

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

Dispo

15 September 1987

Smith Kline Bio-Science Laboratories
45 Adrian Court
Burlingame, CA

*To Moffitt Labs
by 0930.*

To Whom It May Concern,

Enclosed are three serum samples we are sending you today from Dr. Julie Gerberding (client #94110013). For each of the three samples, we have packaged two vials of 1.0cc each with the requisition form. The Smith-Kline Lab #, Dr. Gerberding's patient ID number and our Aids Bank number are listed below...

<u>SMITH-KLINE #</u>	<u>ID NUMBER</u>	<u>AIDS BANK #</u>
742309	F14013	A586-2016
742310	2F14013	A587-2805
742311	20505	A587-2916

Please perform the requested tests and forward all results to the address designated on the requisition....

Dr. Julie Gerberding
SFGH, DEPT OF MEDICINE
1001 POTRERO-SH22
SAN FRANCISCO, CA

If you have any questions regarding these specimens, please do not hesitate to call my technicians at (415) 476-1481.

Sincerely,

John S. Greenspan (yp)

John S. Greenspan
Director, AIDS Specimen Bank

enc.

cc. Dr. Julie Gerberding
Ms. Yvonne DeSouza

Could you please send
 (3) stored serum samples
 to SKLB for hepatitis evalu-
 ation. The (3) samples
 are listed as follows:

Rack Box				7/22/86
✓ 83-9	1)	AS86-2074 ²⁰¹⁶	F 14013	Drawn
✓ 46-1	2)	AS87-2805	2F 14013	7/16/86
✓ 49-1	3)	AS87-2916	20505	7/9/87
				7/17/87

[AS86-2074 is 10415- 7-25-86

7/29 Carlson ✓

Thank you /
 Cary.

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UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

23 September 1986

FROM: AIDS Specimen Bank
University of California, San Francisco
School of Dentistry
Dept. of Stomatology, HSW-604
San Francisco, CA 94143-0512

comp log

TO: Smith Kline Bio-Science Laboratories
45 Adrian Court
Burlingame, CA

RE: Requisitions for laboratory testing

Enclosed is a serum sample we are sending you today from Dr. Julie Gerberding (client #94110013). Two vials of 1.0cc each are packaged with your requisition form. I have listed below the Smith-Kline Lab #, Dr. Gerberding's patient ID number and our Aids Bank number for purposes of cross-reference.

SMITH-KLINE #
133301

PT ID #
[REDACTED]

AIDS BANK #
AS86-1715 ✓

Please perform the requested tests and forward all results to the address designated on the requisition....

SFGH, DEPT OF MEDICINE
1001 POTRERO-5H22
SAN FRANCISCO, CA

If you have any questions regarding these specimens, please do not hesitate to call any of my technicians at.....
(415) 476-1481.

Sincerely,

John S. Greenspan

John S. Greenspan
Director, AIDS Specimen Bank

enc.

cc. Dr. Julie Gerberding
✓ Ms. Yvonne DeSousa

2cc serum of D15479

*to Smith/Kline for hepatitis
results.*

Thanks,

*Kathy
Remember to include ID labels on tubes*

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UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

Sept
4 August 1986

FROM: AIDS Specimen Bank
University of California, San Francisco
School of Dentistry, Dept. of Stomatology
HSW-604
San Francisco, CA 94143-0512

comp 109

TO: Smith Kline Bio-Science Laboratories
45 Adrian Court
Burlingame, CA

RE: Requisitions for laboratory testing

The attached page is a list of sera samples I am sending you today from Dr Julie Gerberding (client #94110013). We have listed our AIDS Bank numbers along with Dr. Gerberding's patient numbers. Two vials of 1.0cc each are packaged with each requisition.

Please perform the requested tests and forward all results to the address designated on the requisition.

SFGH, Dept. of Medicine/attn. Kathy Nelson
1001 Potrero-5H22
San Francisco, CA

If you have any questions regarding these specimens, please do not hesitate to call any of my technicians at (415)476-1481.

Sincerely,

John S. Greenspan (ZW)

John S. Greenspan, DDS
Director, AIDS Specimen Bank

enc.

cc: Dr. Julie Gerberding
Ms. Yvonne DeSouza

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

AIDS SPECIMEN #

SAN FRANCISCO, CALIFORNIA 94143-0512

PATIENT #

AS86-1633 ✓
AS86-1634 ✓
AS86-1635 ✓
AS86-1637 ✓
AS86-1638 ✓
AS86-1639 ✓
AS86-1641 ✓
AS86-1642 ✓
AS86-1646 ✓
AS86-1647 ✓
AS86-1652 ✓



comp log



UNIVERSITY
AIDS SPECIMEN
HSW-604
(415) 476-1481

43-0512

FROM:

TO:

RE: Requisitions for laboratory testing

The attached page is a list of sera samples, I am sending you today from Dr. Julie Gerberding (client #94110013). We have listed your laboratory numbers along with Dr. Gerberding's patient numbers and our Aids Bank numbers. Two vials of 1.0cc each are packaged with each requisition.

Please perform the requested tests and forward all results to the address designated on the requisition....

SFGH, DEPT OF MEDICINE
1001 POTRERO-5H22
SAN FRANCISCO, CA

If you have any questions regarding these specimens, please do not hesitate to call any of my technicians at.....
(415) 476-1481.

Sincerely,

John Greenspan
John S. Greenspan, D.D.S.
Director, AIDS Specimen Bank

enc.

cc. Dr. Julie Gerberding
Ms. Yvonne DeSouza

Tommy Dist
HWS-SK
(Letter)
LISTS SK-HWS
Sorted SK-HWS2

letter Tam. Nancy Wang at Blood Bank.

→ across specimen sent out table BioScience.

- Call Cathy Wells

re slip for 486-1355

and verify SK address do not sent.

to which to send it

1001 zip

UCSF → Specimen Blood Bank

1001



UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

12 August 1986

FROM: AIDS Specimen Bank
University of California, San Francisco
School of Dentistry, Dept. of Stomatology
HSW-604
San Francisco, CA 94143-0512

TO: Smith Kline Bio-Science Laboratories
45 Adrian Court
Burlingame, CA

RE: Requisitions for laboratory testing

The attached page is a list of sera samples, I am sending you today from Dr. Julie Gerberding (client #94110013). We have listed your laboratory numbers along with Dr. Gerberding's patient numbers and our Aids Bank numbers. Two vials of 1.0cc each are packaged with each requisition.

Please perform the requested tests and forward all results to the address designated on the requisition....

SFGH, DEPT OF MEDICINE
1001 POTRERO-5H22
SAN FRANCISCO, CA

If you have any questions regarding these specimens, please do not hesitate to call any of my technicians at.....
(415) 476-1481.

Sincerely,

John S. Greenspan, D.D.S.
Director, AIDS Specimen Bank

enc.

cc. Dr. Julie Gerberding
Ms. Yvonne DeSouza

Comp 100

Smith Kline 2cc

Record# 1
SERUM

GERBERDING -- 12 AUGUST 86
GERBERDING -- 12 AUGUST 86

Record#	BNUM	SERUM
-2	133208	AS86-0918 ✓
-3	133209	AS86-0933 ✓
-4	133210	AS86-0934 ✓
-5	133211	AS86-0936 ✓
-6	133212	AS86-0937 ✓
-7	133213	AS86-0938 ✓
-8	133214	AS86-0960 ✓
-9	133215	AS86-0961 ✓
-10	133216	AS86-0962 ✓
-11	133217	AS86-0963 ✓
-12	133218	AS86-0964 ✓
-13	133219	AS86-1156 ✓
-14	133220	AS86-1157 ✓
-15	133221	AS86-1158 ✓
-16	133222	AS86-1159 ✓
-17	133223	AS86-1160 ✓
-18	133224	AS86-1155 ✓
-19	133225	AS86-1281 ✓
-20	133228	AS86-1282 ✓
-21	133229	AS86-1356 ✓

comp log

Press any key to

Record#	BNUM	SERUM
-22	133230	AS86-1360 ✓
-23	133231	AS86-1365 ✓
-24	133232	AS86-1366 ✓
-25	133233	AS86-1373 ✓
-26	133234	AS86-1374 ✓
-27	133235	AS86-1375 ✓
-28	133236	AS86-1376 ✓
-29	133237	AS86-1377 ✓
-30	133238	AS86-1378 ✓
-31	133239	AS86-1379 ✓
-32	133240	AS86-1380 ✓
-33	133241	AS86-1381 ✓
-34	133242	AS86-1382 ✓
-35	133243	AS86-1383 ✓
-36	133244	AS86-1384 ✓
-37	133245	AS86-1385 ✓
-38	133246	AS86-1386 ✓
-39	133247	AS86-1387 ✓
-40	133248	AS86-1388 ✓
-41	133249	AS86-1389 ✓

Press any key to

Record#	BNUM	SERUM
-42	133250	AS86-1390 ✓
-43	133251	AS86-1630 ✓
-44	133252	AS86-1631 ✓
-45	133253	AS86-1632 ✓
-46	133254	AS86-1707 ✓
-47	133255	AS86-1708 ✓
-48	133256	AS86-1709 ✓
-49	133257	AS86-1710 ✓
-50	133258	AS86-1711 ✓
-51	133259	AS86-1712 ✓

Record#	BNUM	PTNUM	SERUM
-52	133260		AS86-1713 ✓
-53	133261		AS86-1714 ✓
-54	133262		AS86-1769 ✓
-55	133263		AS86-1770 ✓
-56	133264		AS86-1771 ✓
-57	133265		AS86-1772 ✓
-58	133266		AS86-1773 ✓
-59	133267		AS86-1774 ✓
-60	133268		AS86-1775 ✓
-61	133269		AS86-1776 ✓
-62	133270		AS86-1777 ✓
-63	133271		AS86-1778 ✓
-64	133272		AS86-1779 ✓
-65	133273		AS86-1780 ✓

camp 100

14

copy to Yvonne
HEPA

ORIGINAL Request
from Julie
HEPA

50K 1-57-16-5

Not sent to Smith Kline
See attached pages

HEPA7

IDENTIFICATION

IDENTIFICATION

IDENTIFICATION

IDENTIFICATION

To Whom It Concerns, (ie Yvonne, Eileen or Tammy)

Please prepare to send two cc's of serum for Hep B testing to Smith/Klein Labs on the health care workers listed here. I'm talking with the sales rep this afternoon so don't yet know all the details, like who you should send the serum to. But I'll let you know when I know and for now give you a head start on collecting the specimens.

Thanks,

Kathy

~~AS860345~~

~~AS860347~~

~~0365~~

~~0368~~

~~0372~~

0918 ✓

0933 ✓

0934 ✓

0936 ✓

0937 ✓

0938 ✓

0960 ✓

0961 ✓

0962 ✓

0963 ✓

0964 ✓

AS86 1156 ✓

1157 ✓

1158 ✓

1159 ✓

1160 ✓

1155 ✓

AS86 1281 ✓

1282 ✓

~~AS86 1335~~ OMIT

1377 ✓

1378 ✓

1379 ✓

1380 ✓

1381 ✓

1382 ✓

1383 ✓

1384 ✓

1385 ✓

1386 ✓

1387 ✓

1388 ✓

1389 ✓

1390 ✓

AS86 1430 ✓

1431 ✓

1432 ✓

1714 ✓

1769 ✓

1770 ✓

1771 ✓

1772 ✓

1773 ✓

1774 ✓

1775 ✓

1776 ✓

1777 ✓

1778 ✓

1779 ✓

1780 ✓

~~0239~~

~~0240~~

~~0241~~

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~~0246~~

~~0247~~

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~~0249~~

~~0250~~

~~0251~~

~~0252~~

~~0253~~

~~0254~~

~~0255~~

~~0256~~

copy to Yvonne
HEPA1

ORIGINAL Request
from Julie bending
HEPA1

50K1 5K16.5

Not sent to Smith Kline
See attached pages

HEPA7

IDENTIFICATION	
AS860345	
AS860347	
0365	
0368	
0372	
0918	✓
0933	✓
0934	✓
0936	✓
0937	✓
0938	✓
0960	✓
0961	✓
0962	✓
0963	✓
0964	✓
AS86 1156	✓
1157	✓
1158	✓
1159	✓
1160	✓
1155	✓
1586-1281	✓
1282	✓
AS86 1335	OMIT

IDENTIFICATION	
AS86 1356	✓
AS86 1360	✓
1365	✓
1366	✓
1373	✓
1374	✓
1375	✓
1376	✓
1377	✓
1378	✓
1379	✓
1380	✓
1381	✓
1382	✓
1383	✓
1384	✓
1385	✓
1386	✓
1387	✓
1388	✓
1389	✓
1390	✓
AS86 14630	✓
14631	✓
14632	✓

IDENTIFICATION	
AS86 1707	✓
1708	✓
1709	✓
1710	✓
1711	✓
1712	✓
1713	✓
1714	✓
1769	✓
1770	✓
1771	✓
1772	✓
1773	✓
1774	✓
1775	✓
1776	✓
1777	✓
1778	✓
1779	✓
1780	✓

IDENTIFICATION	
AS86 0232	
0233	
0234	
0235	
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0292	

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UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

11 April 1986

SmithKline
Bio-Science Laboratories

To whom it may concern,

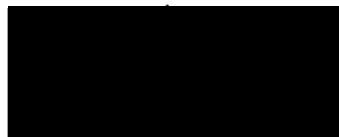
Enclosed in the package are frozen serum samples collected from Dr. Julie Gerberding. She has requested a Hepatitis evaluation IV panel for these samples.

The specimen bank numbers for the specimens are:

SPECIMEN BANK NUMBERS

PATIENT NUMBER

AS85-0191
AS85-0192
AS85-1215
AS86-0103



2CC

If you have any questions pertaining to the above samples please do not hesitate to give me a telephone call at (415) 476-1481.

Sincerely,

Yvonne G. De Souza
AIDS Specimen Bank Coordinator

STAPLE P.O.E. STICKER HERE
SmithKline Bio-Science Laboratories
LOS ANGELES • SAN DIEGO • PHOENIX
SAN FRANCISCO • SEATTLE
PROVIDER # X 05-8238 OR ZZZ 58238 Z

SKBL

STAPLE P.O.E. STICKER HERE

SmithKline Bio-Science Laboratories
LOS ANGELES • SAN DIEGO • PHOENIX
SAN FRANCISCO • SEATTLE
PROVIDER # X 05-8238 OR ZZZ 58238 Z

SKBL

STAPLE P.O.E. STICKER HERE

SmithKline Bio-Science Laboratories
LOS ANGELES • SAN DIEGO • PHOENIX
SAN FRANCISCO • SEATTLE
PROVIDER # X 05-8238 OR ZZZ 58238 Z

SFGH-DEPT MEDICINE

SKBL

STAPLE P.O.E. STICKER HERE

SmithKline Bio-Science Laboratories
LOS ANGELES • SAN DIEGO • PHOENIX
SAN FRANCISCO • SEATTLE
PROVIDER # X 05-8238 OR ZZZ 58238 Z

SFGH-DEPT MEDICINE
1001 POTRERO-5H22
SAN FRANCISCO

BW24 BC CLT-BILL 415-821-8450

REFERRING PHYSICIAN (IF OTHER THAN ABOVE)

☐ CALL RESULTS TO: _____
☐ STAT ☐ PHLEBOTOMY ☐ PREPAID

Date Collected _____ Time Collected _____ 24 hour volume _____

SKBL L B R Grv Grn Yel Ser Bl Wb Cl

sent lcc - 4/8/86

AS85-0191

85-0192

85-01215

AS86-0103

IV

SUBMIT FROZEN

BILLING COPY

N*** AS860191 94110013 684975 3
DATE & TIME RECEIVED CLIENT/LAB NUMBER
PATIENT NAME (LAST) (FIRST) I.D. NUMBER
BIRTHDATE (AGE) SEX TELEPHONE NO. AREA CODE 12260

LAB USE ONLY
94110013 684976 0
DATE & TIME RECEIVED CLIENT/LAB NUMBER
PATIENT NAME (LAST) (FIRST) I.D. NUMBER
BIRTHDATE (AGE) SEX TELEPHONE NO. AREA CODE F12260

AS85 1215

LAB USE ONLY
94110013 684977 5
DATE & TIME RECEIVED CLIENT/LAB NUMBER
PATIENT NAME (LAST) (FIRST) I.D. NUMBER
BIRTHDATE (AGE) SEX TELEPHONE NO. AREA CODE 15929
GUARANTOR NAME (IF OTHER THAN PATIENT) AS86-D192

LAB USE ONLY
94110013 684978 6
DATE & TIME RECEIVED CLIENT/LAB NUMBER
PATIENT NAME (LAST) (FIRST) I.D. NUMBER
BIRTHDATE (AGE) SEX TELEPHONE NO. AREA CODE F15929
GUARANTOR NAME (IF OTHER THAN PATIENT) 86-0103
ADDRESS
CITY STATE ZIP

DIAGNOSIS: _____
ADDRESS, PHONE NO., & P.O.E. STICKERS (MEDI-CAL ONLY) MUST BE PROVIDED TO INSURE PROPER BILLING.

MEDI-CAL #	MEDICARE OR OTHER #
REF. PHYSICIAN PROVIDER #	HMO #

SKBL USE ONLY	
TOTAL	
AMOUNT PAID	
BALANCE	

S	RVS CODE	TESTS / EVALUATIONS
HECK URCE :LOW Cl, CO2) RKER) 3 Ag) ICG) ION		☐ PREMARITAL EVAL. (RPR/RUBELLA) ☐ PRENATAL SCREEN ☐ PRENATAL EVALUATION I ☐ PRENATAL EVALUATION II ☐ PRENATAL EVALUATION III ☐ PROSTATIC ACID PHOS BY RIA, PAP (P) ☐ PROTHROMBIN TIME ☐ RHEUMATOID FACTOR ☐ RUBELLA SCREEN ☐ RUBELLA HAI TITER ☐ THEOPHYLLINE ☐ THYROID EVALUATION I ☐ THYROID HYPERTHYROID EVALUATION II ☐ THYROID HYPOTHYROID EVALUATION III ☐ TSH (THYROID STIM. HORMONE)
		CULTURE SOURCE
		☐ BLOOD ☐ GC ☐ STOOL ☐ THROAT
		☐ URINE ☐ OTHER



University of California
School of Dentistry
Department of Stomatology
HSW - 604
Division of Oral Biology
San Francisco, California 94143

12 March 1986

TO: Smith Kline Biosciences
FROM: Yvonne G. De Souza
RE: Hepatitis Evaluation IV

? AMT ?

Enclosed in the package are ³two serum samples sent to you for hepatitis evaluation IV from Ms Charyl LeBlanc. Please bill account number 94110013 (San Francisco General Hospital, Dept. of Medicine).

The following is a list of the samples being sent to you for analysis:

SPECIMEN BANK NUMBER
AS86-0253
AS86-0354
AS86-0380

PATIENT NUMBER



Please send your results to Ms Charyl LeBlanc, San Francisco General Hospital.

Sincerely,

Yvonne De Souza

Yvonne De Souza

cc: Charyl LeBlanc
Dr. John Greenspan

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UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

19 May 1987

Dr. Yuen T. So, M.D.
University of California, San Francisco
Department of Neurology
M794

Dear Dr. So,

As we discussed over the telephone two weeks ago, it would be advisable that you store your serum samples in our AIDS Specimen Bank. Judging from your comments this sera may prove to be quite informative in terms of neurological problems and AIDS. Enclosed in the envelope are copies of our AIDS specimen bank forms. Please make additional copies for yourself. Each serum sample sent must be accompanied by a specimen bank form. If not, we will discard the sample. All pertinent patient information must be on this form. If you know the patients' AIDS registry number, and/or UCSF medical number, please include these numbers on the form. If not, we will accept the patient's name. Please be specific as to the clinical diagnosis of the patient. Please note down the number and type of tubes you are sending.

If you have any questions please do not hesitate to give me a call at 1481.

Sincerely,

A handwritten signature in cursive script that reads "Yvonne G. De Souza".

Yvonne G. De Souza
Coordinator, AIDS Specimen Bank

cc: Dr. John S. Greenspan

Yuen T. So, M.D., Ph.D.
Department of Neurology
University of California at
San Francisco
San Francisco, CA 94122

May 10, 1987

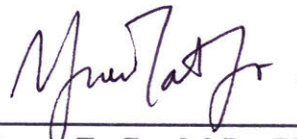
Yvonne DeSouza
Department of Oral Biology
HSW 604
UCSF

Dear Ms. DeSouza,

As I discussed with you over the phone a week ago, several of us in the Department of Neurology are interested in utilizing the AIDS serum bank organized by Dr. Greenspan. We are at present following a number of AIDS or ARC patients either under study protocols or in neurology clinics of the UC hospitals. Many of these patients present with intriguing neurological syndromes. Like several other AIDS-related phenomena, the pathogenesis is uncertain, although they may perhaps be attributed to a viral or immunologic process. It is worthwhile, we believe, to store serums of some of these patients so that we can retrospectively study them in the future. Any help or suggestion you can provide will be most appreciated.

I would greatly appreciate it if you can send information materials to me at the Department of Neurology, M794, or reach me via Extension 1487.

Sincerely yours,

A handwritten signature in dark ink, appearing to read 'Yuen T. So', written over a horizontal line.

Yuen T. So, M.D., Ph.D.

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SANTA BARBARA • SANTA CRUZ

UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

29 May 1985

Dr. Tom Spira
Clinical Immunology Laboratory
Building 1, Room #1225
CDC
Atlanta, Georgia 30333

Dear Dr. Spira,

The following is a list of serum samples I am sending you this week. The sera comes from Dr. Robin Onichi's intravenous drug user study. Each vial contains approximately .2cc of serum. I have included the patient code number along with AIDS bank number so that you may send your results to Dr. Onichi.

If you have any questions pertaining to the samples you have received please do not hesitate to give my technician, Yvonne De Souza a call at (415) 666-1481.

Sincerely,

John S. Greenspan
BSc, BDS, PhD, FRCPath
Director, AIDS Specimen Bank

cc: Dr. Robin Onichi

47

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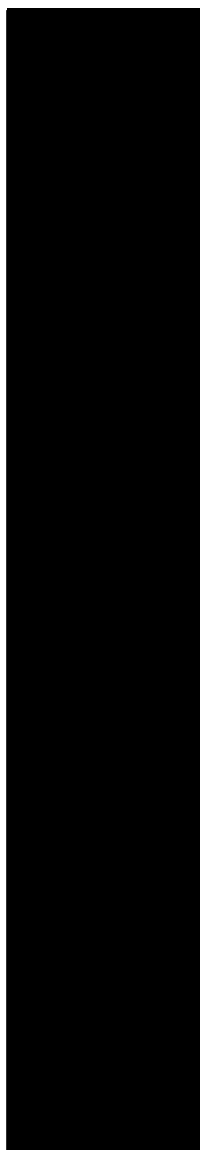
UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

AIDS SERUM NUMBER

PATIENT NUMBER

AS84-1021
AS84-1023
AS84-1070
AS84-1085
AS84-1110
AS84-1157
AS84-1158
AS85-0036
AS85-0058
AS85-0075
AS85-0076
AS85-0103
AS85-0212
AS85-0243
AS85-0314
AS85-0315
AS85-0328
AS85-0350
AS85-0351
AS85-0353
AS85-0354
AS85-0359
AS85-0360
AS85-0361
AS85-0374
AS85-0377
AS85-0378
AS85-0379
AS85-0380
AS85-0400
AS85-0403
AS85-0426
AS85-0434



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SANTA BARBARA • SANTA CRUZ

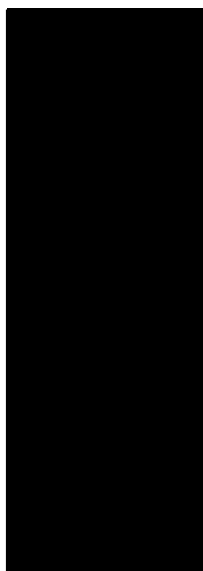
UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

AIDS SERUM NUMBER

PATIENT NUMBER

AS85-0435
AS85-0436
AS85-0484
AS85-0486
AS85-0487
AS85-0503
AS85-0534
AS85-0535
AS85-0576
AS85-0577
AS85-0600
AS85-0603
AS85-0605
AS85-0607



47

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UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

2 November 1984

Dr. Tom Spira
Clinical Immunology Laboratory
Building 1, Room #1225
CDC
Atlanta, Georgia 30333

Logged

Dear Dr. Spira,

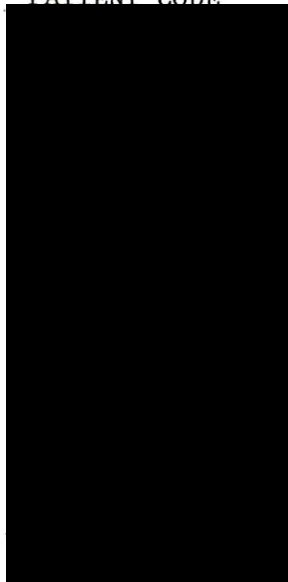
As per Dr. Robin Onichi's request I am sending you sera this week.
There are a total of 17 samples. The patient code number has been included so
that you may communicate your results to Dr. Onichi.

0.5cc

AIDS SERUM NUMBER

AS84-0486
AS84-0782
AS84-0783
AS84-0784
AS84-0785
AS84-0786
AS84-0787
AS84-0788
AS84-0789
AS84-0790
AS84-0791
AS84-0792
AS84-0793
AS84-0794
AS84-0795
AS84-0796
AS84-0797

PATIENT CODE



If you have any questions please do not hesitate to call my technician,
Yvonne De Souza at (416) 666-1481.

Sincerely,

John S. Greenspan
BSc, BDS, PhD, FRCPath
Director, AIDS Specimen Bank

cc: R. Onichi

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SANTA BARBARA • SANTA CRUZ

UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

1 October 1984

Dr. Tom Spira
Clinical Immunology Laboratories
Building 1, Room# 1225
CDC
Atlanta, Georgia 30333

Logged

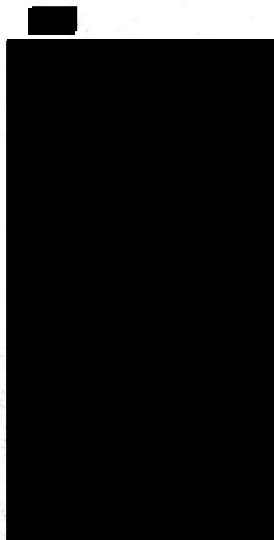
Dear Dr. Spira,

The following is a list of the sera Dr. Robin Onishi requested to be sent to you. The patient code numbers have been included so that you may communicate your results to Dr. Onishi. There are a total of 16 serum samples (1/2cc per sample).

AIDS SERUM NUMBER

PATIENT NUMBER

AS84-0782
AS84-0783
AS84-0784
AS84-0785
AS84-0786
AS84-0787
AS84-0788
AS84-0789
AS84-0790
AS84-0791
AS84-0792
AS84-0793
AS84-0794
AS84-0795
AS84-0796
AS84-0797



If you have any questions please do not hesitate to call my technician, Yvonne De Souza at (415) 666-1481.

Sincerely,

John Greenspan
John S. Greenspan
BSc, BDS, PhD, FRCPATH
Director, AIDS Specimen Bank

cc: R. Onishi

IDU sera $\frac{1}{2}$ cc each.

15 total

A0629	84-0346	12,3
A348	84-0346	12,3
A0778	84-0348	12,3 13,1
A6812	84-0368	13,2
A5507	84-0369	13,2
A1070	84-0403	14,1
A4956	84-0404	14,1
A6277	84-0425	14,2
A7977	84-0435	14,3
A1649	84-0516	16,3
A0717	-0531	17,1
A8919	-0536	17,2
A6014	-0565	17,3
A9561	-0577	18,1
A7284	0673	19,3

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AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

21 Sept 1984

Dr. Tom Spira
Clinical Immunology Laboratory
Building 1, Room # 1225
CDC
Atlanta, Georgia 30333

1688ed

Dear Dr. Spira,

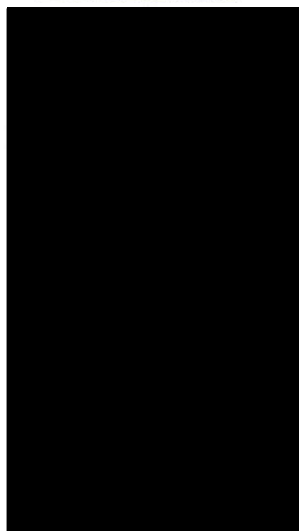
0.5cc

The following is a list of the sera Dr. Robin Onichi requested to be sent to you. There are a total of fifteen serum samples. The patient code number has been included so that you may communicate your results to Dr. Onichi.

AIDS SERUM NUMBER

PATIENT CODE

AS84-0346
AS84-0347
AS84-0348
AS84-0368
AS84-0369
AS84-0403
AS84-0404
AS84-0425
AS84-0435
AS84-0516
AS84-0531
AS84-0536
AS84-0565
AS84-0577
AS84-0673



If you have any questions please do not hesitate to call my technician, Yvonne De Souza at (415) 666-1481.

Sincerely,

John S. Greenspan
BSc, BDS, PhD, FRCPATH
Director, AIDS Specimen Bank

cc: R. Onichi

ASB

OAC

TO: Richard Sweet, M.D.
Professor & Vice Chairman, Ob-Gyn
SFGH 14B, Wd 6D

FROM: John S. Greenspan, B.D.S., Ph.D. 
Director, UCSF AIDS Specimen Bank
Box 0512

DATE: October 19, 1988

RE: Your studies of HIV seroprevalence in pregnant IVDU and their offspring.

I have reviewed the numbers which we discussed at our meeting. I have approached the costing using two methods of assessment:

- (1) Workload, supplies and expense, other costs (like a regular NIH budget)
- (2) Fee-for-service basis

The two methods produce estimates which are less than 10% different. I give you the average of these two numbers. If you decide to proceed, I will provide a detailed budget using the costing method of your choice. However, bear in mind that the fee-for-service approach, while attracting an additional 12 1/2% departmental overhead, will probably be exempt from the 40%-plus UC overhead.

Costs for:

- (1) Short term handling and passing on of approximately 4,600 X 1 tube serum samples.
- (2) Long term handling, storage and withdrawal of the numbers outlined at our meeting. Includes costs for freezers. Does not include overhead.
- (3)

Year 01	\$ 50,200
Year 02	54,600
Year 03	76,000
Year 04	91,000
Year 05	<u>120,000</u>
Total:	\$391,800



University of California San Francisco
AIDS Specimen Bank
HSW-604
San Francisco, California 94143-0512
(415) 476-1481/2943

John S. Greenspan
BSc, BDS, PhD, FRCPATH
Director

FILE COPY

9.0

March 24, 1987

Dr. John Watters
25 Belvedere
San Francisco, CA 94117

Dear Dr. Watters,

The Executive Committee of the UCSF AIDS Clinical Research Center, which is responsible for the UCSF AIDS Specimen Bank, has asked me to write to you. We are concerned about the arrangements for serum handling and storage for your study. This has become a major user of the bank, yet no funds are available to us for this activity.

Please contact me to let me know how you propose to fund the specimens which we have handled and are storing for you and what your plans are for the future. We can then consider what role the Bank might continue to play in your investigations.

Sincerely,



John S. Greenspan

JSG/lm

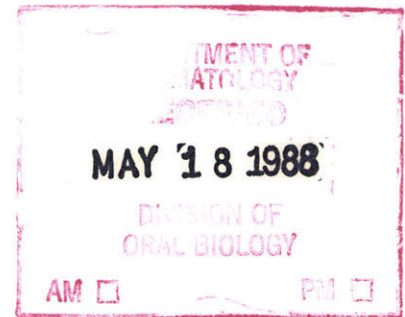
cc: J. Ziegler

URBAN HEALTH STUDY

25 Belvedere St.
San Francisco, CA 94117
(415) 864-8040

May 4, 1988

Lottie Kornfeld, Ph.D.
University of California
Universitywide Task Force on AIDS
764 University Hall
2199 Addison
Berkeley, CA 94721



Dear Dr. Kornfeld:

I am writing pursuant to our telephone conversation of today regarding Urban Health Study use of UC laboratory facilities.

As you know, our application for Task Force funding was approved for July 1, 1987 start-up. Unfortunately, administrative impediments resulted in a number of delays in implementation of the project and that on December 4, 1987 the University decided to withdraw the offer of support for the current period but encouraged us to reapply through a different administrative organization for the upcoming round of awards.

However, by December we had already screened about 700 research subjects using UC laboratory facilities. Consequently we are now in the process of making reimbursement arrangements to the laboratories of Drs. Greenspan and Carlson since UC Task Force funds cannot be applied to our research effort for the period in question. We have received a figure of \$7,500 from Dr. Greenspan (\$3,000 of which we have already paid) and are awaiting a figure from Dr. Carlson. We will, of course, pursue all avenues necessary to secure funding to pay for these services.

We have tried to structure our research budgets in such a way that we are able to make efficient use of existing resources. Our current grant from the National Institute on Drug Abuse (RO1 DA04212) enables us to access a relatively large pool of research subjects who are intravenous drug users (about 1,200 per year are recruited into the study). About 60% of these persons are not connected to drug treatment programs or other clinical services. While this is an interesting research population, a significant effort is required to recruit and follow them as research subjects. The National Institute on Drug Abuse grant pays for most of our operating costs, direct and indirect costs associated with recruiting and follow-up with the research population, and for the data entry, storage, and analysis associated with that effort. The National Institute on Drug Abuse budget does not currently include for HIV serology and only \$3,000 for serum banking.

Our current work suggests that the overall seroprevalence of HIV in this population is about 15%. Thus, we need to screen 1,000 intravenous drug users to locate 150 seropositive individuals. Even so, some of those identified will not wish to participate in the proposed UC Task Force study or will not have sexual partners who can be recruited. Consequently, if we are to be successful in recruiting an adequate number of seropositive intravenous drug users with sexual partners as subjects for the study, relatively large scale screening will be needed. We expect that this will be 1,100-1,200

person per year.

Thank you for your attention in this matter. If this does not fully address your questions and concerns, please contact me immediately.

Sincerely,

A handwritten signature in black ink, appearing to read 'John K. Watters', with a stylized flourish at the end.

John K. Watters, Ph.D.

cc: Dr. Carlson, UCD
Dr. Greenspan, UCSF
Dr. Hartsock, NIDA

URBAN HEALTH STUDY

25 Belvedere St.
San Francisco, CA 94117
(415) 864-8040

May 17, 1988

Lottie Kornfeld, Ph.D.
Universitywide Task Force on AIDS
Office of Health Affairs
764 University Hall
2199 Addison Street
Berkeley, CA 94720

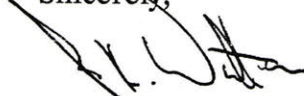
Dear Dr. Kornfeld:

Thank you for your letter of May 10, 1988 regarding University of California laboratory services used in the conduct of my research. I am continuing to pursue alternative means of support for laboratory services not covered by Task Force funding and am in ongoing contact with Drs. Carlson and Greenspan regarding this matter.

As I indicated in my May 4, 1988 letter, it will be necessary to screen over 1,000 intravenous drug users to identify serological status of potentially eligible research subjects (eg. to identify HIV seropositive index cases and determine the serostatus of their sexual partners). Thus, the ability to perform the study proposed to the Task Force is wholly dependent on the availability of HIV serology for this relatively large group of intravenous drug users who are willing to participate. Since the nature of my relationship to the Task Force will be affected by funding decisions that are now pending, Dr. Carlson has suggested that the issue of my financial obligations to his laboratory be resolved after he consults with the Task Force at their June meeting.

I remain optimistic that the issues of reimbursement and availability of laboratory services will be satisfactorily resolved. I regret that my research efforts have resulted in problems that affect your administrative purview. Thank you for your patience and my apologies for the inconvenience that this unusual situation has caused.

Sincerely,



John K. Watters, Ph.D.

cc: Dr. Carlson, UCD
Dr. Greenspan, UCSF
Dr. Hartsock, NIDA



University of California San Francisco
AIDS Specimen Bank
HSW-604
San Francisco, California 94143-0512
(415) 476-1481/2943

John S. Greenspan
BSc, BDS, PhD, FRCPath
Director

FILE

August 16, 1987

John K. Watters, PhD
Principal Investigator
Urban Health Study
1779 Haight Street
San Francisco, CA 94117

Dear Dr. Watters,

Thank you for your letter of August 8, 1987. You are quite right in assuming that we will be willing to continue to store your sera during the lifetime of the Bank, and that you will indeed retain control of those samples. The cost of maintaining your sera after the end of active funding which you may receive and thus contribute to the Bank will, we hope, be supported by the State of California through the Universitywide Task Force on AIDS. If not, then we will all be in the position of having to find alternative sources for the entire project and, in this regard, you will be one of several investigators working together. We have not really faced that problem yet because the Bank and all our other AIDS research activities are very much in a growth phase, and we are more concerned about effective banking and aliquoting and sending out of sera than we are about semipermanent arrangements for the maintenance of the Bank. I should also say that you will be at liberty, at any time, to remove your specimens from the collection and arrange alternative storage for them, if you so choose.

As far as your last paragraph is concerned, let me reiterate what I said in my letter of August 6, which is that the costs of your study, as far as specimen banking is concerned, will be \$5,000 per year to be found by you. I indicated that we expect you to try to find the whole of this, but that if you can only find \$3,000, we will see if we can help you raise the balance. Do not feel that you have to reduce the number of serum specimens from 1,700 to 1,300 because of specimen banking restraints. If you really cannot find the full amount of money that is appropriate, we will nevertheless continue to receive and store your specimens for you.

With best wishes,

Yours sincerely,

John S. Greenspan

JSG/pkr

cc: J. Ziegler, MD

FILE

August 6, 1987

Dr. John Watters
1779 Haight Street
San Francisco, Ca. 94117

Dear Dr. Watters:

I did not hear from you, so I thought I would just jot down for you and me, and for the file, a record of the substance of our discussion on July 10, 1987. We agreed that the UCSF AIDS Specimen Bank would be able to accept your serum deposits in the number of approximately 1,700 per year for two years. We understand that these will come in batches depending upon the cycle of your study and when you see the subjects. We should be able to accommodate them in the way that you outlined with approximately 200 per month in December and July, and a smaller number per month in February, April, August, September and October.

I indicated to you that, although we receive most of our funding directly from the UC University-Wide Task Force on AIDS, we are expected to raise some of the support of the Bank's activities from those who use its services. The proportion of that un-met cost represented by a study of the size which you describe for your own, is \$5,000 per year. You indicated that you would be able to find \$3,000 and that you would try to find the balance of \$2,000 if you could.

In addition, I indicated to you that should any of the biotechnology or pharmaceutical companies with whom we collaborate ask us for small aliquots of sera from subjects such as those in your study, we would contact you with a view towards your participation. If you do so, then we will negotiate a contribution from the industry collaborator as partial support for your study.

If these arrangements are satisfactory to you, please drop me a line confirming this. In addition, I look forward to you transferring the \$3,000 which we have agreed on to the AIDS Specimen Bank account. If this is from a UC fund, then please transfer it directly into our account [REDACTED]. If the sum is not to be transferred directly from our Regents' account, then please send me a check made payable to "The Regents of the University of California - UCSF AIDS Specimen Bank."

Yours sincerely,



John S. Greenspan

JSG/ys

cc: Dr. John Ziegler

URBAN HEALTH STUDY

1779 Haight St.
San Francisco, CA 94117
(415) 751-4221

August 8, 1987

Dr. John S. Greenspan
UCSF AIDS Specimen Bank
HSW-604
University of California
San Francisco, CA 94143-0512

Dear Dr. Greenspan:

Thank you for your letter dated August 6, 1987 which accurately summarizes our earlier telephone conversation. We have already begun to receive your notifications of aliquots sent to Dr. Carlson's lab for analysis.

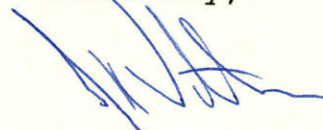
The arrangements outlined in your letter are satisfactory, however some clarification is needed.

There appears to be no specific agreement on the length of time our sera will be banked. We are assuming that sera banked during the study years will remain with the serum bank indefinitely, and that we will retain control of these samples. Any costs engendered could be defrayed through our collaboration in the biotechnology or pharmaceutical industry sponsored research mentioned in your letter.

I have requested funding of serum banking from a third party. If approved, these funds would become available in October, 1987. If not approved we will make other arrangements to pay the \$3,000. In any event, you will receive payment no later than October, 1987. In addition, funding constraints may force us to reduce the number of serum specimens collected to 1,300 from the 1,700 we had originally planned. Should this become the case, we would expect your costs to be reduced proportionately.

Thank you.

Sincerely,



John K. Watters, Ph.D.
Principal Investigator

UNIVERSITY OF CALIFORNIA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

UNIVERSITYWIDE TASK FORCE ON AIDS
OFFICE OF HEALTH AFFAIRS
764 UNIVERSITY HALL
2199 ADDISON STREET
BERKELEY, CA 94720
(415) 642-0732

May 10, 1988

John K. Watters, Ph.D.
Urban Health Study
25 Belvedere St.
San Francisco, CA 94117

Dear Doctor Watters:

Thank you for your letter of May 4, 1988, in which you clarify your use of the UC laboratory facilities of Drs. Carlson and Greenspan for the serological screening for HIV infection of the research subjects who participate in your National Institute of Drug Abuse study.

One key issue which we discussed during our telephone conversation that is not addressed in your letter is that the partner study you proposed to the Universitywide Task Force on AIDS made no mention of first screening over 1000 drug abusers. Thus, even if you had accepted State support for the partner study, the serological screening of the IVDU population could not have been performed by the UC laboratories without reimbursement.

It is my understanding that Dr. Carlson also has now provided you with the cost of the services he performed for you. Since an adjustment for this amount will have to be made in the accounting of his expenditure of State funds, your efforts to secure funding for reimbursing both Drs. Carlson and Greenspan will be appreciated by all parties involved.

Sincerely,

Lottie Kornfeld, Ph.D.
Coordinator-Universitywide AIDS
Research Program

cc: Dr. James Carlson
Dr. John Greenspan

URBAN HEALTH STUDY

25 Belvedere St.
San Francisco, CA 94117
(415) 864-8040

May 4, 1988

Lottie Kornfeld, Ph.D.
University of California
Universitywide Task Force on AIDS
764 University Hall
2199 Addison
Berkeley, CA 94721

Dear Dr. Kornfeld:

I am writing pursuant to our telephone conversation of today regarding Urban Health Study use of UC laboratory facilities.

As you know, our application for Task Force funding was approved for July 1, 1987 start-up. Unfortunately, administrative impediments resulted in a number of delays in implementation of the project and that on December 4, 1987 the University decided to withdraw the offer of support for the current period but encouraged us to reapply through a different administrative organization for the upcoming round of awards.

However, by December we had already screened about 700 research subjects using UC laboratory facilities. Consequently we are now in the process of making reimbursement arrangements to the laboratories of Drs. Greenspan and Carlson since UC Task Force funds cannot be applied to our research effort for the period in question. We have received a figure of \$7,500 from Dr. Greenspan (\$3,000 of which we have already paid) and are awaiting a figure from Dr. Carlson. We will, of course, pursue all avenues necessary to secure funding to pay for these services.

We have tried to structure our research budgets in such a way that we are able to make efficient use of existing resources. Our current grant from the National Institute on Drug Abuse (RO1 DA04212) enables us to access a relatively large pool of research subjects who are intravenous drug users (about 1,200 per year are recruited into the study). About 60% of these persons are not connected to drug treatment programs or other clinical services. While this is an interesting research population, a significant effort is required to recruit and follow them as research subjects. The National Institute on Drug Abuse grant pays for most of our operating costs, direct and indirect costs associated with recruiting and follow-up with the research population, and for the data entry, storage, and analysis associated with that effort. The National Institute on Drug Abuse budget does not currently include for HIV serology and only \$3,000 for serum banking.

Our current work suggests that the overall seroprevalence of HIV in this population is about 15%. Thus, we need to screen 1,000 intravenous drug users to locate 150 seropositive individuals. Even so, some of those identified will not wish to participate in the proposed UC Task Force study or will not have sexual partners who can be recruited. Consequently, if we are to be successful in recruiting an adequate number of seropositive intravenous drug users with sexual partners as subjects for the study, relatively large scale screening will be needed. We expect that this will be 1,100-1,200

person per year.

Thank you for your attention in this matter. If this does not fully address your questions and concerns, please contact me immediately.

Sincerely,

A handwritten signature in black ink, appearing to read 'John K. Watters', with a stylized flourish at the end.

John K. Watters, Ph.D.

URBAN HEALTH STUDY

25 Belvedere St.
San Francisco, CA 94117
(415) 864-8040

April 14, 1988

Dr. John S. Greenspan
University of California
AIDS Specimen Bank
HSW-604
San Francisco CA 94143-0512

Dear Dr. Greenspan,

Thank you for your letter of March 24, 1988.

As I explained in our telephone conversation of last week, The University of California Universitywide Task Force on AIDS grant award that was to cover our serum banking has been delayed. Although our Task Force grant was approved and scheduled to begin July 1, 1987, a number of administrative problems prevented transfer of funds. The \$3,000 co-payment we agreed to has been forwarded. Although we have no NIDA funding for serum banking or serology, we have been able to "borrow" this amount from non-personnel categories in our NIDA grant. With respect to estimating future utilization of the UCSF serum bank facilities, we expect to deposit an additional 250 centrifuged red-tops prior to July 1, 1988. Should we be successful in acquiring the requested grant funds currently under review, we would expect to deposit about 2,400 centrifuged red-tops during FY 88-89.

The administrative problems that delayed initial implementation of the project last year have been resolved, and we remain optimistic that Task Force funding will begin July 1, 1988 (pending favorable review of our resubmitted application). Funding for our serum banking should be available from these sources. Should these funds not be adequate to cover lab costs associated with our research for the current funding period, a supplement to our existing NIDA grant can be requested.

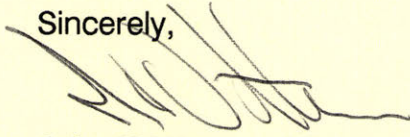
In the past our serum banking and serology has involved collaborative agreements with San Francisco Childrens' Hospital, the San Francisco Department of Public Health, and Dr. Richard Chaisson's study of IVDUs. FY 87-88 is the first and only year the Urban Health Study has used the UCSF serum bank independently.

In addition to our application currently before the Task Force we have a second, larger study of sexual partners of IVDUs under review at NIDA. We have budgeted funds for serum banking and serology in the new NIDA proposal.

As per your request, I have enclosed a list of publications and abstracts relevant to our current research. I have also enclosed three abstracts under review for presentation to the American Public Health Association meetings in October, and a copy of the abstract accepted by the IV international Conference on AIDS.

I want to thank you for your patience and understanding in this matter. Please be assured that we will pursue all possible avenues to insure adequate funding for our utilization of your laboratory.

Sincerely,

A handwritten signature in dark ink, appearing to read 'J. Watters', written over the word 'Sincerely,'.

John K. Watters, Ph.D.
Principal Investigator

Selected Publications and Presentations

Peer review and government publications:

Watters, J.K. "Meaning and context: The social facts of intravenous drug use and AIDS in the inner city." Journal of Psychoactive Drugs 1988, vol 20, no 2 (in press).

Huang, K.H.C., Watters, J.K., Case, P. "Psychological assessment and AIDS research with intravenous drug users: Challenges in measurement." Journal of Psychoactive Drugs 1988, vol 20, no 2 (in press).

Watters, J.K. "Fear and loathing in the inner city: Toward the social meaning of AIDS among intravenous drug users in San Francisco's Tenderloin." In Community Epidemiology Work Group Proceedings-December, 1987. Rockville, MD: U.S. Public Health Service, The National Institute on Drug Abuse 1988 (in press).

Stall, R. and Watters, J.K., Case, P. (Eds.) Intravenous Drug Use and AIDS: Issues in Epidemiology, Policy, and Intervention. Journal of Drug Issues 1988 (in press).

Watters, J.K., Friedman S,R, DesJarlais, D.C., "HIV infection among intravenous drug users in New York City and San Francisco: The social context of HIV transmission." Journal of Drug Issues 1988 (in press).

Stall, R., Watters, J.K. and Case, P. "AIDS and intravenous drug use." Journal of Drug Issues 1988 (in press).

Watters, J.K. and Cheng, Y-T. "HIV infection and risk among intravenous drug users in San Francisco: Preliminary findings." Contemporary Drug Problems 1987, vol 14, no 3 pp. 397-410.

Watters, J.K. "Street-based AIDS prevention for intravenous drug users in San Francisco: Preliminary evaluation." Contemporary Drug Problems 1987, vol 14, no 3, pp. 411-423.

Newmeyer, J.A., Feldman, H.W., Biernacki, P. and Watters, J.K. "Preventing AIDS contagion among intravenous drug users." Medical Anthropology 1987 vol 10, nos. 2 & 3.

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Watters, J.K., Feldman, H.W., Biernacki, P., Newmeyer, J.A. "Street-based AIDS prevention for intravenous drug users: Prospects, obstacles, and options." in Community Epidemiology Work Group Proceedings (Vol. II) Rockville, MD: U.S. Dept. of Health and Human Services, National Institute on Drug Abuse, June, 1986.

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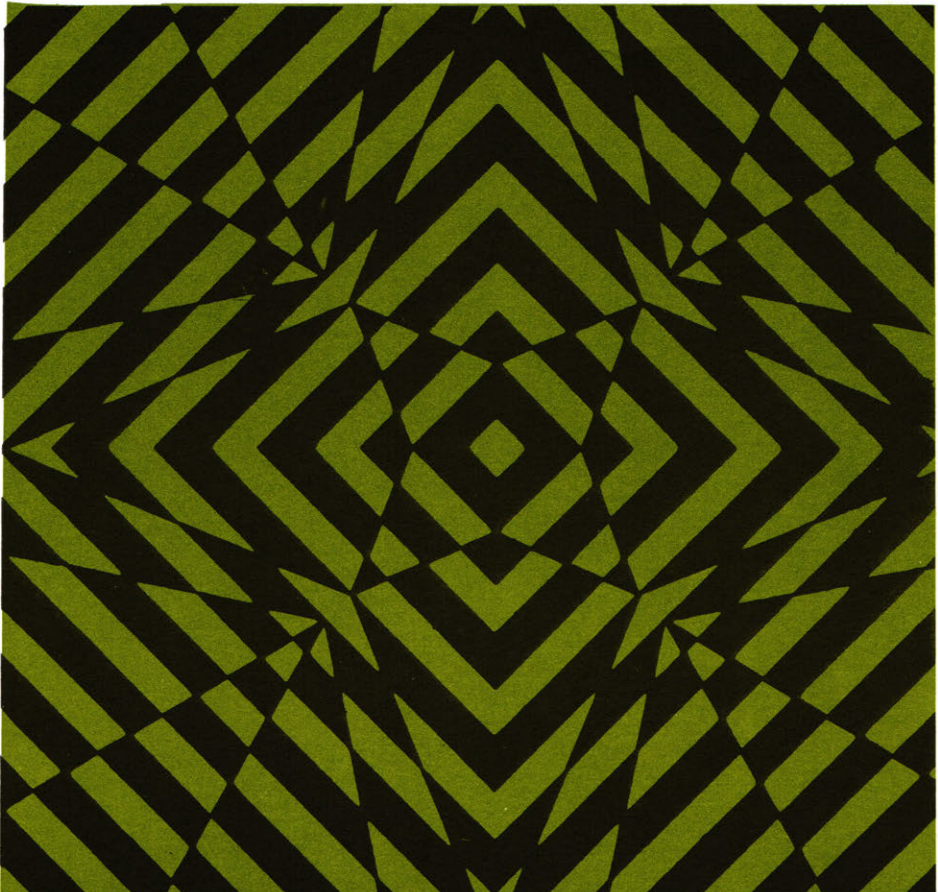
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CONTEMPORARY DRUG PROBLEMS

HIV-1 infection and risk among intravenous drug users in San Francisco: preliminary results and implications

BY JOHN K. WATTERS
AND YU-TEH CHENG

A SPECIAL REPRINT



HIV-1 infection and risk among intravenous drug users in San Francisco: preliminary results and implications

BY JOHN K. WATTERS
AND YU-TEH CHENG

Dr. Watters is a community psychologist and is the director of the Urban Health Study (25 Belvedere St., San Francisco, CA 94117), an independent health-policy research group conducting studies of HIV seroprevalence and AIDS risk among intravenous drug users and their sexual partners. Yu-Teh Cheng is a biostatistician with the Urban Health Study and the Survey Research Center at the University of California at Berkeley.

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AIDS and its related conditions have reached epidemic proportions among intravenous drug users (IVDUs) in a number of cities worldwide. In some European cities human immunodeficiency virus-type one (HIV-1) seroprevalence studies conducted among clinical populations of IVDUs reveal startling infection rates: Milan, Italy, Edinburgh, Scotland, and Madrid, Spain, all evidenced HIV-1 seroprevalence over 50% (Des Jarlais and Friedman 1987). In New York City, similar studies show epidemic rates of infection among IVDUs on the same order of magnitude (Cohen et al. 1985; Des Jarlais 1987). By the end of 1985, there were over 1,300 cases of AIDS among heterosexual IVDUs in New York.

At the time the current study was implemented (late 1985), only 8 (1%) of the 803 AIDS cases reported in San Francisco had occurred among heterosexual IVDUs (San Francisco Department of Public Health 1987). In order to begin to understand why there were such vast differences between New York City and San Francisco, and why so few IVDUs appeared in the AIDS surveillance data, we undertook a study of AIDS knowledge, participation in risk behaviors (needle sharing, needle hygiene, and sexual practices), immunofunctioning as measured by T-cell data, and HIV-1 seroprevalence. This article reports the preliminary findings of this pilot study of 438 IVDUs recruited from three drug treatment clinics and an out-of-treatment comparison group of IVDUs recruited in the Tenderloin District—a dense, inner-city neighborhood known to be a residential and “business” sector for many of San Francisco’s IVDUs.

Methods

Overview In the current study, 438 research subjects were interviewed and medical, sexual, and drug use histories obtained. T-cell subsets were performed, and sera were screened for the

presence of HIV antibodies. Three hundred IVDUs were tested in three 21-day drug detoxification programs located in San Francisco; the remainder of the subjects were out-of-treatment IVDUs recruited through a modified chain-referral method (Biernacki and Waldorf 1981; Biernacki 1986).

The in-treatment group was sampled from three of four detoxification clinics located in San Francisco. Two were typical 21-day methadone detoxification programs, and the third was the "symptomatic detoxification" program at the Haight-Ashbury Free Medical Clinic. This sampling strategy was effective in recruiting opiate injectors, but less so in accessing the stimulant injector (amphetamines and cocaine). For this reason, an out-of-treatment sample of IVDUs was also recruited into the study for purposes of comparison.

**In-treatment
sample**

One hundred IVDUs were to be sampled from each of three clinics. Although 337 IVDUs were interviewed, 37 failed to return for blood drawing.

Interviewers, in collaboration with the clinic nurse or pharmacist, issued an invitation to randomly selected clients to participate in the study. Participation was voluntary and was rewarded with a \$15 stipend upon completion. Informed consent was obtained, and subjects interviewed on the same day. The typical interview was 45 minutes in duration. Where possible, interviews were performed in private offices inside the clinic by one of four trained interviewers. Scheduling private space for interviews was problematic in all clinics owing to the utilization of space in such settings, which is frequently taxed to (or beyond) the limit.

Phlebotomy was performed at least 24 hours after the interview to allow sufficient time for the subject to consider the potential consequences of HIV antibody testing. Blood samples were drawn on-site at clinics by a licensed phlebotomist with considerable experience with the complexities of drawing blood from IVDUs.

Out-of-treatment sample

We wanted to test the null hypotheses with regard to rates of HIV infection between IVDUs who present for treatment and those who do not as a means for making recommendations for focusing prevention efforts. For this reason, we decided to include a "street sample" of IVDUs who were not current treatment program clients. Ethnographic studies on drug, sex, and needle-use practices were conducted in two inner-city neighborhoods where drug use is prevalent (Biernacki and Feldman 1986). Based on the findings of these studies and other data it was decided that the Tenderloin area would be the focus for our research efforts directed at the out-of-treatment IVDU. The Tenderloin is a densely populated area of San Francisco that includes the city's "skid row." It is the most active "sex trade" zone in the city. The Tenderloin is ethnically diverse, and serves as the area residence for many of the city's destitute. The primary reasons for the selection of this site were:

1. The area, though geographically small, held both the largest number and highest density of needle users presenting to city detoxification clinics.
2. The ethnic composition of the Tenderloin was proportionally similar to that of the entire city.
3. Ethnographic research, police reports, and reports of staff in social service agencies and residential hotels concurred that the drug use patterns in the Tenderloin included heroin use, but also a major stimulant abuse scene which was predominantly characterized by intravenous use of methamphetamine. The inclusion of a population with demonstrably different drug use patterns than those of in-treatment opiate addicts was considered desirable, since it was estimated that approximately 40-50% of the city's IVDUs were primary stimulant abusers (Biernacki and Mandell 1986; Newmeyer 1986).

Serology

Whole blood was transported to Children's Hospital for T-cell analysis, HIV-1 antibody screening, and serum banking. Litton ELISA tests for HIV-1 antibodies were performed. Sera that tested ELISA positive for HIV-1 antibodies were subjected to confirmatory testing using

immunofluorescence (IFA) and Western blot (W.B.) assays. IFA confirmation was performed at the San Francisco Department of Public Health Microbiology Lab and W.B. confirmation at the University of California at Davis AIDS Virology Lab.

Findings

Descriptive data for the 438 subjects are displayed in table 1. Fifty percent were white, 27% black, 11% Latino, 11% "other." The mean age was 33.7 years; average number of years in school was 12. Sixty-five percent were male, 32% female, and 2% were transsexual. Involvement in the sex trades was 15% for the total sample. It was highest (16%) among whites, and lowest (12%) among the "Other" category, which is predominantly Asian and Pacific Islander. Seventeen percent of the males (including biological male "transsexuals") had a history of receptive anal sex within the past five years.

In-treatment and out-of-treatment samples differed in a few respects. The out-of-treatment sample contained 80% males, compared to the in-treatment group which was 62% male. There was twice the percentage of IVDUs with histories of prostitution in the out-of-treatment group ($p < 0.02$). Homosexual activity was also more common among out-of-treatment males. Six percent of the in-treatment males had histories of homosexual activity within the past five years, while 31% of the out-of-treatment males had such histories ($p < 0.01$). This difference may be an artifact of sampling, much of which was concentrated in a neighborhood frequented by gay and bisexual male IVDUs.

Serology An overall HIV-1 seroprevalence rate of 9% was found among the 401 IVDUs for whom serological data were obtained. This is in contrast to the estimated seroprevalence of 40–50% for gay males in San Francisco and in contrast to

TABLE 1
Selected variables by ethnicity and treatment status

	N ^a	%	X Age	Last grade school	% male	% female	% trans- sexual	% sex trade involvement	% employed	% male homosexual activity
White	221	50	32.5	12	65	33	2	16	13	20
Black	120	27	34.9	12	70	28	1	15	8	17
Latino	47	11	36.4	11	67	28	4	13	9	7
Other	50	11	33.6	12	52	42	6	12	12	14
All	438	100	33.7	12	65	32	2	15	11	17
In-treatment	335	76	33.8	12	62 ^b	37 ^b	2	15 ^b	14	6 ^c
Out-of-treatment	103	24	33.0	12	80 ^b	13 ^b	8	32 ^b	8	31 ^c

^aN = 438.

^bp < 0.02.

^cp < 0.01.

50% among IVDUs in New York City. The number of diagnosed AIDS cases among heterosexual IVDUs in San Francisco is still quite low (only 28 such cases in the 2,348 AIDS cases diagnosed through August 1986). It is noteworthy, however, that the seroprevalence for the 101 out-of-treatment IVDUs tested was 16% as compared with 7% among the 300 IVDUs tested in 21-day detoxification clinics ($p < 0.02$) (see table 2). This suggests that seroprevalence among out-of-treatment IVDUs in San Francisco is higher than among the in-treatment population. This is due in part to the fact that there was a higher percentage of males who had histories of receptive anal intercourse in the out-of-treatment group. This suggests that these subjects may have become infected either through sexual intercourse with other bisexuals or homosexuals or by sharing injection equipment in social circles that were predominantly gay.

TABLE 2

HIV infection by treatment status

HIV	In-treatment	Out-of-treatment
Negative	93% (279)	84% (85)
Positive	7% (21)	16% (16)
Chi-square = 6.293.		
$p < 0.02$.		
N = 401.		

Unlike New York City, where ethnic minorities comprise disproportionate numbers of the seropositive population, in our study there were no statistically significant differences in seropositivity according to ethnicity. Nine percent of the 221 whites in the sample were seropositive, as were 8% of the 120 blacks, 11% of the 47 Latinos, and 2% of the 50 others. Blacks are, however, overrepresented on most indicators of drug use and may be disproportionately affected in San

Francisco should the course of the infection among IVDUs continue as it has in other geographical areas. Seventy-eight percent of the 37 seropositives were biological males (of whom 14% considered themselves "transsexual") and 22% were female. Forty-four percent had a history of male homosexual activity.

Seventy-five percent of both out-of-treatment and in-treatment groups had been incarcerated during the past five years. Thus it is apparent that correctional facilities and jails will face increasing problems related to HIV infection over the coming years.

False positive test results for HIV antibodies proved to be a problem for IVDUs. Nine (24%) of the Litton ELISA positive sera tested negative when confirmed by IFA and W.B. (*cf.* Carlson et al. 1985). IFA and W.B. were 97% concordant. One case was ELISA positive, IFA negative, and W.B. indeterminate. The fact that sharing of injection paraphernalia was a common practice for this group while the regular disinfecting of needles was far less frequent may help explain this finding. For example, it has been suggested that antigen in the form of bacteria from unsterilized needles and syringes, cells from sharing partners, and various impurities in the substances injected stimulate an immune response in the host. ELISA testing apparently fails—in many cases—to distinguish between the products of these responses and antibodies that are specific to HIV antigen. Thus, the importance of confirmatory testing in screening IVDUs must be emphasized.

Lymphocyte abnormalities

Of the 37 seropositives screened in the current study, most evidenced some signs of lymphocyte abnormalities. Only 15% of the 33 seropositive subjects for whom T-cell data were available had normal T4/T8 ratios (≥ 1.0). The remainder showed varying degrees of lymphocyte abnormalities. Des Jarlais et al. (1986) presented four sequential stages of lymphocyte abnormalities among IVDUs in progression to

clinical symptoms of AIDS and AIDS-Related Complex (ARC). Our findings were similar to those of Des Jarlais et al. Eighty-five percent (28) of the HIV-1 seropositive subjects had progressed to Stage One ($T4/T8 < 1.0$); 39% (13) had the cumulative abnormalities of Stage Two (total T4 count $< 492/\text{ml}$); 21% (7) had reached Stage Three (total lymphocytes $< 1,746/\text{ml}$); and 6% (2) had progressed to Stage Four (total B cells $< 74/\text{ml}$). By way of comparison, 29% of the seronegatives were found to have depressed helper/suppressor ratios in contrast to 85% of seropositives ($p < 0.0001$). These data suggest a marked tendency toward immunosuppression among the seropositive IVDUs in our sample.

Needle hygiene Ninety-five percent of the IVDUs surveyed reported that they shared needles. Most IVDUs (87%) reported that they cleaned needles in some way between sharing partners. Both the in-treatment and out-of-treatment groups were nearly identical in this regard. Unfortunately, the typical cleaning pattern reported employed tap water as the cleaning agent (58%). A substantial minority (42%) reported more useful attempts at decontamination employing alcohol (28%), peroxide (5%), household bleach (3%), boiling water (4%), or disposal (1%).

TABLE 3

Syringe cleaning method

	Unsafe	Possibly safe
In-Treatment	65% (205)	35% (110)
Out-of-Treatment	47% (47)	53% (54)
Chi-square = 6.898.		
p < 0.01.		
N = 416.		

There were significant differences between the in-treatment and out-of-treatment groups in this regard. Thirty-five per-

cent of the in-treatment group reported *disinfecting* needles between sharers. The out-of-treatment group, on the other hand, reported better hygiene, with 53% reporting use of disinfecting materials (bleach, hydrogen peroxide, alcohol) in their cleaning protocol ($p < 0.01$) (see table 3). The reason for this is not well understood. These data were collected prior to implementation of aggressive and coordinated AIDS prevention programs for IVDUs in San Francisco. Some of the variation may be due to interaction with the ethnographic research team who developed the original "snowball" sample of out-of-treatment IVDUs. Ethnographers reported extensive interaction with IVDUs who were highly concerned about AIDS and were eager for any information they might be able to use to protect themselves (Biernacki and Feldman 1986).

Unfortunately, adherence to even these disinfection procedures was not regular. Only a small minority (21%) indicated that they nearly always followed their reported procedure. The majority (64%) failed to report consistent adherence. Between these extremes were relatively small numbers of IVDUs who reported "occasional" cleaning (3%), cleaning half the time (7%), and cleaning "most of the time" (3%). There were no statistically significant differences between the in-treatment and out-of-treatment groups with regard to adherence to needle-cleaning practices. These data suggest that at the time the data were collected, needle hygiene was generally poor among IVDUs in San Francisco, and that the majority of them routinely participated in behaviors known to efficiently transmit the virus.

Discussion

Because our study is intended to inform treatment and prevention efforts as to viable options for intervention, we examined the distribution of IVDUs by neighborhood and in

relation to their treatment status. Synthetic estimates for fiscal year (FY) 1985-86 place the point prevalence of IV drug use in San Francisco at 12,000 individuals, while the period prevalence is 18,000 (Newmeyer 1986). (Point prevalence is the number of persons who are *current* IVDUs at any point in time. The *period* prevalence is the number of persons who used drugs intravenously over a specified period, in this case one year.) Analysis of the San Francisco County drug-treatment data base revealed that 4,820 *different* individuals enrolled in treatment programs during the same period. Thus, only 27% of those at risk for AIDS during FY 1985-86 received drug treatment and benefited from the AIDS risk-reduction information available through treatment programs. Moreover, the average number of treatment episodes per IV drug-using treatment client in San Francisco during FY 1985-86 was 1.6. Thus the population is highly recidivistic. This suggests that, of the general population of IVDUs in San Francisco, there is a subpopulation that are oriented toward treatment, and a larger group that, for a variety of reasons, do not present themselves for treatment, and do not routinely interact with treatment programs. Among the out-of-treatment respondents in our study, we found that roughly two-thirds had not enrolled in treatment programs in the past five years. Moreover, various studies, including our own, suggest that there are substantial numbers of IVDUs who, for various reasons, prefer not to enter treatment programs (Goldsmith et al. 1984; Hanson et al. 1985; Rounsaville and Kleber 1985; Rosenbaum 1981; Zinberg 1984). Thus, even if treatment services were quadrupled in San Francisco, there would in all probability be a large number (perhaps a majority) of IVDUs who would not volunteer for treatment.

While adequate treatment resources are imperative, the feasibility of even doubling treatment dollars and treatment slots in sufficient time to significantly slow the spread of the virus is doubtful. All of this means that AIDS education efforts must be brought to the majority of IVDUs who are not connected to treatment programs in ways that are effective

and have a reasonable likelihood of success. While the role of treatment programs in the array of needed services must not be de-emphasized, there can be no mistaking the necessity for efforts directed toward the large out-of-treatment group (Watters et al. 1986). Thus, our data suggest that cities that rely upon drug treatment as the solution to AIDS among IVDUs will fail to suppress the spread of the AIDS virus in this population.

An illustration may be helpful in this regard. If, for example, there are 18,000 IVDUs active during FY 1985-86, and the overall HIV seroprevalence rate is 9%, then one would expect about 1,600 seropositive IVDUs in San Francisco by the end of that period. The county drug-treatment data base showed an active case load of 4,820 individual IVDUs during that period, leaving about 13,000 IVDUs who did not receive treatment. Applying our 9% overall HIV seroprevalence rate to this group, we can expect to find 1,100-1,200 seropositive IVDUs out of treatment, and 400-450 seropositive IVDUs who were enrolled in treatment programs during the year. Given what we know about the needle hygiene of IVDUs in San Francisco, the epidemic liability appears to be substantial, and the greatest risk for contagion appears to be among IVDUs who do not interact with treatment programs.

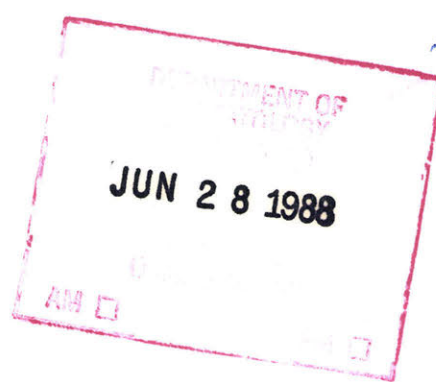
Unfortunately, our research in San Francisco does not tell us how similar or dissimilar our situation is with respect to other metropolitan areas with significant numbers of IVDUs. However, our review of synthetic estimates of numbers of IVDUs and dynamic treatment capacity in the five California counties with the largest number of AIDS cases reveals quite similar proportions. Thus, it must be emphasized that if we are to be successful in thwarting the spread of AIDS among IVDUs, their sexual partners, and their children, we will have to mount a massive public health campaign. This effort must be directed at the IVDU who remains outside of our current array of public health services, and must receive support at a level that is proportional to the magnitude of the problem.

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G.O.
SFHAS
file



27 June 1988

TO: David Kincaid
Survey Research Center

FROM: Yvonne De Souza
UCSF AIDS Specimen Bank

RE: Compliance with Health and Safety Provisions of the NIAID Contract

The UCSF AIDS Specimen Bank, under the direction of Dr. John S. Greenspan, is housed in Health Sciences West 604. This laboratory facility has a P2* rating. This means all researchers and specimen bank technicians work with potential HBV/HIV infected materials such as blood, human cells, saliva, and human tissue.

Standard microbiological practices are maintained throughout the laboratory to ensure laboratory personnel do not become infected with biohazardous materials. These standard procedures involve the following:

- a. No mouth pipetting.
- b. Eating, drinking, smoking, and applying cosmetics are not permitted in lab areas.
- c. **ALL** infectious liquids and solid wastes are decontaminated prior to disposal. This usually involves the use of an autoclave.
- d. Work surfaces are decontaminated daily.
- e. All lab personnel must wash their hands after handling infectious materials and prior to leaving the laboratory.
- f. All lab procedures must be performed carefully to prevent the production of aerosols.
- g. Lab coats or surgical gowns must be worn over street clothes.

In conjunction with standard microbiological protocols, personnel are instructed to handle infectious materials at **Biosafety 2** according to the CDC/NIH Biosafety Manual. These procedures are the following:

- a. All laboratory personnel must be trained and educated in the handling of infectious materials. All personnel **must** read our infection control policies and sign a document stating that they have read and understood our lab policies in the handling of human specimens.

- b. Access to the lab is limited.
- c. Majority of most lab experiments/procedures are performed in a Class II Biosafety hood. ALL specimen bank work such as aliquoting must be performed under the Biosafety Hood.
- d. All entrances leading into our P2* lab facilities have the universal biohazard signs that warn of the type of viral agents that are researched within the lab (eg: HIV,HBV,HSV,CMV, and EBV).
- e. All infectious materials are carried in a closed leak-proof container whenever specimens are to be transported throughout the laboratory.
- f. To prevent contamination through the skin all personnel should wear a lab coat/gown and gloves. All specimen bank workers must wear a gown, 2 pairs of gloves, and a mask in case aerosols are generated.
- g. All lab clothing must be removed from an individual prior to their exiting the lab facilities and entering a non-lab facility.
- h. All lab wastes are decontaminated prior to disposal. (Bleach is added to liquid wastes prior to autoclaving and solid wastes are autoclaved in autoclavable containers).
- i. In the Specimen Bank we try to avoid the usage of needles in our daily procedures. In case a needle must be used, the contaminated needle is placed in a puncture-resistant container, autoclaved, and disposed.
- j. Lab counter tops or instruments are decontaminated with Westcodyne (diluted to 75 ppm titratable iodine) or with 0.5% sodium hypochlorite (bleach).
- k. Any lab accidents such as spills or needle-sticks are reported to me and Dr. Greenspan. Records are maintained and, if necessary, proper medical evaluation; surveillance, and treatment would be administered.

As of May 1988, our laboratory's infection control precautions will be based on a policy of Body Substance Precautions. All who work with human tissues and fluids must practice care in the processing of these specimens whether or not they come from a patient who is diagnosed as having an infection. Thus, by adopting this policy our workers will have increased protection from infectious agents.

Please see the attached copies of the current handout we provide all lab personnel in HSW 604. These documents will demonstrate the strong commitment we have toward infection control.

cc: Dr. John S. Greenspan
Ms Georgette Overby

TO: Sally Elliott
FROM: W. Winkelstein *Wink*
RE: Work statements for AIDS subcontracts
DATE: 18 July, 1988

Here are draft work statements for each of the AIDS subcontractors listed in your memorandum of July 8. I have tried to make these statements as concise as possible and, for that reason, they may not be sufficient. Please advise me promptly. Also, please be advised that I will be away from 25 July through 5 August. During that period, please address requests for information to Jim.

Repository - UCSF - Dr. Greenspan

Subcontractor shall provide the necessary personnel, facilities, and equipment to maintain a specimen repository capable of containing all specimens obtained during the first three years of the San Francisco Men's Health Study and subsequent four years. More than 100,000 specimens have already been accrued and approximately 150,000 more will accrue during the current contract.

Specific

1. Maintain freezers and other storage units capable of holding serum and other specimens at suitable temperatures for the duration of the contract.
2. Establish and maintain a computerized inventory system which can identify and locate specific specimens rapidly and efficiently.
3. Maintain a capability for aliquoting repository specimens for use by collaborating investigators pursuing approved research protocols.
4. Transfer on a regular basis designated specimens to the National Repository in Bethesda, MD as directed by project officer.
5. Observe biohazard procedures as required by NIH in accordance with criteria designated by the project officer.
6. Submit periodic reports as required by the principal investigator or project officer.

HIV Virology - Cancer Research Laboratory - Dr. Levy

In accordance with the objectives stated in the technical proposal and incorporated into the contract (section C, C.2) carry out five studies as described.

Specific

1. Perform virus isolations using the latest procedures developed in the laboratory of the Cancer Research Institute. Isolation from a variety of specimens in accordance with the particular study protocols.
2. Characterize viral isolates according to specific DNA characterization as required by specific protocols. Maintain viral isolates by appropriate techniques for subsequent restudy as new information regarding the natural history of HIV infection is developed.

Children's Hospital of San Francisco - Dr. Lang

Utilize the previous "statement of work" with the following changes:

Delete A.2, A.4.

Add B.8: Provide access to social worker at designated times for counseling regarding HIV related serostatus and symptomatology.

Irwin Memorial Blood Bank - Dr. Perkins

Use the same kind of statement that I used for Jay Levy's work, but add to it the A, B, C statements that are in the previous proposal.

California Public Health Foundation - Dr. Ascher

The viral and rickettsial disease laboratory of the California State Department of Health Services will conduct routine serological testing with confirmation of seroconverters in accordance with the protocol and will conduct a series of studies as outlined in the technical proposal.

Specific

1. All serum specimens from all members of the cohort will be examined by Elisa test at each examination cycle.
2. Newly positive specimens will be confirmed by
 - a. quantitative immunofluorescence
 - b. Western blot pattern analysis

3. Serologic tests for other viral agents will be conducted in accordance with requests by the principal investigator and mutual agreement by the laboratory.
4. Viral isolation will be undertaken on selected specimens in accordance with the protocol and requests of the principal investigator.
5. Limited isolations of other viral pathogens will be attempted in accordance with the protocol.
6. HIV antigen studies will be undertaken on all or a major proportion of serum specimens collected during the course of the study.
7. Other studies including neutralizing antibody and analysis of genetic diversity, cell tropism and cellular immune responses will be carried out.

I realize that these statements do not necessarily cover all of the work to be done in these laboratories and facilities. However, it is difficult to specify exactly what will be done in advance and if it is sufficient to justify the budgetary arrangements, it should satisfy the contractual requirements.

Thank you very much.

cc: Wiley, Meikle, Greenspan, Levy, Lang, Perkins, Ascher

WJH
7/7/88

Survey Research Center
July 8, 1988

To: Warren
From: Sally *SME*
Re: Work statements for AIDS subcontracts

Would you please write out a brief but comprehensive work statement for each of the AIDS subcontractors listed below. They should cover the entire period of the new contract, from 7/1/88 to 9/29/91.

I enclose copies of those done for Irwin and Children's Hospital for the old contract as examples. You should be receiving your copy of the approved contract from Mary any day now.

1. Repository Greenspan's lab
2. Virology Levy's lab
3. Children's Hospital of San Francisco
4. Irwin Memorial Blood Bank
5. California Public Health Foundation

When completed will you send them to me by courier since Bob Edwards is very anxious to get the information he needs to prepare the subcontracts as soon as possible.

Thanks for your help.

SUBCONTRACT NO.,

between

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

and

CHILDREN'S HOSPITAL OF SAN FRANCISCO

RECEIVED BY
ACCOUNTING OFFICE
CONTRACTS & GRANTS

JAN 4 1984

NAME	DATE	INIT
UFA		

SC0280
This subcontract made and entered into this 1st day of December, 1983 by and between The Regents of the University of California ("California") and Children's Hospital of San Francisco ("Subcontractor") pursuant to Contract No. N01-AI-32519 between the National Institute of Allergy and Infectious Diseases (NIAID) and California

26207
26208

ARTICLE 1. STATEMENT OF WORK

Subcontractor shall provide the necessary personnel, facilities and materials to investigate the natural history of Acquired Immune Deficiency Syndrome (AIDS) in twelve hundred designated healthy men (one thousand homosexual and two hundred heterosexual) including but not limited to the following:

A. SPECIFIC

1. Take medical history and perform limited physical examination directed at medical findings pertinent to AIDS

~~2. Conduct a detailed interview covering the social and environmental exposures considered relevant to the occurrence of AIDS using questionnaires designed by California's Survey Research Center.~~

njc
DELETE
OK

3. Collect biomedical specimens (blood, saliva, urine, semen and feces) in sufficient quantities for analysis by Subcontractor, Irwin Memorial Blood Bank (IMBB) and NIAID.
4. Examine the sera of 600 study subjects for the presence of anti-lymphocyte antibodies in the laboratory of Dr. Dobri Kiprov.

5. Perform complete blood counts with differential cell counts on all study subjects at each examination under the supervision of Dr. Thomas Jackson.
6. Process clinical specimens for storage/shipping and accession into repository according to established protocol.

B. GENERAL

1. Subjects will be scheduled for appointments at six month intervals during the three year clinical portion of the study. This will require Subcontractor to conduct approximately sixty examinations each week.
2. Nurse practitioners will perform the routine physical examinations in private examining rooms in Subcontractor's outpatient clinic. Study staff physicians shall be available during clinic hours for consultation regarding study subjects with questionable signs and symptoms.
 - a. Problems pertaining to testing for diagnosis related to AIDS will be closely followed by study physicians who, when possible, will participate in the definition of such problems with the subjects' personal physicians.
 - b. Problems identified by clinical or laboratory evaluations that require intervention will be referred by study staff physicians to subjects' personal physicians or, lacking such, to the providers of subjects' choice within the guidelines of "The -- Screening Protocol and Resource and Referral Lists" published by the San Francisco Department of Public Health.
 - c. Problems requiring urgent care will be handled at Subcontractor's clinical facilities under the supervision of the study staff physician on call in cooperation with subjects' personal physicians if possible.

3. The laboratory facilities employed in the study shall meet P II containment requirements. A twenty-four hour alarm system with on-call coverage in the event of freezer failure is required.
4. Additional tests and storage of biomedical specimens may be performed as mutually agreed upon between Subcontractor and California.
5. Access to and use of repository specimens will be restricted to California, Subcontractor and Irwin Memorial Blood Bank and for the purposes of this study only except as otherwise authorized in writing by California's Principal Investigator.
6. Examination reports will be identified by subject name and number. Upon completion, the reports will be submitted to California for coding and data entry.
7. Semi-annual progress reports will be submitted to Dr. Warren Winkelstein at California's School of Public Health. Progress reports will be due by January 31 and July 31 each year.

ARTICLE II. PERIOD OF PERFORMANCE

The period of performance shall be from the date of execution set forth above through September 29, 1987.

ARTICLE III. ALLOWABLE COST AND PAYMENT

- A. For the performance of this Subcontract, California shall pay to Subcontractor the cost thereof determined by California to be allowable in accordance with:

- (1) 34 CFR Part 74, Appendix E as in effect on the date of this Subcontract; and

112
SUBCONTRACT NO.

between

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

and

IRWIN MEMORIAL BLOOD BANK

This subcontract made and entered into this 1st day of December, 1983 by and between The Regents of the University of California ("California") and Irwin Memorial Blood Bank ("Subcontractor") pursuant to Contract No. NO1-A1-32519 between the National Institute of Allergy and Infectious Diseases (NIAID) and California

ARTICLE I. STATE OF WORK

- A. Subcontractor shall be responsible for analysis of total T cells, helper T cells, suppressor T cells, killer T cells, monocytes and total B cells in approximately 7200 blood samples. Blood samples will be provided to Subcontractor at the rate of approximately 60 samples per week.
- B. The laboratory used by Subcontractor for this work shall meet P11 containment requirements.
- C. Analysis results will be submitted to California continuously, however Subcontractor may batch results and submit them to California no less frequently than every two weeks.

ARTICLE II. PERIOD OF PERFORMANCE

The period of performance shall be from the date of execution set forth above through September 29, 1987.

September 6, 1988

TO: SFMHS Staff

FR: David Kincaid *DK*

RE: Next Meeting - September 13, 1988

The next Core/Administrative Meetings will be held on Tuesday, September 13, in the Survey Research Center Conference Room, 2538 Channing Way, Berkeley. The tentative schedule will be:

9:30 a.m. Core Meeting

10:30 a.m. Administrative Meeting

For your information, neither Jim Wiley nor Karen Garrett will be in attendance. Please let me know if you anticipate any problems or if you have any items for the agendas. Thanks.

DISTRIBUTION - Administrative Staff

BERKELEY:

Warren Winkelstein
Jim Wiley
Nancy Padian
Karen Garrett
Anne Benker
Deborah Dubroff

CHSF:

Bill Lang
Joseph Cecere
Joe Bender
Alan Dennen
Jaime Geaga
Tommy Gossett
Jamie Moran
Muriel Rose

UCSF REPOSITORY:

John Greenspan
Georgette Overby

IMBB:

Gillian Crutcher

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

14 July 1988

TO: Warren Winklestein
University of California, Berkeley
School of Public Health
Earl Warren Hall
Dept. of Biomedical and Environmental Health Sciences

FROM: John Greenspan *John*

RE: SFMHS-Freezers

The 4 freezers and accessories to store your sera within our facilities have arrived. These should provide more than enough space for your needs for quite some time. Please contact Yvonne De Souza at 476-1481 if you have specific questions.

cc: Joseph Cecere
Yvonne De Souza
Tom Gossett
William Lang
✓ Georgette Overby

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

14 July 1988

TO: Warren Winklestein
University of California, Berkeley
School of Public Health
Earl Warren Hall
Dept. of Biomedical and Environmental Health Sciences

FROM: John Greenspan *John*

RE: SFMHS-Freezers

Q.O.
SFMHS

The 4 freezers and accessories to store your sera within our facilities have arrived. These should provide more than enough space for your needs for quite some time. Please contact Yvonne De Souza at 476-1481 if you have specific questions.

cc: Joseph Cecere
Yvonne De Souza
Tom Gossett
William Lang
Georgette Overby

June 20, 1988

^F1^

^F2^

Dear ^F3^,

Enclosed you will find an abstract of a proposal on HIV-associated salivary gland disease we are doing. "We" are Morten Schiodt, Deborah Greenspan, Troy E. Daniels, John S. Greenspan and Emilio Khoury at the Oral AIDS Center, University of California, San Francisco.

We will submit the proposal to NIH by September 1, 1988 and to the AIDS Clinical Research Center (Ziegler) by July 30, 1988.

I would appreciate it if you would agree to participate in this collaborative study which will run for three years from April 1989 if funded.

I would like from you:

- 1) your NIH style curriculum vitae,
- 2) a list of your current support,
- 3) a letter from you telling us that you would like to participate in the proposed projects.

You will of course see and be able to comment on the proposal before it is submitted.

Sincerely,

Morten Schiodt, DDS, Dr. odont
Visiting Associate Professor

MS/lm

cc: J. Greenspan
D. Greenspan
T. Daniels
E. Khoury

Dr. Jay Levy^R
Box 0128, M 1282^R
Dr. Levy^R

^E

Dr. Jay Nelson^R
Department of Immunology
Scripps Clinical Research Center
La Jolla, CA^R
Dr. Nelson^R

^E

Dr. David Chernoff^R
Box 0324, A 548^R
Dr. Chernoff^R

^E

Dr. C. Daniel Sooy^R
SFGH 4M45^R
Dr. Sooy^R

^E

Dr. Jack Whitcher^R
Box 0412, S 315^R
Dr. Whitcher^R

^E

Dr. Joel Palefsky^R
Department of Medical Microbiology
Fairchild Building, Room D-035
Stanford University
Stanford, CA 94305^R
Dr. Palefsky^R

^E

NIAID ~~NIAID~~ children. Better Conf. Team CHMC.

5/21/84

Lang/Winkelstein et al.

① Sampling of heterosexual men is proving to be difficult

③ Five centers

N.W. - Chicago

Hopkins

[39 reviews as yet
1/2 had an abnormality]

* UCLA - Deidre

Pittsburgh

* SF

(Benker's, Bohannon)

③ Clinical "calibration" difficult.

Unlikely to miss important findings.

Shin lesions common - t₁ to refer & follow up.

15-30 mins per physical exam (every 4)

④ Shin testing. Return rate good.

⑤ ? 1 of us both at month blind & then also.

? DG to do training series & then perhaps set up referral pattern.

Mid-June.



- ⑥ Serum.
60 ml whole blood for serum
4 x 3 ml for MH
3 x 1.8" CH
3 x 1.8" Colloidal Deproval

Not getting much for bank.
(Red tops)

* Serum sep. tubes contain chemicals which interfere.

- ⑦ Semen - no good. Too old when received.
⑧ Feces - problems also.
⑨ H/S done at Irwin MBB

Dr. Greenspan

Dr Lang called 5/8/84
4:35.



△ Please call him on Monday
10-12 387-8800 387 8400
1-15- [redacted] 668-8211

Regarding his interest in research
on Thrush in gay men.

Handy

meta

NIDD



Kott.



1200 men

1,000 gay

door. to door

survey

follow every

branch

oral

candidians

are predictors

Bx's



Children's Hospital of San Francisco

Mailing Address: P.O. Box 3805 San Francisco, Ca. 94119

S.F. Men's Health Study

3927 Sacramento Street

San Francisco, California 94118

(415) 751-5459

A Hospital For Adults and Children

May 16, 1984

John Greenspan, B.D.S., Ph.D., F.R.C.
Debra Greenspan, B.D.S.
University of California, S.F.
School of Dentistry
Department of Stomatology
Health Sciences West 604
San Francisco, California 94143

Dear Drs. Greenspan and Greenspan:

Dr. William Lang has asked me to extend an invitation to you to join our staff at it's Monday morning meeting on May 21, 1984 at 9 o'clock. The meeting will be held at Children's Hospital of San Francisco at 3700 California Street in the Bothin Conference Room. Please ask for directions at the Information Booth in the lobby when you arrive. If you are unable to attend, you may reach me or you may leave a message at the number above.

I have enclosed copies of our pilot study plans which you may find useful. If there is anything further I can do for you, please do not hesitate to ask.

Yours truly,

Joseph A. Cecere
Administrative Coordinator

JAC: jac

PLANS FOR THE SAN FRANCISCO AIDS STUDY PILOT

I. INTRODUCTION

As we indicated in our original proposal (see page I-8), we plan to test all procedures through data entry (but excluding analysis) in a pilot study to insure that all aspects of our survey design are adequate -- including sampling techniques, recruitment procedures, interview schedule and related forms, laboratory procedures, plans for physical examinations, and all reporting forms.

In addition to the fact that the San Francisco study does not involve a group of volunteer subjects but instead seeks the cooperation of a probability sample of unmarried men, the size, scope and cost of this undertaking makes it important to anticipate problems and test procedures. The major factors that demand a pilot study include the following:

- A. Unusual sensitivity and nature of the questions: Most surveys involving the kinds of detailed personal questions contemplated on this survey have been restricted to so-called "samples" of volunteers, whose cooperation one can more easily count on. In addition, some of our questions have not been adequately tested. Even if certain questions cannot be changed, we must learn what the potential problems are so that we can alert interviewers on the main study on how to handle them.
- B. Potential contamination problem: If one were sampling the entire city of San Francisco or the entire Bay Area there would be far less danger of respondents either (1) coming to the clinic interview having rehearsed answers because they know what questions will be asked, or (2) refusing to come based on inaccurate reports of what they will be asked to do (including what the questions are).

- C. Atypical setting for field work: While we are delighted with the facilities made available by Children's Hospital, we do not know whether the clinical setting may have unanticipated effects on people's responses. In addition, since the budget does not provide for respondent payments, we must determine whether the location of the clinic (involving a special trip to the other side of the town, often through high crime areas) will be offset by the motivation of free physical examinations and testing.

- D. Coordinating clinical work and interview: Because interview length varies enormously and because the clinic facilities are available only at very limited times, we must learn how best to schedule each participant. We must experiment with switching the sequence of events even though our current plan is to complete the entire interview before the physical examination or specimen collection begins.

- E. Large budget means that potential savings are great: Because we will be interviewing the same people six times and because each interview involves physical exams and testing, small savings per individual loom large.

Because the pilot must help us to anticipate and to deal with all the foregoing issues, we plan to use the "worst case" approach -- it must teach us to deal with the worst problems in locating eligible gay and straight men, the worst difficulties in enumerating households, and the worst problems to be encountered in the clinic interview and exam. Details of this "worst case" approach will be discussed as appropriate in the pages that follow.

II. PLAN OF ATTACK

A. TIME TABLE

1. Starting date: Our pilot study is scheduled to begin on April 16.

While our pilot sample has been drawn and the staff for the pilot screening and interviewing is ready to begin, several obstacles stand in our way: While we will soon have an interview schedule which everyone has agreed upon, we must still allow enough time for (a) printing the interview schedules, (b) briefing the interviewers on both enumeration and screening procedures as well as interview procedures, (c) scheduling the clinic (since we will need it only for a few days), (d) completing and printing physical exam forms, (e) setting up the modum and transmittal system for medical data, checking the budget, hiring needed personnel, completing laboratory procedure manual, training laboratory and data entry personnel, and completing logistical arrangements for transferring specimens among the study sites. Once all of these tasks are accomplished, we can start work, following the calendar of events outlined below.

2. Calendar of events*

Day 1: Letters mailed to sample households
Questionnaires and other materials sent to printer
Recruiting of volunteers
Begin designing DDE instrument

Day 2: Interviewer briefing, study and practice on enumeration, screening and recruitment procedures

Day 5: First screening calls to locate eligible respondents

Days 10-11: Interviewer briefing, study and practice on clinic interviews and related procedures

Day 12: Preliminary debriefing on screening and recruiting procedures

Day 14: Clinic interviewing begins

Day 16: Start dress rehearsal of procedures for picking up specimens not collected in the lab

Day 20: First DDE training and production begins

Day 28: Final clinic interviews with people previously unavailable

* Unless otherwise specified, each task will be completed by the date indicated.

Day 30: All data collection completed
Debriefing of lab personnel
Day 32: Final interviewer debriefing
Day 34: All data reduction complete
Day 38: Complete analysis of pilot interview data and summary of
recommendations (lab, interview, etc.)
Day 40: Complete pilot report and recommended changes

B. SAMPLING

Except as indicated, we plan to follow the same sampling procedures which are to be used on the main study.

1. Sample size: We have selected four blocks and assigned 25 households or addresses in each with the expectation that these 100 households will yield approximately 30 completed interviews. This probability sample will be supplemented with a small sample of volunteers, as outlined in paragraph B-3 below.
2. Criteria for block selection: In keeping with the "worst case" approach, we have selected four blocks which are not part of our final sample.
 - a. Sexual orientation: The blocks chosen are expected to have a higher proportion of heterosexuals than those in the final study. Because the motivation for homosexual men to cooperate is so much more obvious, we must have this opportunity (1) for a few skilled interviewers to develop and to test the best approach (including persuasive arguments) to this less motivated group and (2) for us to learn how big this problem is likely to be. We are hopeful, for example, that these encounters will suggest a few sentences which might be added to either our initial letters to respondents or to the subsequent follow-up letters to initially reluctant respondents who need more information and/or more motivation.

- b. Ethnicity: We have included blocks with various ethnic orientations to determine whether people from certain backgrounds (such as Irish, blacks, Spanish origin, "macho" types, etc.) will require different approaches to obtain adequate cooperation.
- c. Potential contamination: In an effort to minimize the probability that those interviewed during the pilot will pass along information to those included in the final sample, we did not include some blocks in the heart of the "Castro district", from which so many respondents on the final study will come. But this also has one admittedly undesirable effect: the proportion of eligible unmarried men will probably be smaller on the pilot than on the final survey.
- d. Logistical problems: Our blocks present a "best case and worst case" approach to difficulties respondents may encounter in getting to the clinic for interviews, physical exams and lab tests. If public transportation is used, even a person in the "best case" block must transfer at least once to reach Children's Hospital. Since many respondents in the final sample will probably not be automobile owners and since the route to the clinic often involves transfers in neighborhoods that are generally conceded to be "high crime areas," it is essential that we learn now what impact these logistics problems are likely to have on the main study.

3. Supplementary sample of volunteers: In order to insure that we get an adequate sample for pilot interviews even if the area probability sample yields too few eligible unmarried men, we plan to increase our pilot data base at the lowest possible cost by recruiting volunteers (either homosexual or bisexual men). Because we feel it vital to test our clinic procedures under more realistic conditions (with a full "caseload", rather than under more relaxed if not leisurely conditions), it is essential that we augment our probability sample in this way. In addition, recruiting a group of volunteers for inclusion in the pilot will produce one valuable (albeit small) by-product: It may suggest some of the main dimensions of bias in those studies restricted to volunteer participants.

Because at this time we do not want to be inundated with volunteers (especially volunteers from our target area who could quite possibly fall into the main study by chance) we shall use volunteers through personal contacts in other heavily gay neighborhoods such as South-of-Market, Polk Gulch and Pacific Heights. We have had no difficulty in getting volunteers in this way for the earlier pre-tests of the interview schedule, and we expect to encounter even less difficulty in getting volunteers for the pilot, as there is the added benefit of blood and other testing as an inducement.

C. STAFFING

1. Interviewers: Four highly experienced interviewers will be assigned to both the field and clinic phases of this study. Our tentative plans are to use both male and female interviewers, representing both "gay" and "straight" sexual orientations.

2. Supervisory staff: Joe Everds will be on duty at the clinic at all the times we schedule interviews and physical exams there. Selma Monsky will provide back-up as needed, and whenever she is not available, one of the interviewers will work as Assistant Supervisor.

D. PREPARATION OF MATERIALS

Work is underway on the following materials, all of which will be ready before interviewers are briefed and the first calls are made at the blocks in our pilot sample:

1. Letters of introduction and Credentials kits (including supporting letters from representatives of gay community, political leaders, medical people, Dr. Kaslow, etc.)
2. Follow-up letters for reluctant respondents
3. Enumeration folders with screening interview schedule
4. Appointment forms and reminders (to give or send to respondents)
5. Maps, driving and parking directions, info on bus routes, etc.
6. Information sheet to leave with potential respondents (along with Appointment Reminder Form).
7. Informed Consent Form
8. Main questionnaire (interview schedule)
9. Continuation sheets as needed
10. Non-interview report forms
11. Sampling problem report forms
12. Clinic problem report forms (for no-shows, break-offs, missing data, etc.)
13. Follow-up medical advice form (what respondents who get sick should do)
14. Follow-up tracing data report (for respondents who move to complete and return to us).
15. Full-scale written Instructions for Interviewers
16. Pilot Interviewer Report Forms
 - a. Canvassing/screening/recruitment phase
 - b. Clinic interview phase

E. SCREENING CALLS

1. Letters to sample households will be mailed (or, in some cases, hand delivered) a few days before the interviewer's first call. We must find a balance (both in this letter and in the introduction at the household) between providing enough information to establish legitimacy and not providing so much that we encourage people to disguise their eligibility.

2. Scheduling screening calls: Because our target population is single men, it may be that we will find it advisable to change our normal field procedures regarding the times to call on each household. Normally, we make only one weekday daytime call before resorting exclusively to evening and weekend calls (with the exception of those persons whom neighbors or other informed persons suggest are more likely to be found at home during the normally less fruitful weekday daytime hours). While we will ask interviewers to start their screening calls during the weekday daylight hours as usual, we must be prepared to switch to a more flexible pattern if, for example, we find that it is easier to find single men in our age group (and in our sample blocks) at home during usual working hours than in the normally more productive evening and weekend hours. Similarly, we plan to keep our usual careful records on each call made per household (by day of week and time of day) to determine whether we have been overly optimistic in estimating the number of calls needed to enumerate most households which include unmarried adult men.

3. Enumeration and screening: As in most studies, we begin the pilot with the expectation that one occupant of most households can provide the limited data needed to determine whether anyone is eligible for interview. But only the pilot can tell us whether households with two or more eligible men will require more than the usual number of calls to determine how many people are eligible.

4. Recruiting and informing eligible men: Once we locate an eligible man in a sample household, the interviewer will give each (or leave for each who is not at home) a packet consisting of (a) a second letter, which expands on the themes included in the original letter sent to all sample households, (b) an Information Sheet giving more details about the logistics and other important facts, including the value (both medical and monetary) of the clinical procedures. In those cases in which the eligible person is at home, the interviewer will try to schedule an appointment and leave (c) information on bus routes or maps, driving and parking directions. In the course of the pilot, we will also experiment with two approaches regarding informed consent: eligible respondents in half the households will receive copies of the form to read before coming to the clinic, while the remaining half will not receive copies until they arrive at the clinic where someone will be available to answer questions as they arise. In either event, respondents will not be asked to sign the consent form until they come to the clinic.

F. SCHEDULING CLINIC VISITS

1. Time between screening and clinic visit: In order to anticipate the effect of delays in scheduling (and thus determine whether field efficiencies have any untoward effects on overall costs), we plan to schedule appointments for clinic visits at least one week after a respondent agrees to cooperate. This will help us determine when it's important to use written reminders or phone calls to confirm appointments made in advance. This will also permit us to check with "no-shows" to learn why some people who make appointments fail to keep them and will help us to design more effective procedures for the main study.
2. Allowing for failed appointments: The pilot will also tell us approximately what percentage of those who make appointments arrive late -- or fail to appear at all. On the assumption that this will happen more often than we like (as it has on similar studies being conducted with volunteers locally), we plan to overschedule (at the beginning, at least) by as much as 25% of normal. The pilot will help us to decide whether this kind of overscheduling is necessary, and, if so, to what extent. Because there will always be one or more supervisory staff members on hand, there will always be someone available to conduct every interview during those time slots when everyone scheduled actually appears on time (or when someone scheduled earlier appears an hour late).

G. SEQUENCE AND NATURE OF IN-CLINIC PROCEDURES

1. One of a group of volunteers will serve as receptionist every evening and Saturday that we will be operating in the clinic setting.
2. In-take and orientation: Upon arrival at the clinic, participants will be directed to a continuously running slide show which details the project and the scientists involved. A copy of the informed consent form will be given to each participant to sign after an opportunity to (a) read the statement if the person has not yet been able to do so, and (b) ask questions. Simple refreshments will be provided during any waiting period.
3. Vital signs and specimens: A volunteer will record each participant's vital signs and will instruct him on providing a urine specimen and a throat wash specimen. Containers for these specimens will have been prelabeled by laboratory personnel.
4. Interview: The personal interview will be conducted by one of the SRC interviewers assigned to the study, following written instructions that were studied thoroughly prior to a personal group briefing. Given the length of the interview per se, we will delay the previous step (vital signs and specimens) whenever a lengthy earlier interview makes it impossible for an interviewer to start an interview at the appointed time. In no case, however, will we begin an interview unless the consent statement has been read and signed.
5. History and physical exam: The nurse practitioner will take a brief medical history and physical examination, using the attached forms and protocol to record findings. The relevant parts of the completed interview will be given to the nurse practitioner before this part of the process begins. The physical examination will include the collection of a rectal swab in prelabeled holding media provided by the laboratory. Any abnormal findings requiring additional attention or referral will be recorded on the attached

form. After the participant dresses, the nurse practitioner will, with the help of the laboratory assistant, draw the required blood specimens. The required amounts of blood are 20 ml of EDTA anticoagulated blood, 60 ml of blood collected in preservative free heparin, and 60 ml of blood collected without anticoagulants. This blood will be collected via the following procedure: Vein access will be provided after preparation with a FREPP/PREP using an 18 gauge butterfly. The blood will be collected in pre-labeled syringes, containing the anticoagulants, and the syringes capped.

A topical anesthetic will be provided on request.

Following blood collection, the participant will be asked to provide a seminal fluid specimen, if he has been abstinent for two days. If he is unable, he will be provided with a collection kit and instructions for this procedure. The kit will include a container and a freeze-pack, contained in a styrofoam box. Courier pickup will be provided for this specimen two mornings after the interview.

Skin tests will be applied to participants. An appointment to read these tests will be made. For persons unable to return to the clinic, a nurse practitioner will be available to read the tests in the field.

6. Participant debriefing: Following completion of all procedures, the participant will be debriefed (by SRC supervisory staff during the pilot phase) to determine overall acceptability of all procedures. At this stage, the supervisor will attempt to predict the probability of continued participation on future waves.
7. Laboratory protocols: The laboratory will be provided with the identifying numbers of all participants who will be seen in clinic that evening or day. A specimen box containing prelabeled containers for all specimens will be generated and brought to the clinic. Upon completion of all specimen collection, the samples will be brought to the lab for processing. The specimens will be opened under the PII hood and processed according to the methods outlined in the laboratory procedure manual. The procedures are in brief:
 - a. EDTA whole blood will be transferred from syringes or blood bag tubes for transfer to IMBB and the Hematology Laboratory.
 - b. Serum will be decanted from the syringes and the remaining material transferred to a 50 ml centrifuge tube, capped, and centrifuged to recover remaining serum.
 - c. Urine will be mixed by swirling and decanted into vials.
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10. The Laboratory will be shut down and disinfected in accordance with the procedures manual.

H. POST-CLINIC SPECIMEN COLLECTION AND/OR TEST READINGS

Seminal fluid specimens and feces (if needed) will be returned to the lab via three routes:

1. Participants will return to the clinic to have their skin tests read and will deliver specimens at that time as necessary.
2. The nurse practitioner will read skin tests in the field and can also pick up any specimen.
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Results will be posted to the respondent's chart, and the chart will be set aside for review by the study physicians. Any clinically significant findings will be discussed with the participant by the nurse practitioner or study physician, as appropriate.

I. PILOT INTERVIEWER DEBRIEFING

1. Written interviewer reports: Each interviewer will be asked to complete a written questionnaire summarizing his or her experiences with the interview, and suggesting ways of overcoming any major problems encountered. These report forms will be provided before the first day of pilot interviewing in the clinic to insure that interviewers are aware of some of the issues that concern us. The report forms will be delivered to supervisory staff at the group debriefing to permit careful analysis and summary of interviewers' experiences.
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In a separate meeting, the nurse practitioners and other medical personnel assigned to the pilot will meet with both of the P.I.'s as well as with the other key medical staff, including Bob Anderson, Bill Lang and David Lyman. Except for those highly technical medical aspects of the debriefing, Selma Monsky and Joe Everds will also

be invited to attend in the hope that some of the insights that can be gained only by the nurse practitioners in this setting can be passed along and used as appropriate to alter future procedures involving interviewers and other SRC staff.

III. OUTCOMES OF THE PILOT

A. POTENTIAL TROUBLE SPOTS

1. Enumeration: While we do not need data on household composition in those households with no eligible men, we must try to disguise the selection criteria somewhat to insure that we do not at the very outset lose some people who might easily be persuaded to cooperate if they had a fuller picture of the study and its potential benefits. The pilot should tell us the best approach to getting the maximum effect from the minimum number of questions and contacts. Drawing the line between giving potential respondents misleading information and telling them too much promises to be a major outcome which will affect not only overall response rates but costs as well.
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who arrive late or fail to come to the clinic at all. While we do not expect the length of the physical exam and specimen collection to be a major problem, this is yet to be tested. Finally we must learn from the pilot how much interview length varies from one respondent to another, and to find ways to cope with the impact of such variability. Finally, we have no way of knowing whether our inability to schedule weekday, daytime interviews in the clinic will present major or minor problems, but the pilot should give us the answer to this.

4. Transportation and parking problems: Since parking near Children's Hospital at night rarely presents problems, our primary concern in this area centers about the problems involved in getting from the greater Castro area to the clinic using public transportation. If this presents problems during the pilot, we may want to experiment with the relative costs of paying interviewers or someone else to chauffeur respondents to and from the clinic vs the cost of paying interviewers to sit in the clinic when there aren't enough respondents to go around.
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7. Attitudes toward location and atmosphere of clinic: As indicated earlier, we feel that the clinic setting in which interviewers and other staff will be working is excellent, but we must find out whether our respondents share our views. If they find it either sterile or frightening, it is best to learn this now while there is time to make changes.
8. Cooperation of sub-groups: As indicated in paragraph A-2 above, we are more concerned with the problem of getting the cooperation of heterosexuals and closet homosexuals than that of overt, practicing gay men. But there are two other groups that deserve attention: (a) We must find ways to motivate monogamous and/or celibate gay men who feel that their personal risk of contracting AIDS is slight; and (b) We must find ways to gain the cooperation of two or more people in those households with more than one unmarried man in our age group.
9. General respondent reactions: We recognize that reactions to several aspects of the study may spell the difference between success and failure in the follow-up waves of interviewing. We refer primarily to interview length, interview content, nature of lab procedures and specimen collection, waiting time within the clinic (either for interview or for medical exams or procedures). While there is little that can be done about interview length and content between the conclusion of the pilot and Wave I interviewing, there should be time to change lab procedures and/or to find ways of reducing waiting time if that appears to be a major deterrent. Similarly, we must learn

whether there are ways to compensate for loss of interest anticipated after a long elapsed time between recruitment and clinic interview, which could conceivably introduce efficiencies in the field by condensing the field work period.

10. Contamination among respondents in the same block or in the same household: Rarely does a study involving area probability sampling concentrate on such a small geographical area at the same time that it is restricted to a relatively homogeneous group of men. This increases the risk that respondents may come to the interview fully informed -- or misinformed -- about the content, nature or wording of questions. While such word of mouth can be advantageous, it could also be extremely problematic if the gay community reacts negatively to parts of the interview or if the consensus is that the study is not designed to help gay men.
11. Reliability and role of volunteer staff: Because of the excessive length of the core questionnaire and the desirability of asking a number of questions of local interest, especially concerning nutrition, we plan on using, if feasible, a number of volunteers from local Gay organizations in the clinic setting. They can acquaint respondents with the procedures to be followed, guide them (when needed) to interview and examination rooms, and check the forms respondents fill out themselves for completeness. And of course we will attempt to use volunteers to administer an additional short questionnaire.

The pilot will give us a chance to check on their reliability and the quality of the help we can expect from this source and see if such planning is feasible.

PLANS FOR THE SAN FRANCISCO AIDS STUDY PILOT

I. INTRODUCTION

As we indicated in our original proposal (see page I-8), we plan to test all procedures through data entry (but excluding analysis) in a pilot study to insure that all aspects of our survey design are adequate -- including sampling techniques, recruitment procedures, interview schedule and related forms, laboratory procedures, plans for physical examinations, and all reporting forms.

In addition to the fact that the San Francisco study does not involve a group of volunteer subjects but instead seeks the cooperation of a probability sample of unmarried men, the size, scope and cost of this undertaking makes it important to anticipate problems and test procedures. The major factors that demand a pilot study include the following:

- A. Unusual sensitivity and nature of the questions: Most surveys involving the kinds of detailed personal questions contemplated on this survey have been restricted to so-called "samples" of volunteers, whose cooperation one can more easily count on. In addition, some of our questions have not been adequately tested. Even if certain questions cannot be changed, we must learn what the potential problems are so that we can alert interviewers on the main study on how to handle them.
- B. Potential contamination problem: If one were sampling the entire city of San Francisco or the entire Bay Area there would be far less danger of respondents either (1) coming to the clinic interview having rehearsed answers because they know what questions will be asked, or (2) refusing to come based on inaccurate reports of what they will be asked to do (including what the questions are).

- C. Atypical setting for field work: While we are delighted with the facilities made available by Children's Hospital, we do not know whether the clinical setting may have unanticipated effects on people's responses. In addition, since the budget does not provide for respondent payments, we must determine whether the location of the clinic (involving a special trip to the other side of the town, often through high crime areas) will be offset by the motivation of free physical examinations and testing.
- D. Coordinating clinical work and interview: Because interview length varies enormously and because the clinic facilities are available only at very limited times, we must learn how best to schedule each participant. We must experiment with switching the sequence of events even though our current plan is to complete the entire interview before the physical examination or specimen collection begins.
- E. Large budget means that potential savings are great: Because we will be interviewing the same people six times and because each interview involves physical exams and testing, small savings per individual loom large.

Because the pilot must help us to anticipate and to deal with all the foregoing issues, we plan to use the "worst case" approach -- it must teach us to deal with the worst problems in locating eligible gay and straight men, the worst difficulties in enumerating households, and the worst problems to be encountered in the clinic interview and exam. Details of this "worst case" approach will be discussed as appropriate in the pages that follow.

II. PLAN OF ATTACK

A. TIME TABLE

1. Starting date: Our pilot study is scheduled to begin on April 16.

While our pilot sample has been drawn and the staff for the pilot screening and interviewing is ready to begin, several obstacles stand in our way: While we will soon have an interview schedule which everyone has agreed upon, we must still allow enough time for (a) printing the interview schedules, (b) briefing the interviewers on both enumeration and screening procedures as well as interview procedures, (c) scheduling the clinic (since we will need it only for a few days), (d) completing and printing physical exam forms, (e) setting up the modum and transmittal system for medical data, checking the budget, hiring needed personnel, completing laboratory procedure manual, training laboratory and data entry personnel, and completing logistical arrangements for transferring specimens among the study sites. Once all of these tasks are accomplished, we can start work, following the calendar of events outlined below.

2. Calendar of events*

Day 1: Letters mailed to sample households
Questionnaires and other materials sent to printer
Recruiting of volunteers
Begin designing DDE instrument

Day 2: Interviewer briefing, study and practice on enumeration, screening and recruitment procedures

Day 5: First screening calls to locate eligible respondents

Days 10-11: Interviewer briefing, study and practice on clinic interviews and related procedures

Day 12: Preliminary debriefing on screening and recruiting procedures

Day 14: Clinic interviewing begins

Day 16: Start dress rehearsal of procedures for picking up specimens not collected in the lab

Day 20: First DDE training and production begins

Day 28: Final clinic interviews with people previously unavailable

* Unless otherwise specified, each task will be completed by the date indicated.

- Day 30: All data collection completed
Debriefing of lab personnel
- Day 32: Final interviewer debriefing
- Day 34: All data reduction complete
- Day 38: Complete analysis of pilot interview data and summary of recommendations (lab, interview, etc.)
- Day 40: Complete pilot report and recommended changes

B. SAMPLING

Except as indicated, we plan to follow the same sampling procedures which are to be used on the main study.

1. Sample size: We have selected four blocks and assigned 25 households or addresses in each with the expectation that these 100 households will yield approximately 30 completed interviews. This probability sample will be supplemented with a small sample of volunteers, as outlined in paragraph B-3 below.
2. Criteria for block selection: In keeping with the "worst case" approach, we have selected four blocks which are not part of our final sample.
 - a. Sexual orientation: The blocks chosen are expected to have a higher proportion of heterosexuals than those in the final study. Because the motivation for homosexual men to cooperate is so much more obvious, we must have this opportunity (1) for a few skilled interviewers to develop and to test the best approach (including persuasive arguments) to this less motivated group and (2) for us to learn how big this problem is likely to be. We are hopeful, for example, that these encounters will suggest a few sentences which might be added to either our initial letters to respondents or to the subsequent follow-up letters to initially reluctant respondents who need more information and/or more motivation.

- b. Ethnicity: We have included blocks with various ethnic orientations to determine whether people from certain backgrounds (such as Irish, blacks, Spanish origin, "macho" types, etc.) will require different approaches to obtain adequate cooperation.
- c. Potential contamination: In an effort to minimize the probability that those interviewed during the pilot will pass along information to those included in the final sample, we did not include some blocks in the heart of the "Castro district", from which so many respondents on the final study will come. But this also has one admittedly undesirable effect: the proportion of eligible unmarried men will probably be smaller on the pilot than on the final survey.
- d. Logistical problems: Our blocks present a "best case and worst case" approach to difficulties respondents may encounter in getting to the clinic for interviews, physical exams and lab tests. If public transportation is used, even a person in the "best case" block must transfer at least once to reach Children's Hospital. Since many respondents in the final sample will probably not be automobile owners and since the route to the clinic often involves transfers in neighborhoods that are generally conceded to be "high crime areas," it is essential that we learn now what impact these logistics problems are likely to have on the main study.

3. Supplementary sample of volunteers: In order to insure that we get an adequate sample for pilot interviews even if the area probability sample yields too few eligible unmarried men, we plan to increase our pilot data base at the lowest possible cost by recruiting volunteers (either homosexual or bisexual men). Because we feel it vital to test our clinic procedures under more realistic conditions (with a full "caseload", rather than under more relaxed if not leisurely conditions), it is essential that we augment our probability sample in this way. In addition, recruiting a group of volunteers for inclusion in the pilot will produce one valuable (albeit small) by-product: It may suggest some of the main dimensions of bias in those studies restricted to volunteer participants.

Because at this time we do not want to be inundated with volunteers (especially volunteers from our target area who could quite possibly fall into the main study by chance) we shall use volunteers through personal contacts in other heavily gay neighborhoods such as South-of-Market, Polk Gulch and Pacific Heights. We have had no difficulty in getting volunteers in this way for the earlier pre-tests of the interview schedule, and we expect to encounter even less difficulty in getting volunteers for the pilot, as there is the added benefit of blood and other testing as an inducement.

C. STAFFING

1. Interviewers: Four highly experienced interviewers will be assigned to both the field and clinic phases of this study. Our tentative plans are to use both male and female interviewers, representing both "gay" and "straight" sexual orientations.

2. Supervisory staff: Joe Everds will be on duty at the clinic at all the times we schedule interviews and physical exams there. Selma Monsky will provide back-up as needed, and whenever she is not available, one of the interviewers will work as Assistant Supervisor.

D. PREPARATION OF MATERIALS

Work is underway on the following materials, all of which will be ready before interviewers are briefed and the first calls are made at the blocks in our pilot sample:

1. Letters of introduction and Credentials kits (including supporting letters from representatives of gay community, political leaders, medical people, Dr. Kaslow, etc.)
2. Follow-up letters for reluctant respondents
3. Enumeration folders with screening interview schedule
4. Appointment forms and reminders (to give or send to respondents)
5. Maps, driving and parking directions, info on bus routes, etc.
6. Information sheet to leave with potential respondents (along with Appointment Reminder Form).
7. Informed Consent Form
8. Main questionnaire (interview schedule)
9. Continuation sheets as needed
10. Non-interview report forms
11. Sampling problem report forms
12. Clinic problem report forms (for no-shows, break-offs, missing data, etc.)
13. Follow-up medical advice form (what respondents who get sick should do)
14. Follow-up tracing data report (for respondents who move to complete and return to us).
15. Full-scale written Instructions for Interviewers
16. Pilot Interviewer Report Forms
 - a. Canvassing/screening/recruitment phase
 - b. Clinic interview phase

E. SCREENING CALLS

1. Letters to sample households will be mailed (or, in some cases, hand delivered) a few days before the interviewer's first call. We must find a balance (both in this letter and in the introduction at the household) between providing enough information to establish legitimacy and not providing so much that we encourage people to disguise their eligibility.

2. Scheduling screening calls: Because our target population is single men, it may be that we will find it advisable to change our normal field procedures regarding the times to call on each household. Normally, we make only one weekday daytime call before resorting exclusively to evening and weekend calls (with the exception of those persons whom neighbors or other informed persons suggest are more likely to be found at home during the normally less fruitful weekday daytime hours). While we will ask interviewers to start their screening calls during the weekday daylight hours as usual, we must be prepared to switch to a more flexible pattern if, for example, we find that it is easier to find single men in our age group (and in our sample blocks) at home during usual working hours than in the normally more productive evening and weekend hours. Similarly, we plan to keep our usual careful records on each call made per household (by day of week and time of day) to determine whether we have been overly optimistic in estimating the number of calls needed to enumerate most households which include unmarried adult men.

3. Enumeration and screening: As in most studies, we begin the pilot with the expectation that one occupant of most households can provide the limited data needed to determine whether anyone is eligible for interview. But only the pilot can tell us whether households with two or more eligible men will require more than the usual number of calls to determine how many people are eligible.

4. Recruiting and informing eligible men: Once we locate an eligible man in a sample household, the interviewer will give each (or leave for each who is not at home) a packet consisting of (a) a second letter, which expands on the themes included in the original letter sent to all sample households, (b) an Information Sheet giving more details about the logistics and other important facts, including the value (both medical and monetary) of the clinical procedures. In those cases in which the eligible person is at home, the interviewer will try to schedule an appointment and leave (c) information on bus routes or maps, driving and parking directions. In the course of the pilot, we will also experiment with two approaches regarding informed consent: eligible respondents in half the households will receive copies of the form to read before coming to the clinic, while the remaining half will not receive copies until they arrive at the clinic where someone will be available to answer questions as they arise. In either event, respondents will not be asked to sign the consent form until they come to the clinic.

F. SCHEDULING CLINIC VISITS

1. Time between screening and clinic visit: In order to anticipate the effect of delays in scheduling (and thus determine whether field efficiencies have any untoward effects on overall costs), we plan to schedule appointments for clinic visits at least one week after a respondent agrees to cooperate. This will help us determine when it's important to use written reminders or phone calls to confirm appointments made in advance. This will also permit us to check with "no-shows" to learn why some people who make appointments fail to keep them and will help us to design more effective procedures for the main study.

2. Allowing for failed appointments: The pilot will also tell us approximately what percentage of those who make appointments arrive late -- or fail to appear at all. On the assumption that this will happen more often than we like (as it has on similar studies being conducted with volunteers locally), we plan to overschedule (at the beginning, at least) by as much as 25% of normal. The pilot will help us to decide whether this kind of overscheduling is necessary, and, if so, to what extent. Because there will always be one or more supervisory staff members on hand, there will always be someone available to conduct every interview during those time slots when everyone scheduled actually appears on time (or when someone scheduled earlier appears an hour late).

G. SEQUENCE AND NATURE OF IN-CLINIC PROCEDURES

1. One of a group of volunteers will serve as receptionist every evening and Saturday that we will be operating in the clinic setting.
2. In-take and orientation: Upon arrival at the clinic, participants will be directed to a continuously running slide show which details the project and the scientists involved. A copy of the informed consent form will be given to each participant to sign after an opportunity to (a) read the statement if the person has not yet been able to do so, and (b) ask questions. Simple refreshments will be provided during any waiting period.
3. Vital signs and specimens: A volunteer will record each participant's vital signs and will instruct him on providing a urine specimen and a throat wash specimen. Containers for these specimens will have been pre-labeled by laboratory personnel.
4. Interview: The personal interview will be conducted by one of the SRC interviewers assigned to the study, following written instructions that were studied thoroughly prior to a personal group briefing. Given the length of the interview per se, we will delay the previous step (vital signs and specimens) whenever a lengthy earlier interview makes it impossible for an interviewer to start an interview at the appointed time. In no case, however, will we begin an interview unless the consent statement has been read and signed.
5. History and physical exam: The nurse practitioner will take a brief medical history and physical examination, using the attached forms and protocol to record findings. The relevant parts of the completed interview will be given to the nurse practitioner before this part of the process begins. The physical examination will include the collection of a rectal swab in pre-labeled holding media provided by the laboratory. Any abnormal findings requiring additional attention or referral will be recorded on the attached

form. After the participant dresses, the nurse practitioner will, with the help of the laboratory assistant, draw the required blood specimens. The required amounts of blood are 20 ml of EDTA anticoagulated blood, 60 ml of blood collected in preservative free heparin, and 60 ml of blood collected without anticoagulants. This blood will be collected via the following procedure: Vein access will be provided after preparation with a FREPP/PREP using an 18 gauge butterfly. The blood will be collected in pre-labeled syringes, containing the anticoagulants, and the syringes capped.

A topical anesthetic will be provided on request.

Following blood collection, the participant will be asked to provide a seminal fluid specimen, if he has been abstinent for two days. If he is unable, he will be provided with a collection kit and instructions for this procedure. The kit will include a container and a freeze-pack, contained in a styrofoam box. Courier pickup will be provided for this specimen two mornings after the interview.

Skin tests will be applied to participants. An appointment to read these tests will be made. For persons unable to return to the clinic, a nurse practitioner will be available to read the tests in the field.

6. Participant debriefing: Following completion of all procedures, the participant will be debriefed (by SRC supervisory staff during the pilot phase) to determine overall acceptability of all procedures. At this stage, the supervisor will attempt to predict the probability of continued participation on future waves.
7. Laboratory protocols: The laboratory will be provided with the identifying numbers of all participants who will be seen in clinic that evening or day. A specimen box containing prelabeled containers for all specimens will be generated and brought to the clinic. Upon completion of all specimen collection, the samples will be brought to the lab for processing. The specimens will be opened under the PII hood and processed according to the methods outlined in the laboratory procedure manual. The procedures are in brief:
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6. Problems in physical exam or lab procedures: While these procedures seem at this stage to be foolproof, we would be foolish not to expect possible problems which we do not anticipate. If any appear during the pilot, we must face the possible necessity for changing some of those procedures.

7. Attitudes toward location and atmosphere of clinic: As indicated earlier, we feel that the clinic setting in which interviewers and other staff will be working is excellent, but we must find out whether our respondents share our views. If they find it either sterile or frightening, it is best to learn this now while there is time to make changes.
8. Cooperation of sub-groups: As indicated in paragraph A-2 above, we are more concerned with the problem of getting the cooperation of heterosexuals and closet homosexuals than that of overt, practicing gay men. But there are two other groups that deserve attention: (a) We must find ways to motivate monogamous and/or celibate gay men who feel that their personal risk of contracting AIDS is slight; and (b) We must find ways to gain the cooperation of two or more people in those households with more than one unmarried man in our age group.
9. General respondent reactions: We recognize that reactions to several aspects of the study may spell the difference between success and failure in the follow-up waves of interviewing. We refer primarily to interview length, interview content, nature of lab procedures and specimen collection, waiting time within the clinic (either for interview or for medical exams or procedures). While there is little that can be done about interview length and content between the conclusion of the pilot and Wave I interviewing, there should be time to change lab procedures and/or to find ways of reducing waiting time if that appears to be a major deterrent. Similarly, we must learn

whether there are ways to compensate for loss of interest anticipated after a long elapsed time between recruitment and clinic interview, which could conceivably introduce efficiencies in the field by condensing the field work period.

10. Contamination among respondents in the same block or in the same household: Rarely does a study involving area probability sampling concentrate on such a small geographical area at the same time that it is restricted to a relatively homogeneous group of men. This increases the risk that respondents may come to the interview fully informed -- or misinformed -- about the content, nature or wording of questions. While such word of mouth can be advantageous, it could also be extremely problematic if the gay community reacts negatively to parts of the interview or if the consensus is that the study is not designed to help gay men.
11. Reliability and role of volunteer staff: Because of the excessive length of the core questionnaire and the desirability of asking a number of questions of local interest, especially concerning nutrition, we plan on using, if feasible, a number of volunteers from local Gay organizations in the clinic setting. They can acquaint respondents with the procedures to be followed, guide them (when needed) to interview and examination rooms, and check the forms respondents fill out themselves for completeness. And of course we will attempt to use volunteers to administer an additional short questionnaire.

The pilot will give us a chance to check on their reliability and the quality of the help we can expect from this source and see if such planning is feasible.

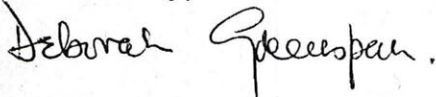
March 18, 1985

Warren Winkelstein, MD, MPH
School of Public Health
140 Warren Hall
UC Berkeley 947 20

Dear Warren:

I am pleased to learn about the ongoing female partners study. I would be happy to examine the mouths of those women who agree, to look for evidence of oral lesions, including oral candidiasis and hairy leukoplakia. In addition, I will refer female partners of men I have examined to you.

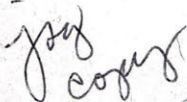
Yours sincerely,



Deborah Greenspan, BDS
Assistant Clinical Professor
Division of Oral Biology

DG/lm

Enclosures



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SANTA BARBARA • SANTA CRUZ

SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF BIOMEDICAL AND
ENVIRONMENTAL HEALTH SCIENCES

EARL WARREN HALL
BERKELEY, CALIFORNIA 94720

March 4, 1985

Drs. John and Debra Greenspan
28 Southridge East
Tiburon, CA 94920

Dear John and Debra,

I am enclosing three interviews currently being used in various AIDS studies. I can help you select particular questions that deal specifically with risk, or ones you might be especially interested in.

I spoke with Warren, and we agreed that a case-control study would be the most efficient way to examine the association between hairy cell leukoplakia and AIDS. I drafted a sample protocol which incorporates some of the methodology a prospective study would employ. This way you can compare cases and controls, and follow them as well, to determine the natural history of hairy cell leukoplakia and its temporal relation to AIDS.

Sincerely,

Nancy Padian

Nancy Padian, MS, MPH



University of California San Francisco
School of Dentistry
Division of Oral Biology
HSW-604
San Francisco, California 94143
(415) 666-2943
John S. Greenspan
BSc, BDS, PhD, FRCPath
Professor and Chairman

December 12, 1984

Warren Winkelstein, Jr., MD, MPH
Professor of Epidemiology
Department of Biomedical and
Environmental Sciences
School of Public Health
Earl Warren Hall
University of California
Berkeley, CA 94720

Dear Warren:

We are now ready to do something on the epidemiology of hairy leukoplakia. Are you and Nancy Padian still interested? Perhaps you could call me when you get a moment.

Sincerely,

A handwritten signature in black ink, appearing to read "John", with a stylized flourish extending from the end.

John S. Greenspan

JSG/lm

cc: Dr. Deborah Greenspan

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SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF BIOMEDICAL AND
ENVIRONMENTAL HEALTH SCIENCES

EARL WARREN HALL
BERKELEY, CALIFORNIA 94720

August 9, 1984

John Greenspan, MD.
Professor and Chairman
Department of Oral Biology
Health Services West 604
UCSF San Francisco, Ca.

Dear John:

Ms. Nancy Padian, a doctoral student in this Department and my advisee, has indicated that she would like to consider studying the epidemiology of "hairy leukoplakia" as her dissertation project. This research would, I understand, be undertaken in your Department under your overall guidance. I think the project would be quite suitable and I'm prepared to provide her with encouragement and advice in this endeavor. I would assume that when her dissertation committee is established, you would be a member.

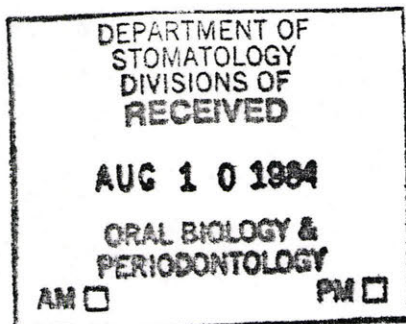
I'm enclosing a copy of my curriculum vitae which, I understand, is necessary for you to be able to procure funds for Ms. Padian's support.

Thank you very much

Sincerely yours,

Warren Winkelstein Jr., MD., MPH.
Professor of Epidemiology

WW:gc





University of California San Francisco

School of Dentistry

Division of Oral Biology

HSW-604

San Francisco, California 94143

(415) 666-2943

John S. Greenspan

BSc, BDS, PhD, FRCPath

Professor and Chairman

August 24, 1984

Warren Winkelstein Jr., MD., MPH.
Professor of Epidemiology
University of California, Berkeley
School of Public Health
Department of Biomedical and
Environmental Health Sciences
Earl Warren Hall
Berkeley, California 94720

Dear Warren,

Thank you for your letter of August 9, 1984. We do indeed hope to collaborate with you and to work with Nancy Padian on the epidemiology of hairy leukoplakia. We are in the process of applying for funding and your letter will be most helpful.

If you happen to have a copy of an NIH style biographical sketch, which you could let me have, it would be useful.

With kind regards.

Yours sincerely,

A handwritten signature in cursive script that reads "John S. Greenspan". The signature is written in dark ink and is positioned above the printed name.

John S. Greenspan

JSG/cf

CURRICULUM VITAE

Warren Winkelstein, Jr., M.D.

BIRTHPLACE & DATE:

CITIZENSHIP: United States

FAMILY STATUS: Married, three children (Wife: Veva Kerrigan Winkelstein)

RESIDENCE:

EDUCATION:

B.A.: University of North Carolina 1943

M.D.: Syracuse University 1947

M.P.H.: Columbia University 1950

POSTGRADUATE TRAINING:

Internship: Charity Hospital of Louisiana (New Orleans) 1947-1948

Apprentice Epidemiologist: N.Y.S. Dept. of Health 1948-1949

Research Fellow, Department of Epidemiology,
Roswell Park Memorial Institute, Buffalo, N.Y. 1956-1957

PROFESSIONAL QUALIFICATIONS:

Medical Licensure: New York, Louisiana

Diplomat, American Board of Preventive Medicine

MILITARY SERVICE:

U.S. Army 1944-1946

U.S. Public Health Service 1951-1953

U.S. Public Health Service (Inactive Reserve;
Permanent Grade: Medical Director) 1953-present

POSITIONS:

County District Health Officer, Erie County Health
Department, Buffalo, N.Y. 1950-1951

Regional Representative, Public Health Division, Special Technical and Economic Mission to Cambodia, Laos, and Viet Nam (Mutual Security Agency), Hanoi, Viet Nam	1950-1951
Director, Division of Communicable Disease Control, Erie county Health Department, Buffalo, N.Y.	1953-1956
Chief, Dept. of Epidemiology, Chronic Disease Research Institute of the University of Buffalo, N.Y.	1957-1963
First Deputy Commissioner, Erie County Health Dept., Buffalo, N.Y.	1959-1962
Associate Professor (Epidemiology), Dept. of Preventive Medicine, State University of New York at Buffalo, School of Medicine	1962-1964
Professor, (Epidemiology) Dept. of Preventive Medicine, State University of New York at Buffalo, School of Medicine	1964-July 1968
Assistant Managing Editor and Editor, American Journal of Epidemiology	1965-1975
Professor of Epidemiology, Department of Biomedical and Environmental health Sciences, School of Public Health, University of California, Berkeley	July 1968-present
Associate Dean for Student and Academic Affairs, School of Public Health, University of California, Berkeley	May 1970-June 1971
Acting Dean, School of Public Health, University of California, Berkeley	July 1971-July 1972
Dean, School of Public Health, University of California, Berkeley	Sept 1972-Dec 1981

TEACHING:

Assistant (Part-time) State University of N.Y. at Buffalo	1953-1954
Instructor (Part-time) " " " "	1954-1955
Associate (Part-time) " " " "	1955-1956
Assistant Professor (Part-time) " " "	1956-1962
Associate Professor (Full-time) " " "	1962-1964
Professor (Full-time) " " " "	1964-July 1968

Visiting Professor, Dept. of Clinical Epidemiology
and Social Medicine, St. Thomas' Hospital
Medical School, London

April 1967

Professor, (Full-time) School of Public Health,
University of California, Berkeley

July 1968-present

HONORS AND AWARDS:

M.D. (Cum Laude) Syracuse University

1947

Special Research Fellow, National Heart Institute
(PHS)

1956-1957

Buswell Research Fellow, University of Buffalo

1958-1959

Research Career (Development) Program Award
HE-K3-6566 National Heart Institute (PHS)

1962-1968

Gold Medal, National University of Ascuncion,
Ascuncion, Paraguay

May 1963

Citation, New York State Air Pollution Control
Board

1968

Delta Omega

1968

MAJOR COMMITTEE APPOINTMENTS:

Air Pollution Training Committee; Division of Air
Pollution, Bureau of State Services, Public Health
Service

1962-1965

Heart Disease Control Program Advisory Committee;
Division of Chronic Diseases; Bureau of State
Services, Public Health Service

1963-1966

Committee on Cardiovascular Disease Epidemiology;
Epidemiology Section, American Public Health
Association

1963-1967

Scientific Advisory Committee for Mass Mammography
Study; Health Insurance Plan of New York (HIP)

1962-present

Committee for the 190 Census (Chairman) Epidemiology
Section, A.P.H.A.

1965

Subcommittee on Epidemiologic Use of Hospital Data,
U.S. National Committee on Vital and health
Statistics

1965-1968

Research Committee, American Heart Association

1966-1971

World Health Organization (Attended meeting on Research and Reporting Programme of the project, Epidemiology of Drug Dependence, Geneva, Switzerland and to assist with preparatory work in this connection. Served as chairman of the meeting

13-17 Sept 1976

PROFESSIONAL ORGANIZATIONS:

American Medical Association	1953-1967
American Public Health Association (Fellow)	1950-present
American Association for Advancement of Science	1954-present
Association of Teachers of Preventive Medicine	1954-present
Council on Epidemiology, American Heart Association	1965-present
American College of Preventive Medicine (Fellow)	1954-present
Pan American Medical Association (Hon.Diploma)	1968-present
New York State Academy of Preventive Medicine	1954-1968
American Epidemiologic Society	1967-present
Society For Epidemiological Research	1968-present
International Epidemiological Association	1968-present

MAJOR OFFICES IN PROFESSIONAL ORGANIZATIONS:

Secretary, Epidemiology Section, APHA	1967-1970
Member Governing Council, APHA	1967-1970
Executive Committee, Council on Epidemiology, AHA	1968-1971
President, N.Y.S. Academy of Preventive Medicine	1966-1967
Chairman, Executive Committee, Continuing Education Program, Western Branch, APHA	1971-1973
President, American Epidemiological Society	1976-1977

Preventive Medicine Research Study Committee (Chairman), American Heart Association	1968-1971
Consulting Committee on Epidemiology of the Inter- Society Commission for Heart Disease Resources	1969-1974
National Air Quality Criteria Advisory Committee	1969-1972
Executive Committee, Association of Teachers of Preventive Medicine	1969-1972
APHA Environmental Health Hazard Project: Panel on Arsenic Studies (Chairman)	1975-1976
California Air Resources Board - Research Screening Committee	1974-1976
National Research Council - Commission on Natural Resources: Panel on Effects of Ambient Environ- mental Quality	1975-1977
National Cancer Institute Ad Hoc Working Group (Epidemiology) on Mammograph Screening for Breast Cancer	1975-1977
American Board of Preventive Medicine, Inc. (member and Trustee of the Corporation)	1970-present

MAJOR CONSULTANT APPOINTMENTS:

International Cooperation Administration: (Surveyed public health problems and health resources in Ivory Coast, Upper Volta, Niger Dahomey, and Togo. Recommended programs for U.S. Aid)	Dec 1960- Mar 1961
University of Buffalo (Reviewed accomplishments of U.B.-U.S. Agency International Development Contract for assistance to Medical School, National Univer- sity of Ascuncion, Paraguay. Renegotiated Project Agreement & Contract National University, U.S.A.I.D. and University of Buffalo)	Jan-Feb 1962
Epidemiology Branch, Communicable Disease Center (PHS) (Assisted in planning and announcing U.S. assistance for smallpox eradication and measles control in 18 countries of West Africa. Visited Upper Volta, Liberia, Fed. Rep. of Cameroon, and Guinea in this connection.)	Nov-Dec 1965
University of Southern California and National Cancer Institute (Advised on study design for epidemiological study of the etiology of cancer in man and household pets)	1968-1972

PUBLICATIONS

Warren Winkelstein, Jr., M.D., M.P.H.

1. Winkelstein W, Jr.: Modified nasal diphtheria in immunized persons. NY State J Med 50:1117-1118, 1950.
2. Braff E, Winkelstein W, Jr.: Field treatment of trachoma in North Viet Nam, Public Health Rep 67:1233-1236, 1952.
3. Winkelstein W, Jr.: Report from Indochina. Pediatrics 2:217-220, 1955.
4. Karzon DT, Barron AL, Winkelstein W, Jr., Cohen S: Isolation of ECHO virus type 6 during an outbreak of seasonal aseptic meningitis. JAMA 162:1298-1303, 1956.
5. Kelly S, Winsser J, Winkelstein W, Jr.: Poliomyelitis and other enteric viruses in sewage. Amer J Public Health 47:72-77, 1957.
6. Winkelstein W, Jr., Karzon DT, Barron AL, Hayner NS: Epidemiologic observations of an outbreak of aseptic meningitis due to ECHO virus type 6. Amer J Public Health 47:741-749, 1957.
7. Winkelstein W, Jr., Stenchever MA, Lilienfeld AM: Occurrence of pregnancy, abortion, and artificial menopause among women with coronary artery disease: a preliminary study. J. Chronic Dis 7:273-286, 1958.
8. Winkelstein W, Jr., Graham S: Factors in participation in the 1954 poliomyelitis vaccine field trials, Erie County, New York. Amer J Public Health 49:1454-1466, 1959.
9. Winkelstein W, Jr., Lilienfeld R, Pickren JW, Lilienfeld AM: The relationship between aortic atherosclerosis and cancer. Brit J Cancer 13:606-613, 1959.
10. Winkelstein W, Jr., Rekate AC: Occurrence of pregnancy, stillbirth, and abortion among women with coronary artery disease. Circulation 20:786-787, 1959 (Abstract).
11. Winkelstein W, Jr.: Selected aspects of the epidemiology of coronary artery disease. Health News 38(3):4-13, 1961.
12. Karzon DT, Eckert GL, Barron AL, Hayner NS, Winkelstein W, Jr.: Aseptic meningitis epidemic due to ECHO 4 virus. Amer J Dis Child 101:610-622, 1961.
13. deGroot I, Winkelstein W, Jr.: Sociological variables in air pollution research. Presented at the 32nd Annual Meeting of the Eastern Sociological Society, Philadelphia, 1962.
14. Winkelstein W, Jr., Jenss R, Gresham GE, Karzon DT, Mosher WE: Inactivated measles virus vaccine. III. A field trial in young school children. JAMA 179:398-403, 1962.

15. Karzon DT, Winkelstein W, Jr., Jenss R, Gresham GE, Mosher WE: Field trial of inactivated measles vaccine. *Amer J Dis Child* 103:425-426, 1962.
16. Karzon DT, Hayner NS, Winkelstein W, Jr., Barron AL: II. A clinical study of ECHO 6 infection. An epidemic of aseptic meningitis syndrome due to ECHO virus type 6. *Pediatrics* 29(3):418-431, 1962.
17. Winkelstein W, Jr.: The Erie County air pollution--respiratory function study. *J Air Pollution Control Assoc* 12(5):221-222, 1962.
18. deGroot I, Winkelstein W, Jr.: Sociological aspects of air pollution. *Progress Report* 2(3):3, 1962.
19. deGroot I, Winkelstein W, Jr.: Sociological aspects of air pollution. Part II. *Progress Report* 2(4):3, 1962.
20. Winkelstein W, Jr., DeGroot I: The Erie County air pollution--pulmonary function study. *Amer Rev Resp Dis* 86(6):902-906, 1962.
21. Guinee VF, et al: A collaborative study of measles vaccines in five United States communities. Preliminary report. *Amer J Public Health* 53:645-651, 1963.
22. Winkelstein W, Jr.: Study of blood pressure in Buffalo, N.Y. *The New York Academy of Sciences* 107:570-575, 1963.
23. Chazen JA, Winkelstein W, Jr.: Household aggregation of hypertension. A report of a preliminary study. *J Chronic Dis* 17:9-18, 1964.
24. Winkelstein W, Jr., Rekate AC: Age trend of mortality from coronary artery disease in women and observations on the reproductive patterns of those affected. *Amer Heart J* 67:481-488, 1964.
25. Sackett DL, Winkelstein W, Jr.: Epidemiology of cardiovascular disease. Aortic and peripheral atherosclerosis. *Nat Conf Cardiovascular Dis* 2:220-221, 229-231, 1964 (Republished - see 38).
26. Sackett DL, Winkelstein W, Jr.: Epidemiology of aortic and peripheral atherosclerosis; a selective review. *J Chronic Dis* 18:775-795, 1965.
27. Winkelstein W, Jr., Kantor S, Ibrahim M, Sackett DL: The relationship of common environmental factors to the aggregation of systolic blood pressure among spouses. Presented at the Conference on Epidemiology of Cardiovascular Diseases, Chicago, 1965.
28. Karzon DT, Rush D, Winkelstein W, Jr.: Immunization with inactivated measles virus vaccine; effect of booster dose and response to natural challenge. *Pediatrics* 36:40-50, 1965.
29. Winkelstein W, Jr., Karzon DT, Rush D, Mosher WE: A field trial of inactivated measles virus vaccine in young school children; protection during 27 months of follow-up. *JAMA* 194:494-498, 1965.

30. Partridge RA, Stebbings JH, Elsea WR, Winkelstein W, Jr.: Epidemiological aspects of an outbreak of acute eye irritation associated with an air pollution incident in Buffalo, New York, September 1963. Public Health Rep 81:153-158, 1966.
31. Winkelstein W, Jr., Kantor S, Ibrahim Ma, Sackett DL: Familial aggregation of blood pressure. JAMA 195:848-850, 1966.
32. Guinee VF, Henderson DA, Casey H, Wingo S, Ruthig DW, Cockburn TA, Vinson TO, Calafiore D, Winkelstein W, Jr., Karzon DT, Rathbun M, Alexander ER, Peterson DR: Cooperative measles vaccine field trial. I. Clinical efficacy. II. Seriological studies. Pediatrics 37:649-665, 1966.
33. deGroot I, Loring W, Rihm A, Samuels SW, Winkelstein W, Jr.: People and air pollution; a study of attitudes in Buffalo, N.Y. J. Air Poll Control Assoc 16:245-247, 1966.
34. Winkelstein W, Jr.: IV. Some retrospective studies of cerebrovascular disease. In Proceedings of Workshop on Cerebrovascular Disease Epidemiology. Public Health Monograph, No. 76, 1966, pp 41-49.
35. Anderson U, Winkelstein W, Jr.: Immunization status of school children in Buffalo, New York. Public Health Rep 81:755-759, 1966.
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38. Sackett DL, Winkelstein W, Jr.: Aortic and peripheral atherosclerosis. In Chronic Diseases and Public Health, edited by Lilienfeld AM, Gifford AJ. Baltimore, Johns Hopkins Press, pp.541-543, 1966.
39. Winkelstein W, Jr., Kantor S, Davis EW, Maneri CS, Mosher WE: The relationship of air pollution and economic status to total mortality and selected respiratory system mortality in men. I. Suspended particulates. Arch Environ Health 14:162-171, 1967.
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45. Kantor S, Winkelstein W, Jr., Ibrahim MA: A note on the interpretation of the riddit as a quantile rank. Amer J Epidemiol 87:609-615, 1968.
46. Harris RW, Turnbull CD, Isacson P, Karzon DT, Winkelstein W, Jr.: Mumps in a northeast metropolitan community. I. Epidemiology of clinical mumps. Amer J Epidemiol 88:224-233, 1968.
47. Ibrahim MA, Pinsky W, Kohn RM, Binette PJ, Winkelstein W, Jr.: Coronary heart disease: screening by familial aggregation. Arch Environ Health 16:235-240, 1968.
48. Winkelstein W, Jr., Kantor S, Davis EW, Maneri CS, Mosher WE: The relationship of air pollution and economic status to total mortality and selected respiratory system mortality in men. II. Oxides of sulfur. Arch Environ Health 16:401-405, 1968.
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50. Ibrahim MA, Sackett DL, Kantor S, Winkelstein W, Jr.: Psychological patterns and coronary heart disease: an appraisal of the determination of etiology by means of a stochastic process. J Chron Dis 20:931-940, 1968.
51. Winkelstein W, Jr.: Stomach cancer: positive association with suspended particulate air pollution. Arch Environ Health 18:544-547, 1969.
52. Kantor S, Winkelstein W, Jr.: The rationale and use of riddit analysis in epidemiological studies of blood pressure. Amer J Epidemiol 90:201-213, 1969.
53. Winkelstein W, Jr., Kantor S: Prostatic cancer: relationship to suspended particulate air pollution. Amer J Public Health 59:1134-1138, 1969.
54. Winkelstein W, Jr., Kantor S, Ibrahim MA, Sackett DL: Remarks on the analysis of familial aggregation of blood pressure in the Alameda County Blood Pressure Study. Amer J Epidemiol 89:615-618, 1969.
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56. Winkelstein W, Jr.: Validation: techniques required, accuracy precision, reliability and requisite populations. In Proceedings of the 2nd Annual Conference on Automated Indirect Blood Pressure, edited by Rochmis PG. New Jersey, Hoffmann-La Roche Inc., 1969, p. 26.

57. Winkelstein W, Jr., Kantor S: Respiratory symptoms and air pollution in an urban population of northeastern United States. Arch Environ Health 18:760-767, 1969.
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59. Kuller LH, and 15 others, including Winkelstein W, Jr.: Nationwide cerebrovascular disease mortality study. II. Comparison of clinical records and death certificates. Amer J Epidemiol 90:545-555, 1969.
60. Kuller LH, and 15 others, including Winkelstein W, Jr.: Nationwide cerebrovascular disease mortality study. III. Accuracy of the clinical diagnosis of cerebrovascular disease. Amer J Epidemiol 90:556-566, 1969.
61. Kuller LH, and 15 others, including Winkelstein W, Jr.: Nationwide cerebrovascular disease mortality study. IV. Comparison of the different clinical types of cerebrovascular disease. Amer J Epidemiol 90:567-578, 1969.
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64. Winkelstein W, Jr., Gay M: Arteriosclerotic heart disease and cerebrovascular disease: further observations on the relationship of suspended particulate air pollution and mortality in the Erie County Air Pollution Study. In Proceedings of the 16th Annual Meeting of the Institute of Environmental Science. Boston, 1970, pp. 441-447.
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66. Winkelstein W, Jr., French FE: The role of ecology in the design of a health care system. Calif Med 113:7-12, 1970.
67. Winkelstein W, Jr., Gay M: Suspended particulate air pollution: relationship to mortality from cirrhosis of the liver. Arch Environ Health 22:174-177, 1971.
68. Ibrahim MA, Borden HH, Pinsky W, Kohn R, Feldman JG, Winkelstein W, Jr.: Screening of the coronary prone by study of offspring. Public Health Rep 86:577-582, 1971.
69. Winkelstein W, Jr., French FE: The role of ecology in the design of a health care system. Ecosphere 2:4-8, 1971.

70. Winkelstein W, Jr.: Utility or futility of ordinary mortality statistics in the study of air pollution effects. In Proceedings Sixth Berkeley Symposium on Mathematical Statistics and Probability. University of California Press, Berkeley, June and July, 1970, pp. 539-554.
71. Winkelstein W, Jr.: Epidemiological considerations underlying the allocation of health and disease care resources. *Internat J Epid* 1(1):69-74, 1972.
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73. Winkelstein W, Jr.: Book review. *Epidemiology: Man and Disease*, Fox JP, Hall CE, Elveback. The MacMillan Company, 1972, 339 p. In *Mayo Clin Proc* 48:222 (March) 1973.
74. Winkelstein W, Jr.: A view of community medicine from UC School of Public Health, Berkeley. In *Community Medicine in California--A Symposium*. *Calif Med* 118:81-82, 1973.
75. Winkelstein W, Jr.: California's Shame--the fluoridation issue (Editorial). *Calif Med* 118:61-62, 1973.
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University of California San Francisco
AIDS Specimen Bank
HSW-604
San Francisco, California 94143-0512
(415) 476-1481/2943

John S. Greenspan
BSc, BDS, PhD, FRCPath
Director

7 April 1988

Dr. David Wofsy
VA Medical Center
111R

Dear David,

Attached are the revised H & E results for Nan's Experiment sacrificed 4-10-86. We re-examined the slides as per your request for organs not observed. Please note the following additions or changes to the original report of 20 April 87...

R86-112 Liver = 2

R86-114 Liver = 1

R86-115 Liver = 1, Thymus is infiltrated with cells appearing to be lymphoblasts or histiocytes.

Note: Further references to lymphoblasts in the remainder of this report refer to these same cells.

R86-116 Thymus enlarged.

R86-118 Thymus enlarged, Parotid = 1, Submandibular gland is normal (previously = 1).

R86-119 Lung = 4 (previously = 1, transcription error)
Thymus enlarged with lymphoblasts, Lymph node huge with lymphoblasts.

R86-120 Sublingual gland = 2, Thymus is enlarged with lymphoblasts, Lymph node enlarged with lymphoblasts.

R86-121 Lymph node enlarged.

R86-122 Liver = normal (previously = 1), Submandibular = 1 (previously = 1/2).

All other organs not previously described in the original report were found to be normal.

If you have any questions, please do not hesitate to call my technician, Tammy, at 476-1481.

Sincerely,



John S. Greenspan

enc.

cc. Tammy L. Fell

tlf

EXPERIMENT: Nan's
SACRIFICE DATE: 4-10-86

KEY
✓ = Normal
↑ = Enlarged
NOB = not observed
SMG = submandibular gland

H&E Results 4/6/88

VA#	R#	KIDNEY		LIVER	LUNG	THYMUS	Salivary Glands			Lymph Node
		Glomeruli	Infiltrate				SMG	Parotid	Sublingual	
2526	R86-112	5	4 with casts	2	2	NOB	3	2	3	↑
2530	R86-113	5	tubules dilated, 3 casts	✓	3	NOB	✓	✓	✓	✓
2532	R86-114	4	3	1	3	↑	2	✓	✓	↑
2533	R86-115	4	2	1	2	lymphoblasts or histiocytes	✓	✓	✓	✓
2502	R86-116	2	1	1	2	↑	2	✓	✓	✓
2501	R86-117	2	1	✓	1	✓	✓	1	✓	✓
2537	R86-118	4	2	1	1	↑	✓	1	✓	✓
2539	R86-119	5	4	✓	4	↑ with lymphoblasts	3	✓	✓	huge with lymphoblasts
2538	R86-120	5	2	✓	2	↑ with lymphoblasts	3	2	✓	↑ with lymphoblasts
2550	R86-121	2	1/2	✓	1	✓	✓	2	✓	↑
2504	R86-122	5	tubules dilated, casts 4	1	2	NOB	1	✓	✓	✓
2503	R86-123	4	1	✓	1	✓	✓	✓	✓	✓

Not officially part of Wotsgy project

Dr. John Greenzian,

April 10, 1986

NANC

Date of Sacrifice - April 10, 1986

mouse - B/w, ♀, D.O.B. July 1, 1985

Summary of Exp. - 5-6 months old B/w mouse
treated 3 times weekly (I.P.) $\pm$ 1mg α BT4,
0.5mg α BT4-Flab¹₂ or Saline until sacrifice

Groups -

<u>Saline</u>		<u>αBT4-Flab¹)₂</u>		<u>αBT4</u>	
Frozen/H&E		Frozen/H&E		Frozen/H&E	
103/112	2526	R 86-102/118	2537	2550	R 86-100/121
104/113	2530	105/120	2538	2501	101/117
108/114	2532	107/119	2539	2502	106/116
111/115	2533	110/122	2504	2503	109/123

Organs for histopath. -

Salivary Gland
Thymus
Lungs
Liver
Kidneys

Organs for sectioning -

Kidney

Observations

- mouse # 2526, 2530 and 2539, kidneys were
discolored and enlarged.
mouse # 2530, small thymus.

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(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

11 November 1986

TO: Dr. Constance Wofsy
c/o Emily Rapaport
SFGH
Ward 86

FROM: Dr. John S. Greenspan
UCSF
HSW 604

A handwritten signature in dark ink, appearing to read "John", is written over the printed name "Dr. John S. Greenspan".

RE: AIDS Bank Update

I am sending you a floppy disc of current AIDS Bank information of serum you have contributed to date. If you have any questions pertaining to this, please do not hesitate to give my technician, Yvonne DeSouza, a call at 476-1481.

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AIDS CLINICAL RESEARCH CENTER
A-523, A-340
(415) 476-1407
(415) 476-1363

SAN FRANCISCO, CALIFORNIA 94143

reply to: 350 Parnassus, Suite 808
S.F. CA 94117

February 14, 1986

MEMORANDUM

To: Dr. John Ziegler, Director,
AIDS Clinical Research Center
VAMC 141

From: Dr. Marcus A. Conant

Re: Longitudinal AIDS Study and
Kaposi's Sarcoma Clinic Education Program

The Longitudinal Study has provided our Tissue Bank with an invaluable collection of extremely well-characterized specimens for serological investigation. I feel that it is imperative that we continue this study until the immune response to HTLV-III is characterized and a vaccine has been developed against the AIDS agent.

The Kaposi's Sarcoma Clinic meetings are extremely well attended and serve as a useful forum to exchange information between clinicians and basic scientists. I would like to continue these programs for at least another year and enlarge the scope of this activity to include bringing a Visiting Professor to the UC Campuses (UCSF, SFGH, VAMC) each quarter. I would appreciate feedback from you, as Director of the AIDS Clinical Research Center, as to the format to apply for funds for these activities for next year and the date by which you will need this information.

cc: Dr. John Greenspan
Mr. Richard Pabich

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SAN FRANCISCO, CALIFORNIA 94143

January 17, 1986

TO: Dr. Dale Bredesen
Neurology, M 794

FROM: John S. Greenspan

*OK
Per 256*

RE: Use of the bank

The bank is available to you for the deposit and storage of CSF, serum, cells and tissue biopsies. We will send specimens to collaborators at your request. We welcome your involvement.

There is no charge to you. We may occasionally use portions of the specimens which you deposit for other studies, but not without consulting you. Those who deposit become members of the Tissue Committee which votes on all new requests for specimens.

Please discuss details with Yvonne de Souza, SRA and bank coordinator (x6-1481).

JSG/pkr

cc: John Ziegler
Yvonne de Souza

Enclosures



AIDS CLINICAL RESEARCH CENTER

John L. Ziegler, M.D., Director
VAMC 141
4150 Clement Street
San Francisco, CA 94121
(415) 221-4810 ext. 3676

July 21, 1986

TO: Tom Coates, Ph D.
Leon McKusick, Ph. D.

FR: Director, AIDS Clinical Research Center

RE: Stress Reduction in AIDS

-
1. Your protocol was re-reviewed by the Advisory Committee, and achieved a fundable priority score. Because our budget is at present quite limited, an award of \$15,000.00 has been granted.
 2. A number of critical points require your attention:
 - a. One Committee member was concerned about sampling bias. You should know the characteristics of non-participants. It seems this could be achieved by the initial questionnaire.
 - b. A six month and one-year follow-up would be desirable.
 - c. The exact nature of the data analysis was not clear, and a statistical consultant was recommended.
 - d. A concerted effort should be expended on reducing high risk sexual behavior in your treatment cohort.
 - e. T helper cells only should be measured in subjects and controls before and after the intervention. The cost of these immune studies after negotiation with Dr. Casavant, should be well within budget. Also, it might be arranged through Dr. J. Greenspan to measure salivary IgA (see Lancet, 1:1400, 1983) as an indicator of stress and stress reduction.
 3. Good luck. We will ask for 6-month Progress reports.


JOHN L. ZIEGLER, MD
Director
UCSF AIDS Clinical Research Center

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AIDS CLINICAL RESEARCH CENTER

John L. Ziegler, M.D., Director
VAMC 141
4150 Clement Street
San Francisco, CA 94121
(415) 221-4810 ext. 3676

July 22, 1986

TO: Raphael B. Stricker, MD

FR: Director, AIDS Clinical Research Center

RE: Chloroquine for ATP

-
1. This is in follow-up to your letter of June 6 and our recent discussion.
 2. Your rationale for chloroquine dose/schedule for AIDS-related ITP is sound and you should proceed as we discussed.
 3. It would be useful to discuss design further with either Drs. Dave Feigal (SFGH) or Ira Tager (VA) regarding the n=1 strategy. This allows all patients to get active drug, permits blinded assay of platelet antibody, and also allows each patient to act as his own control. Dr. Tager on the Committee was a strong advocate of proper design study from the start rather than a "pilot" which later requires a more rigorous clinical trial to confirm. I believe that the conditions of your trial, including the 4-6 week period to achieve an effect, are still compatible with an n=1 design.
 4. I have enclosed some relevant reprints. Your budget is \$5,000 but let me know if, as the trial proceeds, if this is not adequate.

JOHN L. ZIEGLER, M.D.
Director
UCSF AIDS Clinical Research Center

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John L. Ziegler, M.D., Director
VAMC 141

SAN FRANCISCO, CALIFORNIA 94143

January 24, 1986

TO : Executive Committee, AIDS Clinical Research Center

FROM: Director, AIDS Clinical Research Center

SUBJ: Next Meeting

1. Please mark your calendars for the next meeting on Thursday, January 30, 1986 at 3:30 p.m. in Ward 84, SFGH.

2. The agenda will include:

- | | |
|---------------------------------------|---------------------------|
| a. Status of Longitudinal Study | Dr. Conant |
| b. Update on Specimen Bank | Dr. Greenspan |
| c. Submission of Grant Renewal | Dr. Ziegler |
| d. Status of Computers | Mr. Molvig |
| e. Patient Registry and Specimen Link | Dr. Feigal and Mr. Molvig |
| f. Plans for 1986-87 | Dr. Ziegler |

John Ziegler
JOHN L. ZIEGLER, M.D.

cc: ~~Dr.~~ Dr. Greenspan (HSW 604)
Dr. Volberding (Ward 84, SFGH)
Dr. Conant (M 181)
Dr. Hollander (M 1078)
Dr. Abrams (Ward 84, SFGH)
Dr. Feigal (Ward 84, SFGH)
Mr. Molvig (5H22, SFGH)

AIDS CRC.

1/30/86

① Still sep. from Tx Trials Group.
Prob. combine next year.

② Longitudinal Study

Issues :-

① What are the scientific uses?

② Unique specimens?

③ How often follow up?

④ Need to tighten reln. of records to specimens in the Bank

→ Bank Registry.

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AIDS SERUM AND TISSUE BANK MONTHLY REPORT 1986

<u>YEAR</u>	<u>SERUM</u>	<u>TISSUE</u>	<u>CELLS</u>	<u>SALIVA</u>	<u>CSF</u>
<u>DEPOSITS</u>					
1982	0	25	0	0	0
1983	221	72	0	0	0
1984	1194	16	0	0	0
1985	1773	191	154	15	22
1986					
January	190	12	22	0	3
total (1986)	190	12	22	0	3
GRAND TOTAL	3378	316	176	15	25
<u>WITHDRAWALS</u>					
1982	0	0	0	0	0
1983	141	70	0	0	0
1984	2337	184	0	0	0
1985	3371	87	23	17	0
1986	940	19	0	0	0
total (1986)	940	19	0	0	0
GRAND TOTAL	6789	360	23	17	0

Update

① Accidents ↑

withdrawals ↑ → a lot!

Hired 10% Sec

Tx coming ↑

② Survey

③ Problem & response

- Data on specimens
New - could be done
Early (Perhaps 2001) Poor.

- Getting feedback from users
- working on it

- Getting "statements" to users

④ Data person

Bank

1986 - 1987

① New room. Renovation \$ 30,000

② New Road
" centrifuge/rotor 20,000

③

Revs -	257		22
JG	300	24 6	30
Ides	80		27
Eller	60		18
Harsh	10		3
TBA	50		9
Nancy	50		
			<u>93,000</u> ¹⁴ 9
			87,000
			16,000

④ Supplies / Other

⑤ Travel

1200
\$ 154,000

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1983	221	72	0	0	0
1984	1194	16	0	0	0
1985					
January	113	17	0	0	0
February	134	12	0	0	0
March	143	19	0	0	0
April	106	13	12	3	0
May	147	26	8	0	0
June	155	16	13	0	3
July	132	12	8	0	2
August	212	15	15	0	2
September	182	21	18	0	4
October	239	21	28	3	5
November	116	15	20	8	5
December	94	4	32	1	1
total (1985)	1773	191	154	15	22
1986					
January	190	12	22	0	3
total (1986)	190	12	22	0	3
GRAND TOTAL	3378	316	176	15	25
<u>WITHDRAWALS</u>					
1982	0	0	0	0	0
1983	141	70	0	0	0
1984	2337	184	0	0	0
1985					
January	63	14	0	0	0
February	351	4	0	0	0
March	149	2	0	0	0
April	371	8	0	3	0
May	287	10	5	0	0
June	361	23	8	0	0
July	68	1	0	0	0
August	566	0	0	0	0
September	74	1	0	1	0
October	508	23	5	4	0
November	348	1	3	8	0
December	225	0	2	1	0
total (1985)	3371	87	23	17	0
1986					
January	940	19	0	0	0
total (1986)	940	19	0	0	0
GRAND TOTAL	6789	360	23	17	0

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AIDS SERUM AND TISSUE BANK MONTHLY REPORT 1986

<u>YEAR</u>	<u>SERUM</u>	<u>TISSUE</u>	<u>CELLS</u>	<u>SALIVA</u>	<u>CSF</u>
<u>DEPOSITS</u>					
1982	0	25	0	0	0
1983	221	72	0	0	0
1984	1194	16	0	0	0
1985					
January	113	17	0	0	0
February	134	12	0	0	0
March	143	19	0	0	0
April	106	13	12	3	0
May	147	26	8	0	0
June	155	16	13	0	3
July	132	12	8	0	2
August	212	15	15	0	2
September	182	21	18	0	4
October	239	21	28	3	5
November	116	15	20	8	5
December	94	4	32	1	1
total (1985)	1773	191	154	15	22
1986					
January	190	12	22	0	3
total (1986)	190	12	22	0	3
GRAND TOTAL	3378	316	176	15	25
<u>WITHDRAWALS</u>					
1982	0	0	0	0	0
1983	141	70	0	0	0
1984	2337	184	0	0	0
1985					
January	63	14	0	0	0
February	351	4	0	0	0
March	149	2	0	0	0
April	371	8	0	3	0
May	287	10	5	0	0
June	361	23	8	0	0
July	68	1	0	0	0
August	566	0	0	0	0
September	74	1	0	1	0
October	508	23	5	4	0
November	348	1	3	8	0
December	225	0	2	1	0
total (1985)	3371	87	23	17	0
1986					
January	940	19	0	0	0
total (1986)	940	19	0	0	0
GRAND TOTAL	6789	360	23	17	0

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(415) 666-2943

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SAN FRANCISCO, CALIFORNIA 94143

January 17, 1986

TO: Dr. Robert Levy
Neurosurgery, M 786

FROM: John S. Greenspan *ER*
per JSG

RE: Use of the bank

The bank is available to you for the deposit and storage of CSF, serum, cells and tissue biopsies. We will send specimens to collaborators at your request. We welcome your involvement.

There is no charge to you. We may occasionally use portions of the specimens which you deposit for other studies, but not without consulting you. Those who deposit become members of the Tissue Committee which votes on all new requests for specimens.

Please discuss details with Yvonne de Souza, SRA and bank coordinator (x6-1481).

JSG/pkr

cc: John Ziegler
Yvonne de Souza

Enclosures

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SAN FRANCISCO, CALIFORNIA 94143

January 17, 1986

TO: Dr. Mark Rosenblum
Neurosurgery, M 786

FROM: John S. Greenspan

RE: Use of the bank

*OK
per 284*

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cc: John Ziegler
Yvonne de Souza

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MEMORANDUM
OF CALL

TO:

J89

☐ YOU WERE CALLED BY— ☐ YOU WERE VISITED BY—

Dr Ziegler

OF (Organization)

☒ PLEASE CALL → PHONE NO. [REDACTED]
CODE/EXT.. [REDACTED]

☐ WILL CALL AGAIN

☐ IS WAITING TO SEE YOU

☐ RETURNED YOUR CALL

☐ WISHES AN APPOINTMENT

MESSAGE

Data acquisition & transfer
Kjel - donors not
swi, #.

Single print-out & names
& numbers.

RECEIVED BY

WZ

DATE

1-8

TIME

1:30

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<u>DEPOSITS</u>					
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1983	221	72	0	0	0
1984	1194	16	0	0	0
1985					
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total (1985)	1773	191	154	15	22
GRAND TOTAL	3188	304	154	15	22
<u>WITHDRAWALS</u>					
1982	0	0	0	0	0
1983	141	70	0	0	0
1984	2337	184	0	0	0
1985					
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July	68	1	0	0	0
August	566	0	0	0	0
September	74	1	0	1	0
October	508	23	5	4	0
November	348	1	3	8	0
December	225	0	2	1	0
total (1985)	3371	87	23	17	0
GRAND TOTAL	5849	341	23	17	0

* New categories of specimens

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SANTA BARBARA • SANTA CRUZ

UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 666-2943

SAN FRANCISCO, CALIFORNIA 94143

June 13, 1985

Belinda De La Rosa
University of California Systemwide
Taskforce on AIDS
Office of Health Affairs
785 University Hall
University of California
San Francisco, CA 94720

Dear Belinda:

I happened to come across an error which has crept into the statistics on the Specimen Bank for last year. They involve page 39 of the proposal which Dr. Zeigler sent you last and I am enclosing a corrected copy. This shows the correct number of deposits and withdrawals from the specimen bank. If there is time I would be grateful if you could circulate this to the members of the Taskforce.

With kind personal regards.

Sincerely,

John S. Greenspan, BSc, BDS, PhD, FRCPath
Director AIDS Specimen Bank

JSG/lm

Encl.

cc: Dr. J.L. Ziegler

4. Statistics

<u>Year</u>	<u>Serum</u>	<u>Tissue</u>	<u>Cells</u>	<u>Saliva</u>
<u>Deposits</u>				
1982 totals	0	25	0	0
1983 totals	221	72	0	0
1984 totals	1194	160	0	0
<u>1985</u>				
January	113	17	0	0
February	134	12	0	0
March	143	19	0	0
April	<u>106</u>	<u>13</u>	<u>12*</u>	<u>3*</u>
1985 Totals (to 5/1/85)	<u>496</u>	<u>61</u>	<u>12</u>	<u>3</u>

Total Deposits 1911 318 12 3
* New categories of specimens

<u>Withdrawals</u>				
1982 totals	0	0	0	
1983 totals	141	70	0	
1984 totals	2337	162	0	
<u>1985</u>				
January	63	14	0	
February	351	4	0	
March	149	2	0	
April	<u>371</u>	<u>8</u>	<u>12</u>	<u>3</u>
1985 Totals (to 5/1/85)	<u>934</u>	<u>28</u>	<u>12</u>	<u>3</u>
Total Withdrawals	3414	260	12	3

PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR OR AWARD CANDIDATE (Last, first, middle)
 Tagler, John L., M.D.

SOCIAL SECURITY NUMBER

Lennette E	"EBV in AIDS:	Serum/Tissue	In progress
Rutter W	"HBV in AIDS"	Tissue	Discontinued
Scher R	"Traditional KS vs AIDS"	Serum/Tissue	In progress
Smith Roulette	"Nucleoprotein antigen in KS"	Tissue	Discontinued
Smith, Robert	Enzyme assay for AIDS	Cells	Pending
Stites D	'Antibodies in KS'	Serum	In progress
Travenol/Genentech	'HTLVIII antibodies'	Serum	In progress
Vyas G	'HBV in AIDS'	Tissue	Discontinued

4. Statistics

<u>Year</u>	<u>Serum</u>	<u>Tissue</u>	<u>Cells</u>	<u>Saliva</u>
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322 318

12

3

Withdrawals

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Total Withdrawals 3414

212 260

12

3

March 6, 1986

TO: John L. Ziegler

FROM: John S. Greenspan 

RE: Longitudinal Study Specimens

Both you and Marcus Conant asked us to collect data on the use of these specimens. From the attached you will see that 117 longitudinal study sera, 220 non-longitudinal sera and 23 tissue specimens have been sent to 11 investigators. These represent about the last 2 years. The tissue data are misleading, for we have requests for as many KS and control skin specimens as we can procure, and thus many more KS withdrawals could be made.

JSG/pkr

✓ cc: Dr. Conant

March 13, 1986

Dear John:

Thank you for this data. John Ziegler has approved funding for me to supervise biopsies of Kaposi patients for the tissue bank. As soon as these funds are approved, we will begin obtaining one specimen each day and sending them to the tissue bank for you.

Sincerely yours,

Marcus A. Conant, M.D.

cc: Dr. John Ziegler
Dick Pabich

dispor

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UNIVERSITY OF CALIFORNIA
AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

July 11, 1988

Dr. John Phair
N. Western Med. School
3-447 Searle Bldg.
320 E. Superior St.
Chicago, Ill. 60611

Dear Dr. Phair,

Enclosed is a list of sera that I am sending you today as per request by Dr. Richard Chaisson. Each vial contains 0.5cc of sera. Please perform anti-PPD antibody assays and send results to.....

John Hopkins Hospital
Infectious Disease Division
Blalock Bldg.
1111-600 N. Wolfe St.
Baltimore, Md. 21205

If you have any questions pertaining to these samples, please do not hesitate to call my technicians at...(415)476-1481.

Sincerely,


John S. Greenspan
Director, AIDS Specimen Bank

enc.

cc: Ms. Yvonne Desouza
Dr. Richard Chaisson

TBHV STUDY SERA
0.5 CC TO DR. PHAIR

AIDS BANK #	STUDY CODE	DATE DRAWN
AS87-3821	TBHIV135	09/15/87
AS87-3831	TBHIV134	09/15/87
AS87-3832	TBHIV136	09/16/87
AS87-3833	TBHIV138	09/16/87
AS87-3834	TBHIV139	09/16/87
AS87-4109	TBHIV140	09/16/87
AS87-4592	TBHIV143	10/26/87
AS87-4706	TBHIV144	11/06/87
AS87-4743	TBHIV146	11/18/87
AS87-4820	TBHIV145	12/01/87
AS87-4821	TBHIV147	12/01/87
AS87-4998	TBHIV148	12/03/87
AS87-4999	TBHIV149	12/08/87
AS87-5000	TBHIV150	12/08/87
AS87-5001	TBHIV151	12/10/87
AS87-5002	TBHIV146A	12/10/87
AS87-5037	TBHIV152	12/10/87
AS87-5077	TBHIV153	12/18/87
AS87-5078	TBHIV154	12/18/87
AS87-5104	TBHIV155	12/21/87
AS87-5105	TBHIV156	12/23/87
AS87-5106	TBHIV157	12/23/87
AS87-5107	TBHIV158	12/23/87
AS88-0355	TBHIV159	01/28/88
AS88-0430	TBHIV160	01/29/88 - only 0.25cc
AS88-0879	TBHIV161	02/24/88
AS88-0880	TBHIV162	02/25/88
AS88-1044	TBHIV163	03/03/88
AS88-1294	TBHIV164	03/10/88
AS88-1392	TBHIV165	03/15/88

(30) Total

AS87-4591 TBHV142 not pulled - only 1.0cc in bank

AIDS BANK ORDER FORM

DATE OF REQUEST: 4/18/88

delay in delivery of
shipment due to

REQUESTED BY: R. Chaisson

change of ~~delivery date~~
shipment recipient and
response from RC.

Phone #: [REDACTED]

see letter ☐

SEND TO: John Phair ~~at Ziss~~
N. Western Med. School
3-447 Searle Bldg
320 E. Superior St
Chicago, Ill 60611

see letter ☐

FED. EXP. #: AIDS Bank

see letter ☐

CONTACT PERSON FOR DELIVERY:

Gloria

PHONE #: [REDACTED]

TESTS TO BE PERFORMED:

Anti-PPD Antibody Assay

CRITERIA FOR SELECTION - as requested

SPECIMEN TYPE:	Sera		
AMT/SPECIMEN:	0.5cc		
SOURCE(S):	RC		
RANGE:	—		
DIAGNOSIS:	IDU		
HIV STATUS:			
RISK:			
SEX:			
OTHER:			
TOTAL REQ.			

SEND RESULTS TO: Johns Hopkins Hosp.
Infectious Disease Division
Blalock Bldg.
1111-600 N. Wolfe St.
Balt. MD. 21205

LOCATION OF LIST:

FLOPPY NAME:

FILE NAME:

COMMENTS:

821-8830 Dr Chaisson
282-4244

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Department of Epidemiology
and International Health

SAN FRANCISCO, CALIFORNIA 94143

March 8, 1988

Dr Chaisson
VA-943-6600 x 511
312

John Greenspan, BDS, PhD
AIDS Specimen Bank
HSW 604 Box 0512
University of California, San Francisco
San Francisco, CA 94143

Dear John:

I am writing to request that additional specimens from our TB-HIV Study be sent for anti-PPD antibody testing. We previously sent specimens TB-HIV 001-027 (inaccurate). I would like to have all additional patients tested (HIV-TB 028-061 and November 1987 sample from Brad Wright). Please send 0.5 cc to:

I cannot locate
Dr Chaisson
says no bother.

John Phair, MD
Room 3-447 Searle Building
320 E. Superior Avenue
Chicago, Illinois 60611
312/908-8196

sent 001-133
Chaisson wants
all other specimens
rec'd to date sent.
i.e. up to TBHIV 165

Thanks very much for your assistance. Please call me at 476-5325 if you have any questions.

4-18-88

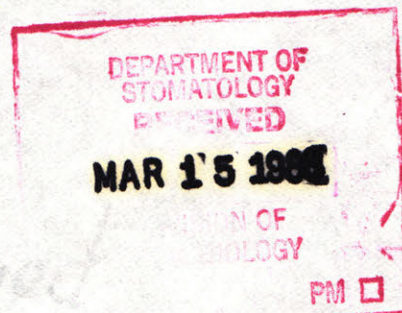
4-6-88

Called Dr Phair prior
to shipment. - They don't
do this test anymore

Sincerely,

Dr Chaisson

Dr E. Chaisson, MD
Assistant Clinical Professor of Medicine



3/21/88

82-8830 Dr Chaisson
282-4244
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SANTA BARBARA • SANTA CRUZ

Department of Epidemiology
and International Health

SAN FRANCISCO, CALIFORNIA 94143

March 8, 1988

Dr Chaisson
VA-943-6600 x 511
312

John Greenspan, BDS, PhD
AIDS Specimen Bank
HSW 604 Box 0512
University of California, San Francisco
San Francisco, CA 94143

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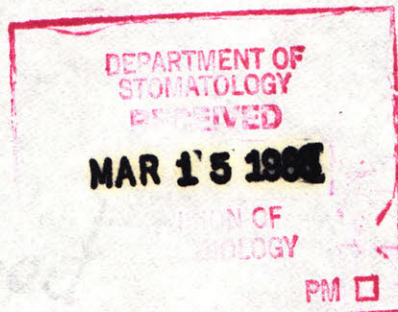
Thanks very much for your assistance. Please call me at 476-5325 if you have any questions.

Sincerely,

Dick

Richard E. Chaisson, MD
Assistant Clinical Professor of Medicine

REC/nh



Approved
3/21/88

JUN 28 1988

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Department of Epidemiology
and International Health

SAN FRANCISCO, CALIFORNIA 94143

Ward 84
SF General Hospital
995 Potrero Avenue
San Francisco, CA 94110
June 23, 1988

Tammy Fell
AIDS Specimen Bank
HSW 604, Box 0512
UCSF

Dear Tammy,

Sorry to take so long to respond to your question about our TB/HIV sera. The sera should be sent to Dr. Zeiss' lab at Northwestern (VA Hospital), as Dr. Phair's lab suggested. If you have any questions I can be reached at Johns Hopkins after 7/1/88 (301-955-3150).

Thanks,

Richard E. Chaisson, MD
Assistant Clinical Professor
of Medicine

called 7-5-88

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SANTA BARBARA • SANTA CRUZ

Department of Epidemiology
and International Health

SAN FRANCISCO, CALIFORNIA 94143

March 8, 1988

John Greenspan, BDS, PhD
AIDS Specimen Bank
HSW 604 Box 0512
University of California, San Francisco
San Francisco, CA 94143

9.0.

Dear John:

I am writing to request that additional specimens from our TB-HIV Study be sent for anti-PPD antibody testing. We previously sent specimens TB-HIV 001-027. I would like to have all additional patients tested (HIV-TB 028-061 and November 1987 sample from Brad Wright). Please send 0.5 cc to:

John Phair, MD
Room 3-447 Searle Building
320 E. Superior Avenue
Chicago, Illinois 60611
312/908-8196

Thanks very much for your assistance. Please call me at 476-5325 if you have any questions.

Sincerely,

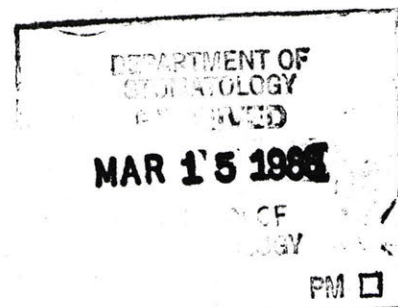
Dick

Richard E. Chaisson, MD
Assistant Clinical Professor of Medicine

REC/nh

Approved

3/21/88



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AIDS SPECIMEN BANK
HSW-604
(415) 476-1481/2943

SAN FRANCISCO, CALIFORNIA 94143-0512

14 September 1987

Dr. John Phair
Room 3-447 Searle Building
320 East Superior Avenue
Chicago, IL 60611
Tel # (312) 908-8196

phoned 9/14
DISPO. DBF

Dear Dr. Phair,

Enclosed is a list of 27 sera I am sending you today as per request of Dr. Richard Chaisson. Each vial contains 0.5cc of sera. Please perform anti-PPD antibody assays and send results to...

Richard E. Chaisson, M.D.
Bldg 80, Ward 84
San Francisco General Hospital
995 Potrero Avenue
San Francisco, CA 94110

If you have any questions pertaining to these samples, please do not hesitate to call my technicians at...
(415) 476-1481.

Sincerely,

John S. Greenspan (yds)

John S. Greenspan
Director, AIDS Specimen Bank

enc.

cc. Dr. Richard Chaisson
Ms. Yvonne DeSouza



QUESTIONS? CALL 800-238-5355 TOLL FREE.

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DATE

09/14/87

Sender's Federal Express Account Number

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Dr. John Greenspan

Your Phone Number (Very Important)

To (Recipient's Name)

Dr. John Phair

Recipient's Phone Number (Very Important)

Company

Department/Floor No.

Company

Street Address

UCSF - Dept. of Stomatology / HSW-604

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Searle Bldg / Room 3-447

City

San Francisco

State

CA

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City

Chicago

State

IL

ZIP Street Address Zip Required

60611

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- 10

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9 LBS

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Total

Total

Total

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