

February 14, 1986

Dear John,

Thanks for the phone message & update! Good for you!! Jim Henry and those other ARC & AIDS patients in San Diego are true heroes compared to the relatively passive Community here. (They are waiting for Volberding to announce the treatment & cure.) The San Diego guys were the first to try the Mexican drugs, and now, while the rest of the nation is still paying through the nose for them through the Blackmarket and they haven't proved so very effective after all, San Diegans are virtually pioneering DNCB treatment in impromptu clinics in their own parlors!

Needless to say, you should probably tie your DNCB story with an interview with the World's foremost DNCB specialist, Dr. Epstein (see attached photocopy of his letter to me, dated 09/13/85). And while Wally is the World's expert and can explain what is involved and significant with AIDS patients showing reactivity, Mills is probably the expert for the clinical evidence in AIDS, as U.C.S.F. (to my knowledge) has yet to try it on patients. (And Mills, as we know, VERY camera shy, will probably be UNAVAILABLE for your cameras even after the JOURNAL publishes his data. So GO GET HIM on the 20th! Or at least get Wally Epstein in the mini-cam can....)

Happy Valentines, guys!

OXOXOX,



P.S. You should know that Dr. Kessler obtained confidential copies of Mills' data and sent it on to Paris & Volberding. This means that Kessler, the co-founder of HPA-23 at the Pasteur, and Volberding (as of this past Tuesday) are the only three doctors outside of the JOURNAL's peer review committee to actually read the data (apart from hearing it over the phone in conversations with Mills, etc.). Perhaps, AFTER the Twentieth when assumedly Mills will be sharing it with Conant's "Study Group", you could contact Volberding and ASK HIM for his opinion as to its significance, etc. That would be powerfully effective in ferreting out the truth in this matter: is DNCB a potential treatment in AIDS?; if so, why is General NOT testing it before the other, more expensive and dangerous drug trials (i.e. cyclosporine)? AT ANY RATE, AS OF TUESDAY LAST (OR AT LEAST) THIS NEXT THURSDAY (THE 20TH) VOLBERDING CAN NOT PLEAD ANY IGNORANCE ABOUT DNCB TREATMENT IN AIDS. (HE KNOWS AS MUCH AS WILL BE PUBLISHED IN THE JOURNAL.)

NOW

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SCHOOL OF MEDICINE
DEPARTMENT OF DERMATOLOGY
DERMATOLOGY RESEARCH, 1092 HSE

SAN FRANCISCO, CALIFORNIA 94143

September 13, 1985

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

Dear Mr. Elswood:

Thank you for your recent letter. In answer to your question, DNCB in a sensitized person would have the same effect as urushiol and we would anticipate that patients with AIDS would be relatively unreactive to both DNCB and poison oak. If they are reactive it would be a sign indicating that they have some cell-mediated immunity and possibly a better outlook.

Very sincerely yours,

A handwritten signature in cursive script, appearing to read "William L. Epstein".

William L. Epstein, M.D.
Professor of Dermatology

WLE:dc

February 11, 1986

Dear Elswood:

Thanks for your note regarding Bell's palsy.

I did notice the interesting article by Dr. Barton in THE SENTINEL and was pleased to see DNCB accounted for--although it seemed awfully low key (probably appropriately so at this time.) It's hard for me to imagine that there is consciously a commercial conspiracy going on--just a lot of ignorance and inattention and protection of vested interests. But I tend to be innocent about business in general.

I don't have a PUSH CART PRESS address--but it shouldn't be any trouble to find it via a library or bookstore. Books in Print would give you the Pushcart Annual Anthology. Or one of those Small Press writer's guides would provide it. The Anthology itself is worth looking at for all the other small magazines that are perused for the annual awards. A word of caution: the editor of Pushcart I've heard has very erratic tastes and conducts a sloppy operation (Sara Vogan has had trouble in this area and might give you more info on this)--but it does seem the right avenue for you to pursue--as would any of the sophisticated, offbeat journals that you might locate through the Pushcart Anthology list.

Thanks for staying in touch.

Yours,

A handwritten signature in blue ink that reads "Michael". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

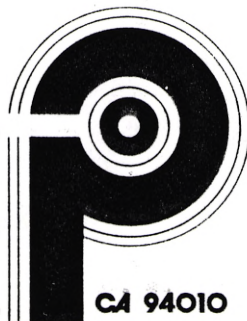
F.Y.I.

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1425 BROADWAY, SUITE 3, BURLINGAME,

CA 94010



February 19, 1986

L. Bruce Mills, MD
450 Sutter Street, Suite 2304
San Francisco, CA 94108

Re: Blaine Elswood
DOB: 9-4-48
Prudential Insurance Company

Dear Dr. Mills:

In accordance with instructions which I received from your staff today on the telephone, I am submitting the following request in writing: we would request that you make a complete copy of all medical records from 7/1/85 to present date concerning the above named patient. Additionally, we would request that you respond as completely as possible to the following questions: (a) what is the reason for the frequent lab tests (b) what symptoms were present which required the tests (c) were any tests done for screening purposes only?

Enclosed is our expense check in the amount of \$75.00 as well as an authorization signed by Mr. Elswood on 2/3/86.

Time is of the essence in this matter, since it is a health benefit claim and we would appreciate your prompt response.

If you have any questions in regard to the above, please feel free to contact me.

Very truly yours,

N.J. Smith (KPP)

Nichols J. Smith

NJS:fls
encls.

L. BRUCE MILLS, M.D.
450 SUTTER STREET
SUITE 2304
SAN FRANCISCO, CALIFORNIA 94108



Mr. Blaine Elswood
633 Post #644
San Francisco, Ca.

94109



Stimulation of T-Cellular Immunity by Cutaneous
Application of Dinitrochlorobenzene

L. Bruce Mills, M.D.
450 Sutter Street, #2304
San Francisco, CA 94108
(415) 362-8915

January 13, 1986

Submitted to the Journal of the American Academy of Dermatology
for consideration in the Journal's Correspondence Section.

To the Editor.--I have collected a series of twenty-six cases from my practice which suggests that topical administration of 1-chloro-2,4-dinitrochlorobenzene (DNCB) to persons of varying immunological status induces changes in numbers of circulating T and B lymphocytes and T-lymphocyte subsets as well as improved transformability of these lymphocytes in vitro by exogenous mitogens which correlates with clinical evidence of enhanced T-cellular function. Normalization of other laboratory abnormalities associated with the acquired immune deficiency syndrome (AIDS) including anemia, thrombocytopenia and hypergammaglobulinemia was noted during the course of the DNCB applications and suggests that topically administered DNCB also promotes reconstitution of T-cell immunoregulatory functions in immune suppressed patients. Laboratory studies were obtained at intervals both before and after weekly application of 2% DNCB in acetone to the ventral surface of the upper extremities until erythema, edema and pruritus could be induced by a 1% DNCB solution within 24 to 72 hours after its application to the quarter-sized site. Immediately following administration of the DNCB solution, the site was covered with gauze and paper tape; the patient was instructed to remove the dressing and cleanse the site the following morning. The number of applications administered prior to the appearance of delayed hypersensitivity was roughly proportional to the severity of the immune deficiency, if present. Alterations of lymphocyte parameters as well as other AIDS-associated laboratory abnormalities were frequently found

even prior to the development of cutaneous hypersensitivity in immune suppressed patients, although eventually all patients were successfully sensitized as judged by clinical examination of the application sites. Normal patients (i.e. with initial OKT4/OKT8 values >1.0) and "moderately" suppressed patients (i.e. with initial OKT4/OKT8 values <1.0 but without diagnoses of Kaposi's sarcoma or opportunistic infections) had increases in total T-cell counts, as well as both OKT4 and OKT8 subsets resulting in an increased OKT4/OKT8 ratio. The "AIDS" patient group (i.e. with diagnoses of Kaposi's sarcoma and/or pneumocystis carinii pneumonia who were not receiving any other treatment concurrently) had decreased total T-cell and OKT8 counts but increased OKT4 counts resulting an approximate doubling of the initial OKT4/OKT8 ratio (Table I). Patients with anemia and/or thrombocytopenia underwent increases in red blood cell numbers, hemoglobin, hematocrit and platelet counts while erythrocyte sedimentation rates, IgG and IgA levels decreased. The immunosuppressed group also demonstrated improved transformability of lymphocytes in vitro to phytohemagglutinin, pokeweed and concanavalin A mitogens while the staphylococcal aureus mitogen test usually remained below normal values. Patients with Kaposi's sarcoma underwent changes in their mucocutaneous lesions, consisting of reductions in lesional size, number and thickness as well as decreased discoloration when DNCB was applied to foci of involved skin. These changes included DNCB-treated as well as untreated lesions and were generally preceded by perilesional erythema, edema and

pruritus. Diminution of the violaceous discoloration began on interfollicular skin, leaving persistent perifollicular violaceous erythema. This anecdotal collection of cases suggests that cutaneous administration of DNCB may prove to be of therapeutic benefit in the amelioration of the immunologic defect in AIDS, primarily or adjunctively.

L. Bruce Mills, M.D.

450 Sutter Street, #2304

San Francisco, CA 94108

Table I. Alterations of Lymphocytic Parameters by Topical Application of Dinitrochlorobenzene.

		WBC'S*	LYMPHOCYTES	B-CELLS	OKT11	OKT4	OKT8	OKT4/OKT8
NORMAL PATIENTS n=8	BEFORE	7984	2528	237	1885	960	841	1.32
	AFTER	7850	2823	329	2002	1087	877	1.42
	% CHANGE	-2	12	39	6	13	4	8
"MODERATELY" SUPPRESSED n=12	BEFORE	5862	1788	356	1152	390	799	0.60
	AFTER	5190	1849	259	1402	518	838	0.76
	% CHANGE	-11	3	-27	22	33	5	27
"AIDS" PATIENTS n=6	BEFORE	4308	1426	185	1055	175	871	0.21
	AFTER	3928	1210	185	886	230	605	0.47
	% CHANGE	-9	-15	0	-16	31	-31	124

* All cell counts are given as cells/mm³.

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450 SUTTER STREET
SUITE 2304
SAN FRANCISCO, CALIFORNIA 94108



Mr. Blaine Elswood
633 Post #644
San Francisco, CA

94109

THE KAMIKAZE ANALYSIS OF JAAD SUBMISSION

The following annotations on Mills' text and submitted data was a cooperative effort of several patients who knew something wasn't straight, in the sense of being frank. Mills', avoidant personality profile fits perfectly with what he avoids here: the most important observations he leaves deliberately UNSAID. We hope, hereby, to make up for the deliberate deficiencies of our reclusive doctor.

Stimulation of T-Cellular Immunity by Cutaneous
Application of Dinitrochlorobenzene

L. Bruce Mills, M.D.
450 Sutter Street, #2304
San Francisco, CA 94108
(415) 362-8915

January 13, 1986

1

Notice: date. JAAD had requested data and revisions in 11/85. Mills put-off doing this until he was pressured by M. Helquist's column in COMING UP! & threats of further action by a couple of patients.

Submitted to the Journal of the American Academy of Dermatology
for consideration in the Journal's Correspondence Section.

2 Of course, more than twenty-six patients are being treated by Mills with DNCB (for whatever reason: some for allergies & warts & others as a rather unorthodox--but supposedly effective--~~treatment~~ for arthritis, etc, one of these Guinea pigs being Mills' own mother!!!) The twenty-six mentioned here are those patients with both BEFORE and AFTER blood values taken.

To the Editor.--I have collected a series of twenty-six cases from my practice which suggests that topical administration of 1-chloro-2,4-dinitrochlorobenzene (DNCB) to persons of varying immunological status induces changes in numbers of circulating T and B lymphocytes and T-lymphocyte subsets as well as improved transformability of these lymphocytes in vitro by exogenous mitogens which correlates with clinical evidence of enhanced T-cellular function. Normalization of other laboratory abnormalities associated with the acquired immune deficiency syndrome (AIDS) including anemia, thrombocytopenia and hypergammaglobulinemia was noted during the course of the DNCB applications and suggests that topically administered DNCB also promotes reconstitution of T-cell immunoregulatory functions in immune suppressed patients. Laboratory studies were obtained at intervals both before and after weekly application of 2% DNCB in acetone to the ventral surface of the upper extremities until erythema, edema and pruritus could be induced by a 1% DNCB solution within 24 to 72 hours after its application to the quarter-sized site. Immediately following administration of the DNCB solution, the site was covered with gauze and paper tape; the patient was instructed to remove the dressing and cleanse the site the following morning. The number of applications administered prior to the appearance of delayed hypersensitivity was roughly proportional to the severity of the immune deficiency, if present. Alterations of lymphocyte parameters as well as other AIDS-associated laboratory abnormalities were frequently found

3 This says it all: Mills isn't claiming DNCB increases all B & T-lymphocytes subsets. Rather, his data shows some going up & others going down, depending on the immune-regulatory malfunction being "normalized".

4 We can assume these results are valid, although no data for these values are submitted to JAAD. (As patients we know the values were taken and monitored.)

5 This is where Mills, while not technically incorrect, nevertheless plays fast & loose with his protocol dosage. In actual fact, obsessed & worried that he not be "responsible" for the first case of DNCB-induced T-cell lymphoma (the opposite of AIDS), he would cut dosage from 2% solution (upon visual signs of reactivity) to 1% and then down to 0.1%! Application sites were "quarter-sized" though obviously (apart from his paranoia) he still doesn't know the MOST EFFECTIVE dosage amount or frequency! Patients treating in San Diego use higher solutions on larger application sites (1) on a more frequent basis without any signs of adverse effects so far, and their results appear to be better than those reported by Mills here.

6 In many cases, these alterations were more pronounced and impressive than those recorded after visual reaction could be noted. This could be because of immunoregulation (as Mills likes to think) OR because he immediately drops dosage from 2% to 1% to 0.1% due to fears of over-reactivity (T-cell lymphoma) and thus undercuts the improvements ("alterations") already started.

7

The fact that ALL patients (both Mills' & AIDS patients in San Diego) prove reactive is proof-positive that AIDS is autoimmune!

8

NOW, we come to the BIG ITEM Mills fails to mention: his theory of blood values showing the transplant/rejection phenomenon in AIDS patients with KS lesions, etc! That DNCB improves T-cell counts and ratios in "normal" and "moderately" suppressed patients, and only increases RATIOS (T-4s) in AIDS patients is explicable--according to Mills--by increased T-cells in the latter group being congregated at the tumor lesion sites (as with rejection episodes in transplant recipients) and not freely circulating in the blood able to be monoconally-tested by blood withdrawal (at least until lesions, etc., have cleared).

9

Again, no data is offered here, but polling of patients familiar with their lab results CONFIRMS improvements in these blood values, relating to autoimmune problems (i.e., platelet counts, etc.)

10

The mitogen improvements here are with both "moderately" suppressed & the six AIDS patients. General improvements in mitogen tests have generally preceded improvements in circulating T-cell numbers/ratios.

(2)

even prior to the development of cutaneous hypersensitivity in immune suppressed patients, although eventually all patients were successfully sensitized as judged by clinical examination of the application sites. Normal patients (i.e. with initial OKT4/OKT8 values >1.0) and "moderately" suppressed patients (i.e. with initial OKT4/OKT8 values <1.0 but without diagnoses of Kaposi's sarcoma or opportunistic infections) had increases in total T-cell counts, as well as both OKT4 and OKT8 subsets resulting in an increased OKT4/OKT8 ratio. The "AIDS" patient group (i.e. with diagnoses of Kaposi's sarcoma and/or pneumocystis carinii pneumonia who were not receiving any other treatment concurrently) had decreased total T-cell and OKT8 counts but increased OKT4 counts resulting an approximate doubling of the initial OKT4/OKT8 ratio (Table 1). Patients with anemia and/or thrombocytopenia underwent increases in red blood cell numbers, hemoglobin, hematocrit and platelet counts while erythrocyte sedimentation rates, IgG and IgA levels decreased. The immunosuppressed group also demonstrated improved transformability of lymphocytes in vitro to phytohemagglutinin, pokeweed and concanavalin A mitogens while the staphylococcal aureus mitogen test usually remained below normal values. Patients with Kaposi's sarcoma underwent changes in their mucocutaneous lesions, consisting of reductions in lesional size, number and thickness as well as decreased discoloration when DNCB was applied to foci of involved skin. These changes included DNCB-treated as well as untreated lesions and were generally preceded by perilesional erythema, edema and

11

See next page

→ 11 & 12 Mills' reported clinical changes in KS lesions is strikingly less impressive than reports from San Diego where dosage is not being diluted. Whereas Mills reports fading of lesions, San Diego reports lesions consistently FALLING OFF!

pruritus. Diminution of the violaceous discoloration began on interfollicular skin, leaving persistent perifollicular violaceous erythema. This anecdotal collection of cases suggests that cutaneous administration of DNCB may prove to be of therapeutic benefit in the amelioration of the immunologic defect in AIDS, primarily or adjunctively.

L. Bruce Mills, M.D.
450 Sutter Street, #2304
San Francisco, CA 94108

13 Finally, left unstated is Mills' "model" for the disease (as he sees it). In this clearly autoimmune model, the investigator is supposed to tremble with fear that overstimulating KS patients' reactivity with DNCB would (NOT stimulate the putative AIDS virus--WHICH IT CLEARLY DOES NOT!) but cause a sudden reversal from an AIDS diagnosis to one of a T-cell lymphoma (leukemia). The first AIDS patient that undergoes this Mills-feared transformation would march right into Medical History (it being so conventionally UNTHINKABLE). And Mills is going to make sure BY CUTTING DOSAGE that he is not the doctor to cause it. The question is: is his fear undercutting further positive improvement in his AIDS patients (as he cuts from 2% to 1% to 0.1%, etc.)? More informal--and courageous--treatment in San Diego should clear the matter.

Table I. Alterations of Lymphocytic Parameters by Topical Application of Dinitrochlorobenzene.

		WBC'S*	LYMPHOCYTES	B-CELLS	OKT11	OKT4	OKT8	OKT4/OKT8
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"AIDS" PATIENTS n=6	BEFORE	4308	1426	185	1055	175	871	0.21
	AFTER	3928	1210	185	886	230	605	0.47
	% CHANGE	-9	-15	0	-16	31	-31	124

* All cell counts are given as cells/mm³.

See comment #8 above.

February 25, 1986

Marcus A. Conant, M.D.
Professor of Dermatology
University California San Francisco
501 Parnassus Avenue
San Francisco, CA 94143

Dear Dr. Conant:

I am writing to comment on last week's virtual NO SHOW by Dr. L. Bruce Mills, and to provide a bit of advice for handling this tremulous doctor in the future. You will recall me as the fellow who kept going out to find Mills, and once having found him (freaking out in the elevator) physically pushing him into conference room. (This, you noticed, as I saw you smiling at the absurdity of the situation: a patient having to find and physically tag a "presenting" doctor/informal AIDS research scientist.

The fact of the matter is that Bruce Mills suffers from an "AVOIDANCE DISORDER" and has for years, with periodic outbreaks of panic, isolation, and ~~quite~~ hysteria. It is nothing really THAT FUNNY when you realize the pain the fellow goes through. When it comes to Mills' DNCB research, I have been the greatest thorn in Mills' side, forcing him to come public, to talk, to communicate his findings to others--when all he wants to do is simply & QUIETLY treat his patients and ignore and block out the rest of world. It is a most peculiar situation, and not helped any by his "peers" (whom he is pathologically afraid of) focusing on his handicap instead of assisting him. If Dr. Mills were blind or crippled, I'm sure you and Dr. Abrams, etc., would provide every convenience to help him--instead of impeding his progress, in this case to the podium of your KS Study meeting podium. Even while I was furiously angry at Mills and pushing him into the meeting room, I was also aware that this feeling I had was patently unfair when directed against someone so mentally/psychically pained. (The Shrinks in your room were aware of the situation, and not any too impressed by the almost jocular barbs that were being thrown...people with Mills' handicap must be handled with kid gloves, if they are to contribute ANYTHING and not be reclusive and avoidant.)

Here's the rub: Dr. L. Bruce Mills DOES have something to contribute to your on-going search for answers to the AIDS problem. What significance his data and clinical findings has can only be judged in a fair and impartial hearing untainted by bullying and medical politics. Dr. Mills was going to read to your group his little submission to JAAD (copy attached) and then show some slides he had especially prepared on Tuesday, and then answer questions. I hope you can SOMEHOW get him to come back (I understand he has now gone to his parents in Florida for a couple of weeks).

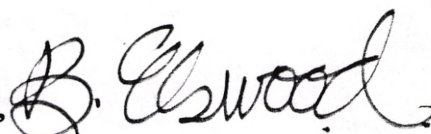
Certainly his virtual NO SHOW and your obvious enjoyment of the scene is nothing of which either of you can be proud. Only Mills DOES have the excuse of long-standing complexes (of which, your crony, Don Abrams is PERFECTLY aware).

When, might I ask, will we unite to assist and help each other (without egotism and turf-battles OR extreme insecurities) to fight this disease that wastes our brothers?

That is my question: WHEN?

Enclosure

Sincerely,



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

cc: Don Abrams, M.D.

February 26, 1986

Christopher, friend, kamikaze:

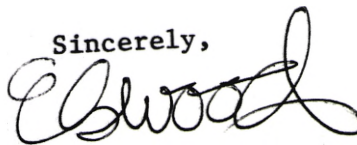
If Dr. "David" still has his bottle of DNCB crystals for sale, please snatch it up for us. Enclosed find a check for \$25.00 to cover costs. If Dr. "David" doesn't have his bottle anymore, can you get someone to order us another bottle.

Randy Boyle, San Francisco, is beginning a DNCB clinic as a direct off-shoot of Jim Henry's patient referrals. (San Franciscians are actually phoning Jim in S.D. to see if they can fly there for solution! Obviously, this is an impossible situation, what with Mills running home to his parents in Florida for two weeks + and many patients not being able to pay him anyway.)

As with Jim's S.D. operation, treatment will be free & no cost for any and all interested parties. (i.e., no gorging like the toothfairies!!!)

Please help if you can. (We won't bother you further if we can obtain crystals to last us for a long while.)

Sincerely,



P.S. If you want to talk to Randy about this, his number is 928-6058.

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SANTA BARBARA • SANTA CRUZ

AIDS CLINICAL RESEARCH CENTER

A-523, A-340

(415) 476-1407

(415) 476-1363

SAN FRANCISCO, CALIFORNIA 94143

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 the first and third Thursdays of March, 1986.

On March 6, our guest will be Donald Maul, D.V.M., from the California Primate Research Center at U.C. Davis. Dr. Maul will be giving an update on simian AIDS research, with particular emphasis on Dr. Maul's investigation of the type-D retrovirus and development of a simian AIDS vaccine. He will also discuss work in progress at the New England Primate Center with the Sooty-Mangabey monkeys.

On March 20, our guests will be epidemiologist John Newmeyer, Ph.D., John Waters, M.A., and Pat Biernacki, Ph.D., all from the Haight-Ashbury Free Medical Clinic. They will discuss AIDS among intravenous drug users in the Bay Area, including results of their HTLV-III antibody testing in that group.

On April 3, 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. (This meeting was rescheduled from February 20th.)

Two new publications will be of interest to you. FOCUS, published by the AIDS Health Project, attempts to translate medical research into easily understood language for non-medical psychosocial health care workers. A form for ordering this new newsletter is attached, and a copy of the latest issue will accompany the next Study Group memorandum. Another newsletter, AIDSFIL, is published by the AIDS Clinic at Ward 84, San Francisco General Hospital; it is designed to apprise health care providers of the latest treatments for AIDS and AIDS-related conditions. A recent copy is attached. AIDSFIL can be obtained by writing "AIDSFIL," San Francisco General Hospital, Ward 84, 995 Potrero Avenue, San Francisco, CA, 94110.

Attached, find AIDS bibliographies for the weeks ending 1/17/86, 1/24/86, and 1/31/86.

Also attached is a form for ordering a compilation of all articles relating to AIDS that have appeared in the Morbidity and Mortality Weekly Report in period between June 1981 and September 1985.

TECHNICAL REPORTS

Reports on AIDS
Published in the
Morbidity and Mortality Weekly Report
June 1981 through September 1985

This publication includes all the articles related to AIDS that have appeared in the Morbidity and Mortality Weekly Report, published by the Centers for Disease Control from June 1981 through September 1985. These articles, arranged in chronological order, track the reporting of information on AIDS, when CDC first published information on Kaposi's sarcoma and Pneumocystis carinii pneumonia occurring in young homosexual men. In 1981, CDC formed a task force to establish risk factors, carry out laboratory studies, and disseminate timely information on the disease now known as the acquired immunodeficiency syndrome (AIDS).

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December 15, 1985

Administrative Offices.

333 Valencia St., 4th Floor
San Francisco, CA 94103
(415) 626-6637

- AIDS Mental Health Program
- AIDS Prevention Program
- Youth & AIDS Prevention Program
- AIDS Health Professional Training Program
- AIDS & Substance Abuse Program
- HTLV-III Counseling Program

Dear Colleague:

The AIDS Health Project is a risk reduction and health education program of the University of California — San Francisco, dedicated to reducing the spread of AIDS. Over the past year and a half, we have served over 500 men and women who have been concerned about the threat that AIDS has brought to their lives. Each has come to learn more effective ways of coping with the changes that AIDS has demanded of them. Another goal is to provide mental health and substance abuse services to those with AIDS at San Francisco General Hospital.

In addition to this direct service component, the Project also offers an active education program. We provide in-service education and consultation to mental health and health care providers sharing our experience and expertise.

We have recently added a new program to our educational efforts: the publication of **FOCUS**, a monthly newsletter. **FOCUS** will bring you the latest medical and psychosocial AIDS research in easy to read language. Our editor is the award-winning journalist Michael Helquist, who has written extensively about AIDS from the early days of the epidemic.

FOCUS is supported by a grant from the State of California and the San Francisco Department of Public Health. We want others to know about it. Please take a minute and cut off the coupon below. Give it to a colleague. The newsletter is free of charge, but we need their name and address if they are to receive a copy. Just have them fill it out and send it back to us.

Being well informed is the key to giving good care.

Happy Reading,

James W. Dilley, M.D.
Project Director

Yes, I want to be on the mailing list of FOCUS.

Name: _____

Institution: _____

Address: _____

City: _____ State: _____ Zip: _____

**A project concerned
with AIDS Prevention
and Health Promotion
University of California
S.F. and Department of
Public Health**

AIDS

Saudi Arabia reports first cases of AIDS.
SF Chron 1/17/86, p.25

Scientists find how AIDS attacks body.
SF Chron 1/17/86, p.25

Summary of nine studies that demonstrate lack of HTLV-III transmission
among family member contacts of HTLV-III infected persons.
Calif Morb #47:1, 1985

Texas drops AIDS patient quarantine.
SF Chron 1/17/86, p.25

Andiman WA, Eastman R, Martin K, et al
Opportunistic lymphoproliferations associated with Epstein-Barr viral
DNA in infants and children with AIDS.
Lancet 2(8469/70):1390-3, 1985

Barton SE, Underhill GS, Gilchrist C, et al
HTLV-III antibody in prostitutes. [letter]
Lancet 2(8469/70):1424, 1985

Beardsley T
AIDS: Pasteur sues over patent.
Nature 318(6047):595, 1985

Benn S, Rutledge R, Folks T, et al
Genomic heterogeneity of AIDS retroviral isolates from North America
and Zaire.
Science 230(4728):949-51, 1985

AIDS FILE

WEEK ENDING : 1/17/86

Garbowit DL, Alsip SG, Griffin FM Jr
Hemophilus influenzae bacteremia in a patient with immunodeficiency
caused by HTLV-III. [letter]
N Engl J Med 314(1):56, 1985

Gerstoft J, Dickmeiss E, Mathiesen L
Cytotoxic capabilities of lymphocytes from patients with the acquired
immunodeficiency syndrome.
Scand J Immunol 22(5):463-70, 1985

Gocke DJ, Raska K Jr, Pollack W
HTLV-III antibody in commercial immunoglobulin. [letter]
Lancet 1(8471):37-8, 1986

Green B
Spreading the truth about AIDS.
SF Chron 1/17/86, p.30, 32

Hicks DR, Martin LS, Getchell JP, et al
Inactivation of HTLV-III/LAV-infected cultures of normal human
lymphocytes by nonoxynol-9 in vitro. [letter]
Lancet 2(8469/70):1422-3, 1985

James JJ, Morgenstern MA, Hatten JA
HTLV-III/LAV-antibody-positive soldiers in Berlin. [letter]
N Engl J Med 314(1):55-6, 1986

Kamradt T, Niese D, Vogel F
Slim disease (AIDS). [letter]
Lancet 2(8469/70):1425, 1985

Kanki PJ, Alroy J, Essex M
Isolation of T-lymphotropic retrovirus related to HTLV-III/LAV from
wild-caught African green monkeys.
Science 230(4728):951-4, 1985

Kotler DP, Wang J, Pierson RN Jr
Body composition studies in patients with the acquired
immunodeficiency syndrome.
Am J Clin Nutr 42(6):1255-65, 1985

CURRENT AWARENESS

3

AIDS FILE

WEEK ENDING : 1/17/86

Kuehnl P, Seidl S, Kurth R, et al
Human T-cell lymphotropic virus antibody screening: data survey on
33,603 German blood donors correlated to confirmatory tests.
Vox Sang 49(5):327-30, 1985

Levy JA, Shimabukuro J, McHugh T, et al
AIDS-associated retroviruses (ARV) can productively infect other cells
besides human T helper cells.
Virology 147(2):441-8, 1985

Marmorstein J
The odds of contracting AIDS, and what can be done to avoid it.
Hosp Trib 17(12):16, 1985

Mirchandani HG, Mirchandani IH, Pak MS
Spontaneous rupture of the spleen due to acquired immunodeficiency
syndrome in an intravenous drug abuser.
Arch Pathol Lab Med 109(12):1114-6, 1985

Mulleady G, Green J
Syringe sharing among London drug abusers. [letter]
Lancet 2(8469/70):1425, 1985

Norman C
AIDS virus presents moving target.
Science 230(4732):1357, 1985

Norman C
HTLV-III and LAV: similar, or identical?
Science 230(4726):643, 1985

Norman C
AIDS therapy: new push for clinical trials.
Science 230(4732):1355-6, 1358, 1985

Norman C
Patent dispute divides AIDS researchers.
Science 230(4726):640-2, 1985

CURRENT AWARENESS

4

AIDS FILE

WEEK ENDING : 1/17/86

Pahwa S, Pahwa R, Saxinger C, et al
Influence of the HTLV/LAV on functions of human lymphocytes: evidence
for immunosuppressive effects & polyclonal B-cell activation ...
Proc Nat Acad Sci 82(23):8198-202, 1985

Pompidou A, Zagury D, Gallo RC, et al
In-vitro inhibition of LAV/HTLV-III infected lymphocytes by dithiocarb
and inosine pranobex. [letter]
Lancet 2(8469/70):1423, 1985

Real RX, Krown SE
Spontaneous regression of Kaposi's sarcoma in patients with AIDS.
[letter]
N Engl J Med 313(26):1659, 1985

Sane DC, Durack DT
Infection with Rhodococcus equi in AIDS. [letter]
N Engl J Med 314(1):56-7, 1985

Schuurman H-J, Kluin PM, Meijling FH, et al
Lymphocyte status of lymph node & blood in acquired immunodeficiency
syndrome (AIDS) and AIDS-related complex disease.
J Pathol 147(4):269-80, 1985

Watkins T
ELISA-2 to reduce false positive test.
Asian Med News 8(1):1, 7, 1986

Watkins T
Truer tests for HTLV-III antibody due soon.
Hosp Trib 17(12):11, 1985

AIDS

Heterosexual transmission of the AIDS virus.
Calif Morb #51:1, 1985

Update: acquired immunodeficiency syndrome - United States.
MMWR 35(2):17-21, 1986

Violations block opening of \$100 AIDS test clinic.
LA Times 1/22/86, Pt.II, p.1

Bloom AL
AIDS in haemophiliacs and homosexuals. [letter]
Lancet 1(8471):36-7, 1986

Burda D, Powills S
AIDS: a time bomb at hospitals' door.
Hospitals 60(1):54-7, 59-61, 1986

Carey J
The rivalry to defeat AIDS.
US News World Rep 100(1):67-8, 1986

Hardy AM, Rauch K, Echenberg D, et al
The economic impact of the first 10,000 cases of acquired
immunodeficiency syndrome in the United States.
JAMA 255(2):209-11, 1986

Iles D
AIDS and mosquitoes. [letter]
Med J Aust 143(10):478, 1985

Jason JM, McDougal JS, Dixon G, et al
HTLV-III/LAV antibody and immune status of household contacts and
sexual partners of persons with hemophilia.
JAMA 255(2):212-5, 1986

AIDS FILE

WEEK ENDING : 1/24/86

Mathez D, Leibovitch J, Sultan Y, et al
LAV/HTLV-III seroconversion and disease in hemophiliacs treated in
France.

N Engl J Med 314(2):118-9, 1986

Norman C

AIDS priority fight goes to court.

Science 231(1):11-2, 1986

Redfield RR, Wright DC, Tramont EC

The Walter Reed staging classification for HTLV-III/LAV infection.

N Engl J Med 314(2):131-2, 1986

Rexroat N

Council passes law to protect AIDS victims.

Daily Cal 18(2):1, 12, 1986

Riesenberg DE

AIDS-prompted behavior changes reported.

JAMA 255(2):171, 176, 1986

Saag MS, Britz J

Asymptomatic blood donor with a false positive HTLV-III Western Blot.

[letter]

N Engl J Med 314(2):118, 1986

Shahoda T, Lashley T, Firshein J

Insurers: watchful but not worried.

Hospitals 60(1):58, 1986

Vadhan-Raj S, Wong G, Gnecco C, et al

Immunological variables as predictors of prognosis in patients with
Kaposi's sarcoma and the acquired immunodeficiency syndrome.

Cancer Res 46(1):417-25, 1986

Westphal R

Potential liability for transfusion-associated AIDS. [letter]

JAMA 255(2):195-7, 1986

CURRENT AWARENESS

3

AIDS FILE

WEEK ENDING : 1/24/86

Williams CK

AIDS and cancer in Nigerians. [letter]

Lancet 1(8471):36-7, 1986

AIDS

Greater precautions urged: health workers given new advice on AIDS.
SF Chron 1/28/86, p.6

Anand R, Moore J, Feorino P, et al
Rifabutine inhibits HTLV-III. [letter]
Lancet 1(8472):97-8, 1986

Andes WA, Daul CB, deShazo RD, et al
Clinical signs of HTLV-III exposure may precede seropositivity in
hemophiliacs. [abstract]
Blood 66(5:Suppl 1):109a, 1985

Andes WA, Daul CB, deShazo RD, et al
The relationship of HTLV-III exposure to lymphadenopathy in
hemophilia. [abstract]
Clin Res 34(1):216A, 1986

Ballester OF, Abdallah JM, Prasad AS
Lymphocyte subpopulation abnormalities in sickle cell anemia: a
distinctive pattern from that of AIDS.
Am J Hematol 21(1):23-7, 1986

Biggar RJ
The AIDS problem in Africa.
Lancet 1(8472):79-82, 1986

Blaser MJ
Insect-borne transmission of AIDS. [letter]
JAMA 255(4):463-4, 1986

Brettler DB, Forsberg AD, Brewster FE, et al
Factor usage, HTLV-III/LAV exposure and immunoregulatory defects in
hemophilia. [abstract]
Blood 66(5:Suppl 1):110a, 1985

AIDS FILE

WEEK ENDING : 1/31/86

Daul CB, deShazo RD, Andes WA, et al
Relationships between immunologic function and seropositivity for
HTLV-III in hemophiliac patients. [abstract]
Clin Res 34(1):219A, 1986

Edelbaum DN
No AIDS among patients on dialysis? [letter]
N Engl J Med 314(3):187, 1986

Eyster ME, Goedert JJ, Salahuddin SZ, et al
HTLV-III infection in hemophiliacs and their spouses. [abstract]
Blood 66(5:Suppl 1):111a, 1985

Firshein J
AIDS funding decisions lack consensus opinion.
Hospitals 60(1):35, 1986

Friedman P
AIDS discrimination banned ...
Berkeley Voice 1/29/86, p.4

Giardina PJ, Robert-Guroff M, Salahuddin SZ, et al
Antibodies to HTLV-III/LAV in transfusion dependent thalassemia.
[abstract]
Blood 66(5:Suppl 1):111a, 1985

Goldsmith JC, Kisker CT, Volsky DA
Natural history of HTLVIII/LAV infection in hemophiliacs: initial
outcomes. [abstract]
Blood 66(5:Suppl 1):112a, 1985

Gonzalez ER
'Quarantine' real to AIDS victims.
Hospitals 60(1):94, 1986

Goodman E
AIDS: beneath the sign of the cross.
Life 9(2):27, 1986

AIDS FILE

WEEK ENDING : 1/31/86

Harfi HA, Fakhry BM

Acquired immunodeficiency syndrome in Saudi Arabia. The American-Saudi connection.

JAMA 255(3):383-4, 1986

Hauptman SP, Batuman O, Friedman L, et al

Amelioration of immunologic deficits and clinical manifestations of AIDS by allogeneic lymphocyte transfusions. [abstract]

Blood 66(5:Suppl 1):113a, 1985

Ioachim HL, Cooper MC

Lymphomas of AIDS. [letter]

Lancet 1(8472):96, 1986

Keller RH, Milson TJ, McFadden PW, et al

In vivo augmentation of immunologic responsiveness with AIDS and ARC using isoprinosine. [abstract]

Blood 66(5:Suppl 1):113a, 1985

Levine AM, Gill PS, Hawkins J, et al

Suramin anti-viral therapy in acquired immunodeficiency syndrome (AIDS) & AIDS-related lymphoma: preliminary results. [abstract]

Blood 66(5:Suppl 1):114a, 1985

Lindhart BO, Gerstoft J, Ulrich K, et al

Antibodies against HTLV-III in Danish haemophiliacs: relation to source of factor VIII used in treatment and immunological parameters.

Scand J Haematol 35(4):379-85, 1985

Lombardo VT, Callea V, Fragomeno C, et al

Viral exposure, T-lymphocyte subsets and HTLV-III positivity in patients with hemophilia. [abstract]

Blood 66(5:Suppl 1):118a, 1985

Luban NL, Williams A, Edwards M, et al

Spectrum of illness in eight children receiving washed RBCs from two HTLV III infected donors. [abstract]

Blood 66(5:Suppl 1):114a, 1985

AIDS FILE

WEEK ENDING : 1/31/86

Ostrow DG

'Understanding AIDS: a comprehensive guide,' edited by Victor Gong.
[book review]

JAMA 255(3):414-5, 1986

Patlak M

Challenges of AIDS: unfinished story of a virus.

News Rep 36(1):10-7, 1986

Poon M-C, Landay A, Paul D, et al

HTLV-III antigen in hemophiliacs: a longitudinal study. [abstract]

Blood 66(5:Suppl 1):115a, 1985

Ragni MV, Winkelstein A, Lewis JH, et al

Immune parameters associated with development of AIDS in hemophiliacs.
[abstract]

Blood 66(5:Suppl 1):116a, 1985

Riffer J

Blood banks still cope with AIDS fears and myths.

Hospitals 60(1):74, 1986

Ross RK, Casagrande JT, Dworsky RL, et al

Kaposi's sarcoma in Los Angeles, California.

J Nat Cancer Inst 75(6):1011-5, 1985

Shannon B, Roach J, Cheek-Luten M, et al

Abnormalities in T lymphocyte distribution and HTLV-III status in
children with hemophilia A. [abstract]

Blood 66(5:Suppl 1):117a, 1985

Spigelman Z, Ahrens A, Duff R, et al

Suramin inhibits DNA polymerase alpha and terminal deoxynucleotidyl
transferase. [abstract]

Blood 66(5:Suppl 1):117a, 1985

T[askal] MR

Proper AIDS care demands better discharge planning.

Hospitals 60(1):70-1, 1986

CURRENT AWARENESS

5

AIDS FILE

WEEK ENDING : 1/31/86

Traska MR

No home means no home care for AIDS patients.
Hospitals 60(1):69-70, 1986

Volberding PA, Mitsuyasu R

Recombinant interferon alpha in the treatment of acquired immune
deficiency syndrome-related Kaposi's sarcoma.
Semin Oncol 12(4:Suppl 5):2-6, 1985

Wachter H, Fuchs D, Hausen A, et al

Are conditions linked with T-cell stimulation necessary for
progressive HTLV-III infection? [letter]
Lancet 1(8472):97, 1986

Wachter RM

The impact of the acquired immunodeficiency syndrome on medical
residency training.
N Engl J Med 314(3):177-80, 1986

Wasserberger J, Ordog GJ, Stroh JJ, et al

AIDS and breast milk. [letter]
JAMA 255(4):464, 1986

Wieder RS

AIDS: a straight man takes the test.
SF Chron 1/28/86, p.16, 18

To the Editor.--I have collected a series of twenty-six cases from my practice which suggests that topical administration of 1-chloro-2,4-dinitrochlorobenzene (DNCB) to persons of varying immunological status induces changes in numbers of circulating T and B lymphocytes and T-lymphocyte subsets as well as improved transformability of these lymphocytes in vitro by exogenous mitogens which correlates with clinical evidence of enhanced T-cellular function. Normalization of other laboratory abnormalities associated with the acquired immune deficiency syndrome (AIDS) including anemia, thrombocytopenia and hypergammaglobulinemia was noted during the course of the DNCB applications and suggests that topically administered DNCB also promotes reconstitution of T-cell immunoregulatory functions in immune suppressed patients. Laboratory studies were obtained at intervals both before and after weekly application of 2% DNCB in acetone to the ventral surface of the upper extremities until erythema, edema and pruritus could be induced by a 1% DNCB solution within 24 to 72 hours after its application to the quarter-sized site. Immediately following administration of the DNCB solution, the site was covered with gauze and paper tape; the patient was instructed to remove the dressing and cleanse the site the following morning. The number of applications administered prior to the appearance of delayed hypersensitivity was roughly proportional to the severity of the immune deficiency, if present. Alterations of lymphocyte parameters as well as other AIDS-associated laboratory abnormalities were frequently found

Stimulation of T-Cellular Immunity by Cutaneous
Application of Dinitrochlorobenzene

L. Bruce Mills, M.D.
450 Sutter Street, #2304
San Francisco, CA 94108
(415) 362-8915

January 13, 1986

Submitted to the Journal of the American Academy of Dermatology
for consideration in the Journal's Correspondence Section.

even prior to the development of cutaneous hypersensitivity in immune suppressed patients, although eventually all patients were successfully sensitized as judged by clinical examination of the application sites. Normal patients (i.e. with initial OKT4/OKT8 values >1.0) and "moderately" suppressed patients (i.e. with initial OKT4/OKT8 values <1.0 but without diagnoses of Kaposi's sarcoma or opportunistic infections) had increases in total T-cell counts, as well as both OKT4 and OKT8 subsets resulting in an increased OKT4/OKT8 ratio. The "AIDS" patient group (i.e. with diagnoses of Kaposi's sarcoma and/or pneumocystis carinii pneumonia who were not receiving any other treatment concurrently) had decreased total T-cell and OKT8 counts but increased OKT4 counts resulting an approximate doubling of the initial OKT4/OKT8 ratio (Table I). Patients with anemia and/or thrombocytopenia underwent increases in red blood cell numbers, hemoglobin, hematocrit and platelet counts while erythrocyte sedimentation rates, IgG and IgA levels decreased. The immunosuppressed group also demonstrated improved transformability of lymphocytes in vitro to phytohemagglutinin, pokeweed and concanavalin A mitogens while the staphylococcal aureus mitogen test usually remained below normal values. Patients with Kaposi's sarcoma underwent changes in their mucocutaneous lesions, consisting of reductions in lesional size, number and thickness as well as decreased discoloration when DNCB was applied to foci of involved skin. These changes included DNCB-treated as well as untreated lesions and were generally preceded by perilesional erythema, edema and

pruritus. Diminution of the violaceous discoloration began on interfollicular skin, leaving persistent perifollicular violaceous erythema. This anecdotal collection of cases suggests that cutaneous administration of DNCB may prove to be of therapeutic benefit in the amelioration of the immunologic defect in AIDS, primarily or adjunctively.

L. Bruce Mills, M.D.

450 Sutter Street, #2304

San Francisco, CA 94108

Table I. Alterations of Lymphocytic Parameters by Topical Application of Dinitrochlorobenzene.

		WBC'S*	LYMPHOCYTES	B-CELLS	OKT11	OKT4	OKT8	OKT4/OKT8
NORMAL PATIENTS n=8	BEFORE	7984	2528	237	1885	960	841	1.32
	AFTER	7850	2823	329	2002	1087	877	1.42
	% CHANGE	-2	12	39	6	13	4	8
"MODERATELY" SUPPRESSED n=12	BEFORE	5862	1788	356	1152	390	799	0.60
	AFTER	5190	1849	259	1402	518	838	0.76
	% CHANGE	-11	3	-27	22	33	5	27
"AIDS" PATIENTS n=6	BEFORE	4308	1426	185	1055	175	871	0.21
	AFTER	3928	1210	185	886	230	605	0.47
	% CHANGE	-9	-15	0	-16	31	-31	124

* All cell counts are given as cells/mm³.

February 25, 1986

Jim Henry
[REDACTED]

Dear Jim:

I talked to Ray Foss this morning. Seems he knows [REDACTED], who is your counterpart here in San Francisco (running a free DNCB clinic from out of his apartment.) Only goes to show you the amount of connecting still to be done to get treatment readily available for everyone. (And San Diego leads the way, it seems!)

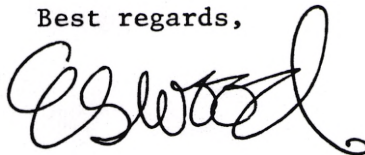
At any rate, if you get any more calls from San Francisco, and the callers don't have money to see Mills, etc., please refer them directly on to [REDACTED] at [REDACTED]. [REDACTED], you should note, has been a DNCB patient of Mills' for over a year now. He's convinced of DNCB therapeutic effects. He has paper tape, gauze, and DNCB--but up to now (& Ray Foss) no patients. What with your referrals and more & more information leaking out (no thanks to Mills!) he should soon be as busy as you are....

Also enclosed is another copy of Mills' submission to JAAD. Again, get it to researchers and AIDS doctors. They are probably the only ones who will be able to interpret its implications accurately. (I know Mills is breaking his bombshell obliquely here--what is vastly important is what he leaves unsaid! But that seems to be his cowardly way of dealing with things of too tremendous importance for his coping abilities--that & being a virtual NO SHOW at the U.C. presentation meeting.)

Good luck to you! I gave Chirstopher your messages, but STRONGLY suggest you start running down your own local sources for the crystals as Randy will be wanting what's available to us here as his clinic expands.

Finally, [REDACTED] & YOU are true heroes of the AIDS Epidemic! (I've dropped Mills from being worthy of your company in the pantheon of "Our Brothers' Keepers"!)

Best regards,



Enclosure

cc: [REDACTED]

City and County of San Francisco



Department of
Public Health

San Francisco General Hospital
Medical Center

SAN FRANCISCO GENERAL HOSPITAL
995 Potrero Avenue, Ward 84
San Francisco, CA 94110
(415) 821-5531

February 27, 1986

David Kessler
UCSF
Langley Porter Psychiatric Institute
401 Parnassus Avenue

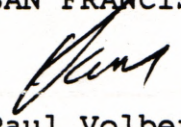
Dear David,

I neglected to mention in our recent phone conversation that I did receive your note and Bruce Mills preliminary data. I have reviewed it and find it interesting. The number of cells do appear to increase, although, the increase does not appear to be significant to my non-statistical eye. I would like to believe that this non-specific immune stimulation might be of value, despite my personal bias, that immune stimulation in the absence of antiviral therapy will probably not work.

I am eager to receive any more information you have.

Sincerely,

SAN FRANCISCO GENERAL HOSPITAL

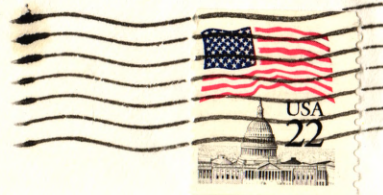

Paul Volberding, M.D.
Chief, AIDS Activities Divisions

Blaine-
Thought you'd be
interested in having
a copy of this -
David

Dr David R Kessler
3005 California Street
San Francisco CA 94115



MADD



Mr. Blaine Elwood
633 Post St. #644
SF CA 94109

March 3, 1986

Jim Henry
[REDACTED]

Dear Jim:

Christopher has demanded that I write to you and strongly insist that you strictly follow Dr. L. Bruce Mills' protocol so as not to cause a T-cell lymphoma in any patients and a resultant backlash against the DNCB treatment. Which protocol Christopher is referring to (the 2%-1% of the JAAD submission or the 2%-1%-0.1%--and even, 0.05%, that Mills actually uses in his office) I really don't know. At any rate, unless and until (as Christopher warns me) you promise only to follow one of the two "mysterious" protocols, he will not provide any more DNCB. That is his ultimatum, and I suppose it also applies to Randy, your counterpart here in San Francisco.

I suppose Christopher's concern is basically valid, and I'm forwarding it on to you as was promised it would be by Paul (who said it was a "fait accompli").

There is a real concern that certain people may prove so overly reactive to DNCB that no amount of solution (however diluted) may be viable as a treatment. In these (presumably rare) cases other contact sensitizers must be found.

A very sad case in point is Don Mills (no relation to the doctor). Don had KS and was the first patient to try the DNCB along with me in December, 1984. Michael Helquist in his first article about DNCB in October, 1985, COMING UP! mentions a patient that proved so reactive that he went off the DNCB after a month (during which his clinical health improved and lesions disappeared) and onto a protocol of Interleuken at SAN FRANCISCO GENERAL. The Interleuken (as Michael reported) seemed to immediately worsen his condition and the lesions quickly reappeared. Going back on DNCB, Don soon recovered the clinical ground he had lost, was feeling better again and returned to work. But by late summer of 1985 he began having such bad reactions to the DNCB (over-reactivity) that he stopped treatment altogether.

I wrote to Dr. Volberding in late October, 1985, and Don Mills was the patient I was referring to in that widely distributed autoimmune letter signed "Deep Throat". (You should have a copy of it in your files.) It's a wonder Don didn't die then. But he's evidently been holding on for a breakthrough. Well, Dr. Mills told me in September that he was "looking around for a different chemical" to use on Don. Knowing the way Dr. Mills operates (how slow he is to do anything!) it came as no surprise to learn this past weekend that Don had died. Just a week or two ago, Dr. Mills was still monkeying around with DDTC, painting it on his own arm, etc., to see if he could use it on a patient "who couldn't tolerate" the DNCB. It is obvious to me this patient was Don Mills. His is the first death that I know of in the family of Mills' DNCB treating patients!

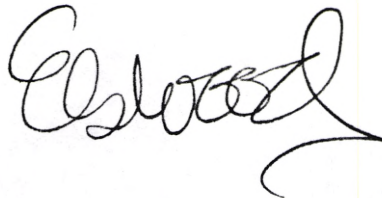
What is sadly ironical about this matter is that Don died on February 22, the exact same day our reprobate doctor left on his undeserved two-week Florida vacation. ("Reprobate": because he left with no other doctor on call to fill-in for him in case of patient emergencies, and because he left many of his

regularly treating DNCB patients in the lurch without any solution to treat themselves with in his absence; "Undeserved": because just two days before he left he betrayed his supporters and professional allies--as well as the prospects of early clinical trials of DNCB--by a virtual no-show at the U.C. KS Study Forum!)

Naturally, I couldn't write a KAMIKAZE NEWS without mentioning the above developments. There is no way for me to be kind in print to Dr. Mills any longer, given the horrendous effects of his behavior on all of us and the cause of AIDS research. Christopher, in his angry phone calls to me, evidently still supports Mills (almost like a hero worship) in all his dealings--though he has never met the man. Further, Christopher ordered me to "cool it" as my name "is mud" amongst local researchers, and I can only do the cause of DNCB treatments "more harm than good" at this point. (Who can do it more harm than what Mills has already done? I would ask if I felt up to asking. What good he HAS DONE (the JAAD submission, etc.) has only been forced upon him by threats & pressure! --Someone should have pressured him a little more to move faster in six months on behalf of Don Mills!!!)

But in another sense, I think Christopher is perfectly right. I'm finished. I'm worn out by dealing and fighting with the man for over a year now. I listened to him sympathetically enough when he told me LAST SEPTEMBER that he was going to find some other chemical to use on Don. I listened to him with excitement when he told me two months ago there was a chemical panel of over thirty different contact sensitizers, any one of which he could use in place of DNCB. Don's death amid Mills' general procrastination and Florida vacation is the very last straw...I resign! (Once again & not subject to any more "drafting" by you guys!)

Michael Helquist (in the attached page from the latest COMING UP!) sums up the events of February 20th with amazing fairness and control, given the provocation. He, in essence, is a far better, objective reporter of DNCB events than I could ever be (or want to be: I'm actually fed up with speaking & hearing about it). If you keep him informed of your progress in San Diego, I am sure he will write about what he considers the important developments there...and if you need a more personal kind of newsletter, draft Bruce Loxley! He used to teach English, and can collate information with much more enthusiasm than I feel. Again, it may very well be the patients and doctors in San Diego that save the day in this situation.



Enclosure

cc: Christopher
Paul
Bruce
Randy
Michael

THE STATE OF THE SCIENCE

By MICHAEL HELQUIST

A Mixed Bag: Politics and Concern

On February 20, Marcus Conant, MD, dermatologist at UC San Francisco, hosted his regular KS Study Group meeting to look at another facet of AIDS research. What resulted was a revealing view of the conflicts, concern and professed cooperation of AIDS researchers and physicians who sometimes appear to be united only in their desire to see an end to the epidemic.

Conant had invited speakers to discuss the goals of Project Inform, a volunteer group researching the combined use of Isoprinosine and Ribavirin. The other presenter was to be Bruce Mills, MD, the local dermatologist who has been looking at the effects of the drug compound DNCB on what he considers the autoimmune factor in AIDS.

Mills, scheduled to be the first speaker, appeared 45 minutes late and thus forfeited his opportunity to finally provide data to his colleagues about the use of DNCB. Conant offered to reschedule Mills for an April appearance. The *Journal of the American Academy of Dermatology* has accepted Mills' revised report including his data about DNCB for publication in an upcoming issue. In addition, Mills gave a copy of his journal submission to this reporter (see following article). Paul Volberding, MD, AIDS researcher at San Francisco General Hospital (SFGH), has also been sent a copy of Mills' report.

Before introducing the Project Inform speakers, Conant discounted the data previously reported by this writer about use of the drug Isoprinosine. That data suggested that the drug had beneficial effects for AIDS and ARC patients. The study results were published in the official proceedings from the African AIDS conference held in Brussels, Belgium, last November. Conant and Don Abrams, MD, AIDS researcher at SFGH, said they were investigators for this Isoprinosine study; yet they refuted the Brussels report presented by the drug manufacturer. Abrams said he had been

told not to talk about the study; but for the record, he added, "There was no improvement at all in my patients who used Isoprinosine."

The strong disagreements about Isoprinosine share some similarities with the varied responses to the drug cyclosporine. When local researchers strongly criticized the use of cyclosporine and the premature reports of its use by French researchers, they countered that suramin offered much more hope to Americans. Suramin has now been discounted at many research centers, including SFGH, as an effective treatment. Ironically, SFGH researchers are now developing protocols for a study of cyclosporine. Preliminary studies with both DNCB and cyclosporine suggest that autoimmunity plays an important role in AIDS. That notion had also been dismissed by many AIDS researchers who are now reconsidering the autoimmune theory.

Late last month the federal Food and Drug Administration joined the Isoprinosine debate and charged that Newport Pharmaceuticals, manufacturer of the drug, had made misleading claims about its effectiveness against the AIDS-Related Complex. The government ordered the company to halt the misleading claims; the federal agency also withdrew approval of the clinical trials of the drug.

The disputed benefits of Isoprinosine thus set the stage for the study being conducted by Martin Delaney and Joseph Brewer of Project Inform. Delaney emphasized several times to the audience at Conant's study group that Project Inform does not encourage anyone to start taking the two drugs. Instead he stated that the project was simply trying to determine whether the drugs produced dangerous side effects and whether any clinical benefit resulted. Delaney asserted that thousands of individuals are already using the two drugs, mostly procured from Mexican sources since the drugs are not approved for use in this country.

"Attempts by others to discourage use of the drugs have not worked, and to ignore the many who are taking them is not practical,"

Delaney said. "We're taking a pragmatic approach by recognizing what is happening anyway and by studying its effects."

Delaney suggested that the many anecdotal reports about people with ARC and AIDS improving after using the combined drugs "may be a mirage."

"But we don't know that yet," he said, "and neither does anyone else."

Joseph Brewer acknowledged the several "inherent weaknesses" in their study, primarily a dependence on participants' own recall of their adherence to the drug protocols, the self-selection of the study participants, and the likelihood of other simultaneous treatments, like use of megadoses of Vitamin C, that may distort the study results. Some of these factors, such as use of other treatments, may also exist in the controlled, officially sanctioned studies.

Brewer also emphasized that Project Inform hopes to study and present a clinical model for

"Because Project Inform operates outside the realm of official research protocol, it inherently challenges the scientific establishment."

clinicians rather than a research model for researchers.

Conant challenged the Project Inform speakers by asserting that there were so many variables in their study that it may be difficult to interpret the results.

"Can you come up with an answer that has any meaning?" he questioned.

Brewer responded that he was not inclined to defend the weaknesses of the study but offered that even if they determined that the drugs were harmful, the information would be valuable to the many individuals on the treatment plan.

Other physicians in the audience suggested that the mere existence of Project Inform "raised false hopes" for many people desperate for an effective treatment. To this observer it seems that testing any drug as a possible AIDS treatment raises hopes. AIDS researchers have been asserting for more than a year that ultimately the effective treatment for AIDS will probably be an antiviral combined with an immune stimulator. People have certainly placed their hopes on this potential treatment, and yet no officially sanctioned combined treatment has been developed or tested.

Abrams announced that he "doesn't see real evidence that a combination will work." He suggested that with currently available drugs, "It's like adding 0 plus 0 to look at the combined use of any of these drugs." On the other hand, while the antiviral drugs may not rid the body of the virus, a few agents appear at least to halt the replication of the AIDS virus.

On the issue of false hope, Brewer asserted, "I am more concerned with false doomsaying than I am with false hope."

Chuck Frutchet, hotline coordinator for the San Francisco AIDS Foundation, suggested that Project Inform issue a statement advising healthy persons, who may be seropositive on the AIDS antibody test, that there is no reason to take these drugs.

Speaker Delaney reiterated that one to three thousand people were already taking the drugs and that the project did not encourage anyone to use them.

Project Inform, continuing its operation amidst the controversy, is an effort based on genuine concern for obtaining treatment information, with no apparent desire for career advancement on the part of the project administrators. They share these traits with a great many local physicians and researchers. Nevertheless, because the project operates outside the realm of official research protocol, it inherently challenges the scientific establishment. In this context, it is surprising that there has been so much cooperation, often quiet and anonymous, between local researchers and physicians, and Project Inform.

Delaney and Brewer hope to have prelimi-

nary results from their study within the next few months. They both assert that once the data is analyzed they are "prepared to go either way": warning of toxic side effects, if any, and confirming clinical benefits, if justified.

In the meantime, the search for an effective AIDS treatment goes on, benefited by much genuine concern of researchers and hampered at times by competition and a lack of medical foresight.

DNCB Data

Dr. Bruce Mills has been looking at the effects of skin applications of DNCB as an AIDS treatment for at least a year. He has now accumulated enough research and clinical information to justify further studies by researchers into the possible role of DNCB as a therapeutic treatment for AIDS. Mills has submitted his report plus corresponding data to the *Journal of the American Academy of Dermatology*, a respected publication that employs a peer review process to screen all submissions. The *Journal* has agreed to publish Mills' report in an upcoming issue.

Mills collected data from 26 individuals of varying immunological status who received initial applications of 2% DNCB in acetone until they developed a skin reaction to the drug compound. Afterwards, the patients received a 1% solution.

Mills found that the applications induced changes in the number of circulating T-cells and B-cells, as well as improved immune T-cell responses tested under laboratory conditions. Mills also noted during laboratory analysis a "normalization" of other AIDS-associated abnormalities such as anemia, thrombocytopenia (an abnormal decrease in the number of blood platelets) and hypergammaglobulinemia (a higher than normal level of antibodies in circulation). Mills notes in his report that these results "suggest that topically administered DNCB also promotes reconstitution of T-cell immunoregulatory functions in immune suppressed patients."

As noted in this column several months ago, patients with Kaposi's sarcoma underwent changes in their skin and mucus membrane lesions after applications of DNCB. There was a reduction in lesion size and thickness, number of lesions, and decreased discoloration of the lesions. These changes included DNCB-treated lesions as well as untreated lesions.

There are currently several dozen individuals being treated with DNCB in San Francisco, San Diego, Santa Monica, Houston and New York. In addition, the American Foundation for AIDS Research has expressed an interest in the DNCB studies and has requested a copy of Mills' data. Since DNCB is an inexpensive, easily obtained chemical compound, there is little commercial incentive for a drug company to provide funding for more advanced studies. The next stage of research will likely require that AIDS researchers seriously consider the DNCB data and find ways to include it within their AIDS research programs.

Mothers United for Support

Stories of gay men sick with AIDS being abandoned by their parents are frequent enough, but probably more common are the number of times that mothers and fathers choose to stand by their sons. Often the needs of parents are overlooked, yet the emotional and physical demands upon them can be considerable. Therapists have encouraged the development of "respite shelters," safe places for relatives and loved ones, caregivers to people with AIDS, to rest and regain their strength for a few days. The most basic need for parents is support, and a new group in San Diego offers just that.

Mothers of AIDS Patients, an organization formed last summer by three mothers who each lost a child to AIDS, reaches out to others facing the same tragedy.

"By uniting, we can help each other bear our losses, and, out of understanding, help other patients and their families," wrote the three founders of the organization in a recent newsletter. But the mothers have made it clear that after support should come action. They intend to apply political pressure for increased funding for research, patient treatment, and in-home service programs. They hope to take their message nationwide.

For more information about the group, write to Mothers of AIDS Patients, c/o San Diego AIDS Project, P.O. Box 81082, San Diego, CA 92138.

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GGBA
BAPHR

THE UNCERTAINTY OF TESTING POSITIVE

Gay men who have tested positive for the HTLV-III/LAV antibody are faced with unique challenges.

Ongoing therapy groups are now forming to offer these individuals the opportunity for developing effective means of coping with uncertainty and achieving desired life changes.

FACILITATORS

Neil Seymour, MA, MFCC
CA license #MX20359

Hal Freeman, MA, MFCC
CA license #MS20041

For information, call 864-4338 or 626-9297.

March 20, 1986

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

Dear John,

My phone calls and contacts with CNN this week reveal that you are probably on vacation. Well, you no doubt deserve it! But I want to let you in on a major scoop (along with Pete Aleshire of THE TRIBUNE & Michael Helquist, the only other "autoimmune" media personae I have told so far).

On St Patrick's Day, March 17th, at a meeting at UCSF entitled "Laboratory Developments in AIDS Research" a team of UC scientists headed by Immunology Chief, Daniel Stike, told a select group of meeting attendees that they have "isolated" and "identified" antibodies to T-cells in AIDS and ARC patients!!!!!! They have not "written-up" this finding, nor as yet named these antibodies, but report that they started "looking for them" six months ago—or along about the time of the cyclosporine reports from Paris and my "Deep Throat" letter to Volberding (read it again!) Dr. Stike speculated that, to conquer AIDS, a monoclonal antibody to attack and destroy these antibodies to T-cells would have to be developed. (They have been at work for over a year on a "silver bullet" vaccine which would knock out the virus in all carriers as well as protect as yet uninfected parties.)

I probably don't have to even tell you this, but the finding fits nit-and-tuck with Mills' theory as to how DNCB is helpful—it overrides the antibody response to the T-cells and redirects the major autoimmune focus against the DNCB painted cells, allowing new T-4s to be induced and not inactivated.

Dr. Bob Gallo and his Infectious Disease Model is being swamped by the overwhelming uprising of autoimmune evidence. (The Antibody to T-cells would be the mysterious and long-sought "co-factor" for AIDS development that Levy, for instance, has been seeking.) Gallo must be soon feeling like Marcos in his last days at the Palace!

Not to be obnoxious (ha! ha!) but I told you so--and told Volberding, Abrams, Levy, Epstein, etc., so last October!!!

OXOXOXOXO,
"Deep Throat" Eswood

P.S. Now, will they give DNCB a clinical try (while they're developing their monoclonal antibodies to antibodies?)

03/27/86

David--

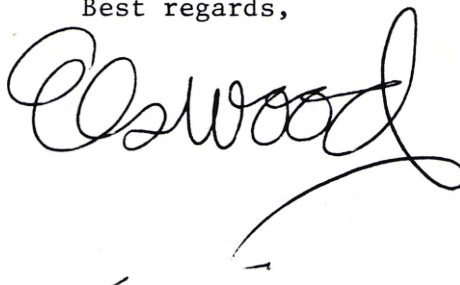
Per our phone conversation wherein you informed me the French are expressing concern that DNCB may stimulate the putative virus:

I don't buy it for the following reasons:

- 1) The fear that any kind of stimulation of the immune system will set off the virus is based on the results of Interleuken and Interferon. That DNCB doesn't stimulate the "virus" is evident by use since 12/84. Also the French themselves (but not the Pasteur doctors) have proved with treatments with DDTC that there are a class of stimulant chemicals that do not set off wild virus replications. (DNCB is a class of the same kind of contact stimulators as DDTC. SEE THE COPY OF THE REPORT FROM LANCET IN YOUR FILES.)
- 2) I don't see why DNCB should be feared if it does stimulate the virus but the patients show consistent signs of clinical improvement anyway. Recent developments may show it is circulating antibodies that cause AIDS conditions, not virus replication per se, else why do all patients still show clinical signs of AIDS no matter that the virus can no longer be cultured out of their serum because of antivirals, etc. or that so many people infected with the virus do not come down with clinical AIDS? Obviously, there is some OTHER FACTOR BESIDES THE VIRUS attacking T-cells. (And we now KNOW it's antibodies.)
- 3) That the French can be voicing these concerns really irks me because it is the type of concerns voiced OVER A YEAR AGO against any experimentation with DNCB! Why the hell don't they try it to SEE if it stimulates the virus AND IF this really means anything, per clinical AIDS symptoms? --After all this while these speculative objections makes me want to tear out my hair (what's left of it)! WHY DON'T THEY READ THEIR OWN COUNTRYMEN'S FINDINGS PER DDTC??? There is probably more than just a tad of jealousy loose at the Pasteur these days!!!

I'll have [REDACTED] and his friends' crystals and solutions ready by tonight for pick-up anytime. (They can flush it down the toilets if they wish, only I want them to have the opportunity to choose what they do without reference to any "lack of supplies.")

Best regards,

A handwritten signature in cursive script, appearing to read "C. Wood". The signature is written in dark ink and is positioned below the "Best regards," text. It features a large, looping initial "C" and a long, sweeping underline that extends to the right.

THE HELQUIST REPORT

Life-Sustaining Care

A large percentage of gay men with AIDS said they wanted to discuss life-sustaining hospital treatments with their physicians, but few of the patients had done so, according to a study published in the *New England Journal of Medicine* (Feb. 13, 1986). Perhaps as a result of this lack of discussion, many of the 118 San Francisco men with AIDS in the study believed life-sustaining treatments might be more effective than they really are.

Bernard Lo MD and his colleagues at the University of California at San Francisco (UCSF), who conducted the study, concluded that physicians should repeatedly discuss life-sustaining care decisions with their patients, starting right from the beginning of the patient/doctor relationship.

AIDS specialists at San Francisco General Hospital and at Houston's M.D. Anderson Hospital recently noted, at an AIDS forum in New York, that they frequently advised critically ill AIDS patients of the odds against long-term survival—after patients had experienced a stay in an intensive care unit.

Other findings from the study revealed that most of the patients had already thought about life-sustaining treatments; that more than half wanted intensive care and a mechanical respirator if they could no longer breathe on their own; and that nearly half wanted to be resuscitated if their hearts stopped. Although half of the patients wanted their partners or friends to be substitute decision-makers if they became incompetent, only 42% of these men had completed "durable powers of attorney" for health care. (This legal option allows the patient to designate a proxy to make decisions about medical care if the patient should become incompetent.)

The UCSF researchers noted, "Without it [a durable power of attorney], partners and friends have no legal standing to share decisions with physicians."

Lo suggested that these legal and treatment decisions should be made by patients, and that physicians should raise these issues with patients before they become too sick or mentally incompetent. Patient advocates, whether lovers or friends, should also encourage these discussions.

Another Saliva Story

No sooner had one research study asserted the lack of the AIDS virus in saliva taken from people with AIDS than another report suggested just the opposite. Researchers recently announced that they could find the virus in the saliva of only one in 71 infected individuals. However, in the March issue of the journal *Blood*, Harvard researchers reported finding antibodies to the AIDS virus in the saliva of individuals who also have such antibodies in their blood. Dr. David W. Archibald of the Harvard School of Public Health said that the presence of antibodies in saliva means that the actual virus is probably there also. His study found antibodies to the AIDS virus in the saliva of each of 28 individuals whose blood tests had indicated viral infection, although they had not developed AIDS.

Archibald suggested that researchers often have difficulty in detecting the virus because it attaches itself to the anti-

bodies. He said this likelihood, combined with the very low levels of virus present in saliva, probably explains why saliva has not been linked with any transmission of AIDS. Epidemiological evidence continues to dismiss saliva as a means of spreading AIDS.

DNCB Data Released

For at least a year, San Francisco dermatologist Dr. Bruce Mills has been looking at the effects of skin applications of the drug compound DNCB as an AIDS treatment. He has now accumulated enough research and clinical information to justify further studies by researchers into the possible role of DNCB as a therapeutic treatment for AIDS. Although Mills recently bypassed a scheduled appearance to present his data to an AIDS study group in San Francisco, he has submitted his report, plus corresponding data, to the *Journal of the American Academy of Dermatology*, a respected publication that employs a peer review process to screen all submissions. The *Journal* has agreed to publish Mills' report in an upcoming issue.

In addition, the DNCB data has been made available to Dr. Paul Volberding, an AIDS researcher at San Francisco General Hospital, and Mills also gave this reporter a copy of the journal submission.

Mills collected data from 26 individuals of varying immunological status who received ini-

tial applications of 2% DNCB in acetone until they developed a skin reaction to the drug compound. Afterwards, the subjects received a 1% solution. The six patients diagnosed with AIDS were not receiving any other treatments, a factor that clarifies the interpretation of their responses to DNCB.

Mills found that the applications induced changes in the number of circulating T-cells and B-cells, as well as improved immune T-cell responses tested under laboratory conditions. Mills also noted, during laboratory analysis, a "normalization" of other AIDS associated abnormalities, such as anemia, thrombocytopenia (an abnormal decrease in the number of blood platelets) and hypergammaglobulinemia (higher than normal levels of antibodies in circulation). Mills observes in his report that these results "suggest that topically administered DNCB also promotes reconstitution of T-cell immunoregulatory functions in immune suppressed patients."

As mentioned in an earlier column, patients with Kaposi's sarcoma underwent changes in their skin and mucous membrane lesions after applications of DNCB. There was a reduction in lesion size and thickness, number of lesions, and decreased discoloration of the lesions. These changes included DNCB-treated lesions as well as untreated lesions.

There are currently scores of individuals being treated with DNCB in San Francisco, San Diego, Santa Monica, Houston and New York. In addition, the American Foundation for AIDS Research has expressed an interest in the DNCB studies and has requested a copy of Mills' data. Since DNCB is an inexpensive, easily obtained chemical compound, there is little commercial incentive for a drug company to provide funding for more advanced studies. The next stage of study will likely require independent research by scientists in well-established AIDS research centers.

—Michael Helquist



San Francisco State University

1600 HOLLOWAY AVENUE • SAN FRANCISCO, CALIFORNIA 94132

SCHOOL OF HUMANITIES

4/8

Elswood --

Thanks for sending me your rejection slip.
I'll file it along with my own!

Seriously, Mark Coovellis is pointing you
in the proper direction for your innovative
stuff. I like his distinction between plotted
stories and stories carried by voice. I must
remember that one for class.

I'm more thrilled by your reaction to Mills'
presentation. I pray that much comes of it
now. Keep me posted please.

My best,

A handwritten signature in blue ink that reads "Michael". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

P.S. I've been occasionally pleading with
Brian Jones of B.A.R. to do more with the
Mills material which he knows about, of course.
He claims that your approach (bludgeoning?)
keeps him at bay. I said, "get past it, girl,"
but I doubt if that helps any either.

M Rubin
SCHOOL OF HUMANITIES

San Francisco State University

1600 HOLLOWAY AVENUE

SAN FRANCISCO, CALIFORNIA 94132



Blaine Elswood
142 Beulah Street
S.F. CA 94117



April 8, 1986

Dear Michael,

Thanks for the note back. Attached you'll find a little memo to myself with a copy of a thank you "to the kamikazes" from Dr. Mills. (I suppose his attempt at humor!) Well...that's all self-explanatory.

What I wanted to tell you was that I've never bludgeoned Brian Jones, never in fact, talked to him, nor written him so much as a sentence! So wherefore is he bludgeoned? I suppose that's a smoke screen for what you once called "conceit" and "vested interests", his being a close friendship with Randy Shilts & a series of articles in the B.A.R. about Ribo and Iso from Mexico. (Which is all well and good!--I guess!) The last time I remember really bludgeoning Randy Shilts was last September when I wrote him a letter about Dr. Epstein's work with poison oak & its very close affiliation with DNCB. Randy seemed to get konked on the head and see only stars (*****!!!) after that—even though he had already interviewed our eccentric Dr. Mills in depth!

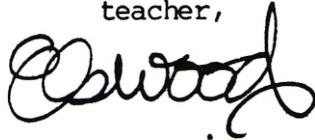
Well, last Thursday at Mills' U.C. presentation, sitting on the front row, was this same Dr. William L. Epstein, Chairman of the Department of Dermatology, University of California at San Francisco, and the World's leading expert (at least until Mills started his impetuous experiments and treatment uprising!) on "delayed contact sensitization" or DNCB/Rhus (poison oak) dermatitis. Dr. Marcus Conant deferred constantly to Dr. Epstein & Epstein listened intently, asking about the only question at the end of the riveting presentation that anyone could think of. (There appeared to be a stunned silence.) That question was: "Why aren't you trying Rhus (poison oak)?" Mills answered that he thought Rhus would work the same way, but that he didn't have the clinical experience with it that he had at Stanford with DNCB. Epstein said later to another reporter (not Shilts or Jones! Where WERE they?) that he thought Mills had discovered something of tremendous import, "and not just for AIDS, but for other diseases as well." He expressed surprise that Mills didn't emphasize this achievement and talk it up more in his humble (yet thoroughly informed) presentation of his clinical and statistical data. He asked why Mills would seem scared of taking credit for such an important discovery. (Ah!....the mystery I've been bludgeoning about for the past twelve months!)

Leaving UC with a friend right after it was over (and you will appreciate this, as only someone familiar with Jung could!) we both decided to get a very late lunch/dinner at the Hunan on Haight. There was only one other couple sitting at a table when we entered. Immediately, from photographs in the newspapers (I had never physically met him before) I recognised—as if he were the only possible person WHO COULD BE THERE—Randy Shilts, and without a falter I walked over to introduce myself. He stood up and I told him my name. He reacted somewhat startled and said he "had heard" about "my Dr. Mills" not showing up last month. "He showed up today," I said. "He did? You were there?" asked Randy. "Yes, I was there standing guard to make sure he was there," I replied, "and you know something?" "What?" "Dr. Mills put on such a good presentation that the wolves had virtually nothing to say and the honest doctors want to research it further." I thereby quietly added, "excuse me", and followed my friend to a table and sat down with my back to Randy, who called out after me: "Well, keep

those cards & letters coming!" "Not so," I said, turning my head back in his direction, "those 'cards and letters' are over--now that it is in the hands of the medical establishment." Perfectly nonplused, I turned back to the menu and ordered garlic chicken....

I suppose there's the difference between just a good writer AND a good reporter. Like a Serpent, this very significant AIDS story (perhaps one of the MOST SIGNIFICANT of his career) has been twisting before Randy's eyes since at least last September, but he has only been blinded by the glare from its scales. (Same goes with B. Jones!) Fortunately, Michael Helquist is both a good writer AND a good reporter. It is unfortunate, though, that Shilts and Jones have the Medium while most of our Brothers continue to die. (What's that snake on the stick in the Hippocratic logo? Do you think they've ever noticed it, really NOTICED? I think not! They seem hypnotized by something else entirely even as it descends--in a Jungian sense--to loop and coil about their feet!)

My love to you, friend &
teacher,

A handwritten signature in cursive script, appearing to read "Michael Helquist".

Attachments

NOTATION TO MYSELF:

Dr. Mills & Steve met Stef & I at 9:30 AM on Thursday, April 3, 1986, the day of his rescheduled presentation to Marcus Conant's KS Study Meeting at UCSF. (I've refused to contact Mills since his virtual "no show" on February 20, 1986. Mills, himself, finally phoned me two weeks ago at work and asked for an "escort" to make sure he "makes it" on new date. I put Stefanie in charge of arranging details, and she decided through Steve for 9:30am--the meeting time being 11:00am. I am reminded of one of those serial killers who phones the papers and says: "help me stop, keep me from killing again!" Well, Mills certainly called asking assistance, fully realizing, I guess, that without it there would be another "no show".)

Going for a bite to eat, all four of us uneasily made our way to the meeting at 10:00. Thereupon began the wait. Everytime Mills went to the restroom, I followed and stood guard outside the door to prevent him from fleeing. (What was especially interesting was that he seemed to actually appreciate this guarding!) Finally, just before the meeting time, as people started to arrive, I got stuck in a conversation with Dr. Kessler and Mills fled through the back door and a private hallway through examination rooms--all unseen by me, but observed by Stefanie who followed him and brought him back. (She said to me: "You're not doing your job!" as I, surprised, watched Mills arrive back through the front door followed by Stef.)

At 11:00am sharp Conat turned the meeting over to Mills and Mills did an absolutely superior job, his voice not cracking, sounding like a gentle father talking to two obedient students: Conant and Epstein were nodding their heads and taking copious notes! When Mills finished there was hardly a question, and Conant dismissed the meeting early--the first time, according to one doctor present. Epstein and Conant scurried away together and could not be found. People gathered around Mills to congratulate him. Later, so impressed by his professional, even professorial, demeanor (Dr. Kessler said Mills should be presenting in Paris this summer, it was so important and well done!) I decided to send flowers in the name of the kamikazes. The card read: Congratulations! It's About Time!--the Kamikazes".

Today at my box I found this "thank-you" note (attached). If anything shows Mills' absolute blindspot to the numbers of, or even acknowledgement of, the lives at stake, it shows here!!! What an obscene, sad, inability to even consider the thousands (perhaps hundreds of thousands) lives at stake in the "game" Mills has been playing, with us as pawns, or rather prods, to keep, to help him help others despite himself. The only thing that quenches my fury is comparison with Don Abrams, etc. Where are they in this dreadful medical game where real human personal lives are the pieces taken...but perhaps I'm just being melodramatic (for an entire year, this month?)

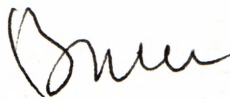
L. BRUCE MILLS, M. D.
450 SUTTER STREET
SUITE 2304
SAN FRANCISCO, CALIFORNIA 94108
—
(415) 362-8915

April 4, 1986

Dear Kamikazes,

Thank you for the flowers. It's certainly one of the loveliest arrangements I've ever seen. If I had known that this was the outcome of giving a talk at UCSF, every effort would have been made to speak there as often as possible. If I should ever speak for an entire hour, would I receive an arrangement twice the size of this one?

Thank you,

A handwritten signature in dark ink, appearing to read 'Bruce', with a stylized, cursive script.

L. Bruce Mills, M.D.

L. BRUCE MILLS, M. D.

450 SUTTER STREET

SUITE 2304

SAN FRANCISCO, CALIFORNIA 94108



The Kamikazes
c/o Mr. Blaine Elswood
633 Post Street #644
San Francisco, CA

94109

Ring happy bells
across the snow.

The year is going -
Let it go!

Ring out the false,
Ring in the True. "

Ring out the Old,
Ring in the New. ^{etc}
(Tennyson)

Vote for Human survival!

Elwood -
Your last packet
had me in stitches -
and had me in tears -
Let's pray that all your
frustration and valor at last
begins to pay off with medical
principles instead of personalities.
Love,
Michael

Affirm Life!

**Keep peace-pipe going round,
to avoid bloodshed.**

**Nuclear freeze is needed now,
with surveillance by U.S. and
USSR satelkites.**

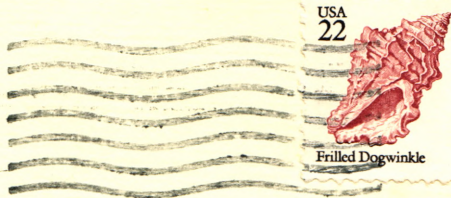
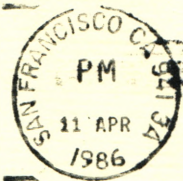
**Then all n~~g~~ations can start
nuclear disarmament, with U.N.
surveillance.**

Vote for Human survival!

Elwood -
Your last packet
had me in stitches -
and had me in tears -
let's pray that all your
frustration and valor at last
begins to pay off with medical
principles instead of personalities.
Love,
Michael



Bkey
San Francisco



Blaine Elswood
% 633 Post # 644
San Francisco,
CA 94109

Rubin

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

11

May 7, 1986

William L. Epstein, M.D.
Professor of Dermatology
Dermatology Research
University of California San Francisco
501 Parnassus Avenue
San Francisco, CA 94117

Dear Professor Epstein:

I am busy contacting various people and forming an "ad hoc" network to recruit subjects for your proposed AIDS DNCB/Rhus Research Project/Study. Please contact me when you and your lead doctors develop a complete profile of the type of study subjects you will need. Dr. Volberding and San Francisco General Hospital will also have an accessible pool of patients to meet any of your requirements--these will all be AIDS/ARC patients; we can supply some people antibody-positive or negative without the most serious AIDS developments from out of the Gay Communities of San Francisco, Los Angeles, and especially, San Diego. (You probably should consult with Volberding about his resources.)

I have communicated directly with Dr. Mills and he is willing to give all assistance appropriate to your project. (He is very happy to hear that you will be tackling it yourself!) Mills asks that you (or your assistants) phone him or request in writing whatever assistance/consultation you need. He also advised me that his submission to the JOURNAL OF THE AMERICAN ACADEMY OF DERMATOLOGY will be printed in the June, 1986 issue, per their editorial offices at the University of Georgia.

We are all really excited about the prospects of your study and the further amplification it will provide on your life-long research: delayed hypersensitivity and contact sensitization (DNCB/Rhus). As we discussed in our telephone conversation of April 28, 1986, the implications of Mills' preliminary findings--if confirmed in a larger and more controlled research study--will have tremendous import, even outside of the context of AIDS.

Very respectfully yours,



(Mr.) B. Elswood
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cc: Paul Volberding, M.D.
Marcus Conant, M.D.
L. Bruce Mills, M.D.
Michael Helquist, journalist
Randy Boyle, ad hoc "recruiter" San Francisco
Paul Herbert, ad hoc "recruiter" San Francisco
Jim Henry, ad hoc "recruiter" San Diego & Los Angeles
Bobby Werdann, ad hoc "recruiter" East Bay

5/23/86

Test-tube experiment impedes AIDS virus

EXAMINER NEWS SERVICES

WASHINGTON — Researchers have taken a new direction in the search for an AIDS vaccine, developing a substance that may prevent the disease in people infected with AIDS virus.

Researchers say they found a remarkable chemical similarity between a part of an immune system hormone and a segment of the core of the virus which causes acquired immune deficiency syndrome.

Using antibodies developed against the normal hormone, scientists from George Washington University Medical Center and the National Cancer Institute stopped the AIDS virus from invading immune system cells it normally infects, according to a report published today in the journal Science.

"If we do successfully develop the vaccine, which we think we have a way to do, the patient population you would consider first would be the high-risk population," meaning those at risk for acquired immune deficiency syndrome, said Dr. Allan Goldstein, professor and chairman of the biochemistry department at George Washington University Medical Center.

"These would be individuals who have been exposed to the virus, but who are asymptomatic. After that, you would deal with the other high-risk groups. I don't think it would be effective for people who already have AIDS.

Because the reported research

only involves laboratory cell cultures, he said, further studies are needed to see whether the results hold true for animals and humans.

Goldstein is a principle researcher in the study along with virologist Prem Sarin, deputy chief of the tumor-cell biology lab at the National Cancer Institute, and others.

The scientists found a protein inside the AIDS virus similar to protein in a hormone produced by the thymus gland, thymosin alpha 1. The thymus gland is the principle regulator of the immune system.

The thymus is destroyed in many AIDS patients, suggesting that when the body tries to attack AIDS virus, it instead attacks its own thymus tissue, Goldstein said.

The scientists injected protein from the thymosin and from the virus into rabbits and found they induced production of antibodies. They extracted the antibodies and a substance called immunoglobulin, Sarin said.

These substances prevented the AIDS virus from invading white blood cells when mixed together in a test tube. The cells, also part of the body's immune system, are among those attacked by the virus in AIDS victims.

Theoretically, a vaccine made from the substances could neutralize the virus after people become infected and thus could prevent development of symptoms of AIDS if it is given soon enough, the researchers said.

This research is a new approach,

because other teams have concentrated on ways of neutralizing the virus through its coat — which is difficult because the virus has many variations, each with a different coat. Only one point on the coat remains the same from variation to variation.

In another report in the same issue of Science, California researchers say they found a new mechanism by which the AIDS virus kills its target cells, known as helper T lymphocytes. These critical white blood cells orchestrate the body's immune system response against infection.

MICHAEL — OBVIOUSLY THE EXAMINER DIDN'T UNDERSTAND THE SIGNIFICANCE OF WHAT THEY WERE REPORTING. REMEMBER THE THYMUS AUTOPSY HEADLINE IN THE EXAMINER ON JUNE 2/3, 1983, (THE DAY MR. FELDMAN DIED)? WELL, GOLDSTEIN THOUGHT IT WAS AUTOIMMUNE THEN. NOW. ARTICLE TRANSLATION: THE AIDS VIRUS IS "A TISSUE-MIMICKING" VIRUS CAUSING THE BODY TO WAGE AN AUTOIMMUNE ATTACK ON ITS OWN THYMUS! THE PIECES ARE ALL FALLING TOGETHER AS WE THOUGHT LAST FALL. DNCR WOULD BE EFFECTIVE IN FORESTALLING OR INTERRUPTING THE THYMUS ATTACK -- BUT PROBABLY LITTLE USE IN END-STAGE AIDS (WHERE THE THYMUS HAS ALREADY BEEN DESTROYED). MEANWHILE, HOPE IS HELD OUT FOR "THERAPY" ANTIBODIES CALLED FROM RABBITS. LET'S HOPE THEY WORK -- IN THE MEANTIME LET'S PAINT DNCR! RHUS!