

CLINICAL NOTES

CURRENT STATUS OF ANTIVIRAL THERAPY FOR AIDS

Paul A. Volberding, MD

As more has been learned about the nature of acquired immunodeficiency syndrome (AIDS), therapy for this deadly disease has changed dramatically. While antibiotics and chemotherapies directed at the specific opportunistic infections and cancers of AIDS often are temporarily successful, we now know that these treatments cannot reverse the underlying immune deficiency or change the ultimate prognosis of the disease. Consequently a substantial effort has been directed at the testing of drugs potentially capable of boosting the damaged immune system and, more recently, of agents that can inhibit reproduction of the AIDS virus.

The virus was isolated in 1983, first by the French, who called it lymphadenopathy-associated virus (LAV), and later by American investigators, who called it human T-cell leukemia virus-III (HTLV-III) or AIDS-related virus (ARV).

Although our knowledge of this virus is still very limited, it now appears that after a susceptible individual has been exposed, the virus infects T-helper lymphocytes, macrophages and probably other cell populations. The outcome of this infection is variable. Some individuals develop full-blown AIDS, others suffer from a group of less immediately life-threatening signs and symptoms called AIDS-related complex (ARC). In many cases, however, the virus and/or the reaction to the virus gradually causes a destruction of the T-helper cells with resulting immune imbalance.

This immune imbalance appears to be chronic and progressive in most cases, although it may proceed at a variable rate. Some individuals, especially those with ARC or early Kaposi's sarcoma (KS), appear to achieve a fair degree of homeostasis between the immune damage and the viral infection. Rare individuals may even recover from the AIDS virus infection.

Immune Stimulators

Although immune stimulators seem a rational addition to conventional antibiotics and chemotherapy in AIDS, the use of such drugs has to date been largely unsuccessful.

The first trials of immune stimulators began in San Francisco, Los Angeles and New York City in 1982 and involved the testing of recombinant alpha interferon in patients with KS, and later in those with lymphadenopathy, one of the symptoms of ARC. In KS it was discovered that high doses of alpha interferon could successfully reduce the number and size of lesions, but this therapy unfortunately did not reverse the underlying immune deficiency. In addition, alpha interferon was somewhat disappointing because subjective toxicities (fever, malaise, fatigue) were associated with high-dose therapy.

The second immune stimulator to be tested was recombinant human interleukin-2. In a major study completed recently at San Francisco General Hospital Medical Center (SFGH), increasing doses of this drug were tested in more than 75 AIDS patients, including those with KS as well as others with opportunistic infections (OI). Although the results of this trial are still being analyzed, no substantial clinical or immunological benefit was seen in any patient group when this drug was used alone. Side effects fortunately were minimal and the drug did not seem to accelerate immune damage.

A number of other immune stimulators have been or are being tested here and elsewhere, including isoprenosine, thymic hormones and DNCB. We now suspect, however, that these drugs or any other approach that simply stimulates the immune system is unlikely to be effective given the chronic infection of the immune system by the AIDS virus. At best, immune stimulators when used alone will only cause new T-cells to appear, which then become infected and damaged. These agents may, however, eventually prove useful in combined therapy, perhaps with an antiviral drug.

Strategies for Antiviral Therapy

With the realization of the limitations of immune stimulation alone and with the discovery of the AIDS virus, therapeutic

About AIDSFILE

This is the premiere issue of AIDSFILE, a free quarterly newsletter designed to help inform physicians in San Francisco and surrounding communities of significant developments in the transmission, diagnosis and treatment of AIDS. Its publication has been made possible through private contributions to the SFGH AIDS Research Fund, established in 1984 to support research, patient care and education. The fund is administered by the Office of the Associate Dean, UC-San Francisco School of Medicine, at

SFGH, and was started with a generous donation from Loy Elser, a director of Atlas Savings and Loan of San Francisco. Primary sources of information for AIDSFILE are UCSF faculty at SFGH and the Parnassus campus and physicians with the SF Department of Public Health.

Let us know if there are particular issues you would like AIDSFILE to address. Letters should be sent to AIDSFILE, San Francisco General Hospital, Ward 84, 995 Potrero Avenue, San Francisco, CA 94110.

AIDS FILE

LAR!

January 2, 1985

Dear Michael,

I'm writing partly because I have to "talk" to someone at the moment. From 10/29/85 (when I had my last DNCB painting and blood test) through 12/26/85 (when I had my next blood test after only 2 applications 1 week apart) my ratio fell from 1.8 (highest it's ever been) to 0.6 (the lowest). I can only guess how low it was before this latest restart of DNCB. Mills thinks it may be AIDS, so has ordered another antibody test. However, my IGE has climbed higher into the 1100 range (when normal is 100!) so maybe (fingers-crossed!) it's just my old allergies/asthma autoimmune problems rearing up again. Good old friends they seem too, when I ponder the possibility of having just autoimmune AIDS instead or in addition to. Mills thinks he has me over a barrel: I "need" him for DNCB! Well, a kamikaze at UC is going to make me a batch (DO YOU NEED SOME?) and I can always get my blood work done through auspices of Dr. Keith Barton, the East Bay would be DNCB-treating hippie. So Mills better not push it! (DON'T WE ALL LONG FOR THE DAYS WHEN HE NO LONGER HAS THE MONOPOLY ON EFFECTIVE AIDS TREATMENTS IN THIS CITY???)

I'm glad and grateful you put both Mills and Conant's feet to the fire regarding this matter. (Forgive me, but at the moment I feel like **Torching the World!**) Obviously, your column in CU! December somehow put Conant's ass on the burner. (Maybe through his patients who started asking those awkward questions like what is DNCB and HOW DOES IT WORK?) Now Mills has battened down his ship and got things (like data) flashing on screens like in the set for BATTLESHIP GALACTICA. All because (BASICALLY) of your columns, Michael. (It certainly hasn't been my letters or yelling for months!)

We both know that Mills has foot-dragged and roadblocked terribly. Yet, when the history is written I'm sure he'll admit to none of it, and present himself as just being "responsibly careful" etc., ad nauseam! An "example" of how he was "victimized" will be his "tempest in a teapot" over the Conant letter. And in this (AND THIS ONLY!!!) he may have some grounds, inasmuch as Conant told you on December 14, that Mills hadn't answered his letter yet—and I saw the letter and it wasn't even dated from the wordprocessing pool until December 12, let alone mailed!!! And Mills can stick out his lower lip and say: "How could I answer it when I didn't even receive it until December 23???" OH SO WHAT, I SAY! THE POINT IS: HE HAS NOW ANSWERED IT (BECAUSE OF YOU, MICHAEL) AND I HOPE THE INVITATION IS EXTENDED ONCE AGAIN FOR HIM TO PRESENT AND THAT HE DOES SO WITHOUT BECOMING TOO FAINT TO SHOW!!! Then (and only then) might I feel in the LEAST BIT SORRY for this "poor misunderstood doctor" and the ensuing "uproar" (something Conant, obviously, has dirty hands—as dirty as mine—from being a party to).

So What, So What, So What, So What, So What?

All that matters to me now is that the DNCB data is published in the JOURNAL as soon as possible and whatever the cost (because I was a party to its results and want it to be available for others—besides me). Ironical, that when I first participated (THROUGH MILLS WOULD STILL HAVE YOU THINK I PRECIPITATED IT!) I thought of it only as possibly benefiting my friends

and unknown brothers--never really thinking clearly that I may be saving myself as well! Basically I have never had a lover, but instead had two hopelessly onesided romances over the past five years (one with a soon-to-vow Catholic priest [I'm irreligious] and the other with an alcoholic bisexual [I don't drink much].) Since they fell apart (I gave up holding them) I've basically been afraid to have sex (safe or otherwise) at least since hearing Mark Feldman on the EARLY SUNDAY MORNING RADIO SHOW listened to by the cold and sexually frustrated minority in the City THEN (which was 1982)! And now, Full Circle, and out of the Blue, Mills tells me I might have AIDS after all (THIS!). Who knows, perhaps I'll find the LOVE OF MY LIFE in my Shanti Counselor...?

I'm proud of you Michael. Good Brave Kamikaze Show! You deserve more than the kudos I can ever give you. And I hope someday when you're working as Science Editor for the N.Y. Times (if that's your ambition and fantasy) you'll stop, on the way to receive your third Pulitzer, and smile a wry sad smile about this old business and melodrama that took place back in 1985 (remember **THAT** year?) and ended (on a High Note?) in early 1986!

That's at least my broken Wishbone for the New Year.

Your friend always,

A handwritten signature in black ink, appearing to read "E. S. Wood". The signature is fluid and cursive, with the first letters of each name being capitalized and prominent.

MEMORANDUM
OF CALL

Previous editions usable

TO:

Ellswood

☒ YOU WERE CALLED BY-- ☐ YOU WERE VISITED BY--

Dr. Meeks

OF (Organization)

☒ PLEASE PHONE ► ☐ FTS ☐ AUTOVON

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU
☐ RETURNED YOUR CALL ☐ WISHES AN APPOINTMENT

MESSAGE

RECEIVED BY <i>[Signature]</i>	DATE <i>1/2/86</i>	TIME <i>12N</i>
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63-110 NSN 7540-00-634-4018

STANDARD FORM 63 (Rev. 8-81)

☆ U.S. G.P.O. 1984-421-529/407

Prescribed by GSA
FPMR (41 CFR) 101-11.6

Mills calls my office and leaves a message (day after COMING UP! comes out with its "Call for DNCB Data". I return the call and Mills says there is "something" about my recent blood work (taken 12/26/85) that he immediately needs to talk to me about. I ask him to tell me over the phone. He says: "It's something that can't be discussed over the phone." We set an appointment for 5:30 P.M. today (01/02/86). I feel almost tearful (is it something seriously wrong?) then consider that perhaps he wants talk about CU!

So, I call M. Helquist. (This is the first time I've talked to him in 2 weeks: his voice is very cool--perhaps because of my pressure regarding R. Shilts????) I tell Michael about Mill's phone call and rush appointment. He says: "I guess that's Mills way of directly dealing with things." Then he tells me that Mills phoned him two weeks ago after getting my letter and that Mills didn't really have anything to say. Michael told him "the article was set & going to be printed." Mills phoned him back to say they had "just received Conant's letter" which was "addressed wrong." Michael said he was insulted by how dumb they thought he was. (I think, of course, that it's a CRUDE LIE inasmuch as they have already admitted to PAUL HERBERT that they had received the letter and that the invite was for "a time Mills couldn't attend.")

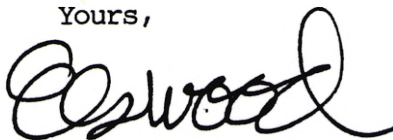
January 3, 1986

Dear George and Tim:

Dr. Mills has just informed me that he has now written to Marcus Conant and accepted the offer to speak at UC-KS Clinic. But he still refuses to tell me whether or not he has now sent along the data as requested by the editors of the JOURNAL OF DERMATOLOGY (a stipulation made prior to publication of his letter there). THIS LATTER ISSUE, OF COURSE, WAS THE REAL CONCERN BEHIND MICHAEL'S "KICK-IN-THE-PANTS" ARTICLE IN JANUARY'S COMING UP!

If you have not done so already, please emphatically and strongly ENCOURAGE him to submit this data ASAP.

Yours,

A handwritten signature in cursive script, appearing to read "Oswald". The signature is fluid and stylized, with a large loop at the end.

P.S. Hope you enjoyed your London trip!

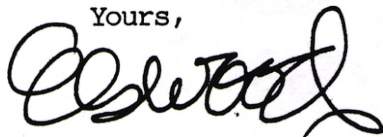
January 3, 1986

Dear Bruce and Pete:

Dr. Mills has just informed me that he has now written to Marcus Conant and accepted the offer to speak at UC-KS Clinic. But he still refuses to tell me whether or not he has now sent along the data as requested by the editors of the JOURNAL OF DERMATOLOGY (a stipulation made prior to publication of his letter there). THIS LATTER ISSUE, OF COURSE, WAS THE REAL CONCERN BEHIND MICHAEL'S "KICK-IN-THE-PANTS" ARTICLE IN JANUARY'S COMING UP!

If you have not done so already, please emphatically and strongly ENCOURAGE Mills to submit this data ASAP.

Yours,

A handwritten signature in black ink, appearing to read "Robert A. Smith". The signature is fluid and cursive, with the first name "Robert" being more prominent and the last name "Smith" following in a similar style. There are some loops and flourishes throughout the signature.

P.S. Hope everything is going well with your lives down there!

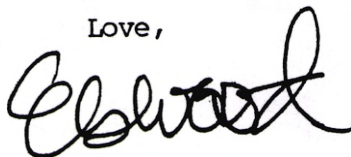
January 3, 1986

Dear Stef:

Dr. Mills has just informed me that he has now written to Marcus Conant and accepted the offer to speak at UC-KS Clinic. But he still refuses to tell me whether or not he has now sent along the data as requested by the editors of the JOURNAL OF DERMATOLOGY (a stipulation made prior to publication of his letter there). THIS LATTER ISSUE, OF COURSE, WAS THE REAL CONCERN BEHIND MICHAEL'S "KICK-IN-THE-PANTS" ARTICLE IN JANUARY'S COMING UP! (See the enclosed.)

If you have not done so already, please emphatically and strongly ENCOURAGE him to submit this data ASAP.

Love,

A handwritten signature in black ink, appearing to read "Robert", written in a cursive style.

P.S. Hope you enjoyed your Christmas trip to the "Real World" and beyond!

January 4, 1986

Dear Dr. Mills:

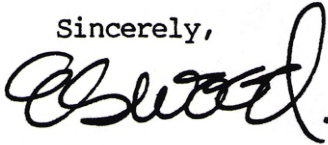
Our conversation Thursday evening when you had me rush in to see you needs some more amplification. First off: that "tempest in a teapot" (as you call it) over Conant's letter was entirely MY tempest and it wasn't in ANY TEAPOT. Many people (and not just Michael Helquist and myself) have put their faith, trust, and reputations on the line in the cause of your research (YES! IT IS RESEARCH!) getting the proper attention it deserves. Your story about "never receiving Conant's letter until Christmas Eve" would have been more believable if other information hadn't been relayed by Paul Herbert (AS YOU REQUESTED HIM TO). Simply put, it appeared you were LYING. It was only NATURAL for Michael, however much he wants to trust you, to believe that you were fibbing—and fibbing BADLY at that. NOW you have shown me the proof about Conant's "misrepresentations" to Michael. And I'll grant it certainly appears that you are "in the right" after all. (But it also reminds me of the Little Boy Who Cried 'Wolf' Too Often—or, in this case, has never been forthright—UP TO NOW?—with his data.)

Michael Helquist is THE BEST FRIEND you've got. He wants to work with you in the cause of effective AIDS treatments. No doubt he feels BADLY about mistrusting you over 'THE TEMPEST', and probably (if I know him) will write and apologize, trying to take full responsibility. Well, I'm the ONE RESPONSIBLE and don't want in any way your previous relationship and developed trust with Michael to be jeopardized by my actions. Conant was obviously feeling the heat of Michael's pressure December 1st (ON YOUR BEHALF) when he tried to "throw the ball back in your court" by claiming on December 14th that you hadn't responded to invites. I'M THE ONE (NOT MICHAEL) WHO THOUGHT IT FIT PERFECTLY WITH YOUR 'SHY' CHARACTER AND PAST BEHAVIOR PATTERNS. In any case, you HAVE now accepted to speak at the KS Meeting Forum and I've called them to be put on the mailing list so as to know the time and date the minute it is arranged. (GET ANOTHER DOCTOR TO HANDLE ANY 'EMERGENCY' THAT 'MIGHT' DEVELOP THEN—THERE WILL BE A 'FULL HOUSE' TO SUPPORT YOUR APPEARANCE AT THE FORUM, I'LL SEE TO IT AND SEE YOU THERE!)

Michael's real concern in COMING UP! (and you notice how carefully and even gingerly he handled you there) was that you get your DATA (as requested) immediately to the JOURNAL for quick publication. THE WORLD'S AIDS PATIENTS—AND NOT JUST FIGURATIVELY—ARE WAITING TO SEE THEM THERE. I note that, while you were quick to show me your written acceptance of Conant's invitation Thursday evening and made a big point of saying that your data is "better than you ['BLAINE'] could even guess" (a response, no doubt, elicited by my last letter to you), you REFUSED POINT BLANK to say whether or not you have now sent that DATA to the JOURNAL. From this petulant refusal ANY REASONABLE PERSON can only assume that you HAVE NOT. And I can assure you these continuing UNREASONABLE DELAYS WILL CREATE A 'TEMPEST' THAT WILL BREAK YOUR TEAPOT. (I'm not referring to Michael here, I'm referring to ME!!!)

Over the past three years of our relationship together (both personal and professional) we have cried and laughed over many things--not least of which were the foibles and OUTRIGHT CRIMES of the Medical Establishment. Since December of 1984, however, when you started painting me with DNCB "as a 'healthy' control subject" for your research (Yes! Research!), it seems I have OFTEN had to fight you for the betterment of my ailing Gay Brothers.

Don't look askance at me: **I am but the Monster YOU have CREATED, Dr. Frankenstein!**

Sincerely,


cc: Michael Helquist

January 6, 1986

Peter Aleshire c/o
THE TRIBUNE
P.O. BOX 24304
Oakland, CA 94623-1304

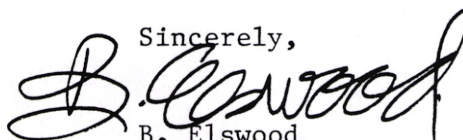
Dear Pete:

Per our phone conversation this afternoon, enclosed and attached find some background material on the AIDS autoimmune/DNCB treatments (including a copy of Mills' submission to the JOURNAL OF DERMATOLOGY.

I suggest you start with "tab A" and "tab B"--then you will know the significance of this startling discovery. (NOTE: this, unlike the cyclosporine treatments in Paris, DOES NOT directly suppress the immune system AND has been in trials since 12/84!)

Good luck! And congratulations for breaking the FIRST STRAIGHT PRESS story of the autoimmune co-factor in AIDS.

Sincerely,



B. Elswood
633 Post #644
S.F. CA 94109

P.S. If you should wish to investigate this whole matter further (and I hope you will!) you should probably talk to Michael Helquist, the journalist who writes for the ADVOCATE and AMA NEWS. Michael, I'm sure, would be willing to discuss this matter fully. His telephone number here in the City is: [REDACTED].

Attachments & Enclosures

January 6, 1986

John McManus
CABLE NEWS NETWORK
50 California Street
San Francisco, CA 94111

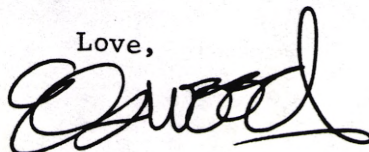
Dear John:

Thanks for the information about that news story in yesterday's OAKLAND TRIBUNE about the autoimmune report of the UC researchers. What is particularly interesting is their talking to the press before publishing their theories. (The NEW ENGLAND ITP report was preliminary, as they admitted there.) My guess (and I think I'm right) is that they are rushing to state what they know is already breaking fast (with the French--as you already know; and with Mills--through my letters of complaint, push, etc. at Volberding along the autoimmune lines). I HOPE YOU DO ~~NOW~~ NOW BREAK THIS STORY NATIONALLY. Years of wasted research have been lost due to the NIH being sheparded by Gallo only along his "infectious disease" model. AND CAN YOU IMAGINE THE POLITICAL IMPLICATIONS OF A.I.D.S ("Auto-Immune Disease Syndrome") BEING SOMETHING LIKE DIABETES? Would they treat diabetics as they now treat AIDS patients and AIDS-risk populations? (Diabetes, I don't have to remind you, is infectious TOO!)

Just as importantly, this "BREAKTHROUGH" (which I have known/or at least heard about from Dr. Mills for over three years) will now allow EFFECTIVE treatments to be discovered. One of these treatments is DNCB and ha ~~he~~ ALREADY BEEN IN TRIAL FOR OVER ONE FULL YEAR!!! But, as you will read from the attached, it takes the Media (i.e. YOU) to get Mills out of his treating closet!!!! Go get him!

Note: Mills (thanks to Michael's--and my--pressure) has accepted in writing the invitation to speak at U.C. (LET THAT BE A LESSON: TREAT HIM DELICATELY BUT FIRMLY. HE KNOWS HE HAS TO SPEAK TO THE MEDIA! Let him know that time is NOW!

Love,



Attached: Michael's latest column in COMING UP!

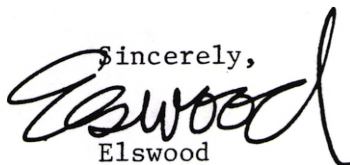
January 6, 1986

Jim Henry
[REDACTED]

Dear Jim:

Per our conversation, here is some background material. And lo! and Behold! even while we were talking the OAKLAND TRIBUNE breaks the first main press story about autoimmunity in AIDS.

I hope you guys go wild like Paul Revere, and save the day for ALL our Gay Brothers....

Sincerely,


Elswood
633 Post #644
San Francisco, CA 94109

Attachments & Enclosures

THE STATE OF THE SCIENCE

BY MICHAEL HELQUIST

The Condom Study, At Last

The virus associated with AIDS does not pass through either latex or natural membrane condoms, according to UCSF researchers Jay Levy, MD and Marcus Conant, MD. Local observers who follow the progress of AIDS research probably greet the release of the condom study findings with both satisfaction and exasperation.

The five brands tested included three types of latex condoms, one made of natural lamb skin, and one manufactured as synthetic skin. Two of the brands were pre-lubricated; one is sold with a spermicidal lubricant. All of the five blocked the AIDS virus.

The UCSF researchers tested condoms marketed under the following brand names: Trojans, with and without lubrication; Ramses, with a spermicidal lubricant; Skinless Skin, a pre-lubricated synthetic type; and Fourerx, made of natural lamb skin.

The results from the study, commissioned by the San Francisco AIDS Foundation, are very important as tools to enhance AIDS prevention messages and general risk reduction education. As staff members at the Foundation often comment, "Prevention is the only vaccine we have." Condoms can prevent the spread of AIDS; anyone who doubted the efficacy of rubbers earlier should now protect themselves and others by making condom use part of their sex play.

The exasperation comes with the lengthy delay for conducting this relatively simple study. Last February UCSF researchers and staff at the AIDS Foundation spoke of the condom study as being imminent. San Francisco was well positioned to conduct the study: viral cultures were available through Dr. Levy's laboratory. And Dr. Conant brought expertise from his earlier condom studies with the herpes virus. Nevertheless, one delay followed another, month by month, providing a local example of how science can be obstructed by misunderstandings, competition, funding problems, and the ever-present crush of other priorities. Only a small portion of the delay can be attributed to the need to run the testing a second time to confirm the findings.

While waiting for the expected study results, the foundation staff delayed for the same ten

months their full-scale condom campaign. (The advertising campaign is now expected "shortly".) At some point, the Foundation's board of directors and administration should evaluate the response time now required by the staff to turn a prevention idea into an education message.

Nevertheless, the San Francisco AIDS Foundation and the researchers involved are to be commended for their efforts. The study will boost AIDS prevention worldwide; and as a result, many lives will likely be saved.

The larger story here is the disinterest of federal researchers and bureaucrats to undertake such a basic research study. Last summer this reporter asked Dr. James Curran, head of the AIDS Activity Office for the Centers for Disease Control, why his office had not conducted or commissioned a condom study. He answered, "I guess we just haven't gotten to it yet." Later in the day Curran told an audience of gay physicians that his office was about to study the role of "bedbugs" in the transmission of AIDS.

A Call for DNCB Data

In October this column presented preliminary findings about a drug compound called DNCB, a substance that, when applied to the skin, often triggers a reaction from the immune system with lymphocytes mounting an attack against the irritant. A local dermatologist, Dr. Bruce Mills, found this reaction occurring in immuno-compromised patients as well as in those with AIDS. A few patients with Kaposi's sarcoma noticed that their lesions began to fade after they had developed a response, basically a localized rash, to DNCB. Dr. Mills noted with special interest that some of the patients using DNCB also experienced considerable increase in their T-cell counts and their ratio of T-helper cells to T-suppressor cells. Since that first report, more than 20 patients have requested the DNCB applications from Dr. Mills. In addition, physicians from around the country have contacted Dr. Mills about the DNCB treatment.

Mills also sent a brief description of his early findings to the editor of the *American Journal of Dermatology*. The journal, which places submitted articles and correspondence before a peer review board, accepted Mills' letter on the condition that he provide more quantitative data. That request underscores a much needed next step for Mills: it is time to gather

data and publish it for others to examine.

While several physicians have dismissed the early reports about DNCB, others have looked at the accounts with interest. Dr. Gaetano Giraldo, an Italian researcher and a Kaposi's sarcoma specialist with the National Institute of Tumors in Naples, told this reporter that the DNCB applications represented "a very reasonable approach, one that needed to be looked at further." Giraldo, who has collaborated on AIDS research studies with Dr. Jay Levy of UCSF, also indicated that he may begin a small study of DNCB as part of his own research.

In San Francisco Dr. Marcus Conant, dermatologist and UCSF researcher, agreed that Dr. Mills' observations about DNCB appeared valid, but he added, "Now we have to look at the science of it." Conant is especially interested to see whether the reported elevations of T-cells and ratios are statistically significant or simply aberrations. "We need to see the data to determine whether the observations are reproducible by other researchers," he said.

Conant noted that he had invited Mills by letter to present his findings and to discuss his observations before the regularly scheduled KS Clinic at UCSF. Mills has yet to respond to the invitation. Conant also advised that special funding may be available for studies of AIDS treatments, even those conducted by physicians in private practice.

Clearly, the burden of proof lies with Mills to present the data that might alert other physicians to the potential value of DNCB and to give worried people with AIDS and ARC a means to evaluate the benefit of this treatment. A respectable amount of time has passed to justify an announcement of the drug's effects; and although the number of participating patients is small, the total is adequate for an early report. Researchers, physicians, and patients will all benefit from an early presentation of DNCB data by Dr. Mills.

Related News from France

The search for an effective AIDS therapy continues to focus on agents that enhance immune function without providing the AIDS virus with new cells to attack. Some research indicates that by stimulating the immune system, the replication, or duplication, of the virus may also be stimulated, certainly a condition to be avoided. Researchers from Strasbourg, France believe they may have found an agent that improves immune response without assisting the virus in any way. The drug they have tested, sodium diethyldithiocarbamate or DDTC, demonstrates mechanisms similar to DNCB, according to Dr. Bruce Mills.

Jean-Marie Lang and her colleagues at the University Center Hospital in Strasbourg reported in a letter to *The Lancet* (November 9, 1985) that they had recruited six gay men with previously untreated ARC and with antibodies to LAV/HTLV-3 for their study. Each was given 8-10 mg. per kg. of body weight orally once a week for three to six months. Upon immunologic follow-up, each patient was tested for numbers of T-helper and T-suppressor cells as well as for his hypersensitivity to a set of recall antigens (a test that measures the ability of the immune system to respond to foreign irritants). Hypersensitivity

clearly improved in three patients and returned to normal in one person. In addition, the researchers report that the proportion and number of T-helper cells increased in all the patients and reached the normal range in two individuals. All the patients reported feeling better.

The researchers emphasized what they recognized as a "critical issue in immunorestitution trials in patients infected with HTLV-3/LAV"; namely, that since there was no decrease in the number of T-cells and since slow clinical improvement occurred, the findings "suggest that DDTC does not render T-lymphocytes more sensitive to the AIDS virus."

Lang did not discount the possibility of spontaneous responses; instead she called for randomized placebo-controlled trials. However, she said she has found such spontaneous improvement uncommon with ARC patients. Lang concluded that DDTC may be a potentially useful biological response modifier in ARC patients. She noted that DDTC may also have potential as an anti-viral.

Dr. Mills in San Francisco suggested that DDTC appears to act as a contact sensitizer, much like DNCB. Although Mills said he thought skin application offered a better chance for an effective response than oral ingestion, he commented that DDTC was his "second choice" after DNCB as an AIDS therapy. DDTC may be especially useful, according to Dr. Mills, for those patients who are highly sensitive to, and therefore reluctant to use, DNCB.

The DDTC report, which presented both qualitative and quantitative data, underlines the need for similar data about DNCB to be published.

The Belgian Drug

Potential therapies for AIDS have begun to acquire an almost nationalistic aura. Already there are French treatments (HPA-23, cyclosporine, and DDTC), a Swedish experimental drug (Foscarnet), Israeli reports (thymus extracts) a few American entries (AL 721, ansamycin, Compound S, and DNCB) and other international possibilities (suramin, ribavirin, and isoprinosine). Now a new drug has been reported by researchers working in Belgium.

Scientists at the Hospital Erasme in Brussels presented preliminary data at the recent African AIDS forum about human clinical trials of Methionine-Enkephalin. The drug, with a name conveniently shortened to Met-Enk, is a substance composed of five amino acids. (Amino acids are the building blocks of which proteins are constructed. Twenty amino acids, out of 80 found in nature, are needed for proper metabolism or growth. Some amino acids are produced by the body, while others are supplied by food. The latter are called essential amino acids; and foods, such as milk, cheese, eggs, and meat, that contain all the essential amino acids are called complete proteins.)

The Belgian researchers said they recruited both AIDS and ARC patients for the clinical trials of Met-Enk, which is non-toxic and has been found to enhance certain cell-mediated immune activities under laboratory conditions. The eight patients showed "dramatic increases" in the number of T-cell counts and in

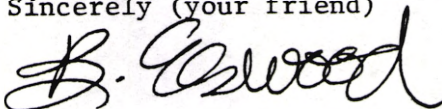
January 8, 1986 10:45 AM

Dear Wally,

Even as I write this note, a personal emissary is enroute to Paris with a bottle of DNCB crystals, a complete protocol description, and a copy of Dr. Mills' submission to JAAD. He is scheduled to meet with the research doctors at the Pasteur Institute quite shortly after arrival.

But you are the DNCB expert. This is YOUR BABY. Go for it!

Sincerely (your friend)

A handwritten signature in dark ink, appearing to read "B. Elswood". The signature is fluid and cursive, with the first letter "B" being large and prominent.

Mr. B. Elswood
633 Post #644
S.F. CA 94109

01/08/86

Michael--

Since you are obviously going to be the "Boswell" of this enduring melodrama, I think I'd better update you with the events of last night.

--Arriving at the VA on the #38 Geary line, I walked into the Emergency and looked for a "white page phone" per the instructions of the kamikaze. There was none. The only phone I could find was in the Police Office, so I phoned the kamikaze's extension from there...

--"Where are you?" he said.

--"I'm in the Emergency Room's Police Office."

--"You're WHERE? What are you doing THERE?!"

--The kamikaze then instructed me to go outside across the breezeway and wait in the other building's lobby. He soon appeared dressed in a white lab coat and we walked outside and towards a picnic bench overlooking the Golden Gate and Land's End. (Multiple ironies!)

--I chatted away--much too manically--when the kamikaze finally told me to "shut-up" and put my backpack in front of him on the table. He then pulled a large bottle out of his lab coat pocket.

--"This is for San Diego," he said.

--Then he pulled two smaller bottles out containing 1% & 2% percent.

--"This is for you," he continued.

--The next out contained DNCB crystals, expertly labeled as to molecular weight and formula.

--"This is for Dr. Kessler's lover," he said, "I once spent some time at Langley-Porter and this helps pay the debt."

--"And this," he said, pulling yet another bottle from out of his lab coat, "THIS IS FOR FRANCE!!!"

* * *

Finally arriving home after this picturesque adventure, I phoned Dr. Kessler's home. His lover, Steve, answered and said Kessler was running late and would it be "okay" if another doctor friend came by to pick up the stuff.

--"Sure" I answered, "have him double park."

--About an hour later, a BMW appeared from out of the fog, and an obviously nervous and uncomfortable little Jewish doctor about 56 years-old got out. (He was darting glances all around as if it were World War II and he was afraid of an SS sting.)

--"Mr. B.--Mr. B. Elswood??" he asked, as I opened the front door to welcome him.

--I gave him the bottles with the detailed instructions as to storage and portability that the kamikaze had given me. (The lids were parafin-sealed against moisture and the seals were not to be broken until ready to mix in solution in France.)

--"You know, he said, "I'm a doctor [pointedly there had been no introductions] and I've been trying to get some of this DNCB all day. The pharmacy at UC doesn't stock it. You know," he continued, "this use to be alot more available twenty years ago when it was used as a diagnostic tool for Hodgkin's."

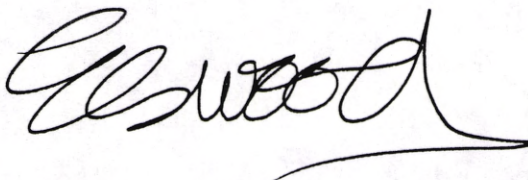
--"Well, the expert is Epstein," I said, "and I think Epstein's more interested in DNCB in AIDS than he's letting on--at least he's writing me letters!"

--"Wally?" he asked. "WALLY Epstein?"

--"William L. Epstein."

--"OH, he goes by 'Wally'!"

--Then I told this mysterious (and somewhat less nervous) doctor: "This bottle is for Dr. Kessler's lover, and THIS BOTTLES FOR FRANCE!!!"

A handwritten signature in dark ink, appearing to read "Elswood". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

January 9, 1986

Dear Michael,

It's three o'clock in the morning and I can't sleep. Seems (as per usual) I forgot to tell you something important. Mills told CNN that in his data those patients who are simultaneously doing other therapies, such as chemotherapy—and ESPECIALLY immunostimulators such as Isoprinosine—show LESS improvement than those that do DNCB alone. While this is not surprizing with regards to chemo, Mills (as reported to me by CNN) feels the Isoprinosine interference with his data is EVIDENCE indicative of AIDS autoimmunity—i.e. that localized and SPECIFIC immune response to the DNCB application site "defeats" autoimmune attack elsewhere and that generalized immune stimulation, such as that claimed by the makers of Isoprinosine, etc., "defeats" the DNCB strategy by also being stimulative to the AIDS autoimmunity—at least until the Ts and Bs have regained control and more normalcy. (As you can see from this: Mills is indeed, if right, on the very cutting edge of new research discoveries. If he's shot any day soon, suspect that pharmaceutical in Newport or the mystics who push visualization immune-enhancement techniques in AIDS!)

But this is NOT TO SAY that what Mills did (in deciding to try DNCB in 12/84) was anything SUPERNATURALLY BRILLIANT. I told a kamikaze about Stricker's report to CNN that DNCB was used on classical, pre-AIDS KS. The kamikaze said: "Ah ha! I bet Mills knew of that, or at least had read it somewhere! Then all that Mills has really done--WHICH WAS BRILLIANT--was to carefully 'Count His Peas' like Mendel!" (I suppose the kamikaze was here referring to Mills' blood work results; and the reference to Mendel was to the FATHER OF GENETICS!)

ANOTHER THING: I bet you dollars-to-donuts that YOU-KNOW-WHO (Bob Gallo) was on the peer-review committee that suppressed Stricker's paper three years ago, just like Bob Bolan was "first reader" and royally trounced Mills' autoimmune research proposal three years ago!!! Remember when I told you that I "feared for the future" and all the harm the coming "BREAKTHROUGH" in AIDS could have for Mills, You, Me, Bolan, Volberding, Etc.? Well, I bet Bolan is quaking in his designer boots right now...

Good luck in New York. Come back soon!!! Things seem to be happening here so fast I can't sleep (as you can well see).

Love,


Attached: My "kick in the pants" to CNN

January 8, 1986

John McManus
CABLE NEWS NETWORK
50 California Street
San Francisco, CA 94111

Dear John:

To follow up on our phone call today (—and by the way, thanks for the update—) I wish to encourage you to report on the Auto-Immune Disease Syndrome. Lord knows, it takes a lot of education to make the public understand the whole mechanics of an autoimmune disease—let alone one that they have previously been told was infectious (in the "infectious disease model" sense, such as flu, colds, syphilis, etc.) However, once you guys have done the groundwork needed, I hope SOMEONE reports on the REAL STORIES.

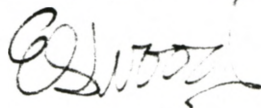
Those REAL STORIES are:

1) Why the detour from previous autoimmune AIDS research (see the thymus autopsy report of June 1, 1982); and why were the remaining "lone voices in the wilderness" (to quote Dr. Stricker) so intimidated (i.e. Mills) and censored by their peers (Stricker himself) that they were AFRAID to voice their objections to and questions of the erroneous mainstream research (read: the monopoly of the National Institutes of Health). Obviously, at fault here is our entire MEDICAL RESEARCH SYSTEM governed with such Hitler-like control by a few bureaucratic U.S. scientists wielding all our tax dollars as if it were their own personal resources. (When they're right, they're "very right"—and when they're wrong, **WE DIE FOR YEARS!!!**)

2) Why AIDS patients should be treated politically and socially ANY DIFFERENT than, say, diabetics. (Diabetes, let me gently remind you, is an autoimmune response to a viral infection, probably passed by MILLIONS of 'healthy' carriers. Where's the call for quarantines and refusals of marriage licenses for diabetics? THEY WOULD PROBABLY HAVE BEEN LYNCHED LONG AGO IF THEY HAD EVER BEEN PERCEIVED AS GAY AND NOT STRAIGHT!)

When these two REAL STORIES are finally reported (after you have done all the preparation and education necessary, rolling—as it were—a RED CARPET for others in the Media to walk on) I hope SOMEBODY also tells the DNCB Story. The French, as usual, will probably be FIRST to really turn on to its possibilities (or that of some other simple contact sensitizer) as a replacement for immune suppression therapies; and the Americans, as usual—and even though it was pioneered HERE--will be the JOHNNY-COME-LATELYS we always have been. (I suppose it's our National hubris for being so obnoxiously **PROUD!**)

Carry on (however),



A KAMIKAZE NEWS EPILOGUE (01/13/86)

When your editor resigned and the KAMIKAZE NEWS (for all practical purposes) ceased to exist on Pearl Harbor Day, 1985, it was little expected that the forward movement of AIDS/DNCB developments would then increase to such a break-neck fury as to call for yet another kamikaze communication. But this has been the hectic and exhilarating pace of events this past month.

First it was reported in the NEW YORK NATIVE (December 16, 1985) that the director of the Pasteur Insititue in Paris is saying that, indeed, AIDS is autoimmune and that the pathology of the virus more closely parallels the development of diabetes than syphilis (as we have generally been told by researchers in the past). Mills, of course, was saying "autoimmune" three years ago, and initially developed his successful DNCB treatment strategy with that disease concept in mind!

Next, it was learned that Dr. Marcus Conant, KS Researcher at the University of California at San Francisco, has invited Mills to present his treatment protocols and answer questions before a U.C. forum composed of patients, researchers, and all interested others. This forum has now been scheduled for Thursday, February 20, 1986. (All interested kamikazes and friends should mark their calendars and plan to attend what will inevitably prove to be a MOST INTERESTING event!)

The autoimmune articles by Michael Helquist in the ADVOCATE & COMING UP! and the report in the N.Y. NATIVE was followed in turn by the FIRST REPORT in the Straight Press on January 5, 1986. This was a very important article written by Pete Aleshire, Science Editor of the OAKLAND TRIBUNE, and placed by the managing editor of that paper—not on the front page where it belonged—but next to the obituaries! (See the attached copy.)

Mills has now begun talking to BOTH the Media and his fellow doctors who report his data as being "good" & "even sensational"—although, of course, it was performed without placebo controls. (Da, da, da, da.) CABLE NEWS NETWORK has talked twice to Mills and will break the DNCB story upon its publication in the JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY. In the meanwhile, Mills has been flown to Houston to present there; his treatment plan is being conducted BY AIDS PATIENTS THEMSELVES (!!!) throughout San Diego County; and Mills has talked at some length with a representative of the CEDARS-SINAI AIDS CLINIC in Los Angeles.

Furthermore, a personal emissary left last Wednesday for Paris with some DNCB crystals, a copy of Mills' protocol, and a full report. He is scheduled to meet shortly after arrival with the co-founder of HPA-23 (the "Rock Hudson Drug") and a co-director of the Pasteur Institute. Early report is that these French scientists will be VERY INTERESTED in the DNCB approach because currently they are all looking only at immunosuppression with no obvious knowledge of the more feasible and less toxic "middleground" of contact sensitization.

DNCB, as of this date, is becoming more and more available through the "underground network" of "Clara Barton" AIDS patients and activists—who, in the breach for our local "wayward" (if not backward) AIDS doctors—are

treating themselves and their friends (sometimes with what seems reckless abandon). These very early results (and especially those coming from San Diego County) are being reported in terms that approach the MIRACULOUS!!!

And last--BUT CERTAINLY NOT LEAST (and as you have probably already guessed by now)--Mills has sent his requested data to the JOURNAL and it is pending early publication there!!! (The AIDS scientists at U.C., Volberding, Abrams et. al., are now presenting a UNITED FRONT OF SILENCE pending their look at this published data in an upcoming issue. Needless to say, none of these researchers are probably any-too-happy at the prospect of a lone dermatologist, working almost on his own and without a single penny of the huge amounts of U.S. AIDS research monies that have been spent by U.C., etc., uncovering AND developing a viable, inexpensive & legal AIDS treatment breakthrough...something they, themselves, have failed miserably at. (See the Suramin story in the current B.A.R.)

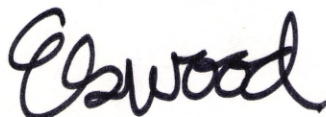
All the fame, of course, will fall to Mills. But there are unsung heroes and heroines in this medical story. Foremost (and I hope not to be totally ignored in the upcoming Hul-a-bloo) is Dr. Deanna Hanes of Pacific Medical Center. If it hadn't been for her volunteering some of her discretionary budget monies for initial free blood work, Mills' investigation would have never gotten off the ground! Then there is--of course--Michael Helquist, himself, who began to investigate this story last April, got derailed by some ignorant and capricious doctors; but when put back on track, barreled forth like a runaway locomotive, scooping the first story like it was one of those whistlestop mailbags. (And let's hope that now that Mills' HAS completed his part in this epic saga--AND PUBLISHED IN THE JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY--Michael will turn to burn the feet of the U.C. Researchers if they fail to carefully investigate and follow through with the results of the pioneering DNCB work.)

Also, you should note, there is John McManus of CABLE NETWORK NEWS to be congratulated once he finally gets off his duff and DOES SOMETHING which, hopefully, will be VERY SOON INDEED!!!

Then, of course, there are you, the kamikazes. We called ourselves "kamikazes" in response to a letter to the editor of the SAN FRANCISCO CHRONICLE wherein this fundamentalist bigot accused Gay people of being "kamikazes of death" who are "destorying America" with a "wicked & unregenerate" lifestyle. Well! Let it now be known that we have brought LIFE where those Christian "regenerates" have brought NOTHING but their fear and hatred!

You are the real heroes and heroines of this crisis, EVERY ONE OF YOU. Doing the groundwork, writing, talking, even doing illegal things like STEALING DNCB for the sake of our ailing brothers and sisters, I marvel at and kudo YOUR bravery. The kamikazes HAVE done their part in true brave kamikaze fashion! We HAVE served a Higher Power than the bigots ever have! (For Our Conscience and Common Humanity is Our Only Emperor!)

Your former editor,



Study offers new theory on AIDS

Virus may cause body's immune system to attack its own cells, UCSF team says

By Peter Alachire
The Tribune

The deadly AIDS virus may do its damage by causing cells of the body's immune system to turn on each other, according to new research findings.

The suggestion that AIDS is, in part, an auto-immune disease runs counter to the more accepted view that the virus causes a lethal succession of infections by killing off certain immune system cells.

If the more recent theory is true, it would have a big impact on research and treatment of the virus that has killed about 8,000 Americans and infected an estimated one million. For instance, doctors may try to find ways to restore the balance of the immune system in addition to finding ways to kill the virus itself.

Researchers say the fact that such fundamental questions remain unanswered is a measure of how difficult it will be to defeat AIDS.

The most recent evidence suggesting that the AIDS virus may produce an auto-immune disease comes from a University of California at San Francisco study of AIDS victims.

Platelets antibodies

The researchers found that the AIDS patients had developed antibodies to their own platelets, the cells responsible for blood clotting.

Antibodies are the part of the immune system that marks foreign cells for destruction, and the findings suggest that the immune system of AIDS patients attacks the patients' own platelets, according to UCSF researcher Dr. Raphael Stricker, one of the authors of a report published in the New England Journal of Medicine.

Dr. John Ziegler, director of the UCSF AIDS clinical research center, said there's a real possibility that AIDS is, at least in part, an auto-immune disease.

"There is probably more going on than a simple viral infection of cells," he said.

Stricker says he thinks that "what's happening is that the AIDS virus is killing certain cells that regulate the immune

system and, because they aren't there, the body starts making antibodies to its own cells."

Stricker focused on this possibility while researching a potentially lethal blood disorder affecting about one in 100,000 American women, in which the immune system for some reason starts attacking platelets.

His findings are further evidence that the AIDS virus somehow prompts the immune system to attack healthy cells of the body. The indicators include:

- AIDS patients have antibodies to their own red blood cells, according to a study at the blood bank at San Francisco General Hospital. About 20 percent of the patients tested had developed antibodies targeting their own red blood cells for destruction, said Stricker.

- UCSF researcher Art Amman found that many AIDS patients have developed antibodies to the nuclei of their own cells. This also happens in several auto-immune diseases.

- Many AIDS patients have antibodies marking the body's own fat cells for destruction by the immune system. Again, a similar antibody has been found in other diseases thought to be auto-immune diseases.

The notion that the AIDS virus causes the immune system to self-destruct also would help explain another oddity of the lethal disease, according to Ziegler. The AIDS virus often is plentiful in the early stages of infection but almost impossible to isolate in the final stages of the disease, when the body has been ravaged by a host of normally rare infections.

Virus shouldn't disappear

"But if the problem in AIDS was the rampant killing of (immune system cells) by the AIDS virus itself, you would expect to find a lot of virus in the final stages," said Ziegler.

The immune system includes several major categories of cells — only one of which is actually infected by the AIDS virus.

These components include:

- Macrophages

These are the shock troops of the immune system, recognizing

and destroying invading viruses and bacteria. But even though the macrophages are the first to recognize invaders, they need the rest of the immune system to mount an all-out assault.

- Helper T-cells

These are the cells the AIDS virus infects, and they are crucial to the disease-fighting process. The helper T-cells are the scouts and messengers of the immune system. Once the macrophages have recognized an invader, the helper T-cells spur the rest of the immune system into feverish activity.

- B-cells

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These immune system cells can recognize and destroy infected cells. Viruses generally invade cells and turn the infected cells into factories for making more viruses.

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- Suppressor T-cells

These cells are thought to play a role in shutting down the immune system once the invader is defeated, which helps ensure that the immune system cells don't go wild and do more harm than good. Some researchers say that one problem in AIDS is that there are too many suppressor T-cells in relation to the helper T-cells. However, other researchers doubt whether suppressor T-cells even exist.

The complexity of the immune system, and the way in which many of its cells stimulate one another, provides a measure of how many things might go wrong when the AIDS virus starts killing helper T-cells.

For instance, the helper T-cells are essential in telling the B-cells which antibodies to produce. Obviously, if the diseased helper T-cells get their signals crossed, the B-cells could start directing the immune system to attack the wrong cells.

In addition, the AIDS virus might mimic the cells of the body to evade the immune system and to attach itself to the helper T-cell.





Bill Kraus with Representative Sala Burton at a 1983 march in San Francisco urging more funds for AIDS research

Burton Aide Bill Kraus

Fighter for Gay Rights Dies of AIDS at 38

By Randy Shilts

Congressional aide Bill Kraus had every reason to be optimistic about the course of the AIDS epidemic because he had created many of the sources of hope.

As an aide to the late Representative Phillip Burton, and later to Representative Sala Burton, Kraus had written and lobbied for the legislation that provided millions of dollars for federal research on acquired immune deficiency syndrome.

Early Saturday morning, in a room at Long Hospital at the University of California in San Francisco, Kraus, 38, became the victim of this disease he had worked so hard to fight.

Long before Kraus' own AIDS diagnosis 15 months ago, he was among the first gay leaders to prod the homosexual community to change lifestyles and close bathhouses, stances which earned him denunciations as a "traitor."

After being diagnosed with AIDS, he fought for more available treatment for victims of the disease and traveled to Paris to participate in the same experimental drug program as actor Rock Hudson.

"Very early on, Bill was one of the first people to concentrate on this issue, far before most people were aware of how serious AIDS would become," said Sala Burton yesterday. "He played a key role to find a solution for the problem. It was such a horrible irony that he would later get it."

Concerns of terminal diseases, death and despair were far from the dreams of the Fort Mitchell, Ky., native when he moved to San Francisco in 1976.

The youngest son of a German Catholic family, the one-time altar boy began his political work during Harvey Milk's early campaigns in the heady first days of gay politicking on Castro Street.

"We were going to change the world," recalled Kraus in a recent interview with The Chronicle. "We had this incredible optimism, because we were doing something that had never been done before, taking control of our own lives."

In the early 1980s, Kraus became a leading gay political strategist, engineering the coalitions that ensconced gays in the local Democratic Party establishment.

Soul Singer Luther Vandross Hurt in Car Wreck

Los Angeles

Soul singer Luther Vandross was seriously hurt yesterday in a traffic accident that killed a passenger in his car and injured four other people, police said.

Vandross, 34, was in fair but stable condition at Cedars Sinai Medical Center with several broken ribs and cuts on his face and scalp. Police Officer Ron Inada said the accident occurred shortly after noon as Vandross was driving his Mercedes-Benz in the San Fernando Valley. The car drifted across the center line and struck two oncoming cars, Inada said.

A 27-year-old man riding in the Mercedes, who was not immediately identified, was killed, and another passenger, 15-year-old Jim Salvemini, was hurt, Inada said. Three people in the other cars suffered broken bones and cuts.

Associated Press

After serving two terms as president of the Harvey Milk Gay Democratic Club, Kraus became an aide to Phillip Burton in 1982, even as a new disease was quickly spreading among San Francisco gay men.

"When I saw a man from my gym, who had been so healthy, begin to wither away from this, it hit home," said Kraus. "I decided to find out what the government was doing about it. I was appalled at the lack of resources being devoted to the disease."

Shuttling between Washington and San Francisco, Kraus lobbied legislators and congressional staff members to assemble the first supplemental appropriations bills for AIDS research.

The bills would finance the studies that would later provide major advances in the understanding of the disease, but the slow pace of government frustrated the aide who saw more than the fiscal side of the epidemic.

"It soon became obvious to me that the government would not move fast enough to halt the disease," he said. "It would be up to gay people to do everything we could to stop the spread of the epidemic."

In early 1983, Kraus began to publicly urge gay men to change their lifestyles, and cut back on sexual activity and drug use.

Although the admonitions were mild by today's standards, they came long before many in the gay community wanted to take AIDS seriously. Kraus was denounced as a "sexual fascist." A year later the rhetoric turned nastier when Kraus was among the gay leaders who pushed for the closing of gay bathhouses.

The Bay Area Reporter, which ran extensive bathhouse advertising, published an editorial that listed Kraus prominently on what became known as its "traitors list" of "collaborators" with anti-gay forces.

AIDS shifted from a political issue to a personal battle in September 1984, when, during a workout in his Upper Market Street gym, Kraus glanced at his leg and saw a purple spot that characterizes the skin cancer associated with the syndrome. When his diagnosis was confirmed days later, he took the course that was most familiar to him — to fight.

"I wasn't going to sit here and die," he said. "I was going to do something. That's when I learned that in America, you can't do anything. You can't get treatment here unless you are one of the few people who fit into one of the tiny studies."

Last March, Kraus left for Paris to take the experimental drug HPA-23. Interest in his treatment program exploded in July when it was revealed that Rock Hudson had gone to France to take the medication. Kraus furiously wrote articles, gave interviews and used his Washington contacts to lobby for greater availability of drug treatment for AIDS patients.

"It doesn't say much that an aide to a congressman and a major movie star feel they have to leave America in order to get treatment for the disease," he said.

Kraus returned to San Francisco in September, and was healthy until a week ago when he collapsed in his Duboce Triangle apartment. William James Kraus died in his sleep in the early morning hours of Saturday, the 887th San Franciscan known to have succumbed to AIDS.

Kraus is survived by his mother, Mary Whitesell of Cincinnati, and his brother, Michael of San Francisco. A memorial service is planned for Thursday at 7:30 p.m. in Herbst Theatre in San Francisco.

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In addition, the AIDS virus might mimic the cells of the body to evade the immune system and to attach itself to the helper T-cell.

SENT TO ALL THE DOCTORS ON MY MAILING LIST.

January 16, 1986

Dear Pete:

There are some more new autoimmune developments you should be made aware of. First off, however, I wish to congratulate you once again for the BREAKTHROUGH story in THE TRIBUNE on January 5, 1986. It was finely, carefully written and even covered the "tissue mimicking" class of viruses announced last November from U.C. San Diego. Your story SHOULD have been front page news in THE TRIBUNE and created a storm of related reporting in the other Media. It didn't, however, and the silence is deafening...EXCEPT for:

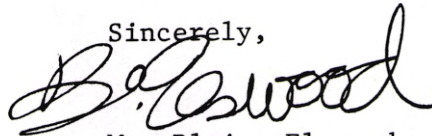
John McManus of CABLE NEWS NETWORK broke the autoimmune story nationwide on Cable, Monday night last (January 13, 1986). Their decision to run with the story was based, in part, on your article and in part on Dr. Mills' DNCB reactivity studies (which STRONGLY indicates autoimmunity as the "missing" co-factor--or even major cause--of AIDS). The CABLE NEWS story had Abrams and Stricker and some other guy in charge of "Grants" for U.C. all saying "autoimmune". But what has been the nationwide reaction??? A silence even more than deafening than that that greeted your scoop!

I phoned David Perlman's office at the CHRONICLE and was informed that he was "aware" of both your article AND the Cable story....but still nothing in THAT paper. (It is obvious that your coverage and that of CNN are but the opening shots in a turn-around on AIDS that is long past due!)

Further, you should know that CNN will be giving NATIONAL COVERAGE to Mills' DNCB report when it is published in the JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY. You should probably start working on your story as well, SCOOPING once again your colleagues on the other papers.

In the meantime, my congratulations once again to you, Michael Helquist of the AMERICAN MEDICAL ASSOCIATION NEWS, and John McManus of CABLE NEWS NETWORK for trailblazing the story of the coming BREAKTHROUGH in AIDS Research AND treatment!

Sincerely,



Mr. Blaine Elsworth
633 Post #644
S.F. CA 94109

P.S. John's # at CNN is 434-1661 (in case you want to get together for celebration drinks/discussion).

cc: Michael Helquist, Journalist
John McManus, News Editor, CNN San Francisco

JANUARY 17, 1986

Dr.s Krajewski
Kessler
Andrews

Today I met with my therapist, Dr. David Levine, and he told me about the BAPFHR meeting this Sunday. Dr. Levine expressed to me a desire to "network" with you guys regarding the AIDS/autoimmune/DNCB developments.

I signed a release so that he could tell you about stuff I've mostly already told you. (Whether--in the past--you wanted to hear or no. Levine has been getting a regular earful from me since 12/07/84 when I started the DNCB protocol!)

I'm delivering this note because:

- a) I want to remind you of this BAPFHR meeting (the first, Levine says, in three months);
- b) I want you guys to decide what to do and then do it most effectively in a coordinated effort; and
- c) for what it's worth, remind you that Levine is also VERY AWARE of the new developments this past year and IS EAGER to spring into action.

Be good kamikazes at your meeting,



January 18, 1986

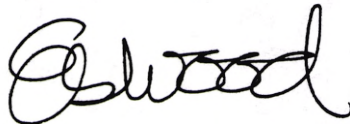
Dear Michael,

I got a phone call today from Jim Henry, of the AIDS Alliance in San Diego. He has lots of interesting things to report regarding ad hoc DNCB treatments there (thanks in large part to your ADVOCATE columns), including involvement of local physicans and U.C. San Diego. This activist is NOT one of Mills' commuter San Diego patients and sounds unusually most INFORMED and RATIONAL about the DNCB potential. (He also has the inside story on Mills' Houston trip--**You should phone him for details!**) His contact information is:

Jim Henry

██████████
██████████
██████████

Take care, and enclosed find a kamikaze check to help cover your phone call.



P.S. There was an autoimmune insurrection at the BAPFHR semiannual meeting this past Sunday, led by Kessler & Levine. I don't have any details as yet. But it appears everyone is taking sides like it was the Super Bowl: the Infectious Disease Team v. the Autoimmune Hosts!!! (**Be sure not to forget to call Jim Henry...!**)

January 20, 1986

Dear John,

Have you heard any feedback from your autoimmune network scoop? Is it being greeted with incredulous silence? That seems to be the local print reaction to Aleshire's scoop in THE TRIBUNE January 5. Nothing in either the EXAMINER or CHRONICLE, so I—full of derring-do—phoned up David Perlman, Science Editor of the latter, and asked him if he was aware of Aleshire's article AND your network broadcast. He answered that, "yes! I am aware!" and then slammed the phone up on my ear.... (Strange, Perlman, for instance, quoted Dr. Abrams at length last October when he trashed the French cyclosporine doctors' announcements; now that Abrams—in effect—is agreeing with the findings of those French doctors [AIDS is autoimmune] people are openly hostile like he was suddenly a TURNCOAT or Something.)

This twist to the medical politics in AIDS took a bizarre local turn yesterday at the bi-annual meeting of the BAY AREA PHYSICIANS FOR HUMAN RIGHTS (BAPFHR). Dr. Kessler (from U.C.) and Drs Rick Andrews, James Krajewski, David Levine, & Keith Barton all networked to push the Autoimmune and DNCB issue to the forefront. They had to fight all the way as if trying to make a touchdown against incredible opposition and betting odds. People have actually begun taking up sides as if it were Super Bowl Sunday: the Infectious Disease Team v. the Autoimmune Hosts!!! Why all the heat and fury about something that may portend REAL BREAKTHROUGHS in AIDS? (Well, your guess is as GOOD as mine! Why, for instance, is David Perlman at the CHRONICLE virtually ignoring your and Aleshire's coverage of the latest research? Instead, he wrote a rather lengthy article about a squid in formalin at Steinhart Aquarium. Is this the SCIENCE NEWS the World is waiting for?????)

Kessler reported to me on Friday that the DNCB presentation was made to the Pasteur and that they are very "intrigued" by Mills' approach to the autoimmune treatment. Kessler further asked me to get him a copy of Mills' data to forward on to them, etc. I told Kessler he would have a much better (and likely) chance of obtaining the data on his own, as Mills would only suspect me of also giving copies to CNN and M. Helquist and anyone else who would read it. (Which is certainly the case: as soon as I "get my hands on it" you'll get it, John!!!) It is likely that Kessler had this data rattling around in his briefcase yesterday, and it was this KNOWLEDGE that hepped him up for a TOUCHDOWN try. (Mills' data has been alternately described as "good", "great", and "fabulous"—depending, I suppose, on how FLAMING QUEER the doctor is whose examining it!)

DNCB treatments are being performed in San Diego by patients themselves (in connivance with the AIDS doctors down there who are still hesitant to apply it themselves, but are willing to monitor the results with clinical examinations, bloodwork, etc.) Early indications from these ad hoc DNCB treatments are VERY GOOD,

maybe even--let me say it!--FAB-B-BULOUS!!! One ARC patient/AIDS activist runs "a clinic" out of his house, painting DNCB on a steady stream of patients who wander in for healing on Saturdays like it was miracle-day at Lourdes! He does "house-calls" on those patients that are bedridden and have been given up for dead by their own doctors. The guy's name is:

Jim Henry
[REDACTED]
[REDACTED]
[REDACTED]

Jim certainly has interesting stories to tell. If you or your buddies from CNN Los Angeles/San Diego want to talk to him, please use my name as having referred you.

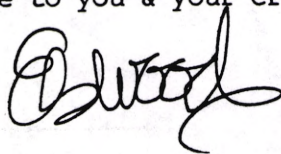
Further, it seems that when the JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY publishes Mills' data, a good approach for you to take would be to report the DNCB protocol/results, etc., with an interview with Mills himself--but MOSTLY to fill your screen time with the REACTIONS of Volberding/Abrams/Conant/Epstein, even Jim Henry (who has never met Mills, but is building his own practical experiences with DNCB). Seeing Volberding waffle on camera about something he should have been investigating last August (or BEFORE) will be PRIME TIME VIEWING at its best! (I may even rent a TV for the occasion!!!)

I am sure you have heard by now about their (Volberding/San Francisco General's) disastrous Suramin study. Based on the anecdotal reporting of only six patients in Rwanda, Africa, Volberding and some other doctors PUT UP THEIR OWN MONEY to finance a testing of this very toxic Sleeping Sickness drug. Twenty-five AIDS patients were sought out and given weekly injections. These patients changed skin colors (to salmon, green & blue, for instance); their livers failed them; their kidneys ruptured; they died from the side-effects and not AIDS; finally the Suramin study was officially abolished last week.

NOW THE FINGER IS ON VOLBERDING! DNCB is an anecdotal report LOCALLY of over **TWENTY** patients with no serious side-effects and good solid clinical improvements. This isn't quite the same bid for Fame and Fortune the doctor's thought they might have had in Suramin--so much so they were willing to invest their own money in it! BUT NOW WE KNOW THAT SURAMIN COULDN'T POSSIBLY WORK BECAUSE AIDS IS AUTOIMMUNE.

NOW THAT DNCB CRIES OUT FOR FURTHER INVESTIGATION, **WHERE IS THEIR MONEY NOW?**

Love to you & your crew,



UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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



SANTA BARBARA • SANTA CRUZ

AIDS CLINICAL RESEARCH CENTER

A-523, A-340

(415) 476-1407

(415) 476-1363

SAN FRANCISCO, CALIFORNIA 94143

January 21, 1986

TO: Kaposi's Sarcoma Study Group
FROM: Marcus A. Conant, M.D.
RE: Regular Meetings

We will meet at our regular time, at 11:00 in the Dermatology Clinic on the third floor of the Ambulatory Care Building (400 Parnassus), on Thursday, February 6th.

Dr. John Greenspan will present an update on hairy leukoplakia, followed by a presentation by Dr. Morten Schiodt, who will discuss presentation of hairy leukoplakia in Denmark as compared to the presentation here in the United States.

On February 20th, Dr. Joseph C. Brewer and Dr. Martin Delaney from Project Inform will describe the status of their research using ribovirin and isoprinosine in combined therapy against AIDS and ARC.

Also on February 20th, Dr. Bruce Mills will discuss his work with the use of DNCB in the treatment of the acquired T-lymphocyte deficiency disorder in AIDS and other disorders.

Attached, find AIDS bibliographies for the weeks ending 12/13/85 and 1/10/86.

Study offers new theory on AIDS

Virus may cause body's immune system to attack its own cells, UCSF team says

By Peter Alshire
The Tribune

The deadly AIDS virus may do its damage by causing cells of the body's immune system to turn on each other, according to new research findings.

The suggestion that AIDS is, in part, an auto-immune disease runs counter to the more accepted view that the virus causes a lethal succession of infections by killing off certain immune system cells.

If the more recent theory is true, it would have a big impact on research and treatment of the virus that has killed about 8,000 Americans and infected an estimated one million. For instance, doctors may try to find ways to restore the balance of the immune system in addition to finding ways to kill the virus itself.

Researchers say the fact that such fundamental questions remain unanswered is a measure of how difficult it will be to defeat AIDS.

The most recent evidence suggesting that the AIDS virus may produce an auto-immune disease comes from a University of California at San Francisco study of AIDS victims.

Platelets antibodies

The researchers found that the AIDS patients had developed antibodies to their own platelets, the cells responsible for blood clotting.

Antibodies are the part of the immune system that marks foreign cells for destruction, and the findings suggest that the immune system of AIDS patients attacks the patients' own platelets, according to UCSF researcher Dr. Raphael Stricker, one of the authors of a report published in the New England Journal of Medicine.

Dr. John Ziegler, director of the UCSF AIDS clinical research center, said there's a real possibility that AIDS is, at least in part, an auto-immune disease.

"There is probably more going on than a simple viral infection of cells," he said.

Stricker says he thinks that "what's happening is that the AIDS virus is killing certain cells that regulate the immune

system and, because they aren't there, the body starts making antibodies to its own cells."

Stricker focused on this possibility while researching a potentially lethal blood disorder affecting about one in 100,000 American women, in which the immune system for some reason starts attacking platelets.

His findings are further evidence that the AIDS virus somehow prompts the immune system to attack healthy cells of the body. The indicators include:

- AIDS patients have antibodies to their own red blood cells, according to a study at the blood bank at San Francisco General Hospital. About 20 percent of the patients tested had developed antibodies targeting their own red blood cells for destruction, said Stricker.

- UCSF researcher Art Amman found that many AIDS patients have developed antibodies to the nuclei of their own cells. This also happens in several auto-immune diseases.

- Many AIDS patients have antibodies marking the body's own fat cells for destruction by the immune system. Again, a similar antibody has been found in other diseases thought to be auto-immune diseases.

The notion that the AIDS virus causes the immune system to self-destruct also would help explain another oddity of the lethal disease, according to Zeigler. The AIDS virus often is plentiful in the early stages of infection but almost impossible to isolate in the final stages of the disease, when the body has been ravaged by a host of normally rare infections.

Virus shouldn't disappear

"But if the problem in AIDS was the rampant killing of (immune system cells) by the AIDS virus itself, you would expect to find a lot of virus in the final stages," said Zeigler.

The immune system includes several major categories of cells — only one of which is actually infected by the AIDS virus.

These components include:

- Macrophages

These are the shock troops of the immune system, recognizing

and destroying invading viruses and bacteria. But even though the macrophages are the first to recognize invaders, they need the rest of the immune system to mount an all-out assault.

- Helper T-cells

These are the cells the AIDS virus infects, and they are crucial to the disease-fighting process. The helper T-cells are the scouts and messengers of the immune system. Once the macrophages have recognized an invader, the helper T-cells spur the rest of the immune system into feverish activity.

- B-cells

These are the factories of the immune system. When the messenger arrives from the helper T-cell, the B-cell begins to make antibodies — each tailored for the invading virus the helper T-cell has located.

- Antibodies

These are proteins that attach themselves to invading cells and mark them for destruction by other immune system cells.

- Killer T-cells

These immune system cells can recognize and destroy infected cells. Viruses generally invade cells and turn the infected cells into factories for mak-

ing more viruses.

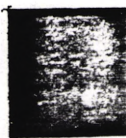
- Suppressor T-cells

These cells are thought to play a role in shutting down the immune system once the invader is defeated, which helps ensure that the immune system cells don't go wild and do more harm than good. Some researchers say that one problem in AIDS is that there are too many suppressor T-cells in relation to the helper T-cells. However, other researchers doubt whether suppressor T-cells even exist.

The complexity of the immune system, and the way in which many of its cells stimulate one another, provides a measure of how many things might go wrong when the AIDS virus starts killing helper T-cells.

For instance, the helper T-cells are essential in telling the B-cells which antibodies to produce. Obviously, if the diseased helper T-cells get their signals crossed, the B-cells could start directing the immune system to attack the wrong cells.

In addition, the AIDS virus might mimic the cells of the body to evade the immune system and to attach itself to the helper T-cell.





San Francisco General Hospital
Medical Center

November 5, 1985

Mr. Brian Elswood
633 Post #644
San Francisco, CA 94109

Dear Mr. Elswood,

Thanks for your ongoing correspondence.

Although I may appear to be inactive regarding your experience with the DNCB, in fact, I am following it with great interest. While we can't possibly explore all interesting developments in the therapy of AIDS, I am eager to hear how things are going with the DNCB program.

As I think I mentioned to you before, my concern remains that immune augmentation is unlikely, ultimately, to be effective against the AIDS virus infection. As I'm sure you know, there has been discussion recently based on some very preliminary data from France that immune suppression may be an effective strategy.

Clearly, the answers are not all in, and until they are, I welcome your ongoing correspondence.

Sincerely,

SAN FRANCISCO GENERAL HOSPITAL

A handwritten signature in cursive script, likely belonging to Paul Volberding.

Paul Volberding, M.D.
Chief, AIDS Activities Division

HOW DNCB MAY BE WORKING

If the key co-factor in AIDS is autoimmune (as suggested by the thymus autopsy report of June 2, 1983; Mills' first official report of DNCB reactivity on September 30, 1985; the French doctors' report on cyclosporin of October 29, 1985; and now the new evidence that multiple sclerosis (MS) is set off by an HTLV virus, reported by the press on November 8, 1985), then the autoimmune response involved can be viewed analogously to damaging lightning and the body (or organ under attack) to a house in a storm. Cyclosporin would work by depressing or eliminating the lightning itself, while DNCB would act like "a lightning rod" redirecting it safely elsewhere away from the autoimmune attack. Cyclosporin would, perhaps, be ultimately self-defeating in the long run as the body (or "house") needs some lightning as part of its necessary immune "housekeeping"*; DNCB (or "a lightning rod" akin to it) would prove to be a better long range therapy by NOT being simultaneously immunosuppressive and highly toxic.

* Directed into a more beneficial focus by painting the DNCB on selected KS lesions, etc.

Caution Over New Study

Virus May Be Key to Multiple Sclerosis

New York

Researchers have discovered a new virus in blood and brain fluids from multiple sclerosis patients in Sweden and Key West, Fla., and they say the virus may be one cause of the unexplained disease.

The virus, which has not been identified, is similar but not identical to HTLV-I, a virus that causes an unusual form of human leukemia.

Genetic material from the new

virus has been identified in T-cells, a type of white blood cells, taken from the cerebrospinal fluid of some multiple sclerosis patients. This fluid bathes the brain and spinal cord.

Multiple sclerosis strikes the brain and nervous system. It attacks myelin, a kind of insulation surrounding electrical nerve fibers, and thereby causes the hardening, or sclerosis, of nerve cells.

"This is a Nobel prize-winning paper if it's true," said Dr. Wallace

Tourtellotte, a neurologist and multiple sclerosis expert at the Wadsworth Veterans Administration Hospital in Los Angeles. "Everybody in the country who can do genetic engineering will be working on this virus."

Elaine DeFreitas, one of the researchers who made the new findings, said, "We are not claiming — because we do not have the data to support the fact — that this is the cause of multiple sclerosis."

"We can only say that it seems clear from our data that the virus nucleic acid (its genetic material) is associated with 86 percent of the patients we've looked at," said DeFreitas, an immunologist at the Wistar Institute in Philadelphia.

Antibodies of the new virus were identified at higher levels in the blood and cerebrospinal fluid of 50 to 60 percent of multiple sclerosis patients than in normal people and in those with other brain disorders, DeFreitas said.

Details of the research cannot be revealed until next week, DeFreitas said, when they are to be published in *Nature*, a British scientific journal.

An estimated 250,000 Americans are afflicted with multiple sclerosis. In some, it produces only mild movement disorders, but in others it causes paralysis, loss of speech and damage to vision and mental

function, depending upon which brain and nerve cells it destroys.

Associated Press

ATTENTION: ALL AIDS RESEARCHERS (SPECIFICALLY, DRS JAY LEVY, PAUL VOLBERDING, L. BRUCE MILLS); ALL KAMIKAZES AND INTERESTED OTHERS.

MS (MULTIPLE SCOLEROSIS) IS AN AUTOIMMUNE DISEASE IN RESPONSE TO AN HTLV INFECTION!

AN HTLV VIRUS

Tuesday, November 12, 1985

San Francisco Chronicle

☆☆☆ 19

Florida Study Hints Multiple Sclerosis May Be Contagious

Key West, Fla.

The unusually high incidence of multiple sclerosis among Key West residents suggests that the crippling nerve disease could be infectious, a newspaper study has concluded.

Prolonged person-to-person contact could play a more critical role in transmitting MS than was previously believed, the Miami Herald said Sunday, citing a cluster of at least 26 confirmed victims and three suspected cases that chal-

lenge the old theory that the disease is not contagious.

Last week, researchers at the University of Miami and the Wistar Institute in Philadelphia said they had identified a new virus in the blood and brain fluids of patients in Key West and in Sweden.

The virus could be one cause of MS, the researchers said, but further research is needed to determine whether it is.

MS occurs when destructive blood cells attack nerves in the

brain and spine, gnawing holes in the nerve cells' myelin insulation, experts say. Like frayed electrical wires, the nerves short-circuit, causing such problems as numbness, blindness, paralysis and loss of bladder control.

The MS rate for Key West is about 100 cases per 100,000 residents, among the highest in the world. Normally, rates there would be expected to fall somewhere between three and 10 people per 100,000.

"It appears to me the data seem

to fit an infectious process, but one that requires multiple, repeated, very close contact," said Lee Hustling, a professor and epidemiologist at the University of South Florida who analyzed the data for the newspaper.

"Even if this is an infectious process, I would not expect to be affected by it as a tourist or as a visitor to the hospital."

Ten victims, including eight nurses and two medical technicians, worked in Key West's biggest hospital, Florida Keys Memorial.

Sixteen suspected victims live or work in about a one-mile-square area of Stock Island, just north of Key West, and four more live in Key Haven, a nearby residential area.

One case was confirmed in Key West in 1971. During the next 10 years, there were 25 diagnosed cases.

Mere coincidence cannot explain the high rate of MS in the city and nearby islands, said Dr. David Hafler of Harvard University, one of the leading researchers of the disease.

"My own personal bias is that there may be something to this, and there may be a group of viruses triggering the deregulation of the immune system," he said.

Associated Press

Hispanic Chamber Chief

Kansas City, Mo.

Kansas City businessman Hector Barreto has been elected to a fifth term as president of the U.S. Hispanic Chamber of Commerce.

Associated Press

S.F. CHRONICLE 11/12/85

Vaunted Drug Fails To Save AIDS Patient

Paris

French doctors yesterday announced the death of an AIDS patient whose medical improvement they had cited in a dramatic news conference heralding an innovative treatment for the disease.

Other physicians, originally skeptical of the medical team's report that the treatment appeared to inhibit the progress of the virus, indicated that the experimental use of the drug cyclosporine-A might have contributed to the patient's death.

Dr. Phillipe Even, a member of the medical team that announced the treatment, said the 38-year-old male AIDS victim died Saturday night at Laennec Hospital despite a "biologically favorable" response to the drug.

Even attributed the death to "medullary aplasia and liver complications linked to a viral infection and a medical intolerance unrelated to cyclosporine." Medullary aplasia is the destruction of bone marrow, which produces certain cells of the immune system.

Dr. Jan Orenstein, associate professor of pathology and director of autopsy services at George Washington University Medical Center in Washington, said cyclosporine, an immunosuppressor, could have been a factor in the death.

"AIDS patients do not inherently get medullary aplasia," Orenstein said. "What they did with the cyclosporine was wipe out his marrow."

Dr. Michael Green said that

AIDS patients have been known to suffer hypoplastic marrow, a decrease in certain cellular elements of bone marrow.

Green, director of developmental therapeutics at the New York University cancer center, said, "It's possible" that cyclosporine could have contributed to the patient's death, but not enough details of the case were known to say for sure.

A second patient with acquired immune deficiency syndrome who had been admitted to Laennec Hospital also died after treatment with cyclosporine, but Even said he died within 12 hours of admission and was too far gone for any treatment to have helped him.

Even defended the use of the drug as a "reasonable hope" and said the deaths will not affect experimentation with cyclosporine, a well-known commercial drug generally used to prevent the rejection of transplanted organs.

Even and his research partners, Drs. Jean-Marie Andrieu and Alain Venet, held a news conference October 29 to announce that their research showed cyclosporine-A appeared to inhibit the AIDS virus.

Other researchers criticized the announcement because it was based on only eight days of tests on two patients, the 38-year-old man, described as "near death" when he began receiving the drug October 23, and a 35-year-old woman in the early stage of the virus who began treatment October 21.

United Press

Wednesday, November 13, 1985

'AIDS Drug' Fails to Save A 3rd Patient

Grenoble, France

A third AIDS patient undergoing an innovative French treatment for the deadly virus has died, and the doctor treating him said yesterday that the patient showed none of the spectacular results announced by a Paris medical team last month.

The patient, an unidentified 27-year-old man, died Saturday in the University Hospital at Grenoble after six days of treatment with the drug cyclosporine-A, said Dr. Max Micoud, the hospital's chief of infectious diseases.

The announcement came just one day after a French medical team revealed that two other patients had died despite treatment with the drug, which is normally used to prevent the body from rejecting transplanted organs.

United Press

AN A.I.D.S. RIDDLE

When is old news new news?

ANSWER: When it's the attached.....



**Mixed views
on canceled
shows**

Dougan/ Page E1



**Gold Rush
BINGO**

Bonus numbers could lead to payday. Page D6



**The man in
the black
shoes**

Mandel/ Page A3

San Francisco Examiner

118th Year No. 305

Thursday, June 2, 1983

25¢

California edition

New clue to how AIDS kills

**Evans, Hammaker
keep S.F. winning**

Sports/Page F1

Today

City/State

Prison study finds thymus gland may be the key

Examiner news services
WASHINGTON — In a new clue to the development of acquired immune deficiency syndrome, two pathologists say studies of tissue from victims of AIDS suggest that it destroys the gland that plays a key role in the body's defenses.

A survey of prisons shows that the disease has killed at least 20 inmates, raising fears among guards of a modern "bubonic plague" and prompting new efforts to identify prisoner victims.

Drs. Thomas Seemayer of the Montreal Children's Hospital in Canada and Arthur Davis of Roche Biomedical Laboratories

Inc., Burlington, N.C., working independently, found that thymus glands taken from the chests of men and women who died of AIDS were virtually destroyed.

They reported their findings yesterday at an international conference on thymic hormones.

AIDS, first recognized in 1981, is known to break down the body's immune system — its defenses against germs. The thymus gland has been called the "master gland of the immune system."

AIDS has occurred primarily among homosexual men, intravenous drug abusers, recent Haitian immigrants and hemo-

philiacs who require numerous blood transfusions.

The Centers for Disease Control in Atlanta has counted more than 1,400 cases and more than 540 deaths in the last two years.

Dr. Allen Goldstein of George Washington University is chairman of the conference. He called the reports by Seemayer and Davis "a very important series of observations."

He said one possibility is that the unknown infectious agent — possibly a virus — that causes the disease infects the thymus gland. Then, he said, it may be the

body reacts against the agent and this reaction destroys the thymus.

Goldstein said much more research is needed to confirm the theory. At least, he said, scientists now have some important clues on where to direct their studies.

Nineteen prisoners in New York state have died since 1980 of AIDS, which wasn't formally named until July 1982. Nine have died of the disease in New Jersey since 1979. In addition, one North Carolina inmate who died last month showed evidence of the illness, and the death of a

↑ ↻ — See back page, col. 2

WHAT HAPPENED?

ed, June 15, 1983 ***** San Francisco Chronicle 7

has y
belgr

including a police officer who has AIDS

she said.
standing at Market Street with her
husband, she nodded sympathetically at

was asked if AIDS patients
become ostracized. On the con-
trary, he said, since people learned of

changes," he said. "I'm not the same
person I was five or six months ago,
and I miss a lot of that person. Now,
no matter where I go or what I do,

6215 1260nd se

are lucky if they can get up in
the morning shower and have break-
fast with-

was hospitalized for several
weeks. Later, he got a virus that

cause

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SAN FRANCISCO, CALIFORNIA 94143

January 21, 1986

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FROM: Marcus A. Conant, M.D.
RE: Regular Meetings

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On February 20th, Dr. Joseph C. Brewer and Dr. Martin Delaney from Project Inform will describe the status of their research using ribovirin and isoprinosine in combined therapy against AIDS and ARC.

Also on February 20th, Dr. Bruce Mills will discuss his work with the use of DNCB in the treatment of the acquired T-lymphocyte deficiency disorder in AIDS and other disorders.

Attached, find AIDS bibliographies for the weeks ending 12/13/85 and 1/10/86.

AIDS

A.M.A. to debate AIDS test.
NY Times 12/9/85, p.14

AIDS in the UK.
Lancet 2(8464):1103-5, 1985

AIDS virus: infection up?
Sci News 128(21):325, 1985

Insurers warn of huge AIDS claims in 2 years.
NY Times 12/12/85, p.8

International Conference on Acquired Immunodeficiency Syndrome,
14-17 April 1985, Atlanta, Georgia.
Ann Intern Med 103(5):653-790, 1985

Recommendations for assisting in the prevention of perinatal transmission of HTLV-III/LAV and acquired immunodeficiency syndrome.
MMWR 34(48):721-6, 731-2, 1985

Altman LK

Rare cancer linked to AIDS takes strange turn in Africa.
NY Times 12/9/85, p.1, 14

Barbanel J

New York City warned of AIDS cost.
-NY Times 12/12/85, p.8

AIDS FILE

WEEK ENDING : 12/13/85

- Beldekas JC, Levy EM, Black P, et al
In vitro effect of foscarnet on expansion of T-cells from people with
LAS and AIDS. [letter]
Lancet 2(8464):1128-9, 1985
- Casareale D, Dewhurst S, Sonnabend J, et al
Prevalence of AIDS-associated retrovirus and antibodies among male
homosexuals at risk for AIDS in Greenwich Village.
AIDS Res 1(6):407-21, 1985
- Casareale D, Volsky DJ
The T4 lymphocyte in AIDS. [letter]
N Engl J Med 313(22):1415, 1985
- Centers for Disease Control
1985 STD treatment guidelines: Acquired immunodeficiency syndrome.
MMWR 34(4S):75S-6S, 1985
- Dowbenko DJ, Bell JR, Benton CV, et al
Bacterial expression of the acquired immunodeficiency syndrome
retrovirus p24 gag protein and its use as a diagnostic reagent.
Proc Nat Acad Sci 82(22):7748-52, 1985
- Epstein LG, Sharer LR, Cho E-S, et al
HTLV-III/LAV-like retrovirus particles in the brains of patients with
AIDS encephalopathy.
AIDS Res 1(6):447-54, 1985
- Erfle V, Hehlmann R, Mellert W, et al
Prevalence of antibodies to HTLV-III in hemophiliacs and other
patients chronically substituted with blood products.
Blut 51:243-9, 1985
- Esteban JI, Shih JW, Tai C-C, et al
Importance of Western blot analysis in predicting infectivity of
anti-HTLV-III/LAV positive blood.
Lancet 2(8464):1083-6, 1985

AIDS FILE

WEEK ENDING : 12/13/85

Fuchs D, Dierich MP, Hausen A, et al
Are homosexuals less at risk of AIDS than intravenous drug abusers and haemophiliacs? [letter]
Lancet 2(8464):1130, 1985

Gazengel C, Larrieu MJ
Lack of seroconversion for LAV/HTLV-III in patients exclusively given unheated activated prothrombin complex prepared with ethanol step. [letter]
Lancet 2(8465):1189, 1985

Glasgow BJ, Steinsapir KD, Anders K, et al
Adrenal pathology in the acquired immune deficiency syndrome.
Am J Clin Pathol 84(5):594-7, 1985

Gupta S
Monoclonal antibody-defined beta 2-microglobulin-positive mononuclear cells in acquired immune deficiency syndrome.
Scand J Immunol 22(4):357-61, 1985

Jagadha V, Andavolu RH, Huang CT
Granulomatous inflammation in the acquired immune deficiency syndrome.
Am J Clin Pathol 84(5):598-602, 1985

Jayaraman KS
India against AIDS.
Nature 318(6043):210, 1985

Johnson TM, Duvic M, Rapini RP, et al
AIDS exacerbates psoriasis. [letter]
N Engl J Med 313(22):1415, 1985

Jovaisas E, Koch MA, Schafer A, et al
LAV/HTLV-III in 20-week fetus. [letter]
Lancet 2(8464):1129, 1985

Marquart K-H, Mueller HA, Sailer J, et al
Slim disease (AIDS). [letter]
Lancet 2(8465):1186-7, 1985

AIDS FILE

WEEK ENDING : 12/13/85

Marwick C

AIDS-associated virus yields data to intensifying scientific study.
JAMA 254(20):2865-70, 1985

Marx PA, Bryant ML, Osborn KG, et al

Isolation of a new serotype of simian AIDS type D retrovirus from
Celebes black macaques with immune deficiency & retroperitoneal ...
J Virol 56(2):571-8, 1985

Merino F, DeSalvo L, Medina JW

Human T cell leukemia virus type I and Epstein-Barr virus antibodies
in homosexuals and hemophilia patients from Venezuela.
AIDS Res 1(6):395-400, 1985

Miller RA, Collier AC, Buchanan TM, et al

Seroepidemiologic screening for antibodies to LAV/HTLV-III in Sri
Lanka, 1980-1982. [letter]
N Engl J Med 313(21):1252-3, 1985

Murray HW, Welte K, Jacobs JL, et al

Production of and in vitro response to interleukin 2 in the acquired
immunodeficiency syndrome.
J Clin Invest 76(5):1959-64, 1985

Norman C

AIDS trends: projections from limited data.
Science 230(4729):1018-21, 1985

Ollero M, Leal M, Wichmann I, et al

Antibodies to the AIDS-associated retrovirus in hemophiliacs & other
individuals from southern Spain: lack of correlation with ...
AIDS Res 1(6):439-45, 1985

Orenstein JM, Simon GL, Kessler CM, et al

Ultrastructural markers in circulating lymphocytes of subjects at
risk for AIDS.
Am J Clin Pathol 84(5):603-9, 1985

AIDS FILE

WEEK ENDING : 12/13/85

Peterman TA, Jaffe HW, Feorino PM, et al
Transfusion-associated acquired immunodeficiency syndrome in the
United States.
JAMA 254(20):2913-7, 1985

Peutherer JF, Edmond E, Simmonds P, et al
HTLV-III antibody in Edinburgh drug addicts. [letter]
Lancet 2(8464):1129-30, 1985

Piszkiewicz D, Kingdom H, Apfelzweig R, et al
Inactivation of HTLV-III/LAV during plasma fractionation. [letter]
Lancet 2(8465):1188-9, 1985

Rodriguez L, Dewhurst S, Sinangil F, et al
Antibodies to HTLV-III/LAV among aboriginal Amazonian Indians in
Venezuela.
Lancet 2(8464):1098-100, 1985

Rosenior J
Origin of AIDS. [letter]
Nature 318(6042):100, 1985

Sarin PS, Scheer DI, Kross RD
Inactivation of human T-cell lymphotropic retrovirus (HTLV-III) by
LD(tm). [letter]
N Engl J Med 313(22):1416, 1985

Schmeck HM Jr
AIDS virus can infect the brain, new studies say.
NY Times 12/12/85, p.8

Sivak SL, Wormser GP
How common is HTLV-III infection in the United States? [letter]
N Engl J Med 313(21):1252, 1985

Stricker RB, Abrams DI, Corash L, et al
Target platelet antigen in homosexual men with immune
thrombocytopenia.
N Engl J Med 313(22):1375-80, 1985

CURRENT AWARENESS

6

AIDS FILE

WEEK ENDING : 12/13/85

Velez-Garcia E, Fradera J

Transfusion induced acquired immunodeficiency syndrome with Kaposi's sarcoma in a patient with congenital factor V deficiency.

AIDS Res 1(6):401-6, 1985

• AIDS

AIDS in San Francisco: the first 1,000 cases.
Calif Morb #44:1, 1985

Acquired immunodeficiency syndrome (AIDS): seventh update and
supplement.
National Library of Medicine Literature search No.85-16.

Africa's latest torment: AIDS.
Newsweek 99(26):8, 1985

Condoms fight AIDS virus.
Post 12/25/85, p.12

Diagnostics 1985 - year of the AIDS test.
Clinica #177/178:20-1, 1985

Drug under AIDS study OK to use in infant illness.
SF Chron 1/3/86, p.7

Hospitals may be AIDS victims too ... and AIDS trials hit more snags.
Med World News 26(23):92-4, 1984

National tests for AIDS backed by 70% in U.S. poll.
SF Chron 1/4/86, p.2

New rules on AIDS for Illinois.
SF Chron 1/4/86, p.2

CURRENT AWARENESS

2

AIDS FILE

WEEK ENDING : 1/10/86

Recommendations for assisting in the prevention of perinatal transmission of HTLV-III/LAV and AIDS.
MMWR 34(48):721-6, 731-2, 1985

Altman LK

Search for an AIDS drug is case history in frustration.
Med J Aust 143(7):300-2, 1985

Anqarano C, Pastore G, Monno L, et al

Rapid spread of HTLV-III infection among drug addicts in Italy.
[letter]

Lancet 2(8467):1302, 1985

Beardsley T

More AIDS money.

Nature 318(6044):306, 1985

Black PH

HTLV-III, AIDS, and the brain.

N Engl J Med 313(24):1538-40, 1985

Busch W, Brodt R, Ganzer A, et al

Suramin treatment for AIDS. [letter]

Lancet 2(8466):1247, 1985

Butler K

Hundreds of hookers sought for AIDS study.

SF Chron 1/3/86, p.3

Carne CA, Tedder RS, Smith A, et al

Acute encephalopathy coincident with seroconversion for anti-HTLV-III.
Lancet 2(8466):1206-8, 1985

Clarke M

UK money for AIDS.

Nature 318(6045):401, 1985

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3

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WEEK ENDING : 1/10/86

Contreras M, Hewitt PE
Prevention of AIDS. [letter]
Lancet 2(8468):1362-3, 1985

Des Jarlais DC, Hopkins W
"Free" needles for intravenous drug users at risk for AIDS: current
developments in New York City. [letter]
N Engl J Med 313(23):1476, 1985

Dwyer JM
Legislating AIDS away.
Med J Aust 143(7):276-7, 1985

Eckholm E
Saliva is discounted as threat in spread of AIDS.
NY Times 12/19/85, p.13

Francis DP, Petricciani JC
The prospects for and pathways toward a vaccine for AIDS.
N Engl J Med 313(25):1586-90, 1985

Goldbaum J
False-positive anti-HTLV-III. [letter]
Med J Aust 143(7):L317, 1985

Goldwater PN, Synek BJ, Koelmeyer TD, et al
Scrapie-associated fibrils and AIDS encephalopathy. [letter]
Lancet 2(8467):1300, 1985

Greenspan JS, Greenspan D, Lennette ET, et al
Replication of Epstein-Barr virus within the epithelial cells of oral
"hairy" leukoplakia, an AIDS-associated lesion.
N Engl J Med 313(25):1564-71, 1985

Grunnet N, Jersild C, Georgsen J
Photometric reading anti-HTLV-III ELISA kits. [letter]
Lancet 2(8467):1302, 1985

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WEEK ENDING : 1/10/86

Handsfield HH

AIDS and sexual behavior in gay men. [letter]

Am J Publ Health 75(12):1449-50, 1985

Harris M

AIDS called top health issue.

SF Chron 1/7/86, p.4

Harris M

Abortion urged in AIDS pregnancies - S.F. panel's report.

SF Chron 1/4/86, p.2

Hattori T, Uchida T, Matsuoka M, et al

HTLV-III infection and epitope recognition by OKT4 monoclonal antibody. [letter]

N Engl J Med 313(24):1543-4, 1985

Ho DD, Byington RE, Schooley RT, et al

Infrequency of isolation of HTLV-III virus from saliva in AIDS. [letter]

N Engl J Med 313(25):1606, 1985

Ho DD, Rota TR, Schooley RT, et al

Isolation of HTLV-III from cerebrospinal fluid and neural tissues of patients with neurologic syndromes related to AIDS.

N Engl J Med 313(24):1494-7, 1985

Houssein I, Wilcox H, Barron J

Effect of heat treatment on results for biochemical analysis of plasma and serum.

Clin Chem 31(12):2028-30, 1985

Ioachim HL, Cooper MC, Hellman GC

Lymphomas in men at high risk for acquired immune deficiency syndrome (AIDS).

Cancer 56(12):2831-42, 1985

Korcok M

AIDS hysteria: a contagious side effect.

Can Med Assoc J 133(12):1241-8, 1985

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WEEK ENDING : 1/10/86

Kristof ND

More insurers screen applicants for AIDS.
NY Times 12/26/85, p.21, 24

L'age-Stehr J, Schwarz A, Offermann G, et al
HTLV-III infection in kidney transplant recipients. [letter]
Lancet 2(8468):1361-2, 1985

Lattin D

Church accused of homophobia in AIDS epidemic.
SF Examiner 1/5/86, p.B-1, B-5

Mariman EC

New strategies for AIDS therapy and prophylaxis. [letter]
Nature 318(6045):414, 1985

Mathur-Wagh U, Midlvan D, Senie RT

Follow-up at 4 1/2 years on homosexual men with generalized
lymphadenopathy. [letter]
N Engl J Med 313(24):1542-3, 1985

McEvoy M

Estimating AIDS (UK). [letter]
Lancet 2(8466):1248, 1985

McKie D

Assault on AIDS and smoking.
Lancet 2(8468):1371, 1985

Murray HW, Killman JK, Rubin BY, et al

Patients at risk for AIDS-related opportunistic infections.
N Engl J Med 313(24):1504-10, 1985

Neurath AR, Strick N, Lee YS, et al

Radioimmunoassay and enzyme-linked immunoassay of antibodies directed
against lymphadenopathy-associated virus (LAV) proteins ...
J Virol Methods 12(1/2):85-92, 1985

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WEEK ENDING : 1/10/86

Norman C
Africa and the origin of AIDS.
Science 230(4730):1141, 1985

Norman C
Politics and science clash on African AIDS.
Science 230(4730):1140, 1142, 1985

Polk BF
Female-to-male transmission of AIDS. [letter]
JAMA 254(22):3177-8, 1985

Raber PE
AIDS: prevent its spread, treat its victims.
Dentistry Today 4(8):1, 21-2, 1985

Resnick L, diMarzio-Veronese F, Shupbach J, et al
Intra-blood-brain-barrier synthesis of HTLV-III-specific IgG in
patients with neurologic symptoms associated with AIDS or ARC.
N Engl J Med 313(24):1498-504, 1985

Rich V
Soviets admit AIDS cases.
Nature 318(6046):502, 1985

Richards T
The pathology of AIDS.
Br Med J 291(6509):1630-1, 1985

Rodgers-Johnson F, Gajdusek DC, Morgan OS, et al
HTLV-I and HTLV-III antibodies and tropical spastic paraparesis.
[letter]
Lancet 2(8466):1247-8, 1985

Rose D
AIDS study findings show less man-to-woman risk.
DC Clip Sheet 61(12):1, 1985

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AIDS FILE

WEEK ENDING : 1/10/86

Saviteer SM, White GC, Cohen MS, et al
HTLV-III exposure during cardiopulmonary resuscitation. [letter]
N Engl J Med 313(25):1606-7, 1985

Schulman R
Meanwhile, back in the lab: a sober search for promising leads.
Bus Wk #2923:86, 1985

Shilts R
AIDS cases in S.F. rising less rapidly.
SF Chron 1/7/86, p.4

Shilts R
AIDS is rapidly invading Europe - experts frightened.
SF Chron 1/3/86, p.2

Shilts R
Dutch speedy, other lag on AIDS warnings.
SF Chron 1/3/86, p.7

Simoes E, Kirubakaran M, John TJ, et al
Absence of HTLV-III antibody in blood donors and recipients in India.
[letter]
Lancet 2(8466):1248, 1985

Stiles BJ
Let's face up to AIDS.
Med J Aust 143(7):300, 1985

Stryker J
AIDS: panic and public policy.
Healthspan 2(10):3-15, 1985

Swinbanks D
AIDS in Japan: no screening of blood donors.
Nature 318(6044):306, 1985

CURRENT AWARENESS

8

AIDS FILE

WEEK ENDING : 1/10/86

Ticer S, Hunter D, Rhein R Jr.

'Fast-buck' artists are making a killing on AIDS.

Bus Wk #2923:85-6, 1985

Yanish DL

No need for routine AIDS screening for healthcare employees - HHS.

Mod Healthcare 15(25):48, 1985



Mr. B. Elswood
633 Post #644
San Francisco , CA 94102

01/21/86

Dear [REDACTED],

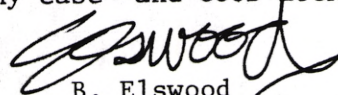
This is just a note to cover the attached copies I promised I would send you. Much of it is now quite dated, excepting the attached article about the "new" theory on AIDS finally being propounded up at U.C. (Perhaps you should read it first.) Then there is a little flurry of copies (one, a letter from Volberding to me and the rest a collection of interesting clippings this past fall + one from 1983 to show that autoimmune theories are not so "new" after all).

The real information is in the tabbed sections. Tab A is a letter (with attachments) to Cable News Network. (You should note CNN broke the autoimmune story January 13 with interviews with Abrams and Stricker at U.C.) Tab C is the first stories in COMING UP! & The ADVOCATE. (I think the COMING UP! article is the most thorough.) Tab D is a draft of the submission to the JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY. (It has since been updated, expanded to include over twenty patients, ^{and} is pending early publication there.) The final Tab (G) is a copy of a letter (plus attachments) I sent to Bill Kraus last summer in Paris (through Sala Burton's office). It is especially sad news last week that Kraus died. He evidently considered my letter "off the wall" and did not even look into the DNCB therapy. What is especially poignant now is that the Pasteur Institute in Paris ~~is~~ investigating Mills' DNCB protocol (as of last week when a presentation was made there).

Well, here's the stuff. If you carefully read this and decide you would be interested, I suggest one of three plans of action (and the same preference order):

- 1) If you have insurance or have the personal funds I suggest you contact Dr. Mills' office before his submission is published in JAAD. That way it is more likely he would accept new patients (before being inundated with them). Dr. Mills' office charges are standard; but the blood work needed is not cheap!
- 2) You could insist that your own treating physician treat you with DNCB. Since it is legal and inexpensive and seemingly very effective, there is NO REASON why other AIDS doctors don't start the clinical protocol.
- 3) If neither of the above options works out, you can always paint yourself. DNCB is readily available to anyone without prescription. Mills' estimates a treatment cost about 25¢ (including the cotton swab and guaze covering). IT IS WISE HOWEVER TO BE IN CLOSE CONTACT --AT LEAST!--WITH A PHYSICIAN WHO IS FAMILIAR WITH THE CHEMICAL AND CAN ORDER NECESSARY BLOODWORK TO MONITOR IMPROVEMENTS AND MAKE SURE NO OVER-STIMULATION TAKES PLACE.

Finally, I'm not THAT good at "leaning on people" and so I hope Jim Henry doesn't blame me too much if you decide to choose some other treatment plan. Tell him you got the information from me, in any case--and GOOD LUCK!


B. Elswood
633 Post #644
S.F. CA 94109

Enclosures

P.S. PLEASE HELP PASS THIS INFORMATION ON. THX'S!

January 26, 1986

Dear Michael,

I was very glad you called over to me today from across Polk Street ("boycotting the Super Bowl") and talked. I needed the acknowledgement and affectionate embrace, especially from you. These past nine months has been a terrible drain on me emotionally, and for a long time I've felt more than isolate: almost desolate. Now, with school beginning only days ahead, I quiver and quake because—apart from my almost voluminous kamikaze/DNCB/AIDS correspondence—I have worked on none of my writing (THE PERILS or DOUGLAS LAYS AN EGG). In fact, the agent for the later sent me a card about Xmas time, spurring me on, and hoping "I hadn't forgotten" about the project. I wrote back immediately to confess: "INDEED I HADN'T!" Then added the perfectly true explanation about being increasingly involved (OBSESSED!) with a desperate battle against AIDS. It wasn't until I mailed my response that I realized she would probably think I HAD AIDS, and there was then no way to reach down the 26-story mail chute and retrieve my open-handed, honest, through probably impolitic reply....

And so IT'S BEEN. I wish ANYTHING the battle to call attention to AIDS being an autoimmune disease and DNCB being an effective, cheap, legal, relatively harmless and readily available treatment for it WAS OVER. I'M SURE my part in the "kamikaze campaign" could have been more effective (and politic) in hindsight. All I knew SINCE LAST APRIL, when I first started telling you about it after classes, was that it seemed to work and Dr. Mills seemed to not want to share it with the World. You'll recall in August I said I thought he should receive the Nobel Prize for his brilliance and insight and even daring (on behalf of his own patients) AND THEN IMMEDIATELY BE GUILLOTINED on the spot for his cowardice and reluctance to publicize it to others. Now, that I, ad hoc, more-or-less took that responsibility on for him, I can more understand (SOMEWHAT!) his hesitancy to do it himself. Look at the French doctors all now saying "autoimmune"; Don Abrams and Dr. Stricker (head of AIDS laboratory research at U.C.) now saying "autoimmune"; CABLE NETWORK NEWS breaking the story ("autoimmune") nationwide on January 13th; Pete Aleshire of THE TRIBUNE writing most carefully about it on the 5th—and still a COLD SHOULDER AND SEEMINGLY UNIVERSAL SILENCE while our ailing brothers and sisters continue to die...

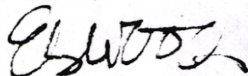
Randy Shilts is a perfect example of my frustration. WHERE IS HE??? A book contract to write about the AIDS battle while the real breakthroughs and battles continue to be rebuffed and ignored through ignorance and lack of follow-through is a MEANINGLESS trophy in my estimation. That he was "put-off" by Mills' coy "avoidance" games last August is quite understandable. Michael Helquist was also sidetracked (more "derailed") from April to September, so Randy shouldn't feel embarrassed or wounded with guilt by his hiatus of the past five months! The URGENT AND IMPORTANT thing now is not to point fingers or make excuses or cast blame. WHAT IS NEEDED IMMEDIATELY IS TO PROCEED TO ALERT EVERYONE THAT HELP (i.e. EFFECTIVE TREATMENT) IS AVAILABLE HERE AND NOW AND CAN SAVE THOUSANDS OF LIVES! (How do you

get this across to people who little understand THE CONCEPT of an autoimmune disease, let alone the treating significance of AIDS being one? —If you CAN ANSWER this, you're automatically the new head of the kamikazes: there are A LOT of AIDS doctors in this town who have a hard time understanding the autoimmune conception!) Helquist and Shilts should be working together (as two Gay compassionate brothers) to carefully investigate all the latest treatment developments (including DNCB) not rivaling and viciously competing with each other like Hedda Hopper and Louella Parsons hot on Hollywood scoops. This seems HOWEVER to be their stance, only "Louella" (i.e. Shilts) lost out (in this case) to "Hedda", and now out of pique she's going to DENY everything. (God, won't they all get on Track, including David Perlman!)

Needless to say, with all this bother and burden (as I take it to be) I haven't given much time to any of my creative projects. (It's hard to WRITE the Great American Novel when you're LIVING ONE!!!) Necessity, however, finally stamps his monster foot: my student loans will be in default if I don't get back into school and SUCCESSFULLY PASS twelve credit hours WHILE WORKING FULLTIME! (The loan monies this year have long been spent and gone in postage, photocopies, phone calls, and general DNCB/autoimmune/AIDS wear-and-tear...) I'm EXHAUSTED already and the semester hasn't even started and I haven't anything to show for it EXCEPT for the feeling that—all things considered—I've done my BEST (and had no choice but to do so). It would certainly be less frustrating if RANDY SHILTS, et al (M. Helquist already is: but his influence only spreads so far AND THIN) were doggedly, tirelessly pursuing the story I've been trying SO HARD to tell them!

So your hug on Polk Street was sincerely welcomed this afternoon, and I fought back the impulse to immediately burst into tears and thoroughly soak your shoulder...thanks! Now it's back to school full-tilt (can I FORGET--Please God!--the AIDS battle and the fact the autoimmune insurrection against Gallo at the NIH--etc.--is only JUST BEGUN and still NEEDS much fanning?) and start writing DOUGLAS for my (probably now depressed and morose) agent and make up for last semester's lost credit hours and stave off the student loan collectors while simultaneously keeping my friends and acquaintances from dying without benefit or knowledge of DNCB (let alone the rest of the World)? Can I??? That's my Game Plan, anyway.

Love,



P.S. I've tried to keep Cynthia in Berkeley and Kathy Bishop of the N.Y. TIMES bureau continuously informed, to what avail I'm not quite sure. (Your referral in Washington D.C. with the L.A. TIMES never responded—I suppose another deaf ear, hearing-aid tuned-out or turned off like Randy's!)

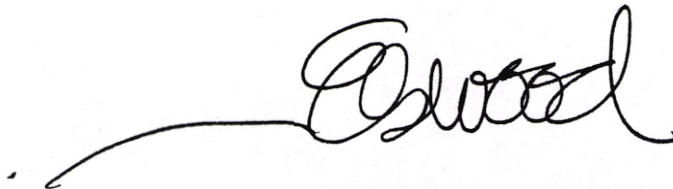
January 27, 1986

Dr. Kessler,

Levine informed me of the events at the Sunday BAPFHR quarterly meeting, or rather, the lack of events. Why he wimped out in interrupting the agenda on red-lining is an absurd tragedy. Mills' presentation at U.C on 2/20 is being set-up as a travesty by Marcus Conant. It makes me mad as a hoot owl! Conant has confirmed Mills' acceptance to present but told him there will be a time limit of 30 minutes and that fifteen minutes of that 30 must be opened up for questions!!! This is a pure, unadulterated slap-in-the-face to Mills: 15 minutes to present his data and explain his clinical observations and findings! Furthermore, Conant has grouped Mills' fifteen minutes with Brewer and the D.A.R.E. group otherwise known as the "Tooth Fairies". (They get their nickname from their inversion of the old legend: AIDS patients leave \$250 under their pillows and while they sleep (or are in a coma) the Tooth Fairies take the money and leave a month's supply of ribavirin smuggled up through the blackmarket from Mexico; isoprinsonine under their pillows will cost these dying patients even more!) The Tooth Fairies are old enemies of the kamikazes, ever since October when we unintentionally disrupted one of their sales meetings by bringing up DNCB and telling all that it was legal, cheap, and freely available. (It was immediately denounced, of course!) That Conant grouped Mills' fifteen minutes to theirs portends trouble. (Not to mention the Media the Tooth Fairies are always trying to bring to their rallies.) I can just see fisticuffs breaking out: the kamikazes v. the Tooth Fairies (and we'll rout them good)!

Naturally, behind all this is the cynical and capricious rath of Dr. Conant who doesn't want to be told by anyone (kamikazes, Mills, Brewer, Tooth Fairies, or anyone else for that matter) that he has been destroying his patients' health with chemo, etc., and a wrong-headed, if not to say, bull-headed, confusion as to what AIDS really is. (But don't ask the Tooth Fairies either-- they don't WANT TO KNOW!)

So when you and Levine decided to say nothing ("it speaks for itself") at the BAPFHR meeting you both wasted a powerful opportunity to educate and expound. That you both are RELYING on the Conant meeting to fill the gap is NOT in Conant's plans.... But I'll be there anyway and be very VOCAL if needs be: NOTHING--I have learned from this affair--SPEAKS FOR ITSELF!

A handwritten signature in dark ink, appearing to read "Edward", with a long horizontal flourish extending to the left.

January 31, 1996

Dear Dr. Kessler:

By the time you pick up this letter in your box here at Social Security, you should already have received through the post from Dr. Mills a copy of his revised current submission to the JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY with its accompanying data.

I guess you are the FIRST DOCTOR (not on the JOURNAL'S peer committees) to actually read this new submission (apart from hearing its statistical contents remarked upon over the phone, etc.) Dr. Mills told me he would "feel comfortable" if you were to send a copy to Steven's physician in Paris, or alternately, if you were to yank Steven home for Mills to treat him himself. Mills told me that he hadn't understood fully WHY you had first requested the data two weeks ago. (This I carefully explained to him as: to save your lover's life--Mills is brilliant, of course, and medically smart BUT at the same time very dense and naive as only those kinds of people can be!) Further, Mills said he "had no problems" with other doctors or research centers seeing his data before publication, but WAS CONCERNED that it did not leak to, and be published in the lay Press before it appeared in the JOURNAL. (WHICH IN MY HANDS IT WOULD VERY QUICKLY DO!!! GUARANTEE IT! I'M NO DOCTOR WITH A MINUET OF PROFESSIONAL ETIQUETTE TO DANCE!)

Now that you've got your copy, I HAVE A FAVOR TO ASK YOU. In August when my correspondence increased in output to Dr. Volberding, he wrote back and asked me to keep him "inform" as to developments in the DNCB "Project". In late October, Dr. Volberding wrote directly to Mills asking him the same thing. In November he wrote again to me and said he "welcomed" my "continuing correspondence" (as his "Deep Throat") until more of the AIDS answers are in. Well, in this past week's B.A.R. Volberding is quoted as acknowledging that AIDS maybe autoimmune and says that they will begin trials of the highly toxic and dangerous immune suppressant, cyclosporine at S. F. GENERAL. Given all the other drugs and treatments they've already unsuccessfully tried, I think it only fair that first they should give DNCB a test.

WHAT I WANT YOU TO DO--given Mills not having problems with his submission copy going to Paris "or other research centers" as long as it didn't leak to the Press--IS TO GET A COPY OF THE SUBMISSION TO DR. VOLBERDING A.S.A.P.

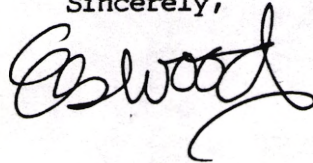
I would love to HAND CARRY a copy and contemptuously introduce myself and place it in Volberding's sweaty little palm and turn on my heels and walk off, excepting that THAT sort of drama probably would not get the data the kind of careful attention it deserves, and the fact that I (with such access to the data) would feel ABSOLUTELY OBLIGATED to send it to the Press--or at the very least to EVERY AIDS DOCTOR IN THE COUNTRY (from which it

would most probably LEAK to the Press). If you do not know the man, or would feel uncomfortable handing it over yourself, there is another contingency I've thought about....

Dr. Rick Andrews is an acquaintance of Volberding's and lives not far from him. Rick told me recently that he would not even want "to see" Mills' data unless an expert could "interpret" its significance for him. This would be an excellent opportunity to have Rick get a few pointers from the AIDS Expert himself, get a copy of it into Volberding's hands or at least his perusal, while letting it be KNOWN that this new intelligence was on the Q.T. and ~~and~~ in professional confidence!!! Similiarly, there would not be any of the AFFRONT TO THE EGO which would be implicit in MY haughtily handing it over to the AIDS expert!

If you can think of a better, more effective plan, then by all means DO IT! ONLY I WANT VOLBERDING TO GET THIS DATA A.S.A.P. FOR THE SAKE OF MY FRIENDS AND BROTHERS WHO ARE PATIENTS OUT AT GENERAL, JUST AS YOU WANT THE DATA FOR STEVE'S SAKE.

Sincerely,

A handwritten signature in cursive script, appearing to read "Eswood". The signature is fluid and stylized, with a long, sweeping underline that extends to the right.

cc: Rick Andrews

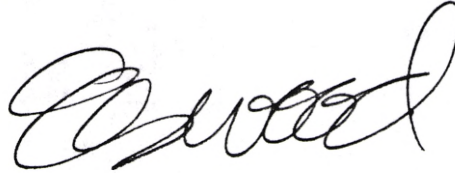
02/04/86

Dear John,

Just a note to inform you of two developments.

- 1) Volberding is quoted in this past week's B.A.R. as saying they will be testing cyclosporin at S.F. General. (Obviously, this is NEWS given the extremely poor reception the Paris doctors got in the U.S. last October; further, this is the best concrete admission yet that AIDS is autoimmune!)
- 2) Next, in the attached copies from the Nurse's Guide (textbook) on Immuno-deficiency, is the PROOF that AIDS is autoimmune. You'll notice they mention that the DNCB "skin test" is one of the indicators of immunosuppression. You'll notice they say immunosuppressed patients will be "anergic" or marked by "anergy". Well, the ONLY TROUBLE is they have never really tested AIDS patients with DNCB "skin tests" EXCEPT Mills who found EVERY SINGLE AIDS patient not *only* NOT anergic, BUT IN SOME CASES SO OVERLY REACTIVE THAT IT POSES ITS OWN SET OF PROBLEMS (i.e. finding a DIFFERENT contact sensitizer). The ONLY answer for this is that AIDS is autoimmune!

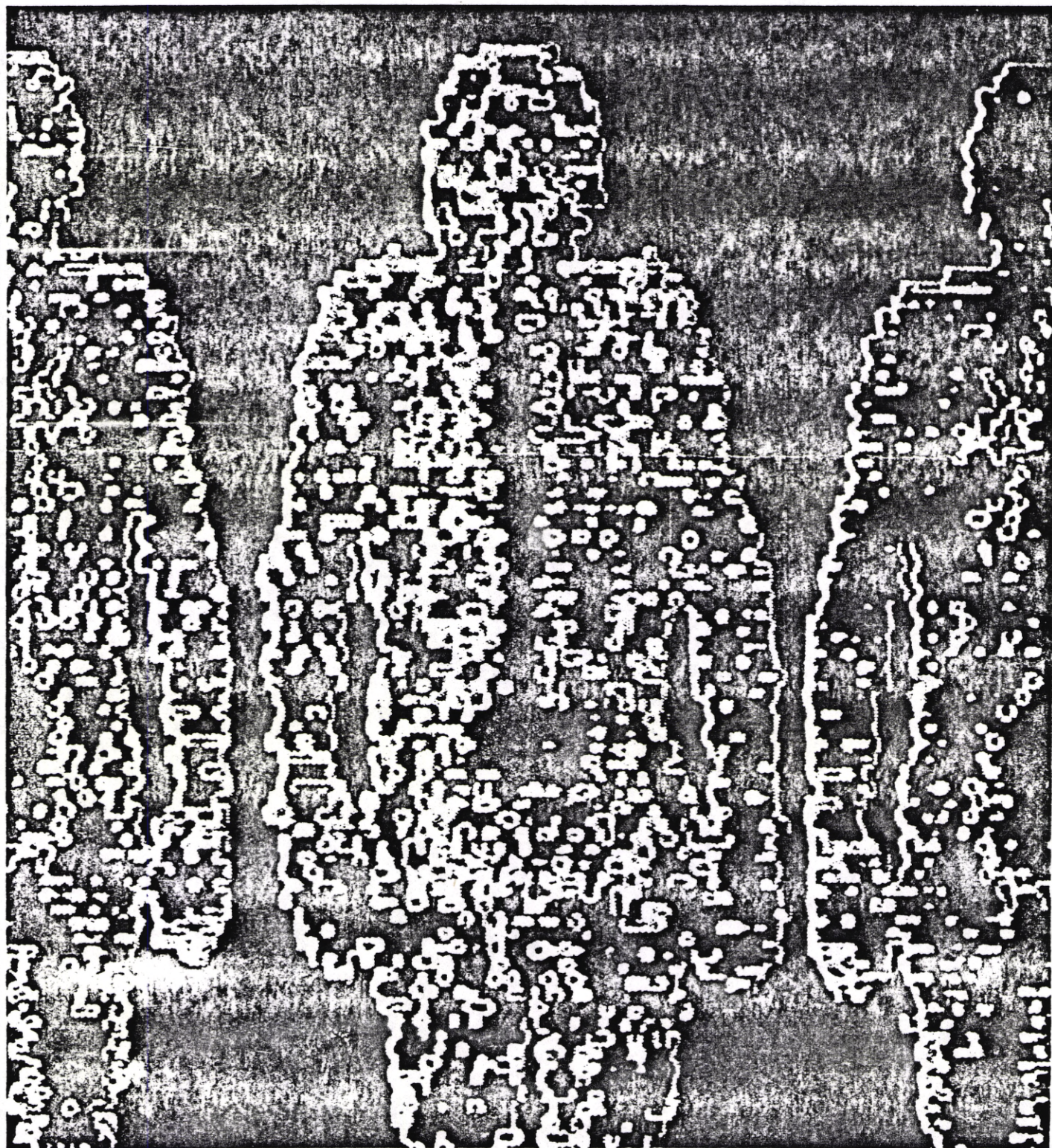
If you should want to cover the cycloporine/Volberding statement, ask the good doctor why he won't test DNCB for its effects in AIDS--given the fact they've tried most EVERYTHING ELSE under the sun (and to little or no avail).



Attachment & Enclosure

cc: M. Helquist

IMMUNE DISORDERS



and other cytotoxic agents may decrease T-cell number and function, primary humoral (antibody) response, and neutrophil and monocyte counts. Corticosteroids cause deficient immunoglobulin synthesis; inadequate phagocytic migration; decreased lysosomal enzyme release, with decreased killing at the inflammation site; reduced T-cell effectiveness; and poor wound healing.

A newer drug, cyclosporine, acts by inhibiting synthesis of T_4 cells, causing deficient cell-mediated immunity. In renal and other organ transplants, it's currently the preferred drug to prevent graft rejection.

Antibiotics and other antimicrobials are known to alter the normal bacterial balance in the pharynx and GI tract, sometimes producing resistant microbes. Prolonged antibiotic therapy may allow proliferation of *Candida* and gram-negative bacilli, such as *Pseudomonas*, *Klebsiella*, and *Proteus*, risking superinfection by resistant organisms.

X-rays cause immunosuppression because lymphocytes are X-ray-sensitive. Therefore, radiation induces profound lymphopenia in the lymphoid organs and general circulation and suppresses T-cell function.

In many patients, secondary immunodeficiencies have multiple causes. For example, in a patient with malignancy, immunodeficiency may result from the tumor and its treatment as well as from the accompanying stress and malnutrition.

MEDICAL MANAGEMENT

First and foremost, good medical management requires a comprehensive history of the patient's present and previous illnesses and infections as well as a careful family history.

Diagnostic tests: Confirming the characteristics

When the history and a detailed physical examination suggest one of the immunodeficiency disorders, specific tests can help establish a differential diagnosis.

Tests for humoral immunodeficiency. A history of recurrent bacterial pneumonia, sepsis, meningitis, and other bacterial infections characterizes a humoral immunodeficiency. *Quantitative immunoglobulin serum levels* by radioimmunoassay or immune electrophoresis confirm or rule out this condition in about 90% of patients. Normal levels of the three major immunoglobulins (IgG, IgM, and IgA) probably rule out a serious defect in humoral immunity, although infrequently an IgG or

IgA subclass may be missing. However, a significant decrease in one or more immunoglobulins probably indicates humoral immune deficiency.

The *Schick test* evaluates IgG function. A delayed hypersensitivity reaction 3 to 4 days after intradermal injection with diphtheria toxin in a patient previously immunized with DPT vaccine indicates the lack of circulating antibody. An *isoheamagglutinin titer* evaluates IgM function; low or absent titers indicate the lack of antibody.

A *total lymphocyte count* may be part of a preliminary screen for immunodeficiencies, but it helps little in diagnosing humoral deficiency because B cells constitute 20% or less of total lymphocytes. Tests are now available to isolate and count B cells; although reduced numbers of B cells indicate humoral deficiency, many humoral deficiencies involve function, not numbers.

If other diagnostic tests point to humoral immunodeficiency, *in vitro* tests can determine lymphocyte function by measuring *B-cell response* to a polysaccharide mitogen, such as pokeweed. A low or absent response indicates a depressed or defective humoral immune system. Pokeweed also stimulates T cells, though to a lesser degree.

Tests for cell-mediated immunodeficiency. A history of recurrent or severe fungal, viral, or other opportunistic infections characterizes cell-mediated immunodeficiency. A *complete blood count and differential* may aid diagnosis because low total lymphocytes can usually be attributed to low T-cell number.

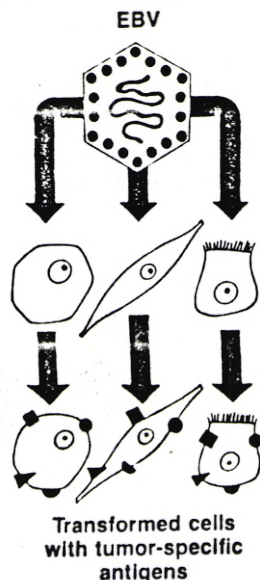
The patient with cell-mediated immunodeficiency is generally anergic, and an important test, the *hypersensitivity skin test*, shows his inability to react to a battery of common skin antigens. Another test, *dinitrochlorobenzene (DNCB) sensitization*, is used occasionally to establish or rule out cutaneous anergy. It detects the failure of the cell-mediated immune system to respond to a new antigen.

A *T-cell count* can quantify T cells themselves as well as T-cell subpopulations by fluorescent activated cell sorter (FACS) analysis. This method separates cells by type using monoclonal antibodies. A patient with DiGeorge's syndrome has few T cells, whereas a patient with AIDS shows a low number of T_4 cells.

Tests for combined T- and B-cell immunodeficiency. A history of early, repeated, and severe infections of various kinds characterizes combined T- and B-cell immunodeficiency.

Understanding virally induced antigens

Viruses have been associated with significant human cell transformation. Epstein-Barr virus (EBV), for example, induces four tumor-related antigens, which are expressed identically on all tumor cell types (see illustration). This virus has been associated with lymphomas (such as Burkitt's lymphoma), Hodgkin's disease, and nasopharyngeal cancer.



Tumor-associated antigens

Typically glycoproteins or glycolipids, tumor-associated antigens differ only slightly from the components in normal cells. Those on tumor-cell surfaces are particularly crucial for immunologic recognition and diagnosis and for immunotherapy. Generally, the larger the tumor, the more antigens it produces. A tumor may shed antigens as well as secrete them; shedding may affect antibodies and lymphocytes far from the primary tumor.

Virally induced antigens. Such antigens, which manifest themselves identically on all cells they affect, appear on the membranes of infected tumor cells when any viral infection alters deoxyribonucleic acid (DNA).

Oncofetal antigens. These antigens are normally produced in large amounts in the fetus and neonate; excessive amounts in maternal blood after delivery may indicate a tumor. Two common oncofetal antigens are carcinoembryonic antigen (CEA) and alpha-feto-protein (AFP). (See *Oncofetal antigen development*.)

Antigens present on other tissues. These are found on tumors and in cells from normal tissues. Cells from acute myeloblastic leukemia (a form of acute nonlymphocytic leukemia), for example, may carry antigens present on normal B cells or monocytes.

Tissue-specific antigens. These are present not only in tumor cells but also in all tissues from which the tumor originated. An example is antigens present on sarcomas.

Tumor-specific antigens. Specific antigens have been identified in multiple myeloma.

Antigens should normally activate the ongoing immune response. Tumors develop with failure of the immune response.

Why immune response fails

Researchers have several theories to explain why antigens may fail to evoke a normal immune response.

Familiar-appearing antigens. Some tumors look *familiar* to the immune system; that is, they contain no recognizably foreign antigens. This is rare, however—most tumors elicit at least weak immunogenicity when tested.

Weak antigens. Some antigens are too weak to elicit a strong immune response. Weakly immunogenic tumors produce cancer cells faster than the body can kill them.

Antigen-antibody complexes. Tumors sometimes shed extra antigens, and these antigen-antibody complexes can "blindfold" lymphocytes so they don't recognize the tumor.

These complexes also suppress lymphocyte toxicity to tumor cells by absorbing into lymphocytes' surfaces. This phenomenon—known as enhancement—is associated with large, progressive tumors; disappears when the tumors are removed; and recurs when the tumors recur. (See *Enhancement and blocking antibodies*, page 118.)

Unstable adhesions. Because tumor cells don't form stable intercellular adhesions, the necessary interaction between them and lymphoid cells might also be abnormal, thereby preventing destruction of the tumor.

Suppressor T lymphocytes. By interfering with tumor-specific antibody production, suppressor T lymphocytes can short-circuit the immune response.

Oncogenic viruses and carcinogenic chemicals. Such agents can inhibit the immune response, at least temporarily. Thus, exposure to a virus in utero or during infancy from mother's milk can contribute to cancer years later when an external stressor releases the latent virus, which the body never recognized as foreign.

MEDICAL MANAGEMENT

Diagnosis and treatment of tumors related to the immune system must begin with a complete history and physical examination. Also, several tests help evaluate immune function and definitively diagnose a tumor.

Tests confirm diagnosis

One key test measures the number of B and T lymphocytes in the blood; another key test is immunoelectrophoresis. (These tests are described in Chapter 3.) Other important tests include tissue biopsies and skin tests.

Lymph node biopsy. Before starting definitive cancer treatment, diagnosis must be confirmed through tissue biopsy of an enlarged accessible lymph node. Needle biopsy does not yield enough material for an accurate diagnosis and shouldn't be used. Frozen-section material shouldn't be used either because slightly crushed lymphoid tissue can be mistaken for other types of malignancies.

Bone marrow aspiration and biopsy. This test reveals the number and type of abnormal cells. Special staining techniques, chromosomal analysis, and cytochemical studies also contribute to a more exact diagnosis.

Skin tests. These include tuberculosis and dinitrochlorobenzene (DNCB) skin tests to determine the host's ability to mount a cell-mediated immune response. In many lymphomas,

mas, these tests reveal cutaneous anergy.

Once tumor diagnosis has been established, special blood tests, skeletal surveys, and computerized tomography scans evaluate how far the disease has progressed.

Tumor markers. These are tumor-associated antigens whose presence in body fluids, particularly blood, helps to pinpoint the primary tumor site, to evaluate and monitor a patient's response to cancer therapy, and to identify recurrence of a tumor. The level of tumor markers in any body fluid reflects the rates at which cancer cells are growing, dying, and creating and secreting markers; the rate at which the host destroys and excretes markers; and the specific interactions between cancer cells and normal tissue.

The glycoprotein CEA occurs normally in minute amounts in serum. However, a tumor in the large intestine secretes large amounts of CEA. Higher-than-normal serum levels of CEA are also associated with tumors of the pancreas, stomach, lung, breast, prostate, endometrium, cervix, and ovary and with cigarette smoking, alcoholic cirrhosis, pancreatitis, and inflammatory disorders.

The glycoprotein AFP is a normally synthesized major plasma protein of the early human fetus. Synthesis occurs mainly in the liver and also in the GI tract and yolk sac. Malignant liver cells secrete large quantities of AFP. High serum levels occur in fetuses with neural tube defects and in adults with hepatoma; in germ cell tumors of the testes and ovaries; in endometrial sinus tumors of the ovaries; and occasionally in cancer of the pancreas, stomach, colon, or lung.

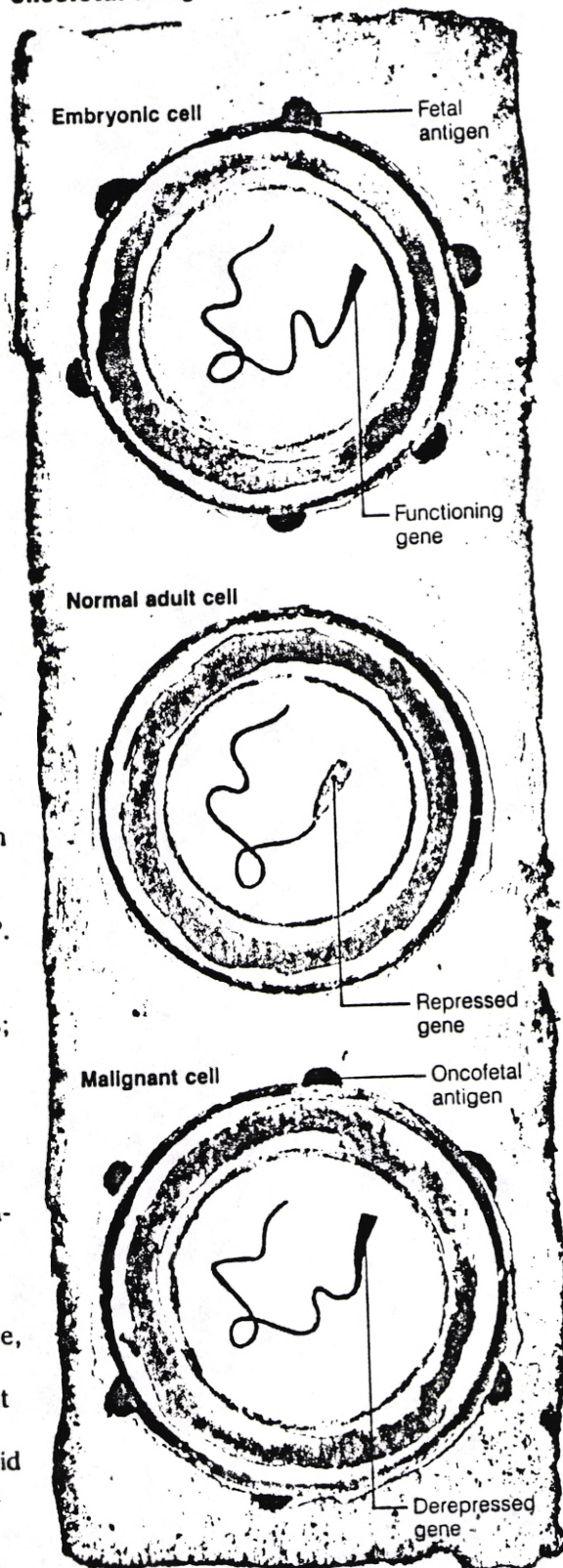
Major cancer treatments

The major cancer treatments—surgery, radiation, chemotherapy, and immunotherapy—may be used alone or in combination.

Surgery. Surgery may be the treatment of choice, depending on the stage of the disease, the growth rate and anatomic boundaries of the tumor, the patient's health and treatment preference, and the degree to which surgery may be mutilating. Surgical excision of a solid tumor with a wide margin can remove most of the tumor, reducing the number of malignant cells and thereby facilitating the effectiveness of chemotherapy, radiation therapy, and the immune system.

Surgery is usually the most efficient treatment for oncologic emergencies in immunosuppressed patients. For example, acute bleeding from pulmonary hemorrhage, esoph-

Oncofetal antigen development



The cell surfaces or serum secretions of many tumors display oncofetal antigens that are thought to result from gene derepression. Normally, functioning genes in the embryonic cell produce fetal antigens, which are repressed in the adult's genes. In malignancy, however, derepression of new genes causes reappearance of fetal antigens—oncofetal antigens.

1/29/86

Dear [REDACTED],

I'm going to have to bow out for tomorrow (i.e. today, 01/30/86). I forgot that I have school starting at 7pm and so wouldn't be able to come in to see you at 6 and still make my first class (First Person: Poetry--a Philosophical Perspective). First impressions being very important (as we both know) I guess I should opt to impress my professor. I'll call you at some point in the future and connect, maybe. (It's not that important anyway.)

By the way, if you're still doing an alternative treatment program and Mills isn't cooperative (no surprize!) try Jim Henry in San Diego. I think he is now painting DNCB ad hoc on over a dozen AIDS patients! His new phone number after 2/1 is [REDACTED].

You guys are simply incredible! I understand CNN was the ONLY network covering the Shuttle launch live, and you're STILL the only network to cover the AIDS/ autoimmune story....

All the best (with your bass fiddle)

