

PERTH GROUP COMMENTARY ON *THE AIDS TRAP*

Presumably *The AIDS Trap* was written to provide a dissident perspective in plain language for anyone contemplating an HIV test. Perhaps a few individuals will take the information and advice offered in this brochure at face value. However, it is more likely most will discuss the content with their doctors. In other words, either overtly or covertly, doctors will be made aware of this document and respond to it when requested by their patients. Others, like the doctors from AIDSTruth.org, may respond even when not requested (although that would appear to contravene their house rules). In this commentary we include responses we believe would be typical of doctors questioned by their patients. The questions to be asked here are: (i) will the brochure help patients in their decision making? (ii) will any of the claims lead people to take actions which are harmful?

Quotations from *The AIDS Trap* and the Press Release are in italics. Our comments follow in normal text.

Note: This commentary, possibly with a small amount of editing, will be posted at the Perth Group website.

Please cite this material as: The Perth Group: Commentary on the Rethinking AIDS Trap brochure. September 2009. www.theperthgroup.com/LATEST/RATPGCommentary.pdf

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Rethinking AIDS Releases New Brochure on AIDS Testing

The press release refers to a “New Brochure on AIDS Testing” yet addresses only “HIV” testing. It does not define what is meant by “AIDS Testing” but presumably this refers to laboratory procedures used to document immune deficiency (AID = low T4 cells) or diagnostic methods for the AIDS indicator diseases. As Brent Leung’s film discloses, many people are confused about the terms “HIV” and “AIDS” and are not always able to distinguish between them. The press release does not alleviate this situation.

SAN FRANCISCO (Rethinking AIDS), May 23, 2009 — *The brochure outlines how tests for HIV (Human Immunodeficiency Virus) or AIDS have no scientific basis and are useless as a diagnostic tool determining who will get AIDS, and describes the dangers of coming up positive on the tests.*

By failing to distinguish between testing for HIV and AIDS diseases the brochure asserts there is no scientific basis for the diagnosis of AIDS indicator diseases. This is incorrect. In regard to the “HIV” tests, (a) there is a scientific basis for serological diagnosis; (b) the RA Board is unaware of or denies the extensive data linking the presence of “HIV antibodies”, whatever their genesis, to an increased probability of developing certain diseases, known as the AIDS indicator diseases. Especially in individuals who comprise the AIDS risk groups. It is scientific nonsense to state the tests “are useless as a diagnostic tool determining who will get AIDS”. Further on the brochure states “They [the antibody tests] test to see if your blood has high levels of the same proteins found at high levels in the blood of most early AIDS patients”. Presumably “high levels of the same proteins” refers to antibodies responsible for a positive ELISA and WB, although it could also refer to hypergammaglobulinaemia, a

typical laboratory feature of HIV positive individuals. Either finding is abnormal and a sign of actual or incipient illness. There are ample data this constitutes one of the “dangers of coming up positive on the tests”.

The Board does not appear to consider the merits of being tested and found to be HIV negative.

This brochure is endorsed by the board of Rethinking AIDS, an association of more than 2,600 doctors, scientists, and other professionals.

The brochure does not divulge its authorship. David Crowe says the only names on the brochure are those of the “editor and illustrator”, implying these two individuals are responsible for its scientific content. But he also says “I am in favour of accepting suggestions for changes to the brochure at any time, and Martin [Barnes] has been very flexible on this point too. Obviously we may decide that non-critical changes are not made immediately or not at all”. In other words, he (?the RA Board) decides the content of this brochure.

In an email to David Crowe, Celia Farber asked “David, I have a short question: I seem to recall the brochure being circulated ages ago, possibly months ago, with invitations to critical feedback. Did that happen or am I remembering it wrong?”

We did not see a reply but in a subsequent email to Torsten Engelbrecht Celia Farber wrote: “Are you certain that PG [the Perth Group] was not given the copy when everybody else received it”. Nobody asked the Perth Group for “critical feedback” in regard to this brochure. Perhaps because, as Celia says, on each subject the Board of RA wants to have the view of the most “pre-eminent experts”. We discovered the brochure only by accident and the only time David Crowe asked for our view was after our last email to him where we said we intend putting a disclaimer to it on our website.

Regardless of who wrote or endorsed it, the inference is that the brochure has the *imprimatur* of “2,600 doctors, scientists and other professionals”. Perhaps the Board did seek the views of some of these individuals but it certainly was not all. It seems most unlikely that “2,600 doctors, scientists and other professionals” would accept the content of this document.

We want you to know a few facts before you take what’s called an HIV test. Facts that doctors, nurses, lab technicians, and clinic staff probably won’t tell you.

Laboratory technicians, non-medical and non-nursing “Clinic staff” do not consult patients.

A positive result on an HIV antibody test does not mean you have or will get AIDS!

Many patients with a positive test “have or will get AIDS!”

That’s right— the tests DON’T test for a virus. *The most common tests used -- the ELISA and the Western Blot -- are called antibody tests. They do not test to see if you have HIV. They test to see if your blood has high levels of the same proteins found at*

high levels in the blood of most early AIDS patients. These are thought to be “antibodies,” that is, footprints of a virus in your immune system but not the virus itself.

Who or what are “early AIDS patients”?

The proteins present in the patient sera which are detected by the antibody tests are not just “thought to be “antibodies””. By definition these proteins are antibodies. The HIV experts will reply the tests DO test for a virus. They DO test to see if you have HIV. It is true that HIV antibody tests are indirect. Like dozens of other serological tests used in clinical practice. For example, those for syphilis, glandular fever, brucellosis, streptococcal infections and influenza. Any doctor will explain there is nothing unusual or mistaken using indirect tests. An X-ray is an indirect test for pneumonia. An electrocardiogram is an indirect test for a heart attack. A Doppler ultrasound is an indirect test for a blood clot in a leg vein. Serological tests are based on the fact the immune system produces antibodies as a result of infections. Does the RA Board regard serological diagnoses as invalid?

Note: Although correct, the repeated reference to antibodies as proteins is confusing because of the need to distinguish between the proteins (antigens) present in the test kits and the antibodies in patient sera, with which the antigens react.

The trouble is, the proteins on the test are also found in people who are or have been pregnant, or have had vaccines (like flu shots) or blood transfusions, used street drugs, or have had infections like herpes, chicken pox and measles. Just having any of these can make you test positive.

This assertion lacks clarity. What is meant by “the proteins on the test”? Are these the (a) the proteins in the test kit; (b) antibodies in patient sera that react with these antigens; (c) the chemically combined antigen/antibodies present in the ELISA or those that constitute the Western blot bands?

Doctors accept no test is perfect. Antibody or otherwise. In this regard the brochure does not state anything new.

This is a view shared by the pre-eminent member of the RA Board, Peter Duesberg: “I think there’s a certain inconsistency on the part of those who so passionately argue that HIV doesn’t exist, because the same people base much of their arguments on the fact that the antibody tests are not reliable. Well, the fact that the antibody tests are not reliable means that there are antibody tests, and there’s an antigen [HIV]. Antibody tests do nothing 100 percent reliably; but by acknowledging that they’re not reliable, they’re acknowledging that an antigen [HIV] exists, and the test exists. The test is not completely random. It’s not 100 percent reliable, which most antibody tests aren’t”. (We have always maintained that nobody has proven the existence of the “HIV antigen”: that the proteins in the test kits (antigens) are cellular proteins and the antibodies are either directed against these proteins (auto-antibodies) or other antibodies which cross-react with them). Any doctor will confirm that antibody tests are “not 100 percent reliable” but will also add that they are routinely used in medical practice and are clinically useful. This is one of the reasons why the antibody tests cannot be used to argue against the “HIV” theory of AIDS. If there is “HIV”, then there are “HIV” antibodies, and there are “HIV” tests.

It is true that a positive antibody test can be found in people who “have had vaccines (like flu shots) or blood transfusions, used street drugs, or have had infections like herpes, chicken pox and measles”. If there is a virus, even if it is a passenger virus, there must be antibodies. The question is, how do you know in the above people which tests are false and which are true? In which street drug users and transfused people is the test false and in which is it true?

Test results are open to interpretation depending on the lab, clinic, or country in which you test. For example, the same test result could be read positive in New York but negative in Canada. Partly because of this, Canada has ten times fewer per capita AIDS cases than the U.S. It's crazy!

This is wrong. A negative Western blot is zero bands. A test that lacks sufficient bands to be positive under one jurisdiction may be indeterminate, that is, not positive but not negative, under another. To compare the Canada *versus* US AIDS prevalence, even “Partly” in this manner, is facile. The difference in the *per capita* AIDS cases between the US and Canada may be the result of many other more significant factors, including the definition of an AIDS case.

Even worse, because HIV tests don't show a definite positive or negative result—only something in between—they are interpreted. When you fill out that form that asks you if you are black, hispanic or gay you are giving out information that will make it more likely than if you were white or heterosexual for a lab to interpret your test as positive. Unfair? You bet it is!

“HIV tests don't show a definite positive or negative result” applies only to the ELISA. By its nature the reading in an ELISA can never be zero (negative). This is no different than counting a sample for radioactivity. The count can never be zero (negative). That is why one has to take into consideration the background reading and make other adjustments before the ELISA is introduced into clinical practice. This fact is well known to the “HIV” experts and they always perform the necessary corrections. Otherwise everybody will be HIV positive.

It is not true to say “HIV tests don't show a definite positive or negative result”. Many, in fact probably most tests are clearcut positive or negative. Laboratory tests are invariably interpreted in light of clinical data. Since no test is 100% specific there will always be false positives. However, the probability that a positive test is due to infection, that is, its positive predictive value, depends on the prevalence of infection in the group represented by the individual being tested. The higher the prevalence the higher the predictive value. There is nothing “Unfair” about this. It is a mathematical fact and how Medicine should be and is practised. If nothing else, this statement illustrates the RA Board's woeful lack of knowledge in regard to the scientific principles underlying the interpretation of diagnostic tests. It is also noteworthy that if, on the basis of an antibody test and clinical data, including prevalence, the doctor is unable to arrive at a definite conclusion, he will order a PCR test as an ancillary test to sort out the “HIV” status.

The “Viral Load” tests don't work either. “Viral load” tests use a technique called PCR to find and multiply small chains of genetic code in your blood that are supposed to

show the presence and amount of HIV. However, finding a chain does not mean they have found a whole virus.

It is true the PCR does not detect full length genomes. However, a doctor will explain you do not need to detect more than a part of HIV to detect HIV. He will argue that a sufficiently distinctive part allows identification of the whole. He will tell his patient a skilled anatomist can tell a skeleton is human by examining just few bones, and possibly only one bone. That even amateur art lovers can identify a painting from a fragment. Who cannot recognise Beethoven's 5th symphony from just four notes? Who doesn't know which make of car's emblem is a three pointed star?

The doctor could also point out that many full length HIV genomes are recorded in the Los Alamos Laboratory database. So will Peter Duesberg. Once one accepts the existence of "HIV" one has no choice but to also accept that the finding of a small bit of "HIV" signifies "HIV" infection. The "small chains" of the HIV genome cannot get into human bodies of their own accord. A small chain must have been the result of infection with a replication competent virus particle. That is, one that contains the complete viral genome. Furthermore, "small chains" of the "HIV" genome cannot be remnants of past infection. All retrovirologists agree that once infected with a retrovirus, always infected. In fact they claim that this is the reason they are unable to cure HIV infection. Because the "HIV" genome persists in the patient's DNA.

The doctor may also say that if the patient's T4 cell count is low that proves the patient is not infected with "bits" of HIV because only the whole virus, either directly or indirectly, kills the T4 cells.

No one even has a theory of how HIV could possibly kill enough T-cells (in your immune system) to cause AIDS.

The assertion "No one even has a theory of how HIV could possibly kill enough T-cells" is not an assertion HIV does not kill T-cells. There are many theories as to how HIV kills T4 cells and the HIV experts are the first to admit none is fully satisfactory. Nonetheless, according to them, HIV definitely does result in the death of the T4 cells, maybe directly or most probably indirectly, although the exact mechanism is not known. There are other infectious agents which are accepted to induce their effects indirectly. The bacteria that cause tetanus and diphtheria act indirectly, by releasing toxins that travel to different parts of the body where they exert their pathological effects. Rheumatic fever is caused by infection with a bacterium known as Group A *Streptococcus*. The lesions in the joints and heart that characterise this condition are caused by "an autoimmune reaction...which leads to damage to human tissues as a result of cross-reactivity between epitopes on the organism and the host" (*Harrison's Principles of Internal Medicine, 17th edition*). The argument put forward in *The AIDS Trap* is that because we do not know "how HIV could possibly kill enough T-cells", the virus is not the cause of AIDS. This is a very weak argument against the HIV theory of AIDS, an argument which no scientist or medically qualified person would consider valid. There are many theories as to how cigarette smoking and radiation cause cancer. None has been proven correct. Would members of the RA Board tell patients cigarette smoking and radiation do not cause cancer?

Research has proven that "viral load" tests are useless in predicting who will get AIDS.

This claim is most probably based on findings published by Rodriguez *et al* from the Case Western Reserve University, Cleveland, Ohio. In Jon Cohen's commentary in *Science* on these findings we read: "...the researchers report that groups of people with higher viral loads lost more CD4 cells each year. But on an individual basis, viral load accurately predicted a person's CD4 decline just 4% to 6% of the time. "It really nicely illustrates that when you look at cohorts and find a general phenomenon-yeah, virus is high and CD4 is low-it can be very, very poorly accountable when you look at individuals," says immunologist Anthony Fauci".

Doctors agree no one can predict what will happen to a particular individual on the basis of viral load levels. The same applies to the level of a person's blood pressure. Would an RA Board member rather have a blood pressure of 150/110 or a blood pressure of 280/150? After all, not all the latter will have a stroke and many strokes occur at lesser blood pressure levels. What doctor would advise his patients against having blood pressure measurements or taking medication to lower blood pressure?

You will probably be told to start taking AIDS drugs right away. These drugs could have side effects like anemia so serious that your life will rely on regular transfusions. You may have liver failure, rotting bones, loss of most of the skin on your body, a heart attack, and/or serious changes in your body's shape because of fat deposits.

Some "AIDS drugs", those used to treat AIDS indicator diseases, are the same drugs used to treat the same diseases if the patient is HIV negative. Is the RA Board suggesting that patients with tuberculosis or PCP do not take the conventional antimicrobials recommended and proven effective for the treatment of these disorders? Even though such advice may result in death?

If by "AIDS drugs" the RA Board means antiretroviral drugs (ARVs) including HAART, then all drugs have a benefit/risk ratio. Anti-cancer chemotherapy is a well known and appreciated example. Although benefit/risk ratio for ARVs has not been documented in randomised, double blind, placebo controlled trials they (a) do not invariably cause serious toxicities; (b) may benefit certain individuals, sometimes dramatically. (Our view there is no proof for the existence of "HIV" does not preclude beneficial effects of these drugs. Drugs have many effects, ARVs included. Our view merely means beneficial effects, if any, must result from non-retroviral mechanisms. We have published our reasons for the latter). Even if "HIV" exists, we and Anthony Brink have shown that at least two ARVs cannot have an antiretroviral effect. And, unlike the Board of *Rethinking AIDS*, Montagnier agrees with us (see below)—the unphosphorylated pro-drug AZT is not sufficiently triphosphorylated into the active compound (although, as usual, he does not credit our publication of this fact). Hence, at least in regard AZT, we are correct.

These patients must have some treatment. If the RA Board is advising patients not to take such drugs what alternative are they offering?

The AIDS medicines have never cured anyone. They do not prolong life.

To what does "never cured" refer? "HIV" or AIDS indicator diseases? If "HIV" then the brochure is not saying anything new. HIV experts freely admit that once infected, always infected. There is no drug and none will be found, capable of curing "HIV".

If by “The AIDS medicines have never cured anyone” is meant AIDS diseases;

- (a) which medicines, the antifungal and antibacterial drugs which have been proven effective long before the AIDS era?
- (b) which diseases, the acute or chronic?

We repeat, would the RA Board advise a person diagnosed with PCP not to be treated with, for example, Septrin? What is the RA alternative?

The brochure does not list any recommendations for treating or preventing AIDS. The RA Board has completely ignored our predictions. Even those proven by the HIV experts themselves in this regard.

Let us repeat these predictions for those not familiar with them.

In the 10th July 1986 re-submission letter to *Nature* regarding her paper *Reappraisal of AIDS : Is the oxidation induced by the risk factors the primary cause?* (ultimately published in *Medical Hypotheses*), EPE wrote: “If my paper does nothing other than draw attention to the oxidative nature of the risk factors and its biological importance, then it offers what is so far the only hope of treatment which will arrest and reverse the otherwise invariable fatal course of the disease. In my opinion this alone would more than justify its publication”.

In 1989 we recommended the following combination therapy [protocol, according to the reviewer] for KS in AIDS therapy.

- “1. Cessation of nitrites intake and anally deposited sperm. The presently observed longer survival of AIDS patients with KS may be due to change in lifestyle.
2. Localised radiotherapy or hyperthermia.
3. Administration of antioxidants and in particular sulphhydryl compounds which are known to correct immune deficiencies, to inhibit the toxic effects induced by radiation in normal tissue thus permitting a more radical local irradiation, and also to augment the effects of hyperthermia”. (Radiation was introduced for the sake of publication.)

At least one oncologist took notice.

“Dear Dr Papadopoulos-Eleopoulos:

I hope you will forgive me for bothering you but I have been intrigued by a hypothesis that you had published in the *International Journal of Radiation Oncology Biology and Physics*, Vol. 17, pp. 695-698, 1989. Perhaps you have seen my name as I wrote the chapter about AIDS in the 6th Edition of *Radiation Oncology* by Moss and Cox. In any case, I am now preparing an update for the 7th Edition and I intend to reference your hypothesis”.

Montagnier and his associates were the first to publish evidence that cessation of exposure to semen, including anally deposited semen, reverses a positive antibody test and leads to the normalisation of the T4 cell count. This was followed by reports from

the MACS and other studies in gay men. (Although no reasons are given by the MACS authors it does not stretch credibility to assume such individuals altered their lifestyle.)

In 1989 Eck proved our prediction that AIDS patients and those at risk will be oxidised. To date, the best support of our 1988 claim that AIDS can be prevented and treated by using “currently available therapeutic [antioxidants in general and SH-containing in particular] substances” has been published by researchers from Stanford University. However, although they most probably were aware of our work (because we sent them our publications) where we identify the oxidising agents to which the AIDS risk groups are exposed, including malnutrition, they wrote: “HIV-infected individuals would be better served if we could identify the mechanism that underlines the GSH depletion and intervene, if possible, to prevent its occurrence”. The best advice they could give in this regard was: “it may be prudent for those individuals to avoid excessive exposure to UV irradiation and unnecessary use of drugs that can deplete GSH – eg. Alcohol and prescription or over-the-counter formulations containing acetaminophen [paracetamol]”.

Nowadays we all know (except the members of the RA Board) that Montagnier is the pre-eminent apologist of our oxidative theory of AIDS and advocates that AIDS patients be treated with antioxidants. This is despite the fact, obvious in his last book, that he has a questionable understanding of the topic. We also know Montagnier advises the same patients be treated at the same time with anti-retrovirals, which he admits may be oxidising!

In 2000, responding to a question regarding EPE’s AIDS theory and antioxidants, Gallo stated, “They can help; but they are not a cure”.

Neither, according to all the HIV experts, are the anti-retrovirals a cure. The difference is that to date billions of dollars have been spent trying to find the most effective ARV drugs, mode of administration and advantageous combinations. However, perhaps with one exception, the Herzenberg study, not a penny has been spent on research into or clinical trials on the use of antioxidant compounds for the treatment of AIDS.

It is true that many people treat AIDS patients and those at risk of AIDS with “antioxidants”. However:

- (1) Most of them do not realise the best known “antioxidants” may not be antioxidants.
- (2) As far back of 1982 EPE showed that biological function is a non-linear. It appears that nobody in the AIDS field, including those who treat patients with AIDS, are aware of this. We have no doubt that if the Herzenberg study had taken this fact into consideration the results may have been considerably improved.
- (3) Drugs are absolutely necessary to treat AIDS indicator diseases and “supplements” to correct proven deficiencies. Lasting health can be obtained only by diet (with very little adjustment a diet can be turned from an oxidising to reducing), avoidance of stress and by cessation of exposure to disease risk factors.

Testing positive on a HIV test is a threat to life itself. It is your right to refuse an HIV test.

We assume the RA Board is asserting that mere knowledge of having a positive antibody test poses a threat to life—akin to the traditional Australian aboriginal custom of pointing the bone. Or, as Peter Duesberg argues, knowing one is HIV positive is *ipso facto* psychologically toxic. No one, including AIDS physicians, would dispute this assertion. Since (a) the brochure asserts, “A positive result on an HIV antibody test may (but not always) mean your immune system has been injured by repeated infections, heavy drug use, or inadequate rest or nutrition”; (b) “This could be a wake-up call to change the way you’re living”, are these not excellent reasons for having an HIV test? How does one get a “wake-up call” without the alarm clock? Especially someone in an AIDS risk group who is symptomatic? Isn’t it dangerous to advise a person to forgo such a test? Yet the RA Board offers the contradictory “It is your right to refuse an HIV test”. In fact two of the most prominent scientists of the RA Board contradict each other regarding the meaning of the test.

In his essay: “Can We Learn from Parenzee?” Henry Bauer says there were many problems in the Perth Group testimony which led to the loss of the case. Unbelievably, one of them was our alleged inability to provide an alternative theory of AIDS and of the meaning of the antibody tests. (Perhaps Henry Bauer has forgotten the many email exchanges he had with us when he first encountered the dissident movement).

He wrote: “If there is indeed the need to present an alternative theory, I point without false modesty to the conclusions reached from my collation of HIV-test data:

1. A positive HIV-test is an entirely **non-specific** indication of a **reversible** stimulation of the immune system (a stimulation that remains to be fully understood, but which quite possibly reflects oxidative stress, as the Perth Group have argued)
2. The likelihood that a given stimulation of the immune system will produce an “HIV-positive” response is mediated by an individual’s age, sex, and race” (emphasis in original).

However, according to Peter Duesberg, the antibody tests detect HIV antibodies. Indeed, if there is a virus, and it infects humans, albeit being “harmless”, antibodies must also exist. Which means for Henry Bauer to convince Peter Duesberg or a jury that the test detects “stimulation”, we must first prove there are no such things as “HIV” antibodies, that is, HIV. (In his latest paper Henry Bauer now claims the antibody tests detect “HIV” antibodies and in fact the antibodies neutralise “HIV” and make it a harmless “passenger virus”.)

If a patient asks the RA Board for advice what is he going to be told? The test measures non-specific stimulation of the immune system? Or “HIV” antibodies? Who decides? Henry Bauer or Peter Duesberg? Or both? If it’s a harmless retrovirus the patient may well ask why people with antibodies to this harmless retrovirus face an increased risk of dying. He will ask the same question if the mechanism is non-specific immune stimulation unrelated to a retroviral infection. Whatever the advice, how will it help him?

Nobel Prize winner Kary Mullis has been asking publicly for years to see scientific references that AIDS is caused by the virus HIV. So far (2009) no one has provided this proof. The epidemiological evidence of “testing HIV positive” correlating with AIDS cases is simply not there.

There are contradictory statements in the brochure. On the one hand it is said, "The epidemiological evidence of "testing HIV positive" correlating with AIDS cases is simply not there" and on the other that the antibodies are "found at high levels in the blood of most early AIDS patients".

In 1989 Peter Duesberg wrote: "The epidemiological correlation between these antibodies [HIV antibodies] and AIDS is the primary basis for the hypothesis that AIDS is caused by this virus...and antibodies to HIV became part of the definition of AIDS". The quote is taken from a paper entitled "Human Immunodeficiency virus and acquired immunodeficiency syndrome: **Correlation** but not causation" published in the *Proceedings of the National Academy of Sciences* (emphasis added).

This is tragic because thousands are suffering from the horror of being classified "HIV Positive."

This brochure will not change this. Doctors will have no problem responding to questions patients ask after reading this brochure. Those who decide to be tested and are HIV positive will suffer but so will those who have to decide whether their doctors or the RA Board are correct about testing. Those who decide not to be tested will worry about their decision. Not being tested may prove more psychologically toxic than being tested. After all, being tested is the only way a patient can find out if he or she is HIV negative. There are many thousands who can avoid the "suffering from the horror of being classified "HIV positive"" by testing HIV negative. On the other hand, the only way to avoid the "suffering from the horror of being classified "HIV positive"" is to prove there is no evidence a retrovirus HIV exists.

The importance of liberating those who have tested positive from an unthinking and uncaring medical system has not yet been widely accepted.

Many if not all health care professionals will be highly and rightly indignant being cast as "unthinking and uncaring". This statement is inconceivably ignorant and serves no good purpose for anyone.

If the RA Board believe in liberating "those who have tested positive from an unthinking and uncaring medical system" what form will this liberation take? What alternative will the RA Board provide? If a patient with PCP takes the advice not to consult an "unthinking and uncaring" doctor and goes to the Directors of the RA Board for help, what help will be offered? Ironically, it is dissidents with HIV or AIDS who will be most troubled by this brochure. If they do not consult a doctor from the "unthinking and uncaring medical system" they risk not being diagnosed or dying. However, if they do consult this doctor they may well feel they are guilty of betraying the dissident movement.

When Eliza Jane Scovill died Celia Farber wrote asking us for help. We responded immediately that we would be delighted to do so. In our email we strongly advised her to "obtain the services of a local paediatric pathologist. Preferably a forensic paediatric pathologist. We are going to try and find a name or two from another colleague in Perth". She responded she had a pathologist. "Our pathologist is an expert in forensics and works frequently in paediatric cases but even still, if John [Papadimitriou] is willing, I

would love another go over just to be sure”. We asked her to send us the autopsy reports and the WB results and any other tests which were used to prove that Eliza was infected with HIV. We wrote 3 questions regarding the WB and asked Christine to give them to the attorney to pass on to the coroner. She sent us the autopsy findings and John wrote a report based on these findings which satisfied her requirement “I want to be sure the report absolutely and without question stands up to challenge and scrutiny”. Based on the data Christine sent us John concluded the cause of death could not be determined.

We were not given any WB results or answers to our questions. After numerous emails (10-15) Christine told us that her pathologist’s name was Mohammed Al-Bayati and she had a few other people helping her as well, including Rodney Richards and “David Crowe is assisting the pathologist by proofing and editing his report [the pathologist’s]. Todd Miller is assisting David with a second look at the proofing and editing”. (For what possible reason would a pathologist require the assistance of laymen in the preparation of his report?). In a subsequent email she said that the “reason” she had David Crowe was “to check for typos”. (Please note: In one of the first emails he sent us defending his interference in the Parenzee case, David Crowe said he did not interfere but “I’d call out the comments, and return them to him [defence Lawyer Kevin Borick] in a cohesive document, performing whatever editing was necessary because many scientists make spelling and pronunciation errors”.) We did not know Al-Bayati and at the time knew very little about Rodney Richards. And at this very same time we were in the aftermath of Harvey Bialy’s (who we do know) involvement in the Presidential AIDS panel pre-absorption experiments. We pointed out to Christine Maggiore that “too many cooks spoil the broth”. In the meantime we were assembling evidence to show that no matter what the WB results were, the test did not prove infection. Unfortunately Christine never sent us the test results. The only thing we heard about the case subsequently was an email Christine sent to an undisclosed list, which included us, stating:

“Dear Friends,

The independent pathologist’s report on my daughter’s case—completed on October 25 and subjected to many rounds of attempted hole shooting by a variety of experts—is now posted for public review and comment at

<http://www.aras.ab.ca/EJ/ej-report.html>

With thanks for your support throughout these dark, dark days”.

Later we read Al-Bayati’s and Andrew Maniotis’ reports and realised there were significant differences between their reports and John’s. There was no mention of questioning whether Eliza was infected with “HIV”, a condition necessary to claim Eliza died from AIDS. We were disappointed that at the end Christine chose to decline our help but in no way blame her. She was in a very stressful situation and had the unenviable task of deciding which advice would prove most beneficial in her circumstances.

We are told that AIDS is spread by sex and body fluids, but this has never been shown by experiment...The idea that AIDS could be spread by sex to everyone was politically

motivated and has since been shown to be wrong. Hysteria about sex has contributed to misinformation about AIDS.

Anybody remotely familiar with the scientific literature and epidemiology of AIDS will know there is an association between sex and AIDS. A summary and interpretation of the evidence can be found in our publications. The best explanation can be found in our evidence in chief and cross-examination in the Parenzee hearing. Unfortunately, David Crowe declined to buy these particular court transcripts although he was specifically asked to by the person who donated most of the money for this purpose. Reading towards the end of the last two emails we sent David Crowe on the Perth Group and the Parenzee hearing are sufficient to realise that the available evidence shows that “sex and body fluids” play a proven role in the development of AIDS. In fact gay men did not need us or any other scientist to tell them the health problems they first encountered in the late 1970s were related to sex and drugs.

Let us take yet another look at some of the evidence. In the above mentioned paper, published by Peter Duesberg in the *Proceedings of the National Academy of Sciences* in 1989, he wrote: “Although HIV does not appear to cause AIDS, it may serve in the U.S. and Europe as a surrogate marker for the risk of AIDS for the following reasons...Indeed, the probability of being antibody-positive correlates directly with the frequency of drug use, transfusions, and male homosexual activity.” One year later in the same journal Peter Duesberg wrote: “A consistent alternative explanation for the high prevalence of antibody to HIV (and other microbes) in AIDS risk groups and AIDS patients proposes that HIV is a marker for American AIDS risks. The probability of becoming HIV antibody-positive correlates directly with the frequency of injecting unsterile drugs with the frequency of transfusions, and with promiscuity. However, in America, only promiscuity aided by aphrodisiac and psychoactive drugs, practiced mostly by 20- to 40-year-old male homosexuals and some heterosexuals, seems to correlate with AIDS diseases.” So, in contradiction to *The AIDS Trap*, according to Peter Duesberg, a correlation does exist between AIDS, HIV and sexual promiscuity.

Given the above correlation and the fact we all agree HIV (either because it has not been proven to exist or because it is a harmless passenger virus), is not the cause of AIDS, it follows some other factor(s) associated with sexual promiscuity must be the cause. Below we cite some of the published evidence in regard to the association between sex, a positive antibody test and AIDS. However, before doing so it will be helpful to emphasise a seminal fact in regard to STDs. All sexually transmitted diseases are bidirectionally transmitted. That is, from active (semen donating) partners (gay and heterosexual men) to passive (semen accepting) partners (gay men, heterosexual women) **and vice versa**.

The only evidence that addresses having or acquiring a positive antibody test or AIDS is epidemiological. There are no studies where the presence of “HIV” is first documented in the genital or rectal secretions of a series of index cases from whence it is transmitted to uninfected sexual partners. Rather than perform this basic, unambiguous, definitive experiment, HIV experts rely on epidemiologists performing mostly cross-sectional analyses on certain groups of individuals and documenting risk factors for the presence of a positive antibody test or AIDS. However, cross-sectional analyses cannot prove sexual transmission of a virus because (a) infection has already occurred and; (b) HIV experts accept there are non-sexual modes of “HIV” transmission. Hence

epidemiologists have also performed a few longitudinal studies where risk factors are assessed for individuals who seroconvert during the course of the study. HIV experts claim such studies demonstrate bidirectional transmission of HIV but in our view there is no such proof in any such study of gay or heterosexual sex. We challenge anyone on any side of this debate to produce even one such study. Significantly, over all the weeks of testimony at the Parenzee hearing, not one HIV expert witness, including an expert in HIV epidemiology, could produce evidence which proved transmission from the passive to the active partner. The same expert has not produced such a study subsequent to the hearing despite specific and repeated requests to do so.

GAY MEN

As far as we know the first epidemiological study which reported the relationship between sexual activity and Kaposi's sarcoma, one of the first AIDS indicator diseases, was published by Marmor, Friedman-Kien and their associates. In *Lancet* in May 1982 they reported: "The distributions of the number of different sex partners per month in different time periods before disease showed that patients were more promiscuous than controls. 50% of patients reported having sex with 10 or more different partners during an average month in the year before onset of disease, compared with 17% of controls. Some reported extreme levels of sexual activity: the most promiscuous patient estimated that he had had sexual intercourse with an average of 90 different partners per month in the year preceding disease...The initial models, constructed to test our primary hypotheses of (1) infection through sexual activity and (2) a carcinogenic effect of amyl nitrite exposure, indicated statistically significant effects of each of these variables after adjustment for the effects of the other."

In their updated paper published in 1984 they concluded: "Many sexual behaviours listed as risk factors in Table 4 were highly correlated with one another, with nitrite use or with cytomegalovirus antibody titers. Therefore, multiple logistic regression analysis of this data set, including sexual activities, nitrite use, cytomegalovirus antibody titers, and additional variables describing lifetime incidence of amebiasis, giardiasis, gonorrhoea, and syphilis, were done to determine which variables were statistically independent in their associations with disease. Stepwise logistic regression analysis indicated that the number of partners per month in receptive anal-genital intercourse with ejaculation, the number of occasions of "fisting", and cytomegalovirus antibody titers were the only independent and statistically significant variables for discriminating patients from controls". Hence this early study established a correlation between exposure of the passive partner to semen and disease.

In the same year, 1984, Gallo reported "of eight different sex acts, seropositivity correlated only with receptive anal intercourse...and with manual stimulation of the subject's rectum...and was inversely correlated with insertive anal intercourse". It goes without saying that an inverse relationship is completely at odds with the existence of a sexually transmitted agent.

In 1986 Gallo wrote: "Data from this and previous studies have shown that receptive rectal intercourse...is an important risk factor for HTLV-III infection [a positive antibody test]...We found no evidence that other forms of sexual activity contributed to the risk".

In 1994 Caceres reviewed more than 20 studies conducted in gay men and concluded "the cited reports yield convincing evidence that unprotected anogenital receptive

intercourse poses the highest risk for the sexual acquisition of HIV-1 infection...there is mounting epidemiological evidence for a small risk attached to orogenital receptive sex, biologic plausibility, credible case reports and some studies show a modest risk, detectable only with powerful designs;...no or no consistent risk of the acquisition of HIV-1 infection has been reported regarding insertive intercourse and oro-anal sex”.

The authors of the largest, longest, best designed and executed prospective study in gay men, the Multicenter AIDS Cohort study (MACS), showed that “receptive anal intercourse was the ONLY sexual practice shown to be independently associated with an increased risk of seroconversion to HIV in this study”, and went one step further and found that “...greater sexual activity [receptive anal intercourse] following establishment of HIV-1 infection leads to exposure to promoters or co-factors that augment (or DETERMINE) the rate of progression to AIDS” (emphasis added). This finding is at odds with the general accepted view that a person needs to be infected only once with a microorganism in order to develop an illness or die from that illness. However, these data are entirely consistent with semen or a non-infectious component being the cause.

HETEROSEXUALS

To date there have been only two longitudinal studies in heterosexuals: Nancy Padian’s in the USA and the European Study Group published by de Vincenzi and her colleagues. Both studies had cross-sectional and prospective components.

In their cross-sectional studies de Vincenzi reported that sexual practices “other than anal intercourse...were not associated with infection of the partner”.

In their four year prospective study the authors of the European Group claimed 4 men and 8 women became infected by having sex with the seropositive partner. Stuart Brody questioned their conclusion pointing out that “The problem of subjects’ lying (often euphemistically termed “social desirability responding”) about engaging in anal intercourse and intravenous drug use plagues most studies of behavioral risk factors for the transmission of HIV, and the study by de Vincenzi and colleagues is no exception. How was the absence of homosexual contact verified? How was the absence of anal intercourse among the women verified? If only 4 men and 6 women among the 121 couples inconsistently using condoms lied when they denied engaging in anal intercourse (or misreported the facts for other reasons), there would be no cases attributable to vaginal intercourse without a condom. At least this much lying should be expected. Before vaginal and anal intercourse are assigned comparable degrees of risk and condoms given the credit for saving lives, the alternative explanation that the disease is spread almost exclusively by anal and intravenous transmission must be more rigorously examined. Other investigators found that HIV infection in women was related to anal intercourse (especially among partners of bisexual men) and the number of exposures to the index patient, but not to condom use or the total number of sexual partners.³”. Ref.3 is Padian’s 1987 paper of male to female transmission.

Responding to Stuart Brody, de Vincenzi wrote: “We agree with Dr Brody that our prospective analysis lacks statistical power to show an increased risk associated with anal intercourse. [That is, they could not exclude the possibility that the positive antibody tests were the result of anal and not vaginal intercourse.] Indeed, we found such an association in the cross-sectional analysis. However, from a public health point of view, no one should state that there is no risk of HIV transmission through vaginal

sex, since the vast majority of cases of AIDS throughout the world are acquired in this manner". It is significant that de Vincenzi admitted her evidence did not prove that HIV is transmitted by penile-vaginal intercourse. Neither did she cite evidence to prove her claim "the vast majority of cases of AIDS throughout the world are acquired" by penile-vaginal transmission.

In the Padian cross-sectional study, in regard to the risk factors of male-to-female transmission, Padian wrote: "The total number of exposures to the index case (sexual contact with ejaculation) and the specific practice of anal intercourse...were associated with transmission...Anal intercourse significantly discriminated between seronegative and seropositive women".

Also, in this cross-sectional arm she reported two HIV positive male partners of infected women. However Padian questioned the validity of both cases and concluded: "That is, it is possible that the discrepancy between the efficacy of male-to-female compared to female-to-male transmission in this study could be even greater". In fact the discrepancy could be infinitely great because there could be zero female-to-male transmissions. She also added: "Of course, because we are relying on risk factors, the same caveats apply to classification of male-to-female cases of transmission as well". These remarks do not sound like a scientist who is convinced "the evidence for the sexual transmission of HIV is well documented, conclusive, and based on the standard, uncontroversial methods and practices of medical science", as she claims at AIDSTruth.

As is well known, in the prospective part of her study Padian did not count even one person who developed a positive antibody test. In a commentary published at AIDSTruth Padian claimed that her study, which began in 1987, was not designed to prove HIV transmission but to examine the effects of "behavioral interventions" on the transmission of HIV. However, when Padian first announced her ongoing study at the 1988 Amsterdam International AIDS Conference, she did not describe it in terms of "behavioral interventions".

"Objective. *To examine the efficiency of heterosexual transmission of HIV* [emphasis ours] and associated risk factors. Methods: We enrolled the opposite sex partners of individuals infected with HIV or diagnosed with AIDS or ARC throughout California. Participants were interviewed about their sexual practices and medical history; Laboratory tests for HIV and other co-factors were conducted, as were physical examinations...Results:...in multivariate analysis, only the practice of anal intercourse (p-.003) and non-white race (p-.013) were significantly associated with infection...We have also enrolled male partners of infected women. In spite of reported unprotected sexual intercourse (median number of sexual contacts = 399) none of the twenty male partners were infected".

There is no mention of "behavioural interventions" and, while at AIDSTruth Padian states "That we witnessed no HIV transmissions after the intervention documents the success of the interventions in preventing the sexual transmission of HIV", in her 1997 paper she wrote, "Nevertheless, the absence of seroincident infection over the course of the study cannot be entirely attributed to significant behavior change. No transmission occurred among the 25 percent of couples who did not use condoms consistently at their last follow-up nor among the 47 couples who intermittently practiced unsafe sex during the entire duration of follow-up".

Padian wants everyone to accept that, because she later decided to label her study as “behavioral interventions” to prevent HIV transmission, it is iniquitous to use her data to question proof of HIV transmission. Hence it remains a mystery why the title of her paper is *Heterosexual transmission of human immunodeficiency virus (HIV) in Northern California: results from a ten-year study*. Why didn’t she choose a title reflecting what she later purported was its true nature? The fact is that in this study there were discordant heterosexual couples who continued to practise unsafe sex who nonetheless, did not seroconvert to HIV. It is acknowledged that the proportion who practised unsafe sex decreased over time, which Padian attributed to her intense program of “behavioral interventions”. However, no scientist can claim the zero transmission rate observed in any couple was due to the success of “behavioral interventions” when, at the beginning of the study, approximately 70% of the couples were not practising safe sex, as were 25% at the completion, despite the many and constant “behavioral interventions”. In an emotive riposte at AIDSTruth Padian stated: “Any attempt to refer to this or other of our publications and studies to bolster the fallacy that HIV is not transmitted heterosexually or homosexually is a gross misrepresentation of the facts and a travesty of the research that I have been involved in for more than a decade”. The evidence shows that it is Padian who is unwilling to face up to her own data. The repackaging of this study illustrates her unwillingness to accept she was conducting an experiment in sexual transmission of “HIV”, whether she likes it or not. And this study did not have any seroconversions. It is significant that in her AIDSTruth commentary Padian did not cite any of her own research as proof of heterosexual transmission. As with de Vincenzi, when it comes to citing proof of heterosexual transmission, Padian cites “everyone else”. Yet “everyone else” cites de Vincenzi and Padian.

From the very beginning of the AIDS era, with few exceptions, there has been a marked epidemiological bias towards an infectious cause of a positive antibody test and AIDS. In other words, despite knowledge that semen is toxic and immunosuppressive, data that may have shed light on a non-infectious cause of AIDS was not sought. The distinction is crucial: the more significant risk factor for semen is the number of episodes of passive anal sex with ejaculation; while for infectious agents it is the number of sexual partners. In case this distinction is not clear consider the following: The volume of the male ejaculate is reported to be 0.1-11 ml. Let us choose 5 ml as a typical quantity. In three months, for example, a gay man could have a hundred partners, each once, which would expose him to 500 ml of semen. Or he could have 50 partners, four times, which would expose him to a litre of semen. That is, half as many partners could expose him to twice the dose of semen. If a virus is the cause of a positive antibody test or AIDS then the hundred partners should pose more of a risk than the fifty partners. And *vice versa*. By performing such a study could have obtained a strong clue to a virus *versus* a non-virus causation. However, virtually no epidemiological study reports such data. What is reported is the number of (different) sexual partners, not the frequency of anal sex. One exception is a study by Janet Nicholson published in the *Annals of Internal Medicine*:

“In the year before testing, homosexual men who were seropositive tended to have a greater number of sexual partners ($p = 0.009$), more episodes of receptive anal intercourse ($p < 0.001$), and more frequent active ($p < 0.001$) and receptive ($p = 0.023$) insertion of hands into the rectum...The number of episodes of receptive anal

intercourse per year was the variable most highly associated with HTLV-III/LAV seropositivity (F - 27. $p < 0.001$). After adjustment for this variable, no other variable was statistically significant”.

In other words, in this study the number of episodes of receptive anal sex had more statistical significance than the number of partners. And in a subgroup of men analysed the quantity of semen was the only significant risk factor. Hence epidemiologists forgot about semen. The early notion that semen may have been a cause of immunosuppression and AIDS was dismissed to the point evidence that could have added weight to this theory was not even collected. Yet these data should have been part of each and every study. But when a study, such as Nicholson's was published, providing a strong clue, it appears to have gone unnoticed. If every study had collected the data Nicholson collected, and obtained the same statistical outcome, scientists may well have had a compelling scientific reason to doubt the claims made by Montagnier and Gallo that they had isolated a retrovirus which is sexually transmitted and is the cause of AIDS.

The evidence we have cited shows that:

- (1) There is a factor(s) associated with sexual activity which play a role in the acquisition of a positive antibody test and AIDS.
- (2) The factor is not drugs. Nowhere in the AIDS/HIV literature is there evidence that the recipient of the ejaculate is preferentially exposed to “aphrodisiac and psychoactive drugs”.
- (3) The factor is not a sexually transmitted infectious agent(s). The reasons are:
 - (a) by definition diseases caused by sexually transmitted agents are transmitted bidirectionally, from the active to the passive (receptive) partner and from the passive to the active partner;
 - (b) once infected with a sexually transmitted agent, the development of the disease does not depend on subsequent infections with the same agent or further sexual activity.
- (4) The fact that only the passive partner develops a positive test and AIDS means that the cause of both behaves like pregnancy, they can be sexually acquired but not sexually transmitted.
- (5) The cause of a positive antibody test and AIDS, like pregnancy, must be a non-infectious agent in the ejaculate (semen) or semen itself. Unlike pregnancy, but like cervical cancer, it is not semen *per se* but the consequences of repeated exposure to it over a long period. The lining of the vagina is thick and acts as a barrier to absorption. The lining of the rectum is a single cell layer designed for absorption. It is also significant that semen is retained in the rectum because of the effectiveness of the anal sphincter muscles. There is no such means of retaining semen inside the vagina. So large quantities of vaginal semen are not absorbed and thus cannot affect other organs. The same cannot be said of large quantities of rectal semen which can be absorbed, especially if the lining of the gut is traumatised—a well documented occurrence with anal sex. As with cervical cancer, other factors may promote or inhibit the development of AIDS. And as with cervical cancer other factors unrelated to sexual activity may be causal.
- (6) That factors in addition to semen, present in the GI tract, may contribute to the acquisition of a positive test is supported by the following data: (a) microorganisms or microbial products present in the lumen of the bowel can also

be absorbed; (b) 90% of the dry weight of faeces is bacteria; (c) in mice, injections of extracts of the bacterium *E. coli*, an organism highly prevalent in the human bowel, result in antibodies that produce a p120 and p41 band on the "HIV" Western blot. Given that at least 30% of even low or no risk individuals possess an "HIV" p24 band, these circumstances may bring about a Western blot test result which is positive under the criteria of most jurisdictions.

In conclusion "sex and body fluids" do play a role in the development of a positive antibody test and AIDS. To claim otherwise is to give detrimental health advice to the very people we have been trying to help over the past 25 years. It is not sexual orientation or even the practice of receptive anal intercourse by gay men or heterosexual women that is the problem. The real culprit is the repeated exposure to large doses of semen. To paraphrase Peter Duesberg, it is the dose not the drug that kills. The claim that "sex and body fluids" play no role in the acquisition of a positive antibody test and AIDS is scientifically wrong and dangerous. The HIV experts, as a matter of course and convenience, lump anyone and everyone who question their theory as dissidents. By making and publicising this statement the RA Board provides the HIV experts with a highly effective plank with which to vilify all dissidents. Especially since the RA Board claims the views expressed in this brochure are representative of an "association of more than 2,600 doctors, scientists, and other professionals". The RA Board's denial of the role of "sex and body fluids" in AIDS plays into the hands of the HIV experts and comes at great expense to those of us who identify such evidence as factual.

Last year, in the popular press we read "Kevin de Cock who has headed the global battle against AIDS, said at the weekend that..."It is very unlikely there will be a heterosexual epidemic in countries [outside Sub-Saharan Africa]". Or that "...at long last, AIDS finally became just another disease". This year in an article published in *Lancet* it is claimed that even in Sub-Saharan Africa AIDS is mainly a gay men's disease. In other words, AIDS is still AIDS and not "just another disease" and "HIV" is still HIV which must be treated with antiretroviral compounds. The only difference is that AIDS now is a gay men's disease and "HIV" is still a deadly virus but, which unlike all other sexually transmitted agents, is spread only by anal intercourse. And this will remain the same if we do not make it known that:

- (1) To date, nobody has proven the existence of HIV. What is referred to as "isolation of HIV" is no more than a collage of nonspecific phenomena which, either alone or in combination, do not prove the existence of a retrovirus, much less a unique retrovirus "HIV". The "molecular signature" of "HIV" cannot be that of HERVs for the simple reason that no one has proven their existence. As Gallo testified at the Parenzee hearing. There are also many reasons why it is not a retrovirus, SINE, LINE or LTR. One suffices to illustrate this point. Since all the above are present in all of us, then the "HIV" molecular signature must be found in all of us. However, to date nobody has proven the existence of the "HIV" molecular signature (the whole "HIV genome") in the uncultured cells of even one AIDS patient, much less in all of us. As far as Andrew Maniotis' recent, "new" interpretation of the vaccine failures (failure to seroconvert) is concerned, please read EPE's presentation to the Geneva AIDS conference, Appendix XI of our mother to child monograph and the analysis of vaccine failures we wrote for Celia Farber. Vaccine failures tell us nothing about the experiment the "HIV" experts

- “wanted Dr. Duesberg to perform on himself”. People do seroconvert after “HIV” vaccination (that is, “HIV gp120”). The problem is that despite this they subsequently develop a full “HIV molecular profile”, that is, “HIV infection”.
- (2) There is no evidence which proves that T4, T8, Th1, Th2 cells have unique immunological functions.
 - (3) The evidence indicates that the cause of AIDS is cellular oxidation induced by the oxidising agents, and malnutrition, to which the patients belonging to the AIDS risk group are subjected.
 - (4) There may be a better way to treat AIDS patients than with HAART.

SUMMARY

Patients who question their doctors based on the content of this brochure will get rational answers that refute most of the assertions. This will leave them even more confused and, far from liberating them from “unthinking and uncaring” doctors, may well make them hostile and angry. Furthermore, AIDS physicians will point out this brochure explicitly denies (a) a connection between a positive test and AIDS; (b) a connection between sex and AIDS; (c) a role for conventional treatment for HIV seropositive and AIDS individuals with and without AIDS indicator diseases. They will argue such assertions are wrong and dangerous to the health of large groups of people.

The all encompassing message in this brochure seems to be:

1. HIV exists. The RA Board, like the HIV experts, claims there is evidence which proves the existence of a unique retrovirus HIV. However, unlike the former, the RA Board claims HIV is not the cause of AIDS. The retrovirus “HIV is a long-established, non-pathogenic passenger virus, neutralized by antibody after asymptomatic, perinatal or non-perinatal infections (just like all other human and animal retroviruses)”. However, the vast majority, if not all immunologists no longer believe there are scientific reasons to justify the long standing claim that viruses are neutralised by antibodies. In fact, as far back as 2000 when David Rasnick and Charles Gesheker wrote to President Mbeki making this claim, we replied and provided reasons, including experimental data published by Sabin as early as 1935, that this is not supported by the scientific evidence.
2. The RA Board, like the HIV experts, accepts there are HIV antibodies. This being the case there are HIV antibody tests. However, while the HIV experts claim these tests are highly specific, the RA Board claims their specificity is low. But they do not indicate how they can discriminate between a true and a false positive antibody test, for example, in a pregnant woman. Furthermore, unlike the HIV experts, the RA Board denies any correlation between a positive HIV test and the risk of AIDS. The Board fails to see that the clinical, laboratory and seroepidemiological data may have clinical utility, and can inform public health policy even if a retrovirus HIV does not exist. Rather than face up to this fact the Board prefers to deny the data.
3. Like the HIV experts, the RA Board claims HIV is sexually transmitted.

4. Both the HIV experts and the RA Board claim HIV kills the T4 cells. However, unlike the HIV experts, the RA Board assert “No one even has a theory of how HIV could possibly kill enough T-cells (in your immune system) to cause AIDS”. In other words, the difference between the experts and the RA Board is only one of degree.
5. At present, at least some if not all of the HIV experts agree with our long standing evidence that T4 cells play no role in the development of the clinical syndrome. Not so the RA Board.
6. At present even Montagnier seems to agree with us, at least in regard to one of the antiretroviral drugs, that antiretroviral drugs do not have an anti-HIV effect. Not so the RA Board. The RA Board claims the ARVs are toxic. So do the HIV experts. The RA Board never mentions their efficacy, or lack of efficacy. Montagnier: “AZT has another drawback: to be active (that is, to be used by the reverse transcriptase enzyme), it must receive phosphate molecules (become phosphorylated). The cellular enzyme that adds phosphates is present in sufficient quantities only in strongly activated lymphocytes. These occur in large numbers during the advanced stage of the illness and are the preferred target of the virus. Yet the virus can also infect and replicate in less activated lymphocytes, in which the concentration of phosphorylated AZT is too weak to inhibit the reverse transcriptase. This is one reason why treatment of asymptomatic patients with AZT alone has proved disappointing. But there are other reasons as well. Since AZT acts only during the phase of reverse transcription, the already infected cells are not at all sensitive to AZT, since the phase of reverse transcriptase has already passed and the viral genes have already been inserted into the cells’ chromosomes. The macrophages, in particular, which have a rather long life span, even when infected, could thus produce considerable amounts of virus, even in the presence of AZT”. (All one has to do to see that AZT is not triphosphorylated *in vivo* at any time, and thus could not act as an antiretroviral or a DNA chain terminator, is read our AZT monograph or Anthony Brink’s books.)

In a few words, the only significant qualitative difference between the HIV experts and the RA Board is that the latter claims HIV is neutralised by its antibodies and sex plays no role in AIDS. Both claims have repeatedly been proven wrong.

Not long after Rethinking AIDS was formed we wrote a small summary of our work to date and asked David Crowe to post it at the RA website. Our summary concluded:

“If anyone is of the opinion that what we have stated is wrong we will be grateful for any corrections using documented evidence. On the other hand, if what we have stated is correct, then anyone who either discusses or writes anything about the above stated topics must clearly state that we were the first to put forward these ideas and that we presented detailed basic scientific evidence to support our claims. This is not only for ethical reasons. It is our view that when people read original scientifically detailed papers they will get a much clearer picture regarding the facts. Otherwise distortions, misinterpretations, inconsistencies and superficial treatment of scientific facts result”.

David Crowe declined our request on the basis we were asking for priority. *The AIDS Trap* brochure is as good an example as any of distortions, misinterpretation, inconsistencies and superficial treatment of scientific facts.

In an email sent to Janine Roberts on 26th July 2009, Peter Duesberg wrote:

“Dear Janine,

Don't you think its an irony to focus a debate on the “contention that HIV has been isolated” on me – Peter Duesberg?

What about focusing such a debate on Montagnier, Barré-Sinoussi, the 2008 Nobel Committee, Gallo, Weiss, Fauci, *Nature* and the over 5000 signatories of the Durban Declaration of 2000, and many others, who are all ahead and above me in their “contention that HIV has been isolated”?”

If we do not take Peter Duesberg's advice and act upon it, not even 1000 *The AIDS Trap* brochures will liberate patients from the “HIV” test, AIDS or ARV drugs. So let us start at the beginning—with Montagnier and Barré-Sinoussi.