DEFECTIVE PRACTICES BY THE CDC

On 11 February 1993, Duesberg wrote to Dr. Harold Jaffe, then Director of the Division of HIV/AIDS at the Centers for Disease Control (CDC). In his letter to Jaffe, Duesberg documents defective practices by the CDC and poses eight specific questions. Jaffe responds a month later. Also included are some “Offhand Comments About the CDC HIV/AIDS Surveillance Report” transmitted by Lang to Dr. David Satcher in 1997, at the time when the latter became the new Director of the CDC.

DCB
To:  Dr. Harold W. Jaffe  
Director, Division of HIV/AIDS  
National Center of Infectious Diseases  
Centers for Disease Control  
Atlanta, GA 30333  
(404) 639-2000  

From: Peter Duesberg  
Re: Critique of the CDC's HIV/AIDS Surveillance Reports and requests for AIDS surveillance information  
Date: 11/Feb/93

Dear Dr. Jaffe,

The hypotheses that HIV causes AIDS, or that HIV serves as an indicator of AIDS, have failed to produce verifiable public health benefits, despite the $4 billion it costs the taxpayer annually: there is no cure, no vaccine, and AIDS continues to spread. The failure to produce benefits is one indication of a flawed hypothesis. Even the simple prediction, that AIDS will "explode" into the general population via the sexually transmitted "AIDS virus", has completely failed. The failure to make accurate predictions is the hallmark of a flawed hypothesis. In such a situation the scientific method calls for a reappraisal and for alternative hypotheses.

A. DEFECTIVE PRACTICES BY CDC

A scientific appraisal of the AIDS situation is obstructed by the following practices of CDC.

§1. Presumptuous definition of AIDS by assuming an HIV correlation. CDC's definition of AIDS involves over 25 different, previously known diseases (Institute of Medicine, 1988; Centers for Disease Control, 1992b). These include immunodeficiency diseases such as pneumonia, yeast infections, tuberculosis and toxoplasmosis, but also non-immunodeficiency diseases such as Kaposi's sarcoma, dementia and wasting. The most recent January 1, 1993 reclassification of diseases under the AIDS umbrella even includes cervical cancer (Centers for Disease Control, 1992a). CDC calls these diseases AIDS only when antibody against HIV is confirmed or presumed to be present. For instance we find in Confronting AIDS Update 1988 (Institute of Medicine, 1988):
p. 207: "The following revised case definition for surveillance of acquired immunodeficiency syndrome (AIDS) was developed by CDC in collaboration with public health and clinical specialists... The objectives of the revision are a) to track more effectively the severe disabling morbidity associated with infection with human immunodeficiency virus (HIV). . ."

p. 208: "For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below."

Thus CDC assumes that HIV is the immunodeficiency virus in its definition of AIDS. If one wishes to investigate whether and how these diseases are caused by HIV, it is prejudicial to call these diseases AIDS only when HIV is present. Statistics based on such a definition are very misleading, because the definition assumes the correlation, and the causal relation is precisely what I am questioning. Medical policy decisions based on such statistics can then be dangerously affected as a result of the improper definition.

§2. Unjustified interpretation of antiviral immunity as a predictor for viral disease. By directing the search for the cause of AIDS toward antibodies against a virus (termed a positive AIDS test if the antibody is against HIV) rather than toward the virus itself, the CDC confuses cause and effect and biases investigation in favor of the virus of its choice.

Since the discovery of vaccination 200 years ago, antibodies have been the only known protection against viral disease. By neutralizing the virus, antibodies restrict the activity and numbers of viruses to non-pathogenic i.e. non-disease causing levels. This is also true for antibodies against HIV and is the reason why even leading AIDS researchers had notorious difficulties in isolating HIV from patients dying from AIDS. Thus directing, without explicit justification, the search for the cause of AIDS toward antibodies against a virus rather than the virus itself is misleading and biasing against rational alternatives.

§3. Unscientific presumptions. To make matters worse, CDC presents us with other types of ambiguous and unscientific practices concerning those diseases and their correlation with HIV. For instance on p. 207 of Confronting AIDS-Update 1988 we find that CDC writes of the "inclusion of AIDS patients whose indicator diseases are diagnosed presumptively (Section IIB)" (Institute of Medicine, 1988). "Presumptions" of HIV-infection have no place in determining data scientifically. HIV infection or lack of infection should be verified, not presumed on the basis of the prevailing hypothesis of HIV etiology of AIDS.

§4. Arbitrary grouping of unrelated diseases called AIDS by CDC. CDC's list of diseases fails to make appropriate distinctions in several ways. The 25 or so diseases listed by CDC fall into two broad categories, which are a priori unrelated:
First Category: Diseases which result from immunodeficiency. Such diseases may be microbial or viral, such as Pneumocystis pneumonia, candidiasis, tuberculosis, herpes and hepatitis. In 1991, 62% of all American patients in the CDC’s own AIDS statistics had diseases of this category (Centers for Disease Control, 1992b).

Second Category: Diseases which do not result from immunodeficiency, and often occur in its absence. Such diseases include Kaposi’s sarcoma, lymphoma, dementia, wasting disease, and now even cervical cancer (Centers for Disease Control, 1992a). The inclusion of cervical cancer into the AIDS definition now, 10 years into an epidemic that has been 90% male in America (Centers for Disease Control, 1992b), appears an arbitrary and possibly a political rather than a scientific decision. In 1991, 38% of all American patients in the CDC’s own AIDS statistics had diseases of this category (Centers for Disease Control, 1992b).

To group such heterogeneous diseases under the same name biases investigation in favor of a common cause.

§5. Failure to report AIDS diseases specific to each risk group. In its HIV/AIDS Surveillance Reports CDC fails to report that different AIDS risk groups have risk group-specific diseases. For example, among patients who have been defined as having AIDS by CDC, Kaposi’s sarcoma is almost totally restricted to male homosexuals; tuberculosis is prevalent in intravenous drug users; microbial and fungal diseases, such as pneumonia and candidiasis, are practically the only AIDS defining diseases ever observed in recipients of transfusions; finally, until the most recent recategorization of diseases under the AIDS umbrella on January 1, 1993, bacterial infections were exclusively diagnosed in babies who were defined as having AIDS according to the CDC (Curran et al., 1984; Selik et al., 1987; Duesberg, 1992). (As of January 1993, some bacterial infections are also defined as AIDS in adults (Centers for Disease Control, 1992a).)

The failure to report different, risk group-specific diseases obscures classical evidence for different causes and biases treatment options in favor of a common therapy.

Example. The Bergalis case. There is a case made famous by the media, according to which a woman caught AIDS from her dentist. In fact, the dentist had Kaposi's sarcoma, while his client Kimberly Bergalis had a yeast infection. CDC called both these diseases by the same name AIDS. As a result, Bergalis was treated with AZT. AZT was developed 20 years ago for cancer chemotherapy. It kills human cells by terminating the synthesis of DNA, the central molecule of life. But it is now used as anti-HIV drug. In the year before her death in December 1991, Bergalis developed all symptoms of AZT toxicity, including anemia requiring blood transfusions, persistent immunodeficiency, weight loss of over 30 lbs, hair loss, and muscle atrophy to a degree that she needed a wheelchair (Duesberg, 1992).

§6. Inadequate definition of AIDS immunodeficiency. The CDC fails to provide
an adequate diagnostic distinction between a transient immunodeficiency, which precedes nearly all infectious diseases, and a seemingly irreversible immunodeficiency that is characteristic of AIDS patients unable to recover from infections. Even this immunodeficiency may be reversible if only the victims were informed about the immunotoxic effects of the recreational drugs they are taking and the AZT they are prescribed as antiviral drug.

A predictable consequence of this diagnostic uncertainty looks like this: Due to a transient immunodeficiency, an HIV antibody positive person develops an opportunistic infection that falls into the CDC's current AIDS definition. This person is then likely to be diagnosed with AIDS and to be prescribed the immunotoxic AZT "therapy", which will inevitably fulfill the AIDS diagnosis—as demonstrated by the Bergalis case.

§7. Incomplete reporting of the correlations between HIV and AIDS diseases. As a corollary of its defective definition and unscientific presumptions, CDC fails to identify in its HIV/AIDS Surveillance Reports what percentage of patients having certain diseases (immunodeficiency, some forms of cancer, etc.) are confirmed for antibodies against HIV, what percentage are "diagnosed presumptively", and what percentage are HIV-free. The failure to identify HIV-free and HIV-uncertain cases of diseases that fall into the CDC's AIDS definition further biases investigation in favor of a common cause and leads to deceptive claims about the achievements of AIDS research.

Example. Blood transfusions. It is frequently claimed that transfusion AIDS was eliminated by eliminating HIV from the nation's blood supply. Of course, screening for HIV did essentially eliminate the transmission of this virus by transfusions. But it did not affect the mortality and morbidity of recipients of transfusions. We must here distinguish between non-hemophiliacs and hemophiliacs.

(a) Non-hemophiliacs. Since all transfusion recipients, other than hemophiliacs, are already severely ill by the time they receive their transfusions, the mortality rates of HIV-positives and negatives provide the most objective statistics on the possible role of HIV as a cause of diseases. In the rare cases where such controlled studies have been done, the mortality has been the same for both groups. For instance, 95 (41%) out of 223 HIV positive and 73 (50%) out of 146 HIV negative transfusion recipients died within the first year after transfusion (Ward et al., 1989).

(b) Hemophiliacs. The mortality of American hemophiliacs has actually decreased since 75% (some 15,000) of them were infected by HIV via transfusions received over a decade ago. The median age of hemophiliacs was 11 years in 1972, but had increased to 20 years in 1982, and to over 25 years in 1986 (Duesberg, 1992). By contrast, the HIV hypothesis predicts a 50% mortality in 10 years (Institute of Medicine, 1988).

As for the incidence of immunodeficiency in hemophiliacs with and without
HIV, at least 16 controlled studies comparing these incidences have shown that immunodeficiency is independent of HIV, but depends on the lifetime dose of transfusions and factor VIII. HIV and all other blood-borne viruses and microbes are merely markers of the number of transfusions received; the more transfusions, the more likely each of these microbes, or more often antibodies against these microbes, will be present in the recipient (Duesberg, 1992). Indeed 99% of the diseases of hemophiliacs that fall into the CDC's AIDS definition, now and also before the AIDS epidemic, are opportunistic infections including >60% pneumonias. Diseases of the above defined second category, that would be expected if diseases of the first and second category had a common cause, are practically never (<1%) observed in hemophiliacs (Aronson, 1983; Evatt et al., 1984; Johnson et al., 1985; Koerper, 1989; Duesberg, 1992).

§8. Failure to conduct controlled epidemiological studies. Since Gallo et al. have advanced the hypothesis that HIV is an AIDS pathogen in 1984 (Gallo et al., 1984), the CDC has failed to report or conduct a single controlled study designed to test this hypothesis. Instead people who acquire diseases that fall into the CDC's current AIDS definition and are HIV-positive are reported as AIDS cases in CDC statistics, while those who acquire the same diseases but are HIV-negative are ignored by CDC statistics. Such reports and statistics are therefore strongly biased, making it appear that all diseases that fall in the CDC's current AIDS definition are caused by HIV to the exclusion of other hypotheses.

Examples: a) AIDS Surveillance. The CDC claims that the risk group-specific diseases of HIV positive hemophiliacs, homosexuals addicted to sexual stimulants like nitrite inhalants (poppers), intravenous drug users and their babies are caused by HIV. The occurrence of exactly the same diseases in the same risk groups in the absence of HIV is ignored by the CDC (Duesberg, 1992).

b) Anecdotal cases. In 1989 the California tax reformer, Paul Gann, was claimed by the AIDS establishment to have died from AIDS (Folkart, 1989). The 77 year old man had presumably received HIV through blood transfusions for two bypass operations performed in 1982 and 1983. He died in 1989 with pneumonia in the hospital while immobilized for a broken hip (Duesberg, 1992). However a control for the mortality of HIV-free 77 year old men with 2 bypass operations and broken hips was not reported. In 1993 the fatal pneumonia of the tennis star, Arthur Ashe, was also blamed on HIV, without taking into consideration two open heart surgeries in 1983 and treatment for at least a year with the highly immunotoxic AZT and ddC (PBS TV, "Tony Brown's Journal", Dec 1992).

§9. Illegitimate re-naming of AIDS in the absence of HIV. CDC has renamed cases of the above-mentioned diseases when they occur HIV-free, by calling them Idiopathic CD4 T-lymphocytopenia (ICL). By such renaming, CDC has obscured the possibility that irreversible immunodeficiency symptoms or diseases of the second category that fall into the CDC's AIDS definition could be caused by agents other than HIV (DeNoon, 1992).
For example in the summer of 1992 the CDC had recognized dozens of "HIV-free AIDS cases". These cases were described in *Newsweek* (Cowley, 1992), *Science* and *The New York Times*. Since the introduction of the poorly recognizable new term ICL, no more such cases have been reported by popular journals and the CDC, by its own definition of AIDS, ignores them.

**B. A NUMBER OF QUESTIONS**

In an effort to resolve the AIDS crisis, I ask you to respond to my critique of the CDC reports, and I would like specific, documented answers to the following questions:

Q1. Why does the CDC in its *HIV/AIDS Surveillance Reports* never identify the number of patients in which HIV was either presumptively diagnosed or found to be absent?

Q2. How many Americans have irreversible immunodeficiency diseases and are HIV positive?

Q3. How many Americans have irreversible immunodeficiency diseases and are HIV negative?

Q4. How many Americans are HIV positive but have no irreversible immunodeficiency diseases?

Q5. How many Americans have irreversible immunodeficiency diseases and previously subjected themselves to drugs such as cocaine, heroin, amphetamines, amyl-nitrite inhalants (poppers), or AZT?

Q6. Are there any known, documented cases of persons having irreversible immunodeficiency symptoms or a disease in the second category who have not also:

(a) subjected themselves for years to recreational drugs, including nitrite inhalants, or injected cocaine and heroin;
(b) been subjected to intravenous and other recreational drugs prior to their birth;
(c) depended for years on transfusions with factor VIII contaminated by many other immunosuppressive foreign proteins;
(d) previously developed life threatening illnesses that necessitated treatment with transfusions;
(e) been treated with the cytotoxic DNA chain terminator AZT for months or years?

(a-e) If there are such cases, how many are there (both in totality and as percentage of all Americans), and what is the documentation? Does their number exceed the normal, low incidence of these diseases in the general population?
Q7. Considering that AIDS is assumed to be a sexually transmitted disease, how many American female prostitutes have developed AIDS but have not used recreational drugs and have not been treated with AZT?

Q8. Exactly which papers are now considered proof or, if there is no proof, the best support for the HIV-AIDS hypothesis? In your own words: "...the evidence that HIV causes AIDS is epidemiological...", and thus only circumstantial (Weiss and Jaffe, 1990).

The CDC is the official U.S. government agency which has the responsibility to provide such figures, and which has the means to provide them. If the figures are not available for any given category, or all of them, I would also like to have this non-availability confirmed explicitly.

Sincerely yours,

Peter Duesberg
Professor of Molecular & Cell Biology

cc: Director of NIH, Dr. Bernadine Healy
Surgeon General, Dr. Antonia Novello
Secretary of Health & Human Services, Dr. Donna Shalala
Dr. Richard A. Ratner, Editor MSDC Physician
Council of the National Academy of Sciences

References


Prof. Peter Duesberg  
Dept. of Molecular and Cell Biology  
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229 Stanley Hall  
Berkeley, California 94720  

Dear Prof. Duesberg:

I am writing in response to your letter of February 11, 1993. Through the end of December 1992, a total of 253,448 persons with AIDS had been reported to CDC. The attached table indicates the reported results of testing for antibodies to HIV by enzyme immunoassay (EIA) and/or Western blot (WB) in these persons. The CDC estimates that approximately one million Americans are now infected with HIV, of whom approximately 900,000 have not developed one of the clinical conditions included in the 1987 AIDS case surveillance definition. Of these persons, an estimated 125,000 will be reportable under the 1993 revision of the case definition because they have CD4+ T-lymphocyte counts of less than 200 cells/ul. As part of its surveillance activities, CDC does not routinely collect behavioral or medical data on persons with AIDS beyond what is necessary to classify them into HIV transmission categories.

The major risk factors for AIDS - receptive anal intercourse in gay men, injecting drug use, transfusion therapy, and use of clotting factor concentrates - were all in existence for years to decades preceding the AIDS epidemic. Yet it was not until the early 1980's that the life-threatening diseases that we now associate with AIDS occurred as an almost simultaneous epidemic in persons with these risk factors. The increase in the rate of these diseases was remarkable. For example, we can estimate that in the 1970's no more than 100 cases of Pneumocystis carinii pneumonia (PCP) occurred each year. By 1985, annual PCP cases had risen to 7,000, and in 1990, 20,000 cases were diagnosed. As you know, the antiviral drug AZT was not licensed until 1987, yet almost 40,000 AIDS cases had been diagnosed before that year.

In my view, all available epidemiologic studies done since the identification of HIV support the conclusion that HIV is the etiologic agent of AIDS. Perhaps the most compelling early studies were those in which HIV-infected persons were identified as blood donors to persons who developed AIDS following transfusion. More recently we have the examples of health-care workers who become infected following an occupational exposure to HIV-contaminated blood, then developed immunodeficiency, followed by an AIDS-defining illness.
Although many questions regarding AIDS pathogenesis remain unanswered, I am convinced that HIV is the etiologic agent of AIDS.

Sincerely yours,

[Signature]

Harold W. Jaffe, M.D.
Acting Director, Division of HIV/AIDS
National Center for Infectious Diseases

Enclosure

AIDS CASES REPORTED THROUGH 12/31/92

<table>
<thead>
<tr>
<th>Test Results</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>EIA-positive and/or WB-positive</td>
<td>209,160</td>
</tr>
<tr>
<td>Both EIA-negative and WB-negative</td>
<td>74</td>
</tr>
<tr>
<td>Inconclusive or missing results</td>
<td>593</td>
</tr>
<tr>
<td>EIA-negative, WB not done</td>
<td>15</td>
</tr>
<tr>
<td>Total tested by either EIA or WB</td>
<td>209,842</td>
</tr>
<tr>
<td>Total not tested</td>
<td>43,606</td>
</tr>
<tr>
<td>Total cases</td>
<td>253,448</td>
</tr>
</tbody>
</table>
Math Dept Yale
10 Hillhouse Ave
New Haven CT 06520-8283
12 August 1997

Dr. David Satcher, Director
Centers for Disease Control
Atlanta Georgia 30333

Dear Dr. Satcher,

I note that you are the new Director of the CDC. For years the CDC has been putting out defective material about HIV and AIDS. As a new Director, you may not be aware of the extent to which this material is defective, but as you do become aware, you may be able to do something about it.

To continue past criticisms of CDC publications, I enclose some offhand comments concerning the December 1996 CDC HIV/AIDS Surveillance Report. I find internal and external inconsistencies, meaningless figures, and overall propaganda rather than science or medicine. Among other things, it is incumbent on the CDC either to withdraw formally its December 1992 definition which does not make immunosuppression a necessary condition to define AIDS, or to correct the false characterization of AIDS defining diseases in the December 1996 Surveillance Report, inconsistent with the December 1992 definition. (Cf. item 2 in my Offhand Comments.) In any case, this inconsistency makes subsequent so-called statistics and figures very unreliable, and even meaningless.

Sincerely yours,

Serge Lang


cc: Arthur Gottlieb, Michael Bukrinsky, Peter Duesberg, Mark Craddock, Arthur Jaffe and John Ewing (President and Executive Director of the American Mathematical Society), Richard Atkinson (UC President), Paul Licht (UC Dean of Biological Sciences), Representative Gil Gutknecht, Donna Shalala, Nicholas Wade (New York Times), David Perlman (San Francisco Chronicle), Floyd Bloom (Science), Richard Horton (The Lancet), Bob Silvers (New York Review of Books), Madeleine Jacobs and Rudy Baum (Chemical & Engineering "News"), etc.
OFFHAND COMMENTS ABOUT THE CDC
HIV/AIDS SURVEILLANCE REPORT (DECEMBER 1996)

by Serge Lang
12 August 1997

Right on the front page, the December 1996 CDC Surveillance Report has a table headed:

Adults/adolescents living with AIDS, by quarter, January 1988 through June 1996, adjusted for reporting delays, United States.

The graph shows an increase between 1988 and 1996 from 30,000 to 220,000. There is a boxed purported definition of AIDS:

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).

1. What does "related" mean? Testing HIV positive on some test or other? Caused by HIV? With the use of the word "related", we see fudging about the role of HIV, as well as another manifestation of the long standing circularity of CDC definitions.

2. The above definition, that the diseases or conditions defining AIDS "are indicative of severe immunosuppression" is inconsistent with the December 1992 definition by the CDC, which defines AIDS to be any one of 29 diseases if and only if the person is also HIV positive. Indeed, one of the defining diseases is a low T-cell count, but about 40% of the 29 diseases defining AIDS in the 1992-1993 CDC list DO NOT INVOLVE IMMUNOSUPPRESSION. For instance, Kaposi's sarcoma and cervical cancer are not "indicative of severe immunosuppression", but according to the December 1992 definition, they are among the AIDS defining diseases in the presence of HIV, INCLUDING CASES WHEN THERE IS NO IMMUNOSUPPRESSION. Therefore under the December 1992 definition immunosuppression, let alone "severe immunosuppression" is not a necessary condition for AIDS. SO THE DEFINITION BOXED ON THE FRONT PAGE OF THE DECEMBER 1996 SURVEILLANCE REPORT IS STILL A NEW DEFINITION, FURTHER CONTRIBUTING TO THE CHAOTIC MESS COMING OUT OF THE CDC.¹ The definition is also incomplete, since it does not provide a list of the diseases or conditions in "the group of diseases or conditions". Purported statistics not taking into account inconsistent and incomplete definitions are worthless and misleading.

One could of course raise more precise empirical questions, for instance how many overall cases of Kaposi's sarcoma (resp. cervical cancer) are there in the US in a given period, with the following additional condition that the person is HIV positive, resp. HIV negative, and has (resp. has not) immunosuppression. The categories used for the CDC statistics at present in connection with AIDS constitute obstructions to dealing with this more precise question. These statistics are systematically biased in favor of HIV pathogeny.

¹I remind the reader of at least 5 definitions of AIDS: (a) the pre 1987 CDC definition; (b) the 1987 CDC definition; (c) the December 1992 definition; (d) the December 1996 definition quoted above; and (e) the African Bangui definition (for which no HIV positivity is required).
3. Does "living with AIDS" mean being sick or does it mean only being HIV positive, or what? In any case, many people have a low CD4 T-cell count, are HIV positive, but in every other respect are healthy. Are these people "living with AIDS"?

4. There is also another group, a control group never mentioned as far as I can tell in the CDC publication, about HIV negative people with a low CD4-T cell count, and healthy according to every other criterion, i.e. healthy to the eye, regarded as healthy by themselves and anyone looking at them. So why is even a low CD4-T-cell count regarded as a disease if there is no visible sign of disease otherwise? In fact, if a person has a low CD4-T-cell count and tests HIV negative, is that person regarded as sick by the CDC, and is there a "Surveillance Report" on such persons? If not, then the CDC statistics are ipso facto biased in favor of the HIV pathogeny hypothesis.

5. The variation of figures, depending on the pre 1987 definition, the 1987 definition, the December 1992 definition, and the latest December 1996 definition on the front page of the Surveillance Report create such a chaos that just on this count, the whole production is questionable. I call it statistical garbage. Furthermore, the statistics are anyhow manipulated in other ways. Cf. item 9 below, for instance.

6. The figure of "581,429 persons with AIDS" reported to CDC p. 5, first paragraph, is a garbage figure. First, it is not clear what AIDS means in this figure, i.e. which definition was used. Second, the figure is cumulative, so presumably depending on different definitions over 15 years.

7. To what extent is Table 11 on p. 17 contradicting other tables, e.g. the graph on the front page?

8. Although there are occasional categories about injective drug users, there are no categories for the poppers or cocaine users. The absence of such categories biases the drug statistics in favor of the HIV pathogeny hypothesis and against the drug pathogeny hypothesis.

9. The use of "statistical methods" p. 5, column 1, line -2, in plain english means that statistics were manipulated in some undetermined way, so again, what does the figure 581,429 mean? Down to the last unit digit?

10. p. 5 second column, line -10, -8, what do the expressions "living with HIV infection or AIDS" and "living with AIDS" mean? What does "diagnosed with HIV disease" mean?

The CDC Report is written under the unstated axiom that there is such a thing as "HIV disease", whatever it means. Then officials try to fit experimental facts into this axiom, and are thereby led to what are euphemistically called "paradoxes", actually inconsistencies and contradictions.

etc. etc.

Serge Lang
Adults/adolescents living with AIDS, by quarter, January 1988 through June 1996, adjusted for reporting delays, United States

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for HIV, STD, and TB Prevention
Atlanta, Georgia 30333

obtainable from www.cdc.gov/nchstp/hiv_aids/stats/hasrlink.htm
or directly from the CDC at the above address.
Notice to readers: This issue of the *HIV/AIDS Surveillance Report* initiates the following additions/changes: (1) Table 12 (year-end edition only) now separates data on AIDS-indicator conditions into (a) those adults/adolescents reported with severe HIV-related immunosuppression as their only AIDS-indicator condition and (b) adults/adolescents reported with other AIDS-defining opportunistic illnesses. The percentages for individual AIDS-defining opportunistic illnesses are based upon the number of adults/adolescents with at least one of the illnesses, rather than upon the total number of reported adult/adolescent cases. (2) Rate calculations for (a) the U.S. Pacific Islands, (b) the Asian/Pacific Islander race/ethnicity group, and (c) the overall U.S., now include population estimates for the Marshall Islands and the Federated States of Micronesia.

The *HIV/AIDS Surveillance Report* is published semiannually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333. The year-end edition contains additional tables and graphs. All data contained in the Report are provisional.

Suggested Citation: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1996;8(no. 2):[inclusive page numbers].

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Cover: The graph illustrates a substantial increase in AIDS prevalence in the United States. As of June 1996, the estimated number of adults/adolescents living with AIDS was 223,000, representing an increase of 65 percent since January 1993. This increase reflects both a decline in AIDS deaths and a stable rate of new AIDS cases. See MMWR 1997;46:165-73. [Graph by Robert L. Frey, Jr., Ph.D.]

Single copies of the *HIV/AIDS Surveillance Report* are available free from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone 1–800–458–5231 or 1–301–217–0023. Individuals or organizations can be added to the mailing list by writing to MASO/MSB/IDS, CDC, Mailstop A-22, 1600 Clifton Rd., N.E., Atlanta, GA 30333. Internet users may view an electronic copy of the Report by visiting CDC’s home page (http://www.cdc.gov) and selecting the topic “Publications & Products.” Confidential information, referrals, and educational material on AIDS are available from the CDC National AIDS Hotline: 1–800–342–2437, 1–800–344–7432 (Spanish access), and 1–800–243–7889 (TTY, deaf access).

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Contents

Adults/adolescents living with AIDS, by quarter, 1988-1996, adjusted for reporting delays .......... Front cover

Commentary .............................................................................................................................................. 5

AIDS tables
Table 1. AIDS cases and annual rates per 100,000 population, by state ........................................... 7
Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population ......................................................... 8
Table 3. AIDS cases by age group, exposure category, and sex .......................................................... 10
Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity .................... 11
Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity ................. 12
Table 6. Pediatric AIDS cases by exposure category and race/ethnicity ........................................... 13
Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category .......... 14
Table 8. AIDS cases by age at diagnosis and exposure category ....................................................... 15
Table 9. AIDS cases by sex, age at diagnosis, and race/ethnicity ...................................................... 16
Table 10. AIDS cases and annual rates per 100,000 population, by race/ethnicity, age group, and sex 17
Table 11. AIDS cases by year of diagnosis and definition category ................................................ 17
Table 12. AIDS indicator conditions, by age group ........................................................................ 18
Table 13. AIDS cases, case-fatality rates, and deaths, by half-year and age group ......................... 19
Table 14. Deaths in persons with AIDS, by race/ethnicity, age at death, and sex ......................... 20
Table 15. Adult/adolescent AIDS cases among Hispanics, by exposure category and place of birth 21
Table 16. Health care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation ......................................................... 21
Table 17. Adult/adolescent AIDS cases by single and multiple exposure categories ...................... 22

AIDS figures
Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population .................................... 23
Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population ............................. 23
Figure 3. Male adult/adolescent AIDS cases .................................................................................. 24
Figure 4. Female adult/adolescent AIDS cases ............................................................................. 24
Figure 5. Pediatric AIDS cases ........................................................................................................ 25
Figure 6. AIDS cases by quarter-year of report and age group ....................................................... 25
Figure 7. Investigations of adult/adolescent AIDS cases ever classified as risk not reported or identified ......................................................................................... 26

Estimated AIDS-opportunistic illness tables
Table 18. Estimated AIDS-opportunistic illness incidence, by region of residence and year of diagnosis ......................................................................................... 27
Table 19. Estimated AIDS-opportunistic illness incidence, by race/ethnicity and year of diagnosis 27
Table 20. Estimated AIDS-opportunistic illness incidence, by age group, sex, exposure category, and year of diagnosis ........................................................................ 28

HIV infection tables
Table 21. HIV infection cases, by state ............................................................................................... 29
Table 22. Male adult/adolescent HIV infection cases, by exposure category and race/ethnicity .... 30
Table 23. Female adult/adolescent HIV infection cases, by exposure category and race/ethnicity ..... 31
Table 24. Pediatric HIV infection cases, by exposure category and race/ethnicity ............................ 32
Table 25. HIV infection cases in adolescents and adults under age 25, by sex and exposure category 33
Table 26. HIV infection cases, by sex, age at diagnosis, and race/ethnicity ...................................... 34
Table 27. Persons living with HIV infection and with AIDS, by state and age group ....................... 35

Technical Notes .................................................................................................................................. 36
Commentary

Following the first reports of cases of AIDS in 1981, AIDS surveillance has monitored the epidemic in the United States. Through December 31, 1996, 581,429 persons with AIDS were reported to CDC by state and local health departments (tables 1-2). Of these, 488,300 (84 percent) were men, 85,500 (15 percent) were women, and 7,629 (1 percent) were children less than 13 years old (tables 4, 5, and 6).

Persons of black or Hispanic race/ethnicity and women continue to represent increasing proportions of persons reported with AIDS. In 1996, blacks represented 41 percent of adults/adolescents reported with AIDS, exceeding the proportion who are white for the first time (table 10). In 1996, the rates per 100,000 population of reported AIDS cases were 89.7, 41.3, and 13.5 among blacks, Hispanics, and whites respectively. The rates were lowest among American Indians/Alaska Natives (10.7) and Asians/Pacific Islanders (5.9). Rates were lower among adult/adolescent women (12.3) than among men (51.9) (table 10). However, in 1996, women represented 20 percent of adults/adolescents reported with AIDS, greater than the proportion in any previous year.

Although the proportion of adult/adolescent AIDS cases who are men who have sex with men has declined to 50 percent of 54,653 men reported in 1996, men who have sex with men continue to account for the largest proportion of reported cases (table 3). Among women, heterosexual contact and injecting drug use accounted for 40 percent and 34 percent, respectively, of cases reported in 1996 (table 5). However, these proportionate distributions by exposure category will increase over time because a large proportion of cases reported in 1996 (15 percent of men [table 4] and 24 percent of women [table 5]) lack risk information and will be updated as additional review of medical records are conducted (figure 7).

The number of AIDS cases reported during 1996 (69,151) was substantially higher (46 percent) than the number reported during 1992, the year before the expansion of the AIDS surveillance case definition. To identify adults/adolescents who meet the AIDS-defining immunologic criteria that were added to the case definition in 1993, some states expanded their AIDS case finding methods to include laboratory-initiated reporting of severe immunosuppression. The proportion of adult/adolescent AIDS cases reported based on the immunologic criteria increased from 39 percent of 104,616 cases reported in 1993 to 57 percent of 68,473 cases reported in 1996. The expanded definition had a major impact on patterns of case reporting. Therefore, to monitor temporal trends in the occurrence of AIDS-defining opportunistic illnesses, CDC uses statistical methods that take into account the change in the case definition and delays in the reporting of new AIDS diagnoses and deaths among persons with AIDS (tables 18-20 and cover figure). Delays in completing HIV exposure information is accounted for by reclassifying persons with AIDS who were initially reported without a risk to the HIV exposure categories listed in table 3 based on how such persons were reclassified in the past (figure 7).

From 1994 to 1995 (the most recent annual period for which data are available), the estimated incidence of AIDS-opportunistic illnesses increased slightly (approximately 2 percent). This national composite includes trends which vary by region, race/ethnicity, age, and HIV exposure category (tables 18-20). Leveling or declines occurred in some groups (e.g., whites, men who have sex with men, male injecting drug users, and children less than 13 years old) while increases continue to occur in other groups (e.g., blacks, women, and persons infected through heterosexual contact). These variations highlight the complex and diverse characteristics of the epidemic and emphasize the importance of monitoring epidemic trends at the state, local, and national levels and by exposure category, sex, and racial/ethnic group to enhance the relevance of the data for planning and evaluating prevention and care programs.

Since 1981, the AIDS surveillance case definition has been revised in response to improved laboratory and diagnostic methods, increased knowledge of the natural history of HIV disease, and improved clinical management. The case definition, which was based initially on highly specific clinical signs and symptoms of disease, was expanded in 1985, 1987, and 1993 to include additional clinical conditions, HIV antibody test results, and laboratory measures of the effect of the virus on the immune system (CD4 test results). These revisions to the AIDS surveillance case definition incorporated advances in diagnostic methods and medical practices in order to provide complete, consistent, and reliable information on the numbers of HIV-infected persons with life-threatening opportunistic illnesses (table 12) and deaths among these persons (table 13).

While HIV infection is not reportable uniformly throughout the United States, states that conduct both HIV infection and AIDS case surveillance can estimate the minimum number of persons living with HIV infection or AIDS (table 27). The number of persons who are living with AIDS continues to increase. Through 1996, over 216,000 persons were living with AIDS. However, the cumulative number of persons living with AIDS underrepresents the number of living persons who have been diagnosed with HIV disease because most HIV-infected persons have not yet progressed to AIDS and many persons infected with HIV have not been tested. In 26 states, adults/adolescents who have been diagnosed
with HIV infection in private clinical and public HIV counseling and testing settings are reported confidentially. Among these states, the number of reported adults/adolescents living either with HIV infection or with AIDS as of the end of 1996 (126,491) was 147 percent higher than the number living with AIDS (51,217). However, these data are not adjusted for reporting delays. Using adjustments for delays in reporting of AIDS cases and deaths among these adults/adolescents, the minimum estimate of AIDS prevalence in mid-1996 was approximately 223,000 (see cover figure). This represents a 10 percent increase in AIDS prevalence compared to mid-1995. The increase in AIDS prevalence reflects stable AIDS incidence and declines in AIDS deaths (see MMWR 1997;46:165-73). The increasing prevalence of AIDS provides a minimum measure of the growing need for medical and other services for persons with HIV disease and for prevention programs to reduce the number of persons becoming infected with HIV.

The HIV/AIDS surveillance system must reflect the latest advances in monitoring and treating HIV disease. Improved survival among persons with HIV/AIDS, which is occurring in response to improvements in medical care and increased availability of antiretroviral therapies and prophylaxis for severe opportunistic infections, will affect efforts to monitor the HIV epidemic based on the current AIDS surveillance case definition. In the future, the HIV/AIDS surveillance system must continue to adapt to changes in the diagnosis and clinical management of HIV disease to ensure that surveillance data are useful for planning and evaluating programs for HIV prevention and care.

Suggested Reading


Table 10. AIDS cases and annual rates per 100,000 population, by race/ethnicity, age group, and sex, reported in 1996, United States

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Adults/adolescents</th>
<th></th>
<th>Children &lt;13 years old</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males No. Rate</td>
<td>Females No. Rate</td>
<td>Total No. Rate</td>
<td></td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>23,341 29.9</td>
<td>2,888 3.5</td>
<td>26,229 16.2</td>
<td>98 0.3</td>
</tr>
<tr>
<td>Black, not Hispanic</td>
<td>20,199 177.6</td>
<td>8,147 61.7</td>
<td>28,346 115.3</td>
<td>429 5.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10,337 88.9</td>
<td>2,629 22.7</td>
<td>12,966 55.8</td>
<td>145 1.7</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>480 13.6</td>
<td>81 2.1</td>
<td>561 7.5</td>
<td>1 0.0</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>166 23.2</td>
<td>41 5.4</td>
<td>207 14.1</td>
<td>3 0.6</td>
</tr>
<tr>
<td>Total</td>
<td>54,653 51.9</td>
<td>13,820 12.3</td>
<td>68,473 31.4</td>
<td>678 1.3</td>
</tr>
</tbody>
</table>

*Totals include 166 persons whose race/ethnicity is unknown.

Table 11. AIDS cases by year of diagnosis and definition category, diagnosed through December 1996, United States

<table>
<thead>
<tr>
<th>Definition category</th>
<th>Before 1993 No. (%)</th>
<th>1993 No. (%)</th>
<th>1994 No. (%)</th>
<th>1995 No. (%)</th>
<th>1996 No. (%)</th>
<th>Cumulative total No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-1987 definition</td>
<td>220,404 (65)</td>
<td>28,265 (36)</td>
<td>22,084 (32)</td>
<td>16,449 (27)</td>
<td>8,227 (22)</td>
<td>295,429 (51)</td>
</tr>
<tr>
<td>1987 definition</td>
<td>80,917 (24)</td>
<td>14,992 (19)</td>
<td>11,942 (17)</td>
<td>9,305 (15)</td>
<td>4,736 (13)</td>
<td>121,892 (21)</td>
</tr>
<tr>
<td>1993 definition¹</td>
<td>35,201 (10)</td>
<td>34,384 (44)</td>
<td>34,933 (51)</td>
<td>35,860 (58)</td>
<td>23,730 (65)</td>
<td>164,108 (28)</td>
</tr>
<tr>
<td>Pulmonary tuberculosis</td>
<td>3,702</td>
<td>1,788</td>
<td>1,356</td>
<td>975</td>
<td>470</td>
<td>8,291</td>
</tr>
<tr>
<td>Recurrent pneumonia</td>
<td>1,151</td>
<td>1,102</td>
<td>935</td>
<td>816</td>
<td>398</td>
<td>4,402</td>
</tr>
<tr>
<td>Invasive cervical cancer</td>
<td>173</td>
<td>101</td>
<td>122</td>
<td>75</td>
<td>18</td>
<td>489</td>
</tr>
<tr>
<td>Severe HIV-related immunosuppression²</td>
<td>30,253</td>
<td>31,445</td>
<td>32,563</td>
<td>34,014</td>
<td>22,856</td>
<td>151,131</td>
</tr>
<tr>
<td>Total</td>
<td>336,522 (100)</td>
<td>77,641 (100)</td>
<td>68,959 (100)</td>
<td>61,614 (100)</td>
<td>36,693 (100)</td>
<td>581,429 (100)</td>
</tr>
</tbody>
</table>

¹Persons who meet only the 1993 AIDS case definition and whose date of diagnosis is before January 1993 were diagnosed retrospectively. The sum of diagnoses listed for the four conditions under the 1993 definition do not equal the 1993 definition total because some persons have more than one diagnosis from the added conditions of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.
²Defined as CD4+ T-lymphocyte count of less than 200 cells/µL or a CD4+ percentage less than 14 in persons with laboratory confirmation of HIV infection.
Mr. Serge Lang  
Math Department Yale  
10 Hillhouse Avenue  
New Haven, Connecticut 06520-8283

Dear Mr. Lang:

Thank you for your letter of August 12 in which you express concern that the "characteristics of AIDS defining diseases in the December 1996 Surveillance Report, [is] inconsistent with the December 1992 definition."

We appreciate your concern. However, it is important to note that the characterization of AIDS you referred to in the December 1996 Surveillance Report, noted below, was not a restatement of, or change in, CDC’s current definition.

"Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV)."

You have referred to this statement as the "boxed" purported definition of AIDS. This statement is not, nor was it meant to be construed as, the CDC definition of AIDS. It also is not meant to be a proxy or substitute for the CDC definition of AIDS. Please understand that the "boxed" statement is meant to be a brief comment to serve as a general guide for those readers of the Surveillance Report who are neither prepared nor find it necessary to read the technical notes that accompany the report or follow the technical problems that arise in the models used to derive the report’s estimates.

We appreciate your interest in and concern about this important public health issue.

Sincerely,

John W. Ward, M.D.  
Chief  
Surveillance Branch  
Division of HIV/AIDS Prevention
Dear Dr. Satcher,

On 12 August 1997 I wrote you to point out certain contradictions in the way the CDC uses the expression AIDS. I enclosed a two-page essay: "Offhand comments about the CDC HIV/AIDS Surveillance report (December 1996)". On 27 October, John W. Ward M.D., Chief of the Surveillance Branch, wrote me an answer to my letter of 12 August. His letter is defective, just like the rest of the stuff CDC puts out on HIV/AIDS. First, he does not address my "Comments". Secondly, the Surveillance Report had a boxed statement as follows:

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).

Dr. Ward writes about this boxed statement of what AIDS "is" in the December 1996 Surveillance Report:

This statement is not, nor was it meant to be construed as, the CDC definition of AIDS. It also is not meant to be a proxy or substitute for the CDC definition of AIDS.

On the other hand, the so-called "Fact Sheet" issued by the National Institute of Allergy and Infectious Diseases of NIH, http://www.niaid.nih.gov/factsheets/evidhiv.htm (11/20/97), copy enclosed, starts with a paragraph:

**Definition of AIDS**

The CDC currently defines AIDS in an adult or adolescent age 13 years or older as the presence of one of 25 conditions indicative of severe immunosuppression associated with HIV infection,...

Here is the contradiction. It's not just my interpretation of your boxed statement. It is the official view of NIH-NIAID, which headlines its paragraph with "Definition of AIDS". Thus the NIAID "Fact Sheet" does not contain facts. It contains propaganda. It continues to provide evidence that you guys at NIH, CDC, NIAID can't tell the difference between a fact and a hole in the ground.

Serge Lang

cc: Arthur Gottlieb, Michael Bukrinsky, Peter Duesberg, Mark Craddock, Arthur Jaffe and John Ewing, Richard Atkinson, Paul Licht, Representative Gil Gutknecht, Donna Shalala, Nicholas Wade, David Perlman, Floyd Bloom, Richard Horton, Bob Silvers, Madeleine Jacobs and Rudy Baum, etc.
The Evidence That HIV Causes AIDS

The acquired immunodeficiency syndrome (AIDS) was first recognized in 1981 and has since become a major worldwide epidemic. AIDS is caused by the human immunodeficiency virus (HIV). By leading to the destruction and/or functional impairment of cells of the immune system, notably CD4+ T cells, HIV progressively destroys the body's ability to fight infections and certain cancers.

Between June 1981 and December 31, 1994, physicians reported 441,528 cases of AIDS, including 270,870 AIDS-related deaths, to the U.S. Centers for Disease Control and Prevention (CDC). AIDS is now the leading cause of death among adults aged 25 to 44 in the United States.

This document summarizes the abundant evidence that HIV causes AIDS. Questions and answers at the end of this document address the specific claims of those who assert that HIV is not the cause of AIDS.

Definition of AIDS

The CDC currently defines AIDS in an adult or adolescent age 13 years or older as the presence of one of 25 conditions indicative of severe immunosuppression associated with HIV infection, such as *Pneumocystis carinii* pneumonia (PCP), or HIV infection in an individual with a CD4+ T cell count less than 200/cells per cubic millimeter (mm³) of blood. In children younger than 13 years, the definition of AIDS is similar to that in adolescents and adults, except that lymphoid interstitial pneumonitis and recurrent bacterial infections are included in the list of AIDS-defining conditions.

*The designation “AIDS” is a surveillance tool.* Surveillance definitions of AIDS have proven useful epidemiologically to track and quantify the recent epidemic of HIV-mediated immunosuppression and its manifestations. However, AIDS represents only the end stage of a continuous, progressive pathogenic process, beginning with primary infection with HIV,