuals" to donate blood. Representatives of the American Red Cross Blood Services, the American Civil Liberties Union, and the New Hampshire Feminist Health Center all testified against the bill, while several sponsoring legislators, including the bill's author, Representative Mildred Ingram (R-Acworth) testified in its favor. Ingram said she was prompted to introduce the bill after she underwent surgery where she received a transfusion of 19 units of blood. Ingram expressed concern that she may have recieved blood from gay men who lived near the hospital where she underwent surgery. She did not explain why lesbians, who are not at risk of contracting AIDS were included. Nationwide, there have been 106 transfusion-associated cases of AIDS, about 1% of the total. This number does not include hemophiliac cases.

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REAGANOMICS HITS AIDS FUNDING

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/23/85

The Reagan administration's fiscal year 1986 budget, presented to Congress early in February, includes a $10 million cut for the Public Health Service's AIDS work, as well as cuts in Medicaid and elimination of revenue sharing--all key factors in the fight against AIDS. The administration's proposal calls for a total of $85.5 million in AIDS-related programs for PHS in FY 1986, down from $96 million in 1985. The budget proposal does not reflect a new federal program for alternative sites for the HTLV-III antibody test. It remains unclear wheter those funds will come out of existing programs or whether additional money will be requested. The 1986 budget also calls for a general reduction in the number of research grants given by the National Institutes of Health from 6500 to 5000. [The administration claims that the $10 million cut accounts for capital investments that are no longer required, according to Nancy Roth, executive director of Gay Rights National Lobby.]

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BONE MARROW BIOPSY CONFIRMS AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/23/85

A bone marrow biopsy may be an inexpensive and easily applied means to confirm a potential diagnosis of AIDS, according to a study in the February issue of Archives of Pathology and Laboratory Medicine. Stephen Geller, MD, of New York's Mount Sinai School of Medicine and colleagues compared biopsies from 30 people with AIDS with those from 20 people with fever of unknown origin. Characteristic biopsy features were recognized in 86% of specimens from PWAs.

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AUSTRALIAN PANIC & PREJUDICE OVER AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/23/85

The New South Wales Anti-Discrimination Board has expressed grave concern over increasing AIDS panic in the public arena, particularly over irresponsible and inaccurate media reporting, mounting anti-gay violence, the rise of myths about the spread of AIDS, the lack of easily understood, readily accessible information on AIDS from government agencies, and the need for guidelines to employers and others on medical facts. In a submission to the National Advisory Committee on AIDS, a federal government official body, the Board reports that at a local railway depot, gay staff were warned that one toilet cubicle had been assigned to them and if they used any other they'd be beaten up. Another example, equally bizarre, concerned a typist at a university who refused to type work for a gay male staff member for fear of "catching AIDS" from handling his written notes. --filed from Sydney by Kendall Lovett

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EVIDENCE FOR EXPOSURE TO HTLV-III IN UGANDA BEFORE 1973

abstracted from Science, volume 227, March 1, 1985

"Fifty of 75 serum samples collected in the West Nile district of Uganda between August, 1972 and July, 1973 contained antibodies reactive with human T-cell leukemia [lymphotropic) virus type 3 (HTLV-III; mean titer, 601), while 12 of 75 samples were positive in a similar test for HTLV-I antibodies (mean titer, 236). The samples were screeded by enzyme-linked immunosorbent assay [ELIZA] and positive results were confirmed by a newly developed unlabeled antibody-peroxidase procedure with enhanced sensitivity for detection of antibody binding to immunoblots of HTLV-III antigen, demonstrating antibodies to proteins with molecular weights of 24,000, 41,000, and 76,000 in nearly all positive samples. Analysis of titration data indicated enhanced titers of antibody against HTLV-III and HTLV-I when coinfection occurred. The high prevalence and relatively low titers (compared to serum from patients with AIDS) of antibodies recognizing HTLV-III proteins in sera from this population at a time that may predate or coincide with the appearance or spread of the AIDS agent (HTLV-III) suggest theat the virus detected may have been a predecessor of HTLV-III or is HTLV-III itself but existing in a population acclimated to its presence. It further suggests an African origin of HTLV-III."

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FURNITURE MISSING FROM SOON-TO-OPEN RESIDENCE FOR INDIGENT PEOPLE WITH AIDS

by Lou Chibbaro, Jr., with thanks to The Washington Blade, 3/15/85

Between $4-5000 worth of furniture slated to be donated to the Schwartz House, a soon-to-be-opened residence for indigent AIDS patients, was discovered missing from the basement storage area of a former gay bar/restaurant where Washington, DC's Whitman-Walker Clinic paid to have it stored. Clinic president Dusty Cunningham said the Clinic will take legal action against the present owner, who is believed responsible for the furniture's disappearance. Ted Kaneko, owner of the recently opened Japanese sushi bar, said he allowed the furniture to be moved by persons he thought were with the Clinic. Most of the furniture had been received through a bequest from a person with AIDS who died. The collection was in excellent condition and included accessories from an expensive gourmet kitchen. "I'm told that furniture was very dangerous," Kaneko said. "I'm told that you can get AIDS if you touch it." Jim Graham, Clinic Administrator, called Kaneko's claim "ridiculous." A lease agreement for storing the furniture with Kaneko was established. The Clinic has retained a lawyer to sue Kaneko. Volunteers and directors for the house have been forced to scramble to find new furniture to accomodate several persons with AIDS who are set to move into the house.

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INSURANCE FOR AIDS

compiled by Stephanie Poggi, with thanks to Boston's Gay Community News, 2/2/85

Coastal Insurance Company has decided to offer policies for people who believe they are in high-risk categories for AIDS, but not for people already diagnosed, according to the Boston Herald. Fifty policies at a cost of $194 a year were sold within days of Coastal's announcement. The plan provides medical benefits up to $73,000 a year. Only Provident American Insurance in Dallas is known to have set up a similar supplemental health plan.

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AUSTRALIAN RESPONSE TO AIDS

filed by Kendall Lovett from Sidney, with thanks to Boston's Gay Community News, 2/2/85

Following a 600-strong public meeting organized in Melbourne, Australia in response to media scare tactics and gay witchhunting, the local AIDS action group has reaffirmed its willingness to cooperate fully with official measures to eradicate AIDS, provided the current emergency is not used to infringe upon the legal, industrial, and employment rights, civil liberties, privacy, and personal freedom of gay people. The group also reaffirmed its longstanding recommendation that gay men, as well as members of all high-risk groups, refrain from donating blood, and challenged the government to provide adequate funding for the work gay organizations are doing to help fight AIDS.

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SAN DIEGO AIDS PROJECT SEARCHES FOR NEW BOARD MEMBERS

The Board of Directors of the San Diego AIDS Project (SDAP) is seeking new members. According to newly elected Board Chair Hal Frank, a priority for the body is fundraising and coordination of education, prevention, and support services for persons with AIDS and AIDS-related complex. "The Board has made the addition of active men and women with track records of service and fund-raising in the community a top priority. Board members must accept a committment to those priorities as one of the primary functions of membership," he said. There are five vacancies on the 13 member Board. Qualified individuals must attend meetins and functions on a regular basis and become actively involved in work regarding finance, program support and development. Interested persons may send a letter of intent along with a resume to the Nominating Committee, SDAP, PO Box 81082, San Diego, CA 92138 by April 1, 1985. For additional information, contact Frank at 619/294-2437.

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[With thanks to Boston's Gay Community News, 3/9/85]

# Gay/Lesbian Community Statement on HTLV-III/LAV Antibody Test

January 11, 1985

With the expected licensing by the U.S. Food and Drug Administration of the test for antibodies to HTLV-III/LAV, the virus considered to be associated with AIDS, it is important to state what we believe this test does and does not do, what its potential misuses are, and what risks members of the gay community face if they take this test.

It is our recommendation that, except in rare circumstances, this test should be used ONLY in the context of screening blood donations and as part of research programs that guarantee strict confidentiality. Individuals should be aware that this test will NOT provide answers to such questions as: am I healthy? do I have AIDS? am I a carrier of AIDS? have I been exposed to AIDS? can I give AIDS to someone else?

The HTLV-III antibody test does NOT diagnose AIDS. It simply measures the development of antibodies to the HTLV-III virus. A positive test result showing the presence of antibodies could mean nothing more than exposure to the HTLV-III virus. It is not known whether individuals with positive test results will go on to develop AIDS, whether they will be harmed by additional infection by the virus, whether they are infectious, or whether they are possibly immune.

Similarly, a negative test result does not necessarily mean an individual has not been exposed to the HTLV-III/LAV virus. It could mean there has been no prior exposure or infection by the virus, that the individual is still in an incubation period before development of the antibody, that there may have been a prior infection and the antibody is no longer detectable, that the test was performed incorrectly, or that the test itself was inaccurate.

Irrespective of test results, we underscore the importance of all members of high-risk groups continuing to follow prevention guidelines that have been put forward by AIDS service organizations, including the adoption of safe sex practices. The declining rates of sexually transmitted diseases among gay men in many cities show the success of these efforts. Whether one has tested positive or negative, whether one has been exposed to HTLV-III virus or not, safe sex practices may help either new or further exposure to the virus or the transmission of the virus to another party.

While the blood test will be used to screen donations to blood banks, the test will not eliminate all donations that have been exposed to the HTLV-III virus and are therefore potentially infectious. There is evidence that individuals who test negative can, in some cases, be carrying the HTLV-III virus. Therefore, this test is simply an added measure to screen donors and is NOT a substitute for the donor deferral guidelines that recommend that those persons falling into at-risk groups should refrain from donating blood at this time. This includes all males who have had sex with more than one male since 1979, and males whose male partner has had sex with more than one male since 1979.

Though we advise against individuals being tested, those who desire a test should NOT use the blood banking system as a means for getting the HTLV-III antibody test. Since the test is not 100 percent accurate and does not always detect infectibility, some blood that should not be transfused might pass through the system if the donor deferral guidelines are not followed in addition to the blood test.

Individuals should be aware of the fact that their test results may be requested and obtained by third parties. Before requesting a blood test under any circumstances, we urge all individuals, particularly those in the gay community, to consider the following risks:

- If a positive antibody test becomes part of your medical record, it could become justification for denial of life or health insurance in the future. (We are already aware of cases where individuals considered at risk to AIDS have been denied insurance.)
- A positive antibody test could also become a reason for denying employment. While lacking in medical justification, we are deeply concerned that this test will become a mechanism for screening out individuals who are at-risk to AIDS from jobs in such fields as health care, food handling, or child care. There is no evidence that AIDS is transmitted except through exchange of vital bodily fluids. This has not stopped some from already discriminating against those somehow associated with AIDS or the groups considered to be at risk to AIDS. Given the high level of exposure to the virus — and initial studies that show a high positive test rate — among gay men, we are also concerned that potential employers may use the test as an indicator for homosexuality.
- The psychological pressures of knowing that one has tested positive to antibodies is one of deep concern to our community. While a positive test result does not necessarily mean one is going to develop AIDS, there has been sufficient inaccurate publicity suggesting that this is indeed a test for AIDS. Until that link is broken, the mental health impact of receiving a positive test result could be devastating. The misconceptions and general level of hysteria among the general public about AIDS increases the likelihood of a panicked response to a positive test result.

We continue to encourage members of our community to participate in research studies that might help find the answers to the AIDS riddle, including studies using this HTLV-III antibody test in the hope that a clearer meaning to positive and negative results might be developed. However, we continue to urge — particularly in light of the risks outlined above — that participation in research be conditioned on strong guarantees of confidentiality for all research subject participants, including the commitment that identifiers will not be shared with third parties.

**This document was prepared and distributed by the following organizations:**

**National Gay Task Force**
**AID Atlanta**
**AIDS Education Project of Key West**
**AIDS/KS Foundation (Houston)**
**American Association of Physicians for Human Rights**
**Baltimore Health Education Resources Organization**
**FARO AIDS Action Council**
**Gay Men's Health Crisis**
**National Lesbian & Gay Health Foundation**
**National Coalition of Gay Sexually Transmitted Disease Services**
**National Coalition of Black Gays**
**Whitman Walker Clinic (Washington, D.C.)**
**Gay Rights National Lobby**
**National Gay Rights Advocates**
**San Francisco AIDS Foundation**
**Lambda Legal Defense & Education Fund**

[With thanks to Boston's Gay Community News, 3/9/85]

# THE ETHICS OF AIDS RESEARCH

## Weighing the Risks

*By Cindy Patton*

When AIDS came on the scene in 1981, it quickly became clear that a great deal of medical research would be necessary if we were to understand, cure and prevent the Syndrome. At first the government and research establishments seemed reluctant to invest much time or money, despite vocal demands from the gay community. Eventually in 1983 there was an upsurge in the number of research projects funded.

But this apparent response to the gay community's outcry proved to be a mixed blessing. Projects looking at the incidence (epidemiology) and cause (etiology) of AIDS were emphasized over treatment, prevention and education. The discovery of LAV and HTLV-III, in 1983 and 1984 respectively, offered a glimmering hope that research results might stem the tide of AIDS. But the premature announcements that these viruses were *the* cause, and that blood tests and vaccines were mere months away, only increased at-risk communities' vulnerability to discrimination and political backlash.

The straight society's primary interest was a "safe" blood supply and assurances that they would not get AIDS. Gay people wanted AIDS to go away, but not by a sacrifice of their civil liberties or recent inroads against homophobia. These conflicting demands caused alarm among gay activists and research subjects who wanted to assist researchers but wanted input and control over the work. Concern about confidentiality and the ethical conduct of research accelerated as the licensing of the HTLV-III blood tests drew near. Most of the AIDS organizations in the U.S. lent their names to a National Gay Task Force statement advising gay men not to have the test (see box), yet many of the same organizations have maintained a relationship with research projects.

Choosing to become a research subject is a difficult and serious decision. The following article discusses some of the historical concerns with bio-medical research and poses some questions about the unique problems that AIDS research in stigmatized communities raises.

### Health Activism: Setting the Stage ■

In the last one hundred years, medical authority and legal authority have emerged and consolidated within professional boundaries. Although the history of the legal profession bears marked differences from the medical profession, they have been interrelated in some important ways, especially in the last few decades as law has entered the realm of medical ethics. It seems that as medicine grew in stature to protect humans from germs, law expanded in scope to protect people from science and doctors. Medicine and law have had a paradoxical relationship in these last few decades, especially in the areas of civil liberties and rights. Legal trends in the 1960s and 1970s tended to expand the enumerated rights of citizens. An unprecedented attempt to democratize medicine through the courts occurred as health activists sued doctors, hospitals, and municipalities for access to services or for the deprofessionalization of some services. The health-rights movement encompassed ethnic minorities, previously untreated or used as guinea pigs by hospitals, and women, who advocated a return of some health-care functions to midwives and other traditional caretakers. This movement demanded an expansion of the availability of modern medicine.

Simultaneously, the individual rights of the patient in the therapeutic setting were viewed in a new way so that "patients" became clients with a contractual or partner-like participation in health-care decisions. The attention to prisoners, mental patients, and the average person who wound up in a medical experiment gave rise to an increased attention to the ethics of medical research.

Ironically, as more disenfranchised people sought access to the marvels of scientific medicine, the industry was unmasked as the unhuman, bureaucratic empire that it is. The emperor had no clothes, but that did not stop the health rights and legal courtisans from going for every piece of flesh they could get their hands on. Both the left and the right were out for blood, though their concerns were oddly-distorted opposites of each other.

The Right decried an industry too liberal to approve miracles and baby-saving machines that looked like the worst of Brave New World, while it proscribed access to simple practices like abortion, birth control, sexually-transmitted disease prevention education, even nutrition programs for the poor. Conservative lawyers geared up to protect the rights of fetuses and infants whose only chance at life was through baboon-heart transplants in relatively uncontrolled (by medical ethics) settings, while they attacked civil measures designed to allow individuals to make simple decisions about their own bodily care.

The Left, the women's movement, and the gay movement, on the other hand, attacked an industry that was inaccessible to community participation and that prioritized expensive, highly technological therapies over simple, holistic measures. Progressive lawyers sought to curtail the prejudices against minorities that were masked by medical terminology and to legislate greater individual choice and participation.

In the 1970s, the medical industry became the site of struggle for political and social concerns, although opposing perspectives were framed in such different language that only in rare cases, like abortion or the reclassification of homosexuality, were medical professionals forced to take a position.

While conservatives and progressives were fighting for social control through realignment of medical science, the medical industry was busy worrying about cost containment: more people demanded services while the federal government and insurance industry drew tighter fiscal limits to compensate for the massive development of expensive medical toys that yielded ever less net health per dollar. The unmasking of modern medicine, and the embarrassing admission that fiscal managers were now setting priorities for the healing profession, led to what has been called a "therapeutic nihilism." Where once medicine received credit for advances that were more appropriately due to urban planning, sanitation engineering, and the educational projects of communities, in the 1970s, medicine was accorded no credit, even when it was due.

We entered the era of AIDS with conflicting feelings about health care. Enormous cynicism surrounded the very enterprise of medicine. Costs were perceived to be too high. Medicine was alternately believed to have caused oppression by inappropriately labelling people, and to have helped relieve some oppression by describing as medical some phenomena once thought to be moral. More people demanded greater access to services, as well as decentralization and deprofessionalization. Ethicists and lawyers sought tighter control over the conduct of research. People wanted more miracles for less money, delivered in non-technocratic ways.

In this mishmash came AIDS, providing even more contradictory demands by both the Left and the Right. Rightists claimed that any money spent on AIDS was too much, that homosexuals had created this disease, and they could just as well die off. Gay activists demanded more funding, faster and more concerted research. The discovery of HTLV-III appeared as a medical advance, but due to political manipulation too quickly left the arena of testing. Research seemed important, but gay activists were concerned that the direction was biased toward blood tests rather than prevention and cure. Gay men were cautioned by community leaders to be skeptical of the HTLV-III test and to think twice about who was doing research projects and how their rights would be protected.

### Medical Ethics and AIDS Research ■

The very emergence of biomedical ethics in the last thirty years is symptomatic of an important shift in the social evaluation of the scientific enterprise versus the social good. Nazi experimentation on Jews, Gypsies, and others confined in concentration camps brought before the public the question of whether doctors and researchers had society's and the individual's best interests in mind. For the first time in the history of scientific medicine, the issue of individual rights versus the public good was weighed in evaluating the methods of researchers. Before World War II's revelation of Nazi atrocities, the presumption had been that medical doctors were interested in saving lives and improving the quality of life. It was believed that by virtue of their calling, they would promote the good of individual patients or research subjects and pursue the common good of increased understanding of sickness and health. The horror of the worthless, cruel, and forced Nazi experimentation, combined with the emergence of the nuclear bomb as an ever-present threat, forced Western consciousness to question the ultimate good of any science. The illusion of prosperity and improvement wrought by science employed for the benefit of select groups had now to be weighed against the possibility of intentional or inadvertent application of science for evil intent.

The vast, overt, and unselfconsciously racist Nazi enterprise masked the fact that very similar experiments had been and continued to be conducted in the U.S.: on rural Blacks, behind the closed doors of prisons, on retarded citizens, and on poor, third-world clients of urban teaching hospitals. The international code of medical ethics formulated after the Nuremburg trials, where Nazi scientists were sentenced to death were never fully implemented in the U.S. Trade secrets laws protect pharmaceutical companies from scrutiny of their research, permitting less scrupulous researchers to hide behind lawyers. The World Health Organization of the United Nations has several times criticized U.S. research policies, bluntly challenging the idea that the U.S. is the most civilized and scientifically advanced country in the world.

Attempts at regulating research are based on unrealistic ideas about the ability of minorities to participate fully as citizens under the law. Minorities — people considered not quite human by dint of some difference — are not always adequately protected under medical ethics guidelines because society does not evenly distribute rights and protections. The idea of "informed consent" — about who can consent and under what circumstances — rests on assumptions that do not necessarily take into account the subtle and obvious ways that people may be forced to trade rights for protection. Virtually any medical researcher who is so inclined could obtain a signed informed consent contract of a person who, because of some kind of disadvantage, might not be considered by an ethicist to have understood fully the effect of their consent. Individuals who lacked the knowledge, resources, or ability to seek redress if their rights were violated might consent, but their consent should be suspect if they cannot freely exercise their right to redress a broken contract. Prisoners, for example, do not always have a clear picture of their rights (and neither do the courts) and are particularly vulnerable to coercion in an experimental setting.

Free and fully acting citizens may also have difficulty weighing choices about consent. If there are cultural differences, researchers may inadequately or erroneously explain what they are doing, resulting in less than informed consent, and, ultimately, compromising the validity of the research, since participants could not reasonably have complied.

In the now infamous Tuskegee study, the project's aims and design changed as time passed. In the beginning, subjects were informed that they were to be treated for "bad blood," a term which the designers for the study believed was synonymous with syphilis. Actually, residents of the study area understood the term to refer to any number of ailments. Participants, therefore, did not have a full understanding of the study. They were often perplexed about why one disease would be treated and another would not. As far as they had been informed, the study was about "bad blood," which they understood in a much broader sense. Racist attitudes about the intelligence of these Black research subjects precluded a public education campaign which might have clarified the purpose of the study and enabled its subjects to demand appropriate treatment.

Ethically, consent must be based in part on an altruistic desire to aid in scientific discovery of benefit to others. If incentives are used, they must not be so great as to encourage people to consent against their best interests. In addition, the possibilities of actually learning something of value in the project must be clear, or a researcher is asking a participant to make some sacrifice of time or to risk some harm for no end. When researchers submit proposals to the Internal Review Board of their affiliated institution for consideration, they must show that the research design will produce valid results.

In the case of AIDS, the very fact of experiencing a life-threatening disease, with no known cause or cure, tips the balance of informed consent, especially in therapeutic trials. If the alternatives are almost-certain death, versus possible death or *perhaps* less discomfort with experimental treatment, it is difficult to feel wholly satisfied with consent as it would be difficult to withhold a possibly beneficial experimental drug. Certainly, cancer researchers have long faced this very problem. Sadly, the record of cancer "cures" makes one cynical about embarking on trial studies.

### We Have All Been Here Before ■

There has been a convergence of medical research and public-health concerns before, perhaps most notoriously in the venereal disease projects from World War I to the present. Tuskegee, along with the surveillance, arrest and study of prostitutes during World War I, offer fuel to the paranoia. Although the issues raised in venereal disease control projects in the past compelled researchers to understand that they had to insure some level of confidentiality if they were to get adequate compliance from those interviewed, the more stigmatized and legally vulnerable groups were easily coerced into compliance. As the Hastings Center Institute on Society, Ethics, and Life Sciences report of Nov. 1984 notes, "Unless they have confidence in the systems designed to protect their privacy and in the people to whom personal information is entrusted, they will face a difficult choice: either to provide inaccurate

or incomplete data, thus compromising the validity of the research; or to give accurate and full data, thus placing themselves at risk." For a closeted gay man with a wife, family, or prestigious job, it may be far easier to claim to have gotten AIDS from a prostitute than to admit to being homosexual. Historically, society has been all too willing to believe prostitutes harbor disease, even if researchers are suspicious of such assertions. Not only does this create research and confidentiality problems, but it fuels the anti-gay fires by apparently demonstrating that AIDS can and will inevitably seep out into the "general population." The whole idea of confidence in the powerful and often conservative medical profession is problematic in the 1980s with the shift away from a national concern for civil rights and a move toward a conservative climate that renews the submerged hatred toward gay people, prostitutes, Blacks, and drug users.

The Hastings Center is quite right, if dissonant with the new conservatism, when it sees part of the ethics problem in AIDS as a social one: "As a society we must express our moral commitment to the principle that all persons are due a full measure of compassion and respect." Though a bit naive, they observe correctly that the people at risk for AIDS will not approach the medical system or its research arms with much trust, and have a well-developed interest in resisting full compliance. It is not enough for doctors to express wishes to protect their clients or subjects. The doctor or researcher must be prohibited by law from releasing names without good reasons. And those reasons must be spelled out clearly, lest a doctor balance the common good against the individual's rights without full understanding of the social, political, and legal ramifications of disclosure for stigmatized clients. In addition, the researcher must have a reasonable assurance that she/he will not be subjected to harassment from the government, insurance companies, or employers.

Many people consider the fear of government subpoena of names and medical information to be sheer paranoia, but both Hastings and Lambda Legal Defense, in its booklet on AIDS legal issues (1984), address just such a possibility. There is no standard set of case law to deal with the problem of confidentiality, since public health laws are by and large left to each state to administer. But with increasingly conservative Supreme and District Court judgeships, and rightist legal theorists who propose constitutional theories that are far more restrictive than what we have become accustomed to, it seems reasonable to imagine the worst possibilities. Hastings, perhaps naively, suggests that a clear and consistent policy of confidentiality will probably hold up better in court than a less thought-out rationale. But if gay researchers or institutions follow guidelines that are more strict than non-gay institutions, or ultimately refuse to comply with subpoenas, this might easily be taken as contempt. Gay rights are rarely protected legally, nor are they sufficiently respected to assert individual gay rights against the ominous "public good."

There is good reason for paranoia on the part of all of the people who have AIDS or who belong to at-risk groups: to some degree all are in violation of law. (Homosexuality is illegal in most states; many Haitians are illegal entrants to the U.S. and face deportation; and IV drug use or ownership of drug-injection apparatus is illegal.) In addition, early in the AIDS epidemic, the Centers for Disease Control several times supplied the names of people with AIDS to other agencies, once by accident. It was clear by the federal hearings on the response to AIDS held in August 1983 that the CDC had not taken adquate precautions to insure the confidentiality of people under its surveillance. New York, because of its number of AIDS cases and the existence of two gay rights organizations, Lamdba Legal Defense and the National Gay Task Force, responded early to the legal aspects of the AIDS crisis and immediately passed legislation designed to protect people with AIDS and others at risk or involved in research projects from disclosure.

The failure to insure adequate confidentiality measures has many possible consequences. On the most distressing level, people who need medical treatment may be afraid of going to doctors for fear that their illegal or stigmatized status may become known. While this may not uniformly inhibit the major affected group — gay or bisexual men in the urban gay ghettos who have access to gay-sensitive health care and the legal resources of the gay community — it is certainly an important factor affecting the decision to seek health care by Haitians and IV drug users.

## "Coming Out" with AIDS ■

If gay or bisexual men, Haitians or IV drug users were already afraid of doctors, their paranoia only increased as AIDS received national medical and media attention. AIDS became a reportable disease in 1983, placing doctors in jeopardy of legal restraint if they failed to report the disease and bringing at-risk groups more solidly under the surveillance of the Public Health Service and state public health departments. Many public health officials recognized the need to protect the clients' confidentiality if they were to get good compliance. If public health officials showed an early concern over the issue of confidentiality, they would inspire confidence in their protocols and increase the likelihood that healthy but exposed people would voluntarily seek remedies of screening or vaccination. However, the government agencies have not been cognizant of the additional concerns of risk groups, having overlooked the past history of abuse of confidentiality and disregarded the special concerns that these people have in seeking medical care.

With the decade-long right-wing backlash accelerated by AIDS's connection with homosexuality, the penalties for risking exposure as a homosexual make the individual increasingly less willing to seek medical assistance that may result in disclosure. Although the medical establishment has in some ways learned that it must cooperate with gay organizations, the stereotype that gay men are irresponsible and self-destructive makes the government view gay men as unlikely to cooperate, a bias that increases in direct proportion to beliefs about gay promiscuity. There is broad, if not always articulate, belief that gay men will not cooperate in attempts to alter their sexual behavior, as well as ignorance about how the gay sexual community functions. While the gay community has launched massive and sensitive educational campaigns about "safe sex," sex education is so discouraged in the U.S. that several states have considered them insufficient and begun to make moves toward public health quarantines or other forms of repression. Shortly after California submitted its public health statutes to lawyers to consider their applicability to AIDS, San Francisco closed all establishments believed to permit sex on the premises. These bars, baths, and bookstores were only allowed to reopen if they enforced the safe-sex guidelines established by the local AIDS organization. Each establishment was required to hire staff to make frequent surveillance rounds, and had to insure that a ratio of staff to clients was maintained. New Hampshire, in 1985, attempted to pass a bill making it a felony for any gay man *or lesbian* to donate blood.

### Living Under the Microscope

In addition to concerns about willful, malicious, accidental or subpoenaed release of subject information, subjects experience heightened anxiety about entering research at all. The emotional experience of research subjects has become a special area of concern with AIDS.

When faced with the seemingly improbable but possible exposure to AIDS versus an almost certain harm resulting from admitting to being gay, it is not surprising that a healthy gay man might reasonably decide not to go to a doctor. For bisexual men whose homosexual activity is hidden, or for gay men who live in smaller towns or regions where homosexuality is highly stigmatized or illegal, the equation tips even further against going to a doctor. But a paradoxical corollary applies: with the equivocal HTLV-III test, gay men who are unaware of the legal or insurance problems a positive test might cause may rush out to get tested when the kit becomes widely available. The gay community will experience a widespread and uncontrollable reaction to test results in individuals, and possibly inter-community tensions which federal agencies may be able to manipulate to their advantage. As AIDS becomes more prevalent outside the close-knit urban gay community, the varying decisions and needs of different types of gay men may create a situation where legal strategies are undermined by lack of a unified front by gay men who do not understand the test or are not aware of their civil rights.

### Loss of Privacy

An additional factor in the legal status of gay men with AIDS is the recent finding by the U.S Court of Appeals for the District of Columbia Circuit that a gay man in the military had no right to privacy concerning his sexuality. The presiding Justice was Robert Bork, a likely appointee to the Supreme Court under Reagan. His Constitution theories run counter to the liberal notions that most left activists cherish and believe to be immutable. Concepts of privacy and civil rights during the tenure of the new left, feminist, and gay movements, have become more inclusive, extending to categories of people or activities that were not originally enumerated. As the political climate shifts, and the composition of the Supreme Court (whose effect ranges far past the administration that appoints its members) changes, there is even greater reason to fear that lists originally procured and protected with the best of intentions may later become a weapon against us. Liberal sentiments of the past might have argued in favor of assisting the homosexual, Haitian, IV drug user, or prostitute, in spite of a tacit moral sentiment against these people. Now the cry is to protect the "innocent victims": children, women, transfusion recipients, even straight men with no risk other than through going to prostitutes.

No one in American society has ever been fully equal under the law, fully innocent until proven guilty, *especially* when the good of "public health" is balanced against individual liberties. But the current political climate, where abortion rights, First Amendment rights, the whole notion of a right to privacy are questioned, there is no pretense that anyone other than traditional, God-fearing, Christian family members deserve equal treatment under the law. The equation promoting the common good is weighted unapologetically against gay people, liberated women, third-world people, and anything liberal. In the dictum that says gay people should sacrifice a little freedom to produce a greater social good, the lives we save through faithful and well-intentioned cooperation with AIDS surveillance and research may not be our own.

[ED NOTE: This MMWR was inadvertently omitted from last year's Newsletter. Thanks to a perceptive reader!]

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# MORBIDITY AND MORTALITY WEEKLY REPORT



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*Epidemiologic Notes and Reports*

## Early Detection of Primary Hepatocellular Carcinoma — Alaska

High rates of primary hepatocellular carcinoma (PHC) and hepatitis B virus (HBV) infection have been found in the Alaskan Eskimo population (*1,2*). Chronic HBV infection is believed to have an etiologic role in the development of PHC. Alpha-fetoprotein (AFP) is frequently elevated in clinically evident PHC, but its use in the preclinical detection of PHC in persons serologically positive for hepatitis B surface antigen (HBsAg) has not been extensively evaluated. In 1980, a pilot AFP screening program was begun among 20 HBsAg-positive Alaskan Natives from three families at high risk for PHC. Each family had a high rate of HBV infection and had two family members die of PHC. In 1982, semiannual AFP screening resulted in the early detection and surgical resection of a 2-cm PHC in an asymptomatic, 19-year-old Eskimo man who has since done well (*3*). After this success, the AFP screening program was expanded to include all HBsAg-positive Alaskan Natives.

Between November 1, 1982, and December 31, 1983, 925 Alaskan Natives with sera positive for HBsAg were tested for AFP. As a result, four asymptomatic persons with proven or suspected PHC were identified. The following is a report of the most recent case and a description of the AFP screening program.

On November 27, 1983, an 11-year-old Eskimo boy was found to have an AFP level of 1,342 ng/ml (normal 25 ng/ml or less, ELISA). He was HBsAg-positive when first tested in 1975 and had a previously normal AFP level in November 1982. While the boy had no previous family history of PHC, three other persons from the same village (population 331) developed PHC since 1980. On evaluation at the Alaska Native Medical Center in Anchorage, the boy was asymptomatic and normal on physical examination, although his alkaline phosphatase and serum glutamic-oxaloacetic transaminase (SGOT) levels were mildly elevated. Ultrasonography, CAT scan, and hepatic angiography showed a 3-cm tumor in the medial portion of the left lobe of the liver. On December 5, the boy underwent successful surgical resection of a 3-cm, encapsulated PHC. He did well post-operatively and returned to his village on December 23. Following surgery, the AFP level rapidly declined and was 7.6 ng/ml on January 8, 1984.

The expanded AFP screening program, begun in November 1982, consists of semiannual AFP testing of all HBsAg-positive Alaskan Natives who are tracked by a computerized register. In the program's first 14 months, 14 persons, including four with liver tumors, have been identified as having elevated AFP not related to pregnancy. Three of the tumors were biopsied and proved to be PHC: one in a 10-year-old boy who is doing well 5 months after a successful resection; one in a 66-year-old man who died 1 year after an unresectable tumor was discovered; and one in the 11-year-old boy reported above. The fourth liver tumor, documented by ultrasonography and CAT scan, was in an elderly man who declined biopsy and surgery. All patients with tumors were asymptomatic at the time of detection, and all had rising AFP levels or a single level above 1,000 ng/ml. Of the 10 remaining people with elevated AFP, one has had low-level elevations (50-90 ng/ml) and is being evaluated, and nine had transient elevations associated with acute HBV infection. These preliminary results suggest that AFP screening of HBsAg-positive persons can, at least sometimes, detect PHC at a stage when surgical resection may be curative.

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**Editorial Note:** PHC is a leading cause of cancer deaths in much of Asia and Africa. Worldwide, it is estimated that over 150 million chronic carriers of HBV infection—900,000 of whom live in the United States—are at risk for developing PHC (*4*).

In the past, a PHC diagnosis usually followed the onset of symptoms, and the 5-year survival rate approached zero (*5*). Of the various treatments for PHC, only surgical resection has resulted in long-term survival. A recent study from the People's Republic of China demonstrated that surgery in asymptomatic patients with tumors less than 5 cm in diameter can result in improved survival (*6*).

Well-designed prospective studies are needed to evaluate the use of AFP screening in the early detection of PHC. These studies should include measures of sensitivity, specificity, and positive predictive value, as well as an analysis of cost-effectiveness. The preliminary Alaskan experience is promising and will hopefully result in recommendations concerning the use of prospective AFP testing among HBsAg carriers.

While early detection of PHC may improve survival rates, detection is only part of the health-care strategy directed against PHC. Because of the presumed etiologic link between chronic HBV infection and PHC, preventing PHC may be possible by preventing HBV infection. The success of future HBV vaccination programs may well determine the future incidence of PHC.

*References*

1. Heyward WL, Lanier AP, Bender TR, et al. Primary hepatocellular carcinoma in Alaskan Natives, 1969-1979. Int J Cancer 1981;28:47-50.
2. Schreeder MT, Bender TR, McMahon BJ, et al. Prevalence of hepatitis B in selected Alaskan Eskimo villages. Am J Epidemiol 1983;118:543-9.
3. Heyward WL, Lanier AP, Bender TR, et al. Early detection of primary hepatocellular carcinoma by screening for alpha-fetoprotein in high risk families: a case-report. Lancet 1983;II:1161-2.
4. Report of a WHO meeting. Prevention of liver cancer. In: WHO Technical Report Series No. 691, 1983.
5. Moertel CG. The liver. In: Holland JF, Frei E III, eds. Cancer medicine. 2nd edition. Philadelphia: Lea & Febiger, 1982:1774-81.
6. Tang Z-y, Yu Y-q, Lin Z-y, Yang B-h, Zhou X-d, Cao Y-z. Clinical research of primary liver cancer: a 10 year (1970-1979) survey. Chin Med J 1983;96:247-50.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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*Epidemiologic Notes and Reports*

## Prevalence of Cytomegalovirus Excretion from Children in Five Day-Care Centers — Alabama

Recent studies have been done in Birmingham, Alabama, to determine the prevalence of cytomegalovirus (CMV) infection among attendees of day-care centers. Samples of urine and saliva from children attending five day-care centers were tested for CMV by viral isolation between March and June 1984 (Table 1). A culture was obtained from each child on a single occasion at both sites in almost all cases. Prevalence of serum antibody to CMV among parents and day-care center workers was determined using a commercial enzyme immunoassay. Centers A, B, and C served mainly middle-income families; centers D and E served primarily low-income families. Although excretion rates varied among the centers, each center had children who were shedding virus. Centers A, B, and C had at least one age cohort with greater than 50% excretion. A small number of children under 3 years of age had CMV in saliva and not in urine. Thus, the percentage of children with excretion from either site for the respective centers was 49% (A), 40% (B), 32% (C), 9% (D), and 13% (E). Frequency of viral excretion was lower in both urine and saliva specimens from children in the lower socioeconomic centers. Questionnaires completed by parents provided past medical histories and histories of recent illness. One 3-year-old in center B had congenital CMV infection proven by viral isolation at birth. No children had histories of mononucleosis-like illness, and there was no association between any specific acute illness during the preceding 6 months and CMV excretion at the time of the study. Previous CMV studies have found infection rates for preschool-aged children in the United States to range from approximately 5% to 30% (*1*). Serologic results revealed that 50%-100% of workers from each day-care center had antibody to CMV, as did 56%-88% of parents (Table 2). These data indicate that CMV infection is common among young children in day-care centers.

**TABLE 1. Isolation of CMV from mouth swab (M) and urine (U) specimens from children in five day care centers*— Alabama, March-June 1984**

| Age (mos.) | Day-care center and source of culture | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | A | | B | | C | | D | | E | |
| | M | U | M | U | M | U | M | U | M | U |
| 0-12 | 1/5 (20%) | 3/5 (60%) | — | — | 2/6 (33%) | 2/5 (40%) | — | — | — | — |
| 13-24 | 10/19 (53%) | 10/19 (53%) | 5/16 (31%) | 4/17 (24%) | 3/8 (38%) | 4/7 (57%) | 0/5 (0%) | 1/6 (17%) | 0/6 (0%) | 0/4 (0%) |
| 25-36 | 1/13 (8%) | 6/12 (50%) | 3/13 (23%) | 7/13 (54%) | 1/11 (9%) | 2/10 (20%) | 0/13 (0%) | 1/12 (8%) | 2/6 (33%) | 1/5 (20%) |
| 37-48 | 0/13 (0%) | 4/12 (30%) | 1/12 (8%) | 5/13 (38%) | 0/13 (0%) | 3/13 (23%) | 0/10 (0%) | 2/9 (22%) | 0/5 (0%) | 1/5 (20%) |
| > 48 | 2/11 (18%) | 4/11 (36%) | 0/15 (0%) | 4/15 (27%) | 0/12 (0%) | 2/11 (18%) | 1/23 (4%) | 0/21 (0%) | 0/6 (0%) | 0/6 (0%) |
| **Total** | **14/51 (27%)** | **27/59 (46%)** | **9/56 (15%)** | **20/58 (34%)** | **6/50 (12%)** | **13/46 (28%)** | **1/51 (2%)** | **4/48 (8%)** | **2/23 (9%)** | **2/20 (10%)** |

*Results are number of children positive/total number of children tested (%).

*Reported by C Hutto, MD, RE Ricks, RF Pass, MD, Dept of Pediatrics, University of Alabama School of Medicine, Birmingham; Div of Viral Diseases, Center for Infectious Diseases, CDC.*

**Editorial Note:** Public awareness that maternal primary CMV infection during pregnancy can result in damaging fetal infections has increased in recent years. Although little is known about how CMV is transmitted in the community, it does not appear to be highly contagious. Acquisition appears to require close or intimate contact with persons who are excreting CMV in their urine, saliva, or other secretions. CMV can also be transmitted via blood transfusions, breast milk, sexual intercourse, and transplanted organs (*2-6*).

Studies have shown that infants and children acquire CMV infection from other children or from their mothers either in utero, at birth, or during the perinatal period (*7,8*). Intrauterine CMV infection is the most common of all recognized intrauterine infections, occurring in an estimated 0.4%-2.3% of all live births, and it can have a variable outcome. It may result from either primary maternal infection acquired during pregnancy or from a recurrent infection (reactivation) or reinfection in a seropositive woman (*9*). Current evidence indicates that most but not all symptomatic congenital CMV infections result from primary infection of the mother. In the United States, 35%-90% of women (depending on race and socioeconomic status) entering their childbearing years are seropositive, and thus, they are not susceptible to primary CMV infection (*9*).

CMV infection is endemic in the community, and infection in childhood is common and usually asymptomatic. Previously published results from a longitudinal study of children in a day-care center indicate that the majority of children acquired CMV after joining the center and that the estimated cumulative infection rate may reach as high as 80% for children during their second year of life (*1*). Excretion of CMV has persisted for months to years in most of the children studied at that center, as it does in congenital CMV-infected children. Another study comparing point prevalence rates of CMV excretion in urine and saliva of children attending infant development centers for the developmentally delayed and those in day-care centers demonstrated that urinary excretion occurred in 22% of children in both types of centers (*10*). Since CMV infection appears to be endemic in the day-care setting, there is very

**TABLE 2. Proportion of seropositivity to CMV among day-care workers and parents of children in five day-care centers — Alabama, March-June 1984**

| | Day-care center | | | | |
|---|---|---|---|---|---|
| | A | B | C | D | E |
| Workers | 17/34 (50%) | 11/14 (79%) | 16/17 (94%) | 12/13 (92%) | 4/4 (100%) |
| Parents | 60/107 (56%) | 45/80 (56%) | 45/69 (65%) | 38/43 (88%) | 11/15 (73%) |

little justification for excluding a child from these settings because the child is known to be excreting CMV (*11-13*).

Unfortunately, concern over the risk of acquiring CMV infection from children known to have congenital infection has led to placement of unwarranted restrictions in some communities on the participation of these children in public programs, such as day care, schools, and even intervention programs for the developmentally disabled. The risk of exposure from a child with congenital CMV infection is minimal, compared to the unavoidable exposures to the many healthy children in the general population who are unrecognized excretors of CMV. The risk of spread of CMV infection to child-care personnel, particularly women of childbearing age, is not fully known. Until more data are available on occupational infections and the potential risk of exposure to pregnant workers, female employees in their reproductive years should be informed that a significant percentage of infected children may be present in any child-care setting, and that care for any infants and children should include hygienic measures, such as washing hands after each contact with urine and respiratory-tract or other potentially infectious secretions and careful handling and disposal of diapers and other articles known to be contaminated with urine or other secretions (*2, 11-14*).

Routine serologic testing of pregnant women who take care of children in institutions is not currently indicated because: the extent of risk is not currently established; testing facilities are not readily available; and the significance of antibody titer in a single test is difficult to interpret (*2, 12-14*). Also, it is not known whether the risk of primary CMV infection would be appreciably reduced by identifying seronegative women and transferring them to areas where there is less contact with infants and children (*11,14*). Until further data are available, the most practical means by which pregnant women or women planning pregnancy can prevent acquiring CMV is rigorous, good personal hygiene throughout pregnancy, particularly in any setting where frequent, close contact with infants and children occur.

*References*


1. Pass RF, Hutto SC, Reynolds DW, Polhill RB. Increased frequency of cytomegalovirus infection in children in group day care. Pediatrics 1984;74:121-6.
2. Onorato IM, Morens DM, Martone WJ, Stansfield SK. The epidemiology of cytomegalovirus infections: recommendations for prevention and control. Rev Infect Dis (in press).
3. Prince AM, Szmuness W, Millian SJ, David DS. A serologic study of cytomegalovirus infections associated with blood transfusions. N Engl J Med 1971;284:1125-31.
4. Nakervis GA. Cytomegalovirus infections in the blood recipient. Yale J Biol Med 1976;49:175-[illegible].
5. Dworsky M, Yow M, Stagno S, Pass RF, Alford CA. Cytomegalovirus infection of breast milk and transmission in infancy. Pediatrics 1983;72:295-9.
6. Ho M, Suwansirikul S, Dowling JN, Youngblood LA, Armstrong JA. The transplanted kidney as a source of cytomegalovirus infection. N Engl J Med 1975;293:1109-12.
7. Alford CA, Stagno S, Pass RF. Natural history of perinatal cytomegalovirus infections. In: Perinatal infections. The Netherlands: Excerpta Med, 1980:125-47.
8. Gold E, Nakervis G. Cytomegalovirus. In: Evans AS, ed. Viral infections of humans. New York: Plenum Medical Books, 1982:167-86.
9. Stagno S, Pass RF, Dworsky ME, Alford CA Jr. Maternal cytomegalovirus infection and perinatal transmission. Clin Obstet Gynecol 1982;25:563-76.
10. Jones LA, Duke-Duncan PM, Yeager AS. Cytomegalovirus infections in infant toddler centers: centers for developmental delay versus regular day care. J Infect Dis (in press).
11. CDC. Day-care center study group. Public health considerations of infectious diseases in day care centers. J Pediatr 1984;105:683-701.
12. Exposure of women to cytomegalovirus infections in medical and educational facilities. California Morbidity Supplement #7, February 25, 1983.
13. Pass RF, Kinney JS. Child care workers and children with congenital cytomegalovirus infection. Pediatrics (in press).
14. Williams WW. Guideline for infection control in hospital personnel. Infection Control 1983, 4:326-49.



CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT




*Epidemiologic Notes and Reports*

## Hepatitis B among Dental Patients — Indiana

Between April 1, and December 30, 1984, nine cases of clinical hepatitis B (HB) occurred in a rural Indiana county (population 35,000); this was nine times the normal yearly HB incidence for the past decade. Two of the cases resulted in fatal fulminant hepatitis; an additional case was complicated by polyarteritis nodosa, mononeuritis multiplex, and paralysis. All cases except one had been treated by a dentist in the county.

In mid-September, the dentist, who had practiced general family dentistry in the county for 20 years and saw between 100 and 150 patients per week, noted that all three of the cases to date had been his patients. Because of his possible involvement, he was tested for hepatitis B surface antigen (HBsAg) and found to be positive. He then voluntarily suspended his practice and notified health authorities. Initial investigation by the Indiana State Board of Health and CDC revealed that seven patients who had developed clinical HB between April 1 and October 1 were among the dentist's patients. All were positive for HBsAg, subtype *ad*, and all of six available sera were positive for the IgM fraction of hepatitis B core antibody (anti-HBc IgM), indicating probable recent infection. Although the dentist had no known history of HB infection, his serum was positive for HBsAg, subtype *ad*, and hepatitis e antigen (HBeAg) but negative for anti-HBc IgM.

The dentist did not routinely wear gloves when treating patients but denied lacerations or dermatitis on the hands. He gave no history of hepatitis and had no knowledge of HB carriers in his practice. Other than practicing dentistry, he denied all risk factors for HB. He was not a blood donor and had never been tested serologically for hepatitis. On April 25, and May 30, 1984, he had received his first two doses of HB vaccine.

Further investigation of the outbreak by CDC in late October concentrated on case-finding and interviews of the dentist, his assistants, and the known HB patients and their families. Appropriate blood specimens were also taken. A comparison of the dentist's 1984 patient list with reported HB cases in Indiana uncovered no new cases. However, a review of county resi-

dents rejected for blood donation because of HBsAg-positivity found one patient, who, asymptomatic at the time, had been treated by the dentist several times between May and July and was rejected for blood donation in August. Since she had donated blood in March, her HB infection was considered outbreak-related. Clinical disease, however, did not develop until November 13, nearly 3 months after she became antigen-positive.

The spouse of one HB patient was found to be HBsAg positive, serotype *ad*, HBeAg positive, and anti-HBc IgM negative. He had not been treated by the dentist within the last 2 years but had other risk factors for HB. No other patient's family member had positive HB markers. The patients had no histories of risk factors for HB except traumatic dental work (procedures that produced bleeding) by the dentist 3-5 months before onset of symptoms. None of the HB patients were taking hepatotoxic drugs. Antibody and antigen tests for delta virus were negative on the dentist and all seven of the HB patients tested.

In mid-December, a large seroprevalence study was carried out on the dentist's patients in an attempt to determine the degree of subclinical transmission; results of this study are pending. The dentist has not resumed his practice.

*Reported by RH Hamm, MD, RB Peare, MD, WL Painter, KC Allman, M Hamilton, K Cutting, CL Barrett, MD, State Epidemiologist, Indiana State Board of Health; Hepatitis Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.*

**Editorial Note:** HB is a significant health risk for dental professionals (*1,2*) but is only rarely associated with transmission from dentist to patient. Seven HB outbreaks traced to dentists or oral surgeons have been reported. In each instance, the dental professional was a chronic carrier of HB virus and was HBeAg positive, indicating high titers of HB virus in blood. None used gloves when treating patients. Transmission of HB virus was thought to occur by transfer of infective serum from the dentist's hands into the patient's mouth through small abrasions, lacerations, or dermatitis. When subclinical transmission was studied, the overall rate of infection ranged from 1.5 infections per 100 patients screened to 11.1/100. The risk of transmission correlated with the amount of trauma involved in the dental procedure. For those dentists who remained carriers and returned to work, wearing gloves was usually successful in preventing further transmission (*3*).

The present outbreak illustrates again that HBsAg-positive dentists can unknowingly transmit infection to patients. Available epidemiologic and serologic data suggest that the Indiana dentist was infected before January 1984, too early to be affected by HB vaccine started in April, and that he probably obtained his infection while treating an HB-carrier patient. The dentist and the HB patients had matching antigenic subtypes. However, since *ad* subtype is extremely common in the United States, this does not prove that the dentist was the source of the outbreak as convincingly as the time/place clustering in his practice and the lack of other risk factors among the HB patients.

The 22% case-fatality rate in this outbreak is much higher than the usual rate of 1% of hospitalized HB patients. Furthermore, one patient suffered severe polyarteritis nodosa, a complication seen in no more than 1 of 500 cases. Neither coinfection with delta virus nor the use of hepatotoxic drugs explain the unusual amount of severe disease in this outbreak. CDC is continuing to investigate the possibility that a non-B hepatitis virus could be a cofactor in the outbreak.

This is the first reported outbreak of HB traceable to a dentist that has involved deaths. It illustrates an uncommon but serious consequence of HB infection in the dental profession. Outbreaks of this type should reinforce efforts to deliver HB vaccine to dental professionals early in their careers.

*References*


1. Mosley JW, Edwards VM, Casey G, Redeker AG, White E. Hepatitis B virus infection in dentists. N Engl J Med 1975;293:729-34.
2. Smith JL, Maynard JE, Berquist KR, Doto IL, Webster HM, Sheller MJ. From the Center for Disease Control. Comparative risk of hepatitis B among physicians and dentists. J Infect Dis 1976; 133:705-6.
3. Ahtone J, Goodman RA. Hepatitis B and dental personnel: transmission to patients and prevention issues. J Am Dent Assoc 1983;106:219-22.



CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT




*Current Trends*

## Update: Prospective Evaluation of Health-Care Workers Exposed via the Parenteral or Mucous-Membrane Route to Blood or Body Fluids from Patients with Acquired Immunodeficiency Syndrome — United States

On August 15, 1983, CDC initiated prospective surveillance of health-care workers (HCWs) with documented parenteral or mucous-membrane exposure to potentially infectious body fluids from patients with definite or suspected acquired immunodeficiency syndrome (AIDS). As of December 31, 1984, 361 HCWs with such exposures were enrolled in CDC's surveillance registry under the auspices of participating hospitals, other health-care institutions, and state and local health departments in the United States. Each enrolled HCW is followed for 3 years with a semiannual interview, physical examination, and blood specimen collection. None of the HCWs have developed signs or symptoms suggestive of AIDS; 143 (40%) have now been followed for 12 months or longer.

Exposed HCWs have been reported from 33 states and the District of Columbia. Fifty-nine percent of the HCWs were reported from six states: New York (61), California (39), New Jersey (36), Pennsylvania (28), Florida (25), and Texas (23). As of December 31, 1984, the length of follow-up of HCWs ranged from 1 month to 45 months (mean 11 months; median 10 months). Two hundred eight (58%) HCWs were nurses; 66 (18%), physicians or medical students; 31 (9%), laboratory workers; 26 (7%), phlebotomists; 15 (4%), respiratory therapists; and the remaining 15 (4%) had less direct patient contact. Eighty-five percent were white, and 78% were female. Ages ranged from 18 years to 62 years (mean 33 years).

The majority of exposures occurred in direct patient-care areas; 187 (52%) occurred in patients' rooms or on the wards: 99 (27%), in intensive-care units; and seven (2%), in emergency clinics. Thirty-two (9%) incidents took place in laboratories, and 36 (10%) occurred in operating or procedure rooms and morgues. The types of exposures were: needlestick injuries (68%); mucosal exposures (13%); cuts with sharp instruments (10%); and contamination of open skin lesions with potentially infected body fluids (9%). Eighty-eight percent of the exposures were to blood or serum; 6%, to saliva; 2%, to urine; and the remaining 4%, to other body fluids or unknown sources. Postexposure care varied considerably. Forty-eight percent of ex-

posed HCWs received either no specific treatment or local wound care only, while 35% received immune globulin either alone or in combination with other treatment.

Complete epidemiologic data have been collected on 226 of the patients to whom these HCWs were exposed. Two hundred nine (92%) were AIDS patients meeting the CDC surveillance definition, and 17 (8%) were suspected AIDS cases. Two hundred three (97%) of the 209 AIDS patients were in an identified risk group for acquiring AIDS. The distribution of the AIDS cases by disease category included: *Pneumocystis carinii* pneumonia (PCP), 62%; Kaposi's sarcoma (KS), 12%; both KS and PCP, 5%; and other opportunistic infections, 21%.

Tests for T-cell subsets have been performed at CDC on blood specimens from 269 (75%) of the exposed HCWs. The mean T-helper/T-suppressor (Th/Ts) ratio for the initial whole blood sample from these HCWs was 2.2 with a range of 0.4-5.4 (normal range 1.0-3.9). One hundred eighty-three (68%) of these initial blood specimens were obtained within 180 days from the dates of exposures. Six-month and 12-month follow-up Th/Ts ratios were performed on 69 and six of these 269 HCWs, respectively. All Th/Ts ratios on follow-up specimens were within the normal range, including those from nine HCWs whose initial ratios were less than 1.0.

Serologic testing using the enzyme-linked immunosorbent assay (*1*) and the Western blot technique (*2*) for antibody to the human T-lymphotropic virus type III (HTLV-III) has been done, with specific informed consent, on 40 HCWs enrolled in the surveillance system. The mean duration between the date of exposure and the latest serum sample tested was 10.5 months (range 0-29 months; median 8.5 months). The types of exposures included: needlestick injuries (29), cuts with sharp objects (five), mucosal exposures (five), and contamination of open skin lesions (five). None of the HCWs tested were HTLV-III-antibody positive. However, with a sample size of 40, the upper limit of the 95% confidence intervals for this incidence of seropositivity (0%) is 7%.

*Reported by Acquired Immunodeficiency Syndrome Needlestick Surveillance Cooperative Group; Immunization Div, Center for Prevention Svcs, Div of Host Factors, Div of Viral Diseases, Hospital Infections Program, Center for Infectious Diseases, CDC.*

**Editorial Note:** Because HTLV-III can be transmitted among intravenous drug abusers by sharing needles and through transfusion of blood and blood products, there is concern that HTLV-III could be transmitted to HCWs by unintentional needlestick or other parenteral or mucous-membrane exposures. A recent report describes an HCW in England who is believed to have developed HTLV-III antibody following parenteral exposure to the blood of an AIDS patient (*3*). The HCW reportedly had none of the recognized risk factors for AIDS and remains asymptomatic.

To date, there are no reported cases of AIDS among HCWs in the United States that can be linked to a specific occupational exposure. Of the 8,218 AIDS patients reported to CDC as of February 11, 1985, 278 (3%) have been HCWs. All but 24 (9%) of these HCWs belong to known AIDS risk groups. Epidemiologic investigations have been completed on 17 of these 24 HCWs; four are currently under investigation, and three died before investigations were completed. In six of the 17 completed investigations, nonoccupational exposures were the most likely sources of infection. No known risk factors for infection were identified in the remaining 11 patients; however, specific occupational exposures to definite or suspected AIDS patients could not be documented.

In December 1984, CDC began testing sera from HCWs enrolled in the surveillance system for antibody to HTLV-III. Testing was performed only with the specific informed consent of enrolled personnel and the agreement of cooperating investigators. Initial results from this analysis and from other similar investigations (*4*) suggest the risk of transmission of HTLV-III infection from AIDS patients to HCWs may be very small. Thus, to accurately determine the true risk of transmission of HTLV-III from AIDS patients to HCWs, large cohorts of exposed HCWs must be studied. Additional studies with larger cohorts of HCWs are in progress, and CDC will continue immunologic and serologic testing of HCWs from whom institutional investigators have obtained informed consent.

Studies of seroprevalence of HTLV-III among exposed HCWs are of great value from an epidemiologic perspective. However, serologic testing of asymptomatic HCWs for HTLV-III antibody should be done only with informed consent, and a mechanism should exist for transmitting the test results to the HCW in an appropriate manner. The U.S. Public Health Service has developed specific recommendations for individuals, within or outside known risk groups for AIDS, who test positive for HTLV-III antibody (*5-7*). Health-care professionals should become familiar with and consider these recommendations when serologic testing of asymptomatic HCWs for HTLV-III antibody is contemplated.

Until additional data are available, HCWs should continue to follow previously published precautions when caring for persons with definite or suspected AIDS or when handling specimens from these patients (*8,9*).

*References*


1. Getchell JP, Kalyanaraman VS. Unpublished data.
2. Tsang VC, Peralta JM, Simons AR. Enzyme-linked immunoelectrotransfer blot techniques (EITB) for studying the specificities of antigens and antibodies seperated by gel electrophoresis. Methods Enzymol 1983;92:377-91.
3. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984;I: 1376-7.
4. Hirsch MS, Wormser GP, Schooley RT, et al. Risk of nosocomial infection with human T-cell lymphotropic virus III (HTLV-III). N Engl J Med 1985;312:1-4
5. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983;32:101-3.
6. CDC. Antibodies to a retrovirus etiology associated with acquired immunodeficiency syndrome (AIDS) in populations with increased incidences of the syndrome. MMWR 1984;33:377-9.
7. CDC. Provisional Public Health Service interagency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985;34:1-5.
8. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
9. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.

CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT



*Epidemiologic Notes and Reports*

## Suboptimal Response to Hepatitis B Vaccine Given by Injection into the Buttock

Hepatitis B (HB) vaccine was licensed in November 1981 as a highly immunogenic and effective vaccine against hepatitis B virus (HBV) infection. Large studies before licensure demonstrated, with one exception, that the vaccine induced antibody* in over 90% of healthy adult recipients of the three-dose series (*1-3*). The one exception, in which only 85% of recipients responded to vaccination, was later shown to be caused by partial freezing of the vaccine during shipment (*4*).

Since vaccine licensure, however, the vaccine manufacturer (Merck, Sharp & Dohme) and CDC have received reports of suboptimal response to vaccine in the health-care personnel of a number of hospitals and other vaccine users. Two such examples, in which only 82% and 68% of normal adults responded to vaccination, have recently been published (*5-6*). Initial investigations of these and other reports by the manufacturer and by CDC included site visits, repeat serologic testing of vaccine recipients to confirm poor response, assays of residual vaccine for evidence of freezing and for retention of potency, and review of vaccine lots used. These investigations generally confirmed suboptimal vaccine response but failed to identify any specific cause. The investigations did indicate that, in many such instances, vaccine had been given by buttock (gluteal) injection, in contrast to the arm (deltoid) injection used in all prelicensure vaccine studies.

Two recent investigations, one by the vaccine manufacturer and the other by CDC, indicate that site of vaccine injection is important in explaining suboptimal response to vaccine in many vaccine programs. Both studies were retrospective telephone surveys of hospitals or hemodialysis units that had vaccinated and then serotested significant numbers of persons after vaccination.

**Vaccine manufacturer's study:** In December 1984, the vaccine manufacturer surveyed two groups of vaccine users: over 90 hospitals that had contacted the manufacturer reporting suboptimal vaccine response and an additional 12 hospitals known to have conducted large vaccination programs and to have done postvaccination testing. The telephone survey verified the exact number of persons completing vaccination and the number failing to respond to vaccine and determined the vaccine injection site. Injection site for the hospital was classified as arm if over 90% of persons received vaccine in the arm; buttock if over 90% received vaccine in the buttock, and mixed for all others.

In both surveys, vaccine response rate was significantly higher in hospitals using arm injection than in those using buttock injection (Table 1). Among hospitals that reported suboptimal vaccine response, the pooled response rate for vaccinees was 88% in hospitals using arm injection and 73% in those using buttock injection ($p < 0.01$). Among the 12 other hospitals, response rates were higher, as would be expected for hospitals not selected for poor vaccine response; however, response to arm injection was higher than for buttock injection. Furthermore, when 55 hospitals that had vaccinated and tested 50 or more persons were ranked by response rate to vaccine and compared, arm injection was clearly superior (Figure 1). Among 18 institutions reporting 90% or better response, 13 used arm injection, and one used buttock. Among 21 reporting lower than 80% response, 18 used buttock injection, and two used arm injection.

**CDC's study:** To avoid selection bias inherent in the above study and to more accurately assess vaccine response in a representative group of vaccine users, in January 1985, CDC's Hepatitis Branch assessed vaccine response among staff in all hemodialysis units known to have vaccinated 20 or more staff as of December 1983. Sixty-three centers were contacted and interviewed, and 57 were included in the final data. Among six centers not included, one refused to participate; two did not do postvaccination testing; two tested only a small sample of vaccinees; and one had participated in a prelicensure vaccine trial. In addition to the questions in the first survey, centers were asked to identify the laboratory method of postvaccination testing, length of needle used for injection, and proportions of vaccinees who were over 40 years of age or who were significantly overweight. Among the 57 centers, 20 used arm injection (as defined above); 23 used buttock injection; and 14 used mixed sites of injection.

Antibody response was significantly higher in centers using the arm as the injection site (Table 2). The average vaccine response in such centers was 93%, compared with 82% response in sites using buttock injection ($p < 0.01$). This difference remained highly significant when the method of postvaccination testing and the proportions of vaccinees who were over 40 years old or overweight were considered in the analysis. Despite overall poorer response with buttock injection, response in individual centers varied widely (Figure 1). Among centers using buttock injection, eight (35%) reported excellent response to vaccine (over 90% responding), and nine (39%) reported poor response rates (fewer than 80% responding). In contrast, 75% of centers using arm injection reported excellent response, and only one (5%) reported poor response. Seventeen centers using the buttock as injection site reported using 1½-inch needles, while the other six used 1-inch needles. There was no difference in response rates among these two groups.

*Reported by AA McLean, HA Guess, EM Scolnick, Merck, Sharp & Dohme, West Point, Pennsylvania; Hepatitis Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.*

**Editorial Note:** Although these studies are preliminary, they strongly suggest that response

**TABLE 1. Vaccine response in hospitals reporting suboptimal and normal response to HBV vaccine, by injection site — Merck, Sharp & Dohme study, December 1984**

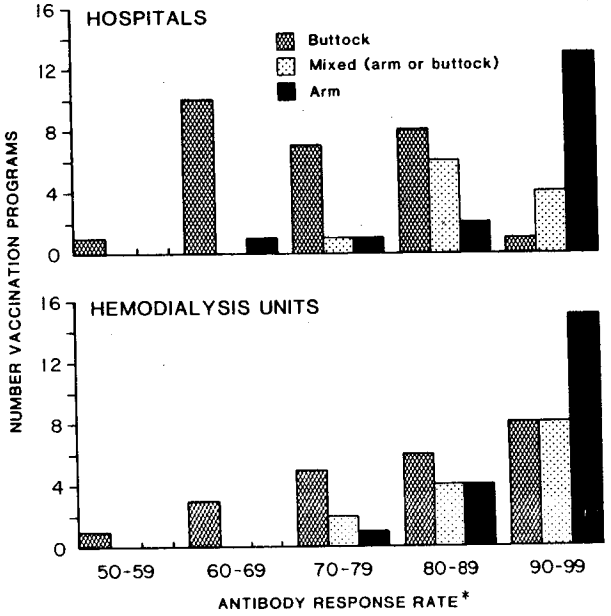
| Group | Injection site | Reported seroconversion rate: No. tested | Reported seroconversion rate: % with antibody | p value* |
|---|---|---|---|---|
| Suboptimal response† | Arm | 1,780 | 88 | < 0.01 |
| | Mixed | 764 | 85 | |
| | Buttock | 4,786 | 73 | |
| Normal response§ | Arm | 2,058 | 96 | < 0.05 |
| | Mixed | 307 | 94 | |
| | Buttock | 81 | 90 | |

*Arm, compared with buttock.
†Ninety-three institutions.
§Twelve institutions.

*Detectable by commercial radioimmunoassay or enzyme immunoassay tests.

to HB vaccine is higher when vaccine is given in the arm than in the buttock. Furthermore, they appear to provide an explanation for poor rates of response to HB vaccine reported in some vaccine programs. These data are the first to indicate that response to any inactivated vaccine given intramuscularly to adults may vary with injection site. The Immunization Practices Advisory Committee (ACIP) has previously recommended that the arm is the preferred site of injection for all adult vaccines (*7*). However, the present studies demonstrate that the buttock is a commonly used site for HB vaccination. Because of the important implications for use of HB vaccine and other killed vaccines, a prospective study has been initiated to confirm these data.

**FIGURE 1. Response rates to hepatitis B vaccine in hospitals and hemodialysis units, by injection site — Merck, Sharp & Dohme and CDC studies, December 1984 and January 1985**




*Percentage of vaccinated persons in each program who developed antibody after vaccination. Antibody was detected by commercial radioimmunoassay or enzyme immunoassay tests.

**TABLE 2. Response to hepatitis B vaccine in hemodialysis staff, by injection site — CDC study, January 1985**

| Injection site | No. centers | Average response (%) Mean | S.D. | Total seroconversion rate in vaccinees No. vaccinated | % with antibody |
|---|---|---|---|---|---|
| Arm | 20 | 93.0 | ± 7.3 | 733 | 93.9 |
| Mixed | 14 | 89.1 | ± 8.7 | 478 | 91.2 |
| Buttock | 23 | 81.9 | ± 12.1 | 664 | 81.0 |
| Buttock, compared with arm | | $p < 0.01$ | | $p < 0.001$ | |
| Mixed, compared with arm | | NS | | NS | |

The physiologic reasons for lower response rate to vaccine injections in the buttock are yet to be defined. The most likely explanation is that injections given in the buttock frequently fail to reach muscle and are instead deposited in fat where the vaccine may not be well mobilized. The authors of a recent study using CAT scans to assess gluteal fat thickness estimated that, when adults are given injections in the buttock using a 3.5-cm (1-3/8-inch) needle, 85% of injections in men and 95% of those in women are deposited in fat rather than muscle (*8*). An earlier study showed that lidocaine is mobilized more slowly when injected in the buttock than when given in the arm (*9*).

Pending further data, the ACIP and CDC recommend that the arm be used as the site of HB vaccine administration in all adults. For hemodialysis patients, who do not respond as well to vaccine as immunocompetent individuals, vaccine should be given in the arm unless this will jeopardize shunt access. For infants born to HBV-carrier mothers, the preferred site for HB vaccination remains the anterolateral thigh.

*References*


1. Krugman S, Holley HP Jr, Davidson M, Simberkoff MS, Matsaniotis N. Immunogenic effect of inactivated hepatitis B vaccine: comparison of 20 microgram and 40 microgram doses. J Med Virol 1981;8:119-21.
2. Szmuness W, Stevens CE, Harley EJ, et al. Hepatitis B vaccine: demonstration of efficacy in a controlled clinical trial in a high-risk population in the United States. N Engl J Med 1980;303:833-41.
3. Francis DP, Hadler SC, Thompson SE, et al. The prevention of hepatitis B with vaccine. Report of the Centers for Disease Control multi-center efficacy trial among homosexual men. Ann Intern Med 1982;97:362-6.
4. McLean AA, Shaw R Jr. Hepatitis B vaccine [Letter]. Ann Intern Med 1982;97:451.
5. Strickler AC, Kibsey PC, Vellend H. Seroconversion rates with hepatitis B vaccine [Letter]. Ann Intern Med 1984;101:564.
6. Schaaff DM, Lender M, Snedeker P, Graham LA. Hepatitis B vaccine in a hospital. Ann Intern Med 1984;101:720-1.
7. CDC. General recommendations on immunization. MMWR 1983;32:1-16.
8. Cockshott WP, Thompson GT, Howlett LJ, Seeley ET. Intramuscular or intralipomatous injections? N Engl J Med 1982;307:356-8.
9. Cohen LS, Rosenthal JE, Horner DW Jr, et al. Plasma levels of lidocaine after intramuscular administration. Am J Cardiol 1972;29:520-3.


## NCGSTDS SETS ANNUAL MEETING DURING NATIONAL L/G HEALTH CONFERENCE IN DC

The NCGSTDS has established the 7th National Lesbian/Gay Health Conference and 4th National AIDS Forum as the place for its 7th Annual Meeting. Conference organizers are planning to set aside two separate times for organizations to host meetings sometime during the four day Conference, June 28-July 1 at Washington, DC's George Washington University Marvin Center. Please submit adgenda items to Mark Behar, Chairperson, NCGSTDS, PO Box 239, Milwaukee, WI 53201. A more detailed announcement will be published in the May/June Newsletter, scheduled for mailing in mid-June. Plan to share information about your STD/AIDS Service!

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT



*Epidemiologic Notes and Reports*

## Pseudo-outbreak of Intestinal Amebiasis — California

In October 1983, the Los Angeles County (California) Department of Health Services was notified by a local medical laboratory of a large increase in the laboratory's diagnoses of intestinal amebiasis (*Entamoeba histolytica* infection). Thirty-eight cases were identified from August to October. The laboratory staff estimated that, before August, they had diagnosed approximately one *E. histolytica* infection per month.

A preliminary investigation failed to identify a common source of the infection. There had been no increase in the number of specimens examined, and although the laboratory served several health facilities, there was no clustering of cases in particular facilities. Finally, most patients did not belong to groups recognized to be at high risk for acquiring amebiasis (such as male homosexuals, tourists to or immigrants from developing countries, or institutionalized persons). The most common complaint of patients was gastrointestinal symptoms, and most improved after treatment with metronidazole. A review of amebiasis diagnoses from other laboratories in Los Angeles County did not reveal other instances of increased reporting.

To evaluate the accuracy of *E. histolytica* diagnoses, 71 slides from the 38 patients were reexamined by the University of California at Los Angeles Clinical Laboratory or the California Department of Health Services' Public Health Laboratory. Only four slides from two (5.3%) patients were found to contain *E. histolytica*. Of specimens from the 36 patients found not to have *E. histolytica*, 34 contained polymorphonuclear neutrophils and/or macrophages, and two contained nonpathogenic protozoa.

The laboratory reporting the increase follows approved procedures for the collection and examination of stools for protozoa. Permanent slides are prepared from fecal material preserved in polyvinyl alcohol and stained by the Gomori-trichrome method (*1*). One technician was responsible for reading parasitology slides and had performed that job for the preceding 4 years. The technician's supervisor reviewed all positive slides. The only change in procedure that had been recently introduced was the assignment of a different person to the preparation of the initial smears. This person prepared slides that were "less dense," and the slides were "easier to read."

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**Editorial Note:** This pseudo-outbreak of intestinal amebiasis serves as a reminder that identification of *E. histolytica* is difficult. Although *E. histolytica* can be confused with other intestinal protozoa, a more common problem is that leukocytes or macrophages in stool specimens are identified as *E. histolytica* (*2*). In 1981, the College of American Pathologists (CAP) conducted a proficiency survey using a stool specimen, which contained many leukocytes, from a patient with inflammatory bowel disease (*3*). None of 15 referee laboratories but 100 (16.7%) of 599 participating laboratories reported one or more intestinal protozoa, most commonly *E. histolytica*. Similarly, as shown in a report of seven suspected outbreaks of amebiasis in the United States between 1971 and 1974, three laboratories might have mistakenly diagnosed amebiasis in as many as 1,200 patients a year for 20 years (*2*).

A summary of proficiency surveys for parasites conducted by the CAP from 1973 to 1977 showed that *E. histolytica* infections are also often overlooked (*4*). Twenty-seven percent of participating laboratories overlooked trophozoites, and 37% overlooked cysts of *E. histolytica* in stool specimens.

Results of CDC's Proficiency Testing Program in Parasitology closely paralleled those reported by the CAP. In 1982, CDC conducted a parasitology proficiency testing survey using a stool specimen that contained no parasites and numerous leukocytes. None of the 17 reference or referee laboratories reported the presence of intestinal parasites; however, 74 (14.0%) of the 528 participant laboratories incorrectly reported one or more intestinal parasites, most commonly *E. histolytica* cysts. A summary of CDC proficiency testing surveys in parasitology from 1973-1977 also demonstrated that *E. histolytica* is often overlooked. Twenty-nine percent of participating laboratories overlooked *E. histolytica* trophozites, and 33% overlooked *E. histolytica* cysts in stool specimens .

To avoid errors when attempting to diagnose parasitic diseases, physicians should identify laboratories in their areas whose staffs are experienced in diagnostic parasitology and who participate in and score well on proficiency testing for parasitic diseases.

*References*

1. Garcia LS, Ash LR. Diagnostic parasitology clinical laboratory manual. St. Louis, Missouri: CV Mosby, 1975:16-7.
2. Krogstad DJ, Spencer HC Jr, Healy GR, Gleason NN, Sexton DJ, Herron CA. Amebiasis: epidemiologic studies in the United States, 1971-1974. Ann Intern Med 1978;88:89-97.
3. College of American Pathologists. Special parasitology survey (critique specimen P-12), 1981.
4. Smith JW. Identification of fecal parasites in the special parasitology survey of the College of American Pathologists. Am J Clin Pathol 1979;72:371-3.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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*International Notes*

## Update: Acquired Immunodeficiency Syndrome — Europe

As of December 31, 1984, 762 cases of acquired immunodeficiency syndrome (AIDS) have been reported to the World Health Organization (WHO) Collaborating Centre on AIDS. During 1984, 417 cases were diagnosed—over half those reported since the disease was first reported and nearly twice the number reported in 1983 (235 cases). The number reported during the last quarter should be considered provisional because of the time lapse between date of diagnosis and notification to the national surveillance centers (Table 1).

For the last 6 months, the greatest increases in the number of cases were observed in France—80 cases (three per week); Federal Republic of Germany—56 cases (two/week); United Kingdom—54 cases (two/week); Netherlands—21 cases (one/week); and Switzerland—13 cases (one/2 weeks).

The 15 countries collaborating with the Centre for the last report (*1*) have reported 125 new cases, an increase of 11 cases per week.

Two countries, Austria and Belgium, have just joined the Centre. Austria had reported seven cases at the first European Meeting on AIDS held in Aarhus, Denmark, in October 1983 and now reports 13 cases (six additional cases); Belgium, which had reported 38 cases, now reports 65 cases (27 additional cases).

The highest rates of AIDS cases per million population (1983 populations, Institut National D'Etudes Démographics [INED], Paris) were observed in Belgium and Denmark (7/million). However, 83% of the Belgian patients (54/65) were Africans, of whom only 18 lived in Belgium before the onset of the first symptoms, in contrast with Denmark, where no African or Caribbean patients have been registered. The rate in Switzerland was six per million; France—five per million; Netherlands—three per million; Federal Republic of Germany and United Kingdom—two per million.

Among the 762 AIDS patients, 376 deaths were reported, for a case-fatality rate of 49% (Table 2). Sixty-one percent of the patients diagnosed 1 year ago and 83% diagnosed 3 years ago have died. Sixty-four percent (484/762) of the patients presented with one or more opportunistic infections; 20% (151/762) had Kaposi's sarcoma (KS) alone; 16% (121/762) opportunistic infection with KS. The category "Other" includes three cases of progressive multifocal leukoencephalitis (France—two; Denmark—one) and three cases of cerebral lymphoma alone (one each in Federal Republic of Germany, Switzerland, and the United Kingdom). The case-fatality rate was 67% in the category "Other"; 60% for opportunistic infection with KS; 55% for opportunistic infection alone; and 24% for KS alone (Table 2).

Ninety-two percent of the patients were men (Table 3). The sex ratio was 11.7, compared with 15.3 at the last report and can be explained by 20 new cases among women diagnosed in Belgium. Forty-six percent of the patients belonged to the 30- to 39-year age group. The

**TABLE 1. Reported acquired immunodeficiency syndrome cases and estimated rates per million population — 17 European countries***

| Country | Oct. 1983† | July 1984 | Oct. 1984 | Dec. 1984 | Rates§ |
|---|---|---|---|---|---|
| Austria | 7 | 0 | 0 | 13 | 1.7 |
| Belgium | 38 | 0 | 0 | 65 | 6.6 |
| Czechoslovakia | 0 | 0 | 0 | 0 | 0.0 |
| Denmark | 13 | 28 | 31 | 34 | 6.6 |
| Finland | 0 | 0 | 4 | 5 | 1.0 |
| France | 94 | 180 | 221 | 260 | 4.8 |
| Federal Republic of Germany | 42 | 79 | 110 | 135 | 2.2 |
| Greece | 0 | 2 | 2 | 6 | 0.6 |
| Iceland | 0 | 0 | 0 | 0 | 0.0 |
| Italy | 3 | 8 | 10 | 14 | 0.3 |
| Netherlands | 12 | 21 | 26 | 42 | 2.9 |
| Norway | 0 | 0 | 4 | 5 | 1.2 |
| Poland | 0 | 0 | 0 | 0 | 0.0 |
| Spain | 6 | 14 | 18 | 18 | 0.5 |
| Sweden | 4 | 7 | 12 | 16 | 1.9 |
| Switzerland | 17 | 28 | 33 | 41 | 6.3 |
| United Kingdom | 24 | 54 | 88 | 108 | 1.9 |
| **Total** | **260** | **421** | **559** | **762** | **2.0** |

*Austria, Belgium, Czechoslovakia, Denmark, Finland, France, Federal Republic of Germany, Greece, Iceland, Italy, Netherlands, Norway, Poland, Spain, Sweden, Switzerland, and United Kingdom.

†These data were reported at the 1st European Meeting on AIDS held in Aarhus, Denmark, October 1983.

§Based on 1983 populations, INED, Paris.

**TABLE 2. Acquired immunodeficiency syndrome cases and number of deaths, by disease category — 17 European countries, through December 31, 1984**

| Disease category | Cases (%) | Deaths (%) |
|---|---|---|
| Opportunistic infection | 484 (64) | 264 (55) |
| Kaposi's sarcoma | 151 (20) | 36 (24) |
| Opportunistic infection and Kaposi's sarcoma | 121 (16) | 72 (60) |
| Others | 6 (*A* 1) | 4 (67) |
| Unknown | 0 (0) | 0 (0) |
| **Total** | **762 (100)** | **376 (49)** |

**TABLE 3. Acquired immunodeficiency syndrome cases, by age group and sex — 17 European countries, through December 31, 1984**

| Age group | Males | Females | Total No. (%) |
|---|---|---|---|
| 0-11 months | 4 | 1 | 5 (< 1) |
| 1-4 years | 0 | 0 | 0 (0) |
| 5-9 years | 0 | 0 | 0 (0) |
| 10-14 years | 2 | 0 | 2 (< 1) |
| 15-19 years | 4 | 0 | 4 (< 1) |
| 20-29 years | 106 | 31 | 137 (18) |
| 30-39 years | 335 | 18 | 353 (46) |
| 40-49 years | 188 | 8 | 196 (26) |
| 50-59 years | 45 | 2 | 47 (6) |
| ≥ 60 years | 7 | 0 | 7 (< 1) |
| Unknown | 11 | 0 | 11 (1) |
| **Total*** | **702** | **60** | **762 (100)** |

0- to 1-year age group comprised: one boy from Burundi and one from Zaire diagnosed in Belgium; one French girl with a Zairian father, one Haitian boy, and one Zairian boy diagnosed in France. Two children with hemophilia in the 10- to 14-year age group were diagnosed in France. The 15- to 19-year age group comprised: two hemophilia patients (one each in Austria and Spain); one homosexual (France); and one unspecified case (Federal Republic of Germany).

Cases were geographically distributed as follows (Table 4):

**European***: 605 cases (79% of total). Five hundred seventy-eight patients lived in Europe before the onset of the first symptoms of AIDS, and 27 (4%) of the 605 patients lived outside Europe (United States—six; Zaire—four; Haiti—three; and one each in Togo, Gabon, Nicaragua, Venezuela, Ghana, South Africa, Burundi, and Bermuda). For six patients, the country of residence was not specified.

**Caribbean**: 24 cases (3%). Twenty-two patients lived in Europe before the onset of the first symptoms: 18 Haitians diagnosed in France and one in Belgium; one Dominican and one Jamaican lived in the United Kingdom; one of unspecified origin lived in Switzerland. Two other Haitian patients diagnosed in France lived in Haiti.

**African**: 111 cases (15%). In the previous report, 8% of the patients were Africans; the increase is due to the participation of Belgium. These cases were diagnosed in seven European countries and originated from 18 African countries. Sixty-seven percent were from Zaire, and 11%, from the Congo. Among the 16 other countries, the number of cases diagnosed in Europe varied from one to three. This distribution cannot be considered representative of the AIDS situation in Africa. The majority (52%) of these patients lived in Europe before the onset of the first symptoms.

*The word European refers to the patients originating from one of the 32 countries belonging to the WHO European region.

**TABLE 4. Acquired immunodeficiency syndrome cases, by patient risk group and geographic origin — 17 European countries, through December 31, 1984**

| Patient risk groups | Nationality | | | | |
|---|---|---|---|---|---|
| | European | Caribbean | African | Others | Total |
| 1. Male homosexual or bisexual | 514 | 2 | 5 | 16 | **537** |
| 2. Intravenous-drug abuser | 11 | 0 | 0 | 0 | **11** |
| 3. Hemophilia patient | 20 | 0 | 0 | 0 | **20** |
| 4. Transfusion recipient (without other risk factors) | 4 | 0 | 4 | 0 | **8** |
| 5. 1- and 2-associated | 9 | 0 | 0 | 2 | **11** |
| 6. No known risk factor | | | | | |
| male | 29 | 17 | 64 | 2 | **112** |
| female | 15 | 4 | 29 | 0 | **48** |
| 7. Unknown | 3 | 1 | 9 | 2 | **15** |
| **Total** | **605** | **24** | **111** | **22** | **762** |

**Other origins**: 22 cases (3%). Most of these patients originated from the American continent: United States—16; and one each in Nicaragua, Argentina, Peru, and Canada. One patient originated from Pakistan, and one, from Australia. Thirteen of these patients did not live in Europe before the onset of the first symptoms.

Among the Europeans: 85% (514/605) were homosexual or bisexual (Table 4); 2% (11/605) were drug abusers; and 1% (9/605), both homosexual and drug abusers. The latter 20 cases were diagnosed in the Federal Republic of Germany—nine; Spain—three; France—three; Austria—two; Italy—two; Switzerland—one.

Three percent (20/605) were hemophilia patients. For four of the 605 European patients, the only risk factor found was blood transfusion. For 7% (44/605), no risk factor was found. The information was not obtained for three patients.

Among the Caribbean patients, two of 24 were homosexual; 21 presented no risk factors; for one, the information was not obtained.

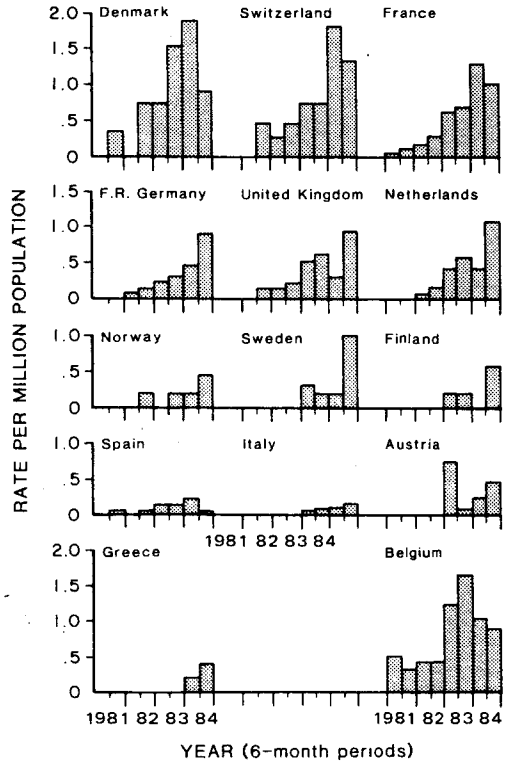
The overall presentation of the progress of the AIDS situation in Europe does not take into account the important differences between the countries. Furthermore, the total increase in the number of cases in each country is only of informative value if it is related to the total

population of the country. Figure 1 shows the variation in the rates per million population per half year for each country where cases have been diagnosed. This figure is difficult to interpret given the qualitative differences in the national surveillance systems. Nevertheless, three situations stand out: for six countries (Denmark, France, Netherlands, Federal Republic of Germany, Switzerland, United Kingdom) the general trend of these rates show a constant increase (the data of the second half of 1984 should be considered provisional).

The situation in Belgium is different; stable in 1981 and 1982, it showed an increase in 1983 and a decrease in 1984. This is explained by the arrival of African patients, mainly from Zaire, for treatment in 1983. In 1984, facilities were set up in Zaire for these patients, hence the decrease in the number of cases in Belgium for that year. Of the 65 cases reported, only seven originated from Belgium. For the third group of countries (Austria, Finland, Greece, Italy, Norway, Spain, and Sweden), the half-year trends do not clearly indicate an increase. If the African cases were excluded, Belgium would come into this group.

**Editorial Note:** As of December 31, 1984, 17 countries were taking part in the surveillance of AIDS in Europe by reporting their respective data to the Centre. Since the last report (October 15, 1984) (*1*), two more countries, Austria and Belgium, have provided data. The Centre used the CDC case definition. One source per country, recognized by the respective national health authorities, provides the information, and each source is responsible for the quality of the data provided.

**FIGURE 1. Incidence rates of acquired immunodeficiency syndrome, by 6-month period of diagnosis — 14 European countries, through December 31, 1984***




*Denmark, Switzerland, France, Federal Republic of Germany, and United Kingdom had cases reported before 1981, which are not included.

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*Reference*

1. CDC. Update: acquired immunodeficiency syndrome—Europe. MMWR 1985;34:21-2, 28-31.

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## SPECIAL REPORT

### THE AIDS EPIDEMIC

During 1984 several important developments advanced our understanding of the acquired immunodeficiency syndrome (AIDS). A retrovirus known as human T-cell leukemia (lymphotropic) virus type III (HTLV-III),[1] also called lymphadenopathy-associated virus, was identified as the probable cause of AIDS.[2] AIDS-associated retrovirus[3] is also probably the same agent. An enzyme-linked immunosorbent assay (ELISA) has been developed to detect antibodies to HTLV-III,[4] thereby providing an indicator of whether or not a person has been exposed to the virus. Clinical researchers have identified various therapeutic agents that appear to inhibit viral replication in vitro.[5,6] Although the ultimate goal of all these research activities is a better understanding of the pathogenesis of diseases related to HTLV-III and the development of definitive preventive and therapeutic measures, no therapeutic intervention has permanently reversed the HTLV-III–associated immunodeficiency, nor has the full meaning of HTLV-III seropositivity been elucidated. In spite of the extraordinarily rapid scientific progress to date, AIDS remains an epidemic disease whose natural history and cure are unknown.

Seroepidemiologic information gathered in recent months indicates that the extent of HTLV-III infection is more serious and complex than was originally anticipated. We review here the magnitude of HTLV-III exposure, the outcome of such exposure, the economic burden of HTLV-III–related disease, and the social, ethical, and public implications of this epidemic for the future.

#### HTLV-III Seropositivity — Extent of Exposure

The ELISA serum antibody test for HTLV-III is useful for screening purposes and in epidemiologic AIDS research.[7] When it is used for diagnostic purposes, an additional confirmatory test is recommended to rule out false positive results.[7-9] A confirmed positive test indicates that a person has been exposed to the virus and has mounted an immunologic response (serum antibodies). However, this test does not indicate whether the person currently harbors the virus (i.e., is an HTLV-III carrier), although HTLV-III has been isolated from antibody-positive subjects.[1] Furthermore, additional studies are required to demonstrate that there are not antibodies to other viruses that cross-react in the test. In this issue of the *Journal*, Evatt et al. present data indicating that there had been extensive exposure to HTLV-III among patients with hemophilia by 1981-1982. They also found that by 1984 virtually all the hemophiliac patients they studied were antibody positive.[10] Similar studies by Goedert et al.,[11] Melbye et al.,[12] and Eyster et al.[13] also document the recent and nearly total HTLV-III seroconversion of patients with hemophilia — a process linked to the use of factor VIII concentrates prepared in the United States.

Seroepidemiologic studies have been conducted among other high-risk populations. In San Francisco, the prevalence of HTLV-III antibodies among homosexual men attending a clinic for the treatment of sexually transmitted diseases rose from 1 per cent in 1978 to 25 per cent in 1980 and to 65 per cent in 1984.[14] Homosexual communities in nonepidemic cities are also experiencing rising rates of HTLV-III seropositivity. For example, seropositivity for lymphadenopathy-associated virus rose from less than 10 per cent in 1978 to 49 per cent in 1984 among unselected homosexual men attending a clinic for sexually transmitted diseases in Denver (Judson F, et al.: unpublished data). In a prospective cohort of homosexual men from Pittsburgh, HTLV-III antibody seropositivity rose from 10 per cent in 1983 to 28 per cent in 1984 (Rinaldo C: personal communication).

An analogous situation exists among users of parenteral drugs. In Queens, New York, 29 per cent of parenteral-drug users admitted to a methadone detoxification treatment program in 1981-1982 were positive for HTLV-III antibodies (Robert-Guroff M: personal communication), and 87 per cent of the patients admitted to a Manhattan methadone detoxification program were antibody positive in 1984.[14] Fifty per cent of parenteral-drug users in Newark and Jersey City, New Jersey, who were in drug-treatment programs were positive for antibodies to HTLV-III in 1984 (Weiss SH, et al.: unpublished data).

The difference between the high rates of HTLV-III seropositivity noted in some major urban coastal cities over the past several years (based on ELISA testing of previously stored samples) and the lower seropositivity rates in inland cities and suburban areas is narrowing as the virus continues to spread. Similarly, HTLV-III–related disease is being reported more frequently from less densely populated regions of this country.

Surprisingly, the rate of HTLV-III seropositivity among Haitian immigrants was found to be less than 5 per cent in a survey conducted in New York City.[15] This relatively low seroprevalence rate is in marked contrast to the rates observed among asymptomatic patients with hemophilia and among homosexual men and parenteral-drug users in the New York City area.[7] From these data, it does not appear that being of Haitian extraction by itself, in isolation from other risk factors, increases the relative risk of being exposed to HTLV-III.

Seropositivity is extremely low among heterosexual men and women who are not members of known high-risk groups.[4,7] This does not mean, however, that heterosexual people are not at risk for AIDS. AIDS is a sexually transmissible disease, and thus any sexual partner of a person exposed to the virus may contract the virus. The extent of intimate sexual contact needed to transmit the virus from one partner to another is unknown. Sexual contact with prostitutes previously exposed to the virus may explain some of the cases currently classified by the Centers for Disease Control as being in the "no known risk" category.[16] A link between prostitutes who use nonparenteral drugs and HTLV-III seropositivity is also suggested from studies in Africa and Haiti. In the United States, approximately one third of all women entering treatment for narcotic addiction have at some time engaged in prostitution to earn money to buy drugs.[17] Therefore, the HTLV-III seroprevalence rate may be high among prostitutes, with obvious potential risk for their clients as well.

At present it is impossible to give an accurate figure for the total number of persons in this country who are positive for HTLV-III antibodies. On the basis of the above data, however, one can estimate the total to be at least 400,000 persons. The potential pool of people at increased risk of exposure to the virus is larger. The population of parenteral-drug users is approximately 400,000.[18] In addition, more than a million people may occasionally use parenteral drugs (cocaine and heroin).[18] If one uses Kinsey's historical estimate that 10 per cent of the adult male population are homosexual,[19,20] then on the basis of the estimate of 159 million persons in the United States aged 18 and older,[21] there are approximately 8 million homosexual men in the United States. Given what is already known about the high and rising seroprevalence of HTLV-III in known risk groups and the potential for spread to other populations, the implications of the presence of this virus in a community are staggering.

Although seroconversion has been documented in both human beings and chimpanzees between two and eight weeks after inoculation with material from persons positive for HTLV-III or from patients with AIDS,[22,23] detectable antibodies have not developed in some asymptomatic, immunologically normal persons infected with HTLV-III virus for more than six months.[9,24] These virus-positive, antibody-negative persons may represent the earliest stage of HTLV-III infection, with active viral replication and very little or no antibody response — possibly a stage of antigen excess. The unknown number of such serologically negative but virologically positive persons further complicates the AIDS picture.

#### Outcome in Persons Positive for HTLV-III Antibody

The complete clinical spectrum of HTLV-III–related disease is unknown.[7,25] There are numerous prospective, retrospective, and cross-sectional studies that are attempting to provide sufficient information about the viral infection and its sequelae. These studies will assist clinicians in developing therapeutic interventions and public health officials in developing primary prevention programs.

Information from some of these studies is sobering. In each of six different studies, the proportion of HTLV-III seropositive persons in whom full-blown AIDS developed during follow-up periods of one to five years ranged from 4 to 19 per cent[9,13,26,27] (and Marmor M: personal communication; Weiss SH, et al.: unpublished data). In several of these studies nonspecific symptoms suggesting early stages of AIDS-related illnesses have developed in up to an additional 25 per cent of those exposed to the virus. These symptoms have included weight loss, chronic unexplained fever or diarrhea, oral candidiasis, generalized lymphadenopathy, and thrombocytopenia. We do not know the proportion of these persons who will subsequently have full-blown AIDS.

An emerging concern about those being exposed to HTLV-III is that they may eventually acquire lymphomas,[25] such as Burkitt's-like lymphomas.[28] Both Hodgkin's and non-Hodgkin's lymphomas may also be associated with AIDS.[29-31] Iatrogenic and congenital immunodeficiency syndromes are associated with an excess of lymphoid-type malignant conditions,[32] such as the non-Hodgkin's lymphomas that develop at an increased rate among recipients of renal allografts after several years of immunosuppressive therapy.[33] HTLV-III is associated with chronic immunosuppression. It has been reported to share properties of both known leukemia-associated retroviruses and slow viruses (lentiviruses).[34] Both slow viruses and HTLV-III have been associated with neurologic disorders.[35] Therefore, it is not unreasonable to anticipate an increase during the next two decades in the number of lymphomas and perhaps other long-term sequelae among persons currently exposed to HTLV-III.

The Centers for Disease Control currently estimates that 8000 new cases of AIDS will be reported for the 12-month period ending in October 1985 (Curran JW: unpublished data). Because the epidemic has not yet peaked, the total number of cases for all of 1985 will exceed 8000. Quinn,[36] using data from the work of Hardy et al.,[20] recently estimated that there will be 40,000 new cases of AIDS in the next two years. AIDS is not on the wane.

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### Economic Considerations

An epidemic of this magnitude severely stresses the health care system in terms of its financial cost, use of resources, and effect on medical and support personnel. A recent study of hospitalized patients with AIDS indicates that they have an average life span of 224 days after being hospitalized for their first opportunistic infection (Bienstock J: personal communication). The average direct lifetime hospital cost for the care of such patients is calculated to be $42,000. If there are at least 8000 new cases of AIDS in 1985, then the estimated cost of inpatient care for patients with newly diagnosed disease will be approximately $336 million. This is an underestimate of the total medical care costs, since it does not include the costs of outpatient care or medication. It also fails to consider the other elements of social cost, such as lost employment, reduced productivity, shortened life expectancy, and social-welfare services. In this country there are approximately 12 million units of blood products collected each year.[37] The cost of the ELISA antibody test and associated expenses for the replacement of suspect blood products, notification of donors, and counseling of donors when necessary would add approximately another $100 million per year.[37] Therefore, it is not unreasonable to estimate that AIDS will cost our society more than half a billion dollars during the next calendar year.

The less tangible costs of the AIDS epidemic can be viewed on any ward providing medical care to patients with the disease. The psychological strain on the patients, their friends and relatives, and the medical and nursing staff is great. For several decades, medical practitioners have not had to face an epidemic of a fatal infectious disease among previously healthy persons.

### Implications of HTLV-III Antibody Testing

The anticipated widespread introduction of tests for HTLV-III antibodies in the near future has sparked controversy among certain segments of the population. The current major clinical application of the HTLV-III antibody ELISA is to screen blood products, thereby helping to minimize the risk of transfusion-associated AIDS. However, it is clear that the ELISA and its confirmatory tests will be used for other clinical and diagnostic applications. All the uses of this test pose complex legal, medical, social, and ethical issues. False positive and false negative results are to be expected, as with all screening tests.[7] The adverse consequences of a false positive test are obvious. Those of a false negative test, especially when the test is being used to screen donated blood products, are clear as well. The successful implementation of these tests in the setting of the blood-collection agency is contingent on the continuation of self-exclusion guidelines. Donors who are members of high-risk groups or at potential risk of HTLV-III exposure (e.g., sexual contacts of risk-group members) must not donate. If self-exclusion is not continued, it is possible that contaminated blood products could slip through the screening net and lead to an increased risk of transfusion-associated AIDS.

Persons who are tested by blood-collection agencies for the presence of antibodies to HTLV-III will be notified of the results of the test.[9] How intrusive may blood-collection agencies be in attempting to notify people of the results of their tests? Issues like this surrounding the use of the test are being addressed by a number of governmental and private panels; guidelines will be forthcoming when the new test is approved by the Food and Drug Administration.

The implications of a true positive HTLV-III test for an apparently healthy person are evident. It is possible that in the future health and life insurance could be denied or employment could be terminated. States may require compulsory reporting of HTLV-III–positive results to their health departments for surveillance purposes. States may require HTLV-III testing before issuing a marriage license. Some people may consider a positive result as presumptive evidence that a never-married man 30 years of age or older is homosexual or that a minority person from the inner city is a narcotics addict.

### Social, Ethical, and Public Health Considerations

The complexities associated with AIDS transcend the medical diagnosis and treatment of the disease. The great social and economic burden associated with AIDS and the more subtle personal effects of a positive ELISA test create a multitude of difficulties that cannot be resolved in isolation or piecemeal.

Adequate financial resources for research dealing with this catastrophic and ultimately fatal illness must continue. Resources for the treatment of patients with full-blown AIDS and other HTLV-III–related diseases are also necessary, as are companion funds for needed social services for the patients, their friends, and service providers. The health dollars currently allocated to treat HTLV-III–related illnesses are at the expense of other health programs. Given the finite resources of our economy, any decisions either to commit new resources or to reallocate existing ones must be made consciously, and the consequences acknowledged. Private and public funding sources will be needed. The feasibility of creating a national catastrophic fund for HTLV-III–related disease, modeled after the end-stage-renal-disease program, needs to be considered.

Hospitals in cities with large numbers of patients with AIDS have either already established AIDS wards or are considering doing so. There are ample historical precedents for the development of disease-specific wards (wards for fever, diabetes, tuberculosis, and poliomyelitis have all existed in the past). Current medical practice has permitted the establishment of oncology wards. Such an approach may enhance patient care by permitting better coordination of inpatient services, improving follow-up of patients, and allowing the more efficient use of social services. Because the medical and nursing staffs of these wards are likely to be knowledgeable about the medical, social, and emotional aspects of the disease, they will become a major educational and emotional resource for patients and their families. Supportive services for the health care providers will also be easier to maintain. AIDS wards will also facilitate clinical trials of new chemotherapeutic agents and diagnostic techniques.

However, the establishment of AIDS wards could provoke controversy. Members of high-risk groups may fear the stigma associated with their overrepresentation on such wards. Nonetheless, the practicality and efficiency of such specialized wards or hospitals may justify their existence.

The licensing of the HTLV-III antibody test is imminent. There are conflicting and legitimate interests surrounding HTLV-III testing that must be addressed at this time. It is not enough to say that neither medical management nor public health policies can rationally be based on seropositivity.[37] Confidentiality is a central issue in HTLV-III testing; many persons and organizations may want or demand to see certain people's test results. Access to this private medical information will vary with the circumstances under which the test is performed. The person being tested should be aware of who may have access to the results. Therefore, the general use of an informed-consent procedure before the HTLV-III test is performed by either clinicians or blood-collection agencies should be considered. Such a consent form would place the patient on notice about what would happen to the assay results and how he or she could obtain the results, with adequate explanation.

As outlined above, current seroprevalence and seroconversion estimates indicate that large numbers of persons are or will become infected with HTLV-III; tens of thousands will contract AIDS and subsequently die.[36] The need for a nationally coordinated health program managed by the states and the cities and towns has been recognized. The initial steps have been taken in this cooperative effort to minimize morbidity and mortality from AIDS and to address the related social and economic burdens. However, it is important to recognize that as far as we have come in understanding HTLV-III exposure and related diseases this year, there needs to be a continued commitment of resources, because we have a great deal more to learn and to do.

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### References

1. Gallo RC, Salahuddin SZ, Popovic M, et al. Frequent detection and isolation of cytopathic retroviruses (HTLV-III) from patients with AIDS and at risk for AIDS. Science 1984; 224:500-3.
2. Barré-Sinoussi F, Chermann JC, Rey F, et al. Isolation of a T-lymphotropic retrovirus from a patient at risk for acquired immune deficiency syndrome (AIDS). Science 1983; 220:868-71.
3. Levy JA, Hoffman AD, Kramer SM, Landis JA, Shimabukuro JM, Oshiro LS. Isolation of lymphocytopathic retroviruses from San Francisco patients with AIDS. Science 1983; 255:840-2.
4. Sarngadharan MG, Popovic M, Bruch L, Schüpbach J, Gallo RC. Antibodies reactive with human T-lymphotropic retroviruses (HTLV-III) in the serum of patients with AIDS. Science 1984; 224:506-8.
5. Mitsuya H, Popovic M, Yarchoan R, et al. Suramin protection of T-cells in vitro against infectivity and cytopathic effect of HTLV-III. Science 1984; 226:172-4.
6. McCormick JB, Getchell J, Mitchell S, Hicks DR. Ribavirin suppresses replication of lymphadenopathy associated virus in cultures of human adult T-lymphocytes. Lancet 1984; 2:1367-9.
7. Weiss SH, Goedert JJ, Sarngadharan MG, et al. Screening test for HTLV-III (AIDS agent) antibodies: specificity, sensitivity, and applications. JAMA 1985; 253:221-5.
8. Schüpbach J, Haller O, Vogt M, et al. Antibodies to HTLV-III in Swiss patients with AIDS and pre-AIDS and in groups at risk for AIDS. N Engl J Med 1985; 312:265-70.
9. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing AIDS. MMWR 1985; 34:1-5.
10. Evatt BL, Gomperts ED, McDougal JS, Ramsey RB. Coincidental appearance of LAV/HTLV-III antibodies in hemophiliacs and the onset of the AIDS epidemic. N Engl J Med 1985; 312:483-6.
11. Goedert JJ, Eyster ME, Sarngadharan MG, et al. Antibodies reactive with human T-cell leukemia viruses in the serum of hemophiliacs receiving factor VIII concentrate. Blood 1985; 65:492-5.
12. Melbye M, Froebel KS, Madhok R, et al. HTLV-III seropositivity in European hemophiliacs exposed to factor VIII concentrate imported from the USA. Lancet 1984; 2:1444-6.
13. Eyster ME, Goedert JJ, Sarngadharan MG, Weiss SH, Gallo RC, Blattner WA. Development and early natural history of HTLV-III antibodies in persons with hemophilia. JAMA (in press).
14. Antibodies to a retrovirus etiologically associated with acquired immunodeficiency syndrome (AIDS) in populations with increased incidences of the syndrome. MMWR 1984; 33:377-9.
15. Frank E, Weiss SH, Compas JC, et al. AIDS in Haitian-Americans, a reassessment. Cancer Res (in press).
16. Chamberland ME, Castro KG, Haverkos HW, et al. Acquired immunodeficiency syndrome in the United States: an analysis of cases outside high-incidence groups. Ann Intern Med 1984; 101:617-23.
17. Ginzburg HM, Weiss SH, MacDonald MG, Hubbard RL. HTLV-III exposure among drug users. Cancer Res (in press).
18. Ginzburg HM. Intravenous drug users and the acquired immune deficiency syndrome. Public Health Rep 1984; 99:206-11.
19. Kinsey AC, Pomeroy WB, Martin CE. Sexual behavior in the human male. Philadelphia: WB Saunders, 1948.
20. Hardy AM, Allen JR, Morgan WM, Curran JW. The incidence rate of acquired immunodeficiency syndrome in selected populations. JAMA 1985; 253:215-20.
21. United States Bureau of the Census. Population estimates and projections. Current Population Rep. July 1982. (series P-25, No. 917).
22. Gajdusek DC, Amyx HL, Gibbs CJ Jr, et al. Infection of chimpanzees by human T-lymphotropic retroviruses in brain and other tissues from AIDS patients. Lancet 1985; 1:55-6.
23. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984; 2:1376-7.
24. Salahuddin SZ, Groopman JE, Markham PD, et al. HTLV-III in symptom-free seronegative persons. Lancet 1984; 2:1418-20.
25. Goedert J, Blattner W. The epidemiology of the acquired immunodeficiency syndrome. In: DeVita VT, Hellman S, Rosenberg SA, eds. AIDS. Philadelphia: JB Lippincott (in press).
26. Goedert JJ, Sarngadharan MG, Biggar RJ, et al. Determinants of retrovirus (HTLV-III) antibody and immunodeficiency conditions in homosexual men. Lancet 1984; 2:711-6.
27. Melbye M, Biggar RJ, Ebbesen P, et al. Seroepidemiology of HTLV-III antibody in Danish homosexual men: prevalence, transmission, and disease outcome. Br Med J 1984; 289:573-5.
28. Biggar RJ, Horm J, Lubin JH, Goedert JJ, Greene MH, Fraumeni JF Jr. Cancer trends in a population at risk of AIDS. JNCI (in press).
29. Ziegler JL, Beckstead JA, Volberding PA, et al. Non-Hodgkin's lymphoma in 90 homosexual men: relation to generalized lymphadenopathy and the acquired immunodeficiency syndrome. N Engl J Med 1984; 311:565-70.
30. Metroka CE, Cunningham-Rundles S, Pollack MS, et al. Generalized lymphadenopathy in homosexual men. Ann Intern Med 1983; 99:585-91.
31. Schoeppel SL, Hoppe RT, Dorfman RF, et al. Hodgkin's disease in homosexual men with generalized lymphadenopathy. Ann Intern Med 1985; 102:68-70.
32. Blattner WA, Hoover RN. Cancer in the immunosuppressed host. In: DeVita VT, Hellman S, Rosenberg SA, eds. Cancer: principles and practice of oncology. Philadelphia: JB Lippincott (in press).
33. Hanto DW, Frizzara G, Purtilo DT, et al. Clinical spectrum of lymphoproliferative disorders in renal transplant recipients and evidence for the role of Epstein-Barr virus. Cancer Res 1981; 41:4253-61.
34. Gonda MA, Wong-Staal F, Gallo RC, Clements JE, Narayan O, Gilden RV. Sequence homology and morphologic similarity of HTLV-III and visna virus, a pathogenic lentivirus. Science 1985; 227:173-7.
35. Shaw GM, Harper ME, Hahn BH, et al. HTLV-III infection in brains of children and adults with AIDS encephalopathy. Science 1985; 227:177-82.
36. Quinn TC. Perspectives on the future of AIDS. JAMA 1985; 253:247-9.
37. Goldsmith MF. Medical news. JAMA 1985; 253:173-81.