

Second thoughts concerning viruses, vaccines and the hiv/aids hypothesis - part 3 HIV/AIDS and the monomorphic disease model

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Conceptual paper

In 1960 a veteran retro virologist urged his peers to “raise questions whether the known facts about viruses suffice to account for it.” The subject was cancer, the veteran was Peyton Rous, and the quote is from a paper in *Cancer Research*. Mindful of that example, in 1987 I asked a similar question in a paper likewise published in *Cancer Research*: whether the known facts about two human retroviruses suffice to account for leukemia and AIDS.

Clearly, following Rous’s example did not make me very popular with the multinational club of retrovirologists. My article was officially ignored and not “dignified” with a response because the AIDS virus establishment was “too busy . . . saving lives” and testing for antibodies to HIV. I was often shunned like an AIDS patient by my former fellow retro virologists. My views were unwelcome for several reasons: after a frustrating, twenty-year-long search for a human cancer virus, the retro virologists were craving for clinical relevance and hence happily adopted HIV-“the AIDS virus”-as the cause of AIDS. The discovery of HIV was announced in the U.S. at a press conference and the virus-AIDS hypothesis became instant national dogma. On this basis, the retrovirologists convinced their governments to spend billions of dollars to stop the predicted viral epidemic, already being labelled “the epidemic of the 20th century.” The virus was also the immediate darling of the biotechnology companies. Due to its very low complexity, it can be readily cloned for diagnostic test kits and vaccines. In turn, the virus was a hit with the press because it mobilized in readers the instinctive fears of a contagious disease, and appealed to the public prejudice that all evil comes from without.”

What proof?

Perhaps the foremost thing that should be said about HIV is that it has never been proven to be the cause of AIDS, or any human illness for that matter. Not one scientific paper exists that demonstrates it. Based on activity in contrived situations in test tubes, among other illogical things, its culpability was a pronouncement handed down by an authority figure at the National Institute of Health. It is the same authority (Dr. Robert Gallo, head of NIH cancer labs) behind the expenditure of around a trillion dollars in cancer research which has produced nothing but an epidemic that is virtually out of control. (One wonders what it will take before people finally get the idea and stop creating walks, rides, telethons and cake sales to contribute money to the bottomless pit of biased, misdirected, wasteful and cruel orthodox medical research in cancer and degenerative disease.) And it is the same authority who has taken out two patents whose value depends upon HIV being accepted as the cause or a co-factor. One patent is for the technique of testing for HIV, and the other for a method of laboratory cultivation. No one in a position to do anything about it questions this obvious conflict of interest.

Kary Mullis, microbiologist inventor of the Polymerase Chain Reaction, says, “I can’t find a single virologist who will give me references which show that HIV is the probable cause of AIDS If you ask a virologist for that information, you don’t get an answer, you get fury”¹. Mullis has continued his outspoken criticisms of the AIDS establishment: “Where is the research that says HIV is the cause of AIDS? We know everything in the world about HIV now. There are 10,000 people in the world now who specialize in HIV.

None have any interest in the possibility HIV doesn’t cause AIDS, because if it doesn’t, their expertise is useless”². Their embarrassment would also be considerable.

AIDS exists on paper. It is just a new label applied to a defined combination of immune-deficiency symptoms, which are not new, and a group of existing “diseases.” Intense public attention has been focused on the combination using statistical manipulation and fear that is bred in a general lack of understanding about health and disease. The question is whether all the destruction of AIDS can be laid at the feet of a nearly undetectable virus that defies every rule of medical microbiology. For example, HIV is said to cause AIDS *after* the appearance of antiviral immunity. Furthermore, the establishment has shown irresponsibility in referring to this syndrome as a disease. And the fact that it has been given the handy four-letter word encourages others to do likewise. This reinforces programmed notions, especially the idea of a single evil entity causing the whole thing. To emphasize these important points, AIDS will be here designated as “AID Syndrome” in many instances.

A medical establishment on the elastic band wagon

The HIV/AIDS theory is so elastic it stretches to embrace all reasonable criticism. Typical of this elasticity is the so-called latent period of the virus, which has gone from about one year to twelve, and shows potential of going to twenty. The elasticity is equalled only

by the degree of credulousness required to accept HIV dogma. For example, it is said that in spite of the extremely low incidence of HIV in the body, it (mysteriously) tricks the immune system into attacking itself! I use the term HIV/Elastic Theory, or HIV/ET.

Another major factor is oppressive socio-economic and political conditions. Such conditions exist in the Third World particularly, but in their own way in sections of the United States. This aspect will not be detailed here, but includes such phenomena as corporate dumping of banned drugs on unregulated Third World markets, pesticide manufacture and use with frightening disregard for safety, squalid living conditions, and rainforest destruction. These, not HIV, are among the primary causes of what is labelled AIDS syndrome in the Third World. Pharmaceutical companies are heavily involved in the pesticide market. The corporate-interest connection with these abominations goes: pharmaceuticals, pesticides, agriculture, petroleum, international banking. Therefore, since the HIV/ET hoax has to cover a lot of financial territory, it must have considerable stretchability.

AID syndrome scenarios

The first recorded AIDS syndrome case in history, one of five reported by the CDC in June 1981, was a 33-year-old Los Angeles male. He was engaged in a lifestyle which we now consider high risk; but there are reasons for risk other than those defined by AIDS syndrome "viromania" (a word coined by microbiologist Peter Duesberg). For one thing, he admitted using "poppers," the aphrodisiac amyl nitrite (a poisonous secondary mycotoxin), then popular in homosexual bathhouses and discos. We are familiar with nitrites, used in tiny amounts as a preservative in meat. Sodium nitrite, a relatively weak member of the family, has been regulated for years as a potential carcinogen. It is well known that once in the body it is converted into carcinogenic nitrosamines (via its reaction with mycotoxins-not so well known).

Few mycotoxins, however, are more toxic than the organic nitrites (poppers), which react violently with almost anything. In water, they form the unstable nitrous acid, which destroys any biological molecule within reach. Nitrites and their breakdown products have long been known to scientists for their ability to mutate DNA, a point recently verified by direct experiment.³

During the 1960s and '70s, poppers and other drugs were heavily abused, especially by sections of the male gay community. As a result, in 1969 prescription laws were tightened, and as usual, contaminated illegal products appeared on the streets adding insult to injury. In addition, impure products were marketed as "room odorizers." According to a former nitrite researcher with the CDC, doses from inhalation are likely to exceed those from eating preserved meats by a million times.⁴ Yet this massive insult to the body and the drug abuse factor in general, including filthy street injectable, OTC drugs, and especially prescription drugs such as antibiotics, antifungal and other immunosuppressive chemicals, are not considered causative, in favour of a scarce, barely detectable, inactive, difficult-to-transmit retrovirus. However, HIV/ET would respond by saying that, if anything, the drug factor increased susceptibility to a virus that invaded him and destroyed his immune system.

Popper use has been associated with one "AIDS indicator"- *Pneumocystis carinii* pneumonia (PCP)⁵ officially said to be caused by a protozoa. But the corresponding organism is not a protozoa; studies show the DNA sequencing of PCP to be identical to that of the *Saccharomyces cerevisiae* yeast.⁶ PCP is responsible for 62% of all AID Syndrome mortality in America and Europe,

candidiasis is responsible for 23%, and *Cryptococcus neoformans* is responsible for 12%. This means that yeast and fungus-the culminate microform symptoms of disease-contribute 97% of all AIDS-related mortality in those continents.

Thus, in the first recorded AIDS syndrome patient, a yeast infestation of the lung instigated pneumonia (symptom of over-acidification from fermentation processes), and oral thrush, a thick overgrowth of *Candida albicans*, choked him to death. He died, not from the ravages of a scapegoat retrovirus, but from an overdose of mycotoxins-nitrites-and the mycotoxins of yeast and fungal infestation-acetyl aldehyde, alcohol, and uric acid.

In Kenya, Africa, a 39-year-old woman from Zaire entered the hospital for treatment of her lung condition, which had begun with a relatively innocent cough and an unexpected drop in weight. Soon her coughs began to bring up blood, and tuberculosis was the diagnosis. But the patient had a strong allergic reaction to prescribed drugs, and her condition progressed from bad to worse, producing diarrhea, uncontrollable fever, swollen lymph nodes, and anemic blood disorders (all symptoms of a compromised biological terrain). The woman was then diagnosed with AIDS syndrome (but not I-AIDS-Iatrogenic-AIDS).

The woman's husband, whom doctors assumed must have transmitted AIDS syndrome to his wife, was suffering entirely different symptoms. He had pneumonia, a *Candida* infestation in his mouth, and lesions of Kaposi's sarcoma on his now irregularly pigmented skin. He lost weight to a relentless diarrhea and was constantly fighting off episodes of gonorrhoea. Their children had no symptoms.⁷

We are asked by national public health officials to believe that the Los Angeles case and the two Zaireans all suffered the same affliction from the same cause. The irony is that in terms of germ theory this is highly questionable, but when considered in the light of microzymian principle, it is highly plausible. With one instance of overlap, each person was affected with radically different symptoms-a *Pneumocystis pneumonia* (as noted, yeast in the lungs); a tuberculosis (symptom of exotoxin from an intermediate pleomorphic stage); and a Kaposi's sarcoma, or papular tumors of the skin and mucous membranes (caused by mycotoxins). Before AIDS syndrome, these conditions never would have been connected by clinical doctors. Now they are struggling to believe that the common factor is the presence of nearly undetectable antibodies against HIV, and they could not be at a much worse disadvantage.

African AIDS

The World Health Organization's definition for African AIDS syndrome includes some opportunistic infections, like tuberculosis; also, the African version of wasting called "slim disease," a composite of weight loss, diarrhoea, and fever; plus such conditions as persistent cough, skin problems and swollen lymph nodes. These signs comprise old, indigenous African health problems. But here is another example of HIV/ET. Compromised immunity makes "diseases" worse, so whatever "diseases" are already common become the indicators. All we have to do is plug HIV into the equation and we have AIDS. This makes sense to most people.

On the other side of the coin, malaria, for example, the leading killer in the Third World, produces fever and other symptoms frequently misdiagnosed as AIDS.⁸ Tuberculosis, also a common killer and part of the defined African syndrome, presents a challenging situation there, as described by a Nigerian medical professor: "The serologic demonstration of HIV infection in patients with tuberculosis in Africa

is very important because it aids the separation of seropositive from the seronegative patients, since such a separation may be impossible in all cases on clinical grounds".⁹

According to a Ugandan doctor treating AIDS cases, "A patient who has TB and is HIV-positive would appear exactly the same as a patient who has TB and is HIV-negative. Clinically, both patients would present with prolonged fever; both patients would present with loss of weight-massive loss of weight, actually; both patients would present with prolonged cough, and in both cases the cough would equally be productive. Now, therefore, clinically I cannot differentiate the two".¹⁰ What can be the difference? Of course, a major one is that the AIDS case may be given expensive poison drugs which are nearly certain to end the patient rather than the illness, while filling pharmaceutical coffers.

Doctor Konotey-Ahulu has illustrated the confusion created by the HIV/ET: "Immunosuppressive diseases, of course, there always have been in Africa and elsewhere before antiquity was born. ... I have clinical photographs from 1965 of a Ghanaian man who looked like some of the AIDS patients I saw in Africa recently. The man, who was like a skeleton, had severe nonbloody diarrhea (more than twenty bowel actions a day); he had what looked like fungus in the mouth candidiasis, skin changes, periodic fever and cough-all the classical features of African AIDS. . . . The patient (according to relatives) had literally consumed on average one and a half bottles of whisky a mycotoxin every single day for the previous eighteen months before admission. We found it difficult to believe the story, but there are photographs today showing a complete reversal in 1966 of physical signs and symptoms, including the diabetes, when hospitalization cut short his alcohol supply and active treatment was administered, with gradual protein calorie build up and pancreatin supplements".¹¹

Ongoing HIV testing since 1985 has revealed that eight times more Africans than Americans are infected (6 to 8million),¹² yet the continent has produced fewer AIDS cases: 129,000 by 1992 and 345,639 as of December 1994.¹³ By contrast, several large studies recently published findings that among thousands of randomly selected Africans with standard AIDS diseases, fewer than half were HIV-positive.¹⁴ What does this say about a supposedly raging epidemic?

A completely separate epidemic seems to affect rural Africans, this one having no identified risk group. Some reports suggest a correlation between AIDS there and the symptoms of malnutrition. Doctors observe that AIDS patients who eat least often, or whose diets are skewed by food availability, suffer the most rapid decline in health. This should surprise no one. In rural Africa, the most important aspects to be considered, as in the entire history of epidemics, are: sanitation, which rarely exists; clean water supplies, also rare or nonexistent; and decent nutrition. It would seem that HIV/AIDS has created no new epidemic in Africa. But since HIV/ET is such a well-received hoax, it jumps in and "takes credit," while obfuscating relevant issues.¹⁵

In 1985, 250 patients from a local hospital in a remote area of Zaire, none of whom had clinical AIDS, were tested for HIV. Twelve percent clearly showed positive, while another 12 percent were borderline; but there was no correlation with any health complaints. The researcher concluded, "Thus, if antibodies indicate prior exposure to the AIDS virus, this population must have had and survived AIDS-virus infection without lasting health problems".¹⁶ In a similar situation in Venezuela, Indians who live cut off from the rest of the country's people were found with from 3.3 to 13.3 percent infection, with no symptoms.¹⁷ Being so isolated, they are highly unlikely to have been infected within the latent period. In both these cases, investigators

concluded that people could have been living with the virus for a generation or more.

One might be challenged, as the Ugandan doctor was, to distinguish between an AIDS/tuberculosis and a traditional one. Since the clinical symptoms are identical, the CDC has stipulated in its current definition that tuberculosis must be renamed AIDS if HIV antibodies are also found. In the absence of HIV antibodies, the disease is classified under its old name, tuberculosis, and treated accordingly. Therefore, simply by definition/elasticity, HIV antibodies can never be found apart from AIDS, and vice versa; and any symptomology has the potential to become an AIDS indicator with HIV around. In general, if doctors can tell the difference between AIDS on the one hand, and non-AIDS presence of its indicator diseases on the other, only by testing for antibodies to HIV, which sometimes don't even have to be present (discussed below), it would seem we have a syndrome of contrived or arbitrary origin, circularly defined.

HIV/AIDS and Koch's postulates

Koch's postulates are a set of conditions long accepted as the requirements for establishing a fixed microorganism as the cause of a specific disease. The case for HIV as the AIDS virus, as with the identification of any causative infectious agent, should depend upon meeting these parameters, of which there are four. (Keep in mind that researchers disagree about what constitutes proof that any germ causes a disease.)

- a. The germ must be found in all cases of the disease. Tissues said to be affected by HIV include primarily the white blood cells of the immune system, particularly the T-cells, the brain neurons in dementia, skin cells in lesions of Kaposi's sarcoma, as well as, theoretically, any cell in the body expressing the CD4 surface receptor said to be the key to HIV cell entry. But no trace of the virus can be found in either the Kaposi's sarcoma or the neurons of the central nervous system. HIV/ET has now moved from involving only immune cells to other types of cells in order to explain certain AIDS-defining symptoms which are not immune deficiencies anyway, including the cancers, dementia and wasting diseases, and which have not been, or cannot be, explained in terms of a germ-theory virus model that involves destruction of the immune system.

And if HIV were actively infecting T-cells or other members of the body's immune system, extracellular viruses should easily be found circulating in the blood. But in most individuals suffering from AIDS syndrome, no particles can be found anywhere in the body.

Another aspect of HIV/ET is that now several HIV "reservoirs" have been suggested. One encyclopedia, which will go unnamed, says: "Researchers have also been able to show direct infection of bone-marrow cells-the precursors of circulating blood cells-and the proliferation of the virus within these cells. Thus bone marrow may represent an important reservoir of HIV in an infected person and provide a potential mechanism for dissemination of the virus through the body." This is misinformation, pure speculation, a conclusion based on laboratory pyrotechnics, or scientific fraud. It is also said that macrophages can support HIV replication while harboring the virus from immune surveillance. Circulating macrophages are said to play an important role in the distribution of HIV throughout the body, including the brain. The question is, wouldn't there be significant amounts of virus in a reservoir? The fact remains: it is nearly impossible to recover HIV from its "victims." (See below under "Autoimmune Theory.") One paper published in March 1993 reported

two individuals with about 100,000 particles per milliliter of blood, among dozens of patients with little or no detectable extracellular particles.¹⁸

The abundance of uninfected T-cells (about one in 500) in all AIDS patients is the definitive argument against the false claims for high cell-wall particle “loads,” or “burdens,” in AIDS patients. The absence of active, infectious virus automatically disqualifies HIV as a player in the AIDS Syndrome.

- b. The germ must be isolated from the host and grown in pure culture. Even for the most experienced virus hunters, a virus that is so extremely scarce is difficult to find. Only with rare luck and extreme persistence has HIV been extracted from an antibody-positive person. This amounts to finding the proverbial needle of HIV in a haystack of human DNA. This difficulty speaks to HIV's lack of potential in disease.
- c. The purified germ must cause the disease again in another host. There is no animal or human model for HIV and AIDS, and where there is no animal or human model, you cannot establish Koch's postulates. (It is more than disconcerting to think of the number of primates that have been injected to this day in an attempt to produce AIDS.) HIV/ET jumps in and says that HIV should receive special dispensation from Koch's postulates. A major stumbling block is the latency which is claimed, but whose modus is not explained by authorities. In 1989 the official latent period between HIV infection and the onset of AIDS was one year. This period of “incubation” has since been stretched to 1012 years. For each year that passes without the predicted explosion in AIDS cases, approximately one year is added to this period. Even this is insufficient; with only 5 percent of infected Americans developing AIDS each year, the average latent period would have to be revised to more than 20 years for 100 percent to become sick.

HIV should cause AIDS within two weeks of infection at most, but it does not, and with the complete lack of a demonstrated process by which HIV diminishes immune function, belief in a decade or more of unexplained latency requires a level of “faith” beyond this writer's capacity. Another major stumbling block is that even once the latent period is apparently over, there is still precious little development of the virus.

- d. The germ must then be isolable from the newly infected host. We are now backing to the problem of meeting requirement number 2.

The antibody that isn't

According to germ theory, an antibody is a certain antidote to a pathogen. According to HIV/ET, however, the more antibodies you have to HIV, the sicker you are said to be. AIDS syndrome is the only “disease” in the allopathic file cabinet in which antibodies to the causative agent mean you're in trouble; and it defies just about every known law, rule, guideline, fact, and behaviour in the germ theory book. This includes, as we have seen, Koch's postulates, and, as we will see below, Farr's Law. Furthermore, vaccine research proceeds on the basis of producing antibodies to HIV in the patient. Apparently, these “synthetic” antibodies will signal recovery, while one's own signal death.

The autoimmune theory

One explanation put forth for the deadliness of such a scarce pathogen is that it somehow induces a self-destructive immune

response (the system attacks itself). Evidence for this is said to be low white cell counts in people with AIDS syndrome; however, there is nothing to support the hypothesis, i.e., no plausible process by which this occurs has been suggested (see “What's Overlooked” below).

For the sake of discussion, let us allow germ-theory interpretation of immune function and autoimmunity. With only one in 500 immune cells said to be infected in HIV positives, it would seem to require a virus of extraordinary cunning to get uninfected cells to attack each other and not infected ones, which would be self-defeating for the virus. Or in the latter event, such cunning could be matched only by the adroitness required to move quickly from one host cell to another just before destruction. Or, if macrophages are involved, the process should lead either to increasing titers of virions in the blood, lymph, etc., as infected cells are lysed, or to increasing concentrations in macrophages if they are ingesting T-cells. This supports the reservoir notion (if there were any viruses to be found in them). It is thus easy to expand HIV/ET.

HIV/AIDS and Farr's law

Established in the early 1900s, Farr's Law, which is fundamental to virology, states that viral disease develops exponentially, and dictates that illness will strike soon after infection. The rate-determining factor of the exponential growth of viruses is viral generation time, which is between 8 and 48 hours. Since laws are made to be broken or excepted, viruses with incubation periods longer than allowed by Farr's Law are called “slow viruses.” And since HIV joins an exonerated class of viruses by not multiplying according to this law of virology, virologists stretch HIV/ET to accommodate it. The question arises, though, of how anyone can determine or demonstrate when a “natural” HIV infection takes place, and thus determine latency, since no one is being tested daily or weekly, etc., and there is no animal model. Within the slow-virus concept, adopted as an exception to Farr's Law, retro virologists can find refuge, hold on to their theory, hibernate in their labs, and hope the long winter of HIV latency is over before they expire.

According to expert retro virologist Dr. Peter Duesberg, “The slow virus concept has never been reconciled with the short generation time of viruses and the immune system. Once the virus lies totally dormant, an intact immune system will never allow any virus to be reactivated to multiply into numbers that would threaten the host. For a virus to be reactivated, the immune system first must be destroyed by something else—the real cause of a disease. A reactivated virus would just contribute an opportunistic infection. Thus, there are no slow viruses, only slow virologists.”¹⁹ Also, says Duesberg, “Retroviruses are all very similar. I mean, there are differences, but as far as pathology is concerned, you don't see a marker in one which is going to explain why it supposedly wakes up from sleep and becomes active.”²⁰

The chemotherapy drug azidothymidine (AZT)

HIV-antibody-positive individuals suffer major health risks from AIDS medications routinely administered by physicians uncritical of drug-company propaganda. AZT, an isolate from herring sperm, was first synthesized in 1964 by Jerome Horwitz, heading a lab at Detroit Cancer Foundation and financed by an NIH grant. Designed to kill cancer cells, Horwitz's creation is a chemically modified form of a DNA building block. When a cell divides, it must copy its complete genetic code, which is stored in long chromosome chains. The DNA components (nucleotides) are linked to one another in a sequence. But Horwitz's altered DNA building block enters the growing DNA chain

while a cell is preparing to divide and acts as a premature terminator, blocking addition of DNA components. Being unable to copy its DNA sequence, the cell dies.

AZT was the perfect killer of dividing cancer cells. When the compound was tested on cancer-ridden mice, however, it failed to perform as expected and instead revealed its extraordinarily deadly nature. The experimental drug was withdrawn from testing and never approved for human use-until AIDS syndrome. Side effects of AZT include

- i. Ulcerations and haemorrhaging
- ii. Damage to hair follicles and skin
- iii. Destruction of mitochondria, the energy dynamos of cells
- iv. Wasting of muscles
- v. The destruction of the immune system and other blood cells.

Children are affected more severely, because many more of their cells are dividing than in adults.

Amid scandal

1. The single, human trial that was ruined, yet was claimed to have proven effectiveness;
2. Free corporate (Burroughs Wellcome) acquisition of large amounts of National Cancer Institute (taxpayer) raw material and technology; and
3. Government stonewalling of other, potentially less expensive antiviral-AZT was first approved for treatment of AIDS in 1987.²¹ The cost was \$250 a shot, or about \$18,000 per year, per case. In 1990 it was approved for AIDS prevention, and has currently reached an average cost of \$6,000 per year.

I have worked with many HIV-antibody-positive individuals who have for years remained completely free of any AIDS-indicator symptoms or any other significant ones. When treated with medications like AZT, however, people are observed to sicken and die from “wasting disease” in a short period of time. I, as well as other molecular cell biologists, know of no one who has been treated with AZT and lived for more than around one year. Fortunately, it has begun to fall out of favor as the drug of choice.

Use of AZT is a good example of two other medical phenomena:

- A. The odds game called the therapeutic index, or the relationship between a drug’s effectiveness and its toxicity; and
- B. The dependence upon destruction that informs “scientific medicine.” The acceptable toxicity of a drug is directly proportional to, and established by, the deemed deadliness of the disease. However, to this date the *Physicians’ Desk Reference* quotes the low toxicity of AZT reported by Broder, Barry, Bolognesi, and colleagues in 1986. According to at least four independent studies published since, however, the toxicity of the drug is a thousand times higher.²²

Broder, Barry, Bolognesi, and colleagues overlooked or disregarded two basic factors in their lab experiments:

- a. In the test tube in which they tested AZT, there was a high concentration of “infected” cells. But, as noted earlier, in a person with HIV, titers are very low, and the ratio of infected to healthy cells is very low (only 1 in about 500 T-cells in HIV antibody-positive persons is ever “infected”)

- b. Like all other chemotherapy drugs, AZT is unable to distinguish between target cells and healthy cells. The disastrous consequence is that AZT must poison 499 good T-cells in order to poison one inhabited by the AIDS “virus.”

Real fallout

Various individuals diagnosed with AIDS who were paraded in the media, trapped into following the AIDS “company line,” later died of AIDS-related symptoms. Many were treated with AZT from the very beginning, even though they showed no signs, or few signs, of ill-health at the start of the program. Two examples are Kimberly Bergalis (featured in the October 22, 1990 issue of *People* magazine) who supposedly “caught” HIV from her Florida dentist, and Arthur Ashe, the heterosexual tennis professional. (Kimberly had only a minor yeast infection at the start of her AZT program.) In typical fashion, the news media focused upon, and widely broadcast, the details of their gradual degeneration and painful deaths, which exhibited all the classic symptoms of AZT poisoning. “AIDS” death and AZT death are outwardly indistinguishable. Here is a perfect combination: an illness incorrectly billed as universally fatal, treated by a useless, frequently fatal drug.

What’s overlooked

Shades of doubt concerning HIV/ET validity in terms of germ theory have arisen since three-quarters of the 20,000 hemophiliacs in the United States were infected by HIV through the blood supply a little more than a decade ago. During that period, clotting factor VIII doubled life expectancies, while relatively few developed AIDS syndrome. HIV has made no measurable impact on the well-being of hemophiliacs, except for devastation of those who are treated with AZT.²³ No evidence has shown that death rates from blood transfusions ever increased from HIV transmission, nor has anyone demonstrated that death rates declined once the virus was screened out of the blood supply.

Even if AID Syndrome does exist as a new phenomenon, perhaps insufficient scrutiny has been paid to the idea that it is not virus-based, but related to an inverted way of living and eating. For these reasons, and the socio-political ones mentioned earlier, illness is simply on the rise in general, and individual cases are often more intense and intractable. Cancer is now epidemic, for example. “Flesh-eating” bacteria have made an appearance. Disease intensity and statistics must also be considered in terms of the ineffectiveness and iatrogenic influence of the orthodox approach to illness—the equivalent of trying to remove a screw with a hammer. HIV/ET attempts to divert responsibility for health disaster from an inept, sometimes malfasant, pharmaceutically controlled medical tradition. A century of medical practice and health concepts based on the scientifically erroneous germ theory is as much the cause of AIDS as any single factor—probably more. AIDS could easily have been predicted epidemiologically as an aspect of the burgeoning crisis in health. It had to be blamed on a virus in order to distract attention from the real problems.

Speaking of prediction: Several doctors and writers have made a strong connection between AID Syndrome and syphilis. The consequences of misdiagnosed or improperly treated (including penicillin) syphilis may be misinterpreted as AIDS indicators. According to one researcher, almost every AID Syndrome indicator has been seen in syphilis.²⁴ An interesting corollary here is the Tuskegee Alabama Syphilis Study, in which 400 Alabama sharecroppers were allowed to suffer and die with untreated syphilis (which they were not told they had) for 40 years until the study was exposed in 1972. Did a medical establishment (CDC, Public Health

Service, NIH) capable of such behaviour learn anything about syphilis which might have helped predict, and formulate a description of, the “new” AIDS syndrome epidemic?

With the primary U.S. AIDS groups, or with any group for that matter, if you understand microzymian principle and consider the blood as a flowing tissue, it will be seen in general that body fluids which find their way from one individual directly into the blood of another are a stress factor on the body. This is by virtue of the introduction of foreign tissue and possibly morbidly evolved microzymas. Total impact depends on the degree to which the terrain is already compromised. In fact, a major danger is blood transfusion itself, essentially a “tissue transplant,” which is a threat or irritant to immune function. There is no reason to believe that such repeated stress will not, by itself, overwork and weaken immune function and drain overall energy reserves.

Current medical science gives credence to the so-called autoimmune response, where white cells said to be deranged indiscriminately destroy and/or clear out healthy and unhealthy cells. This misconception arises as a consequence of germ theory mentality, which misunderstands the central function of the immune system. It is essentially a sophisticated janitorial service. It operates to keep the place clean and to recycle usable material. Should “self cells or tissue become useless or even dangerous to the body, the immune system will clean them out. Thus, it is not deranged, but is doing its job correctly. The host is somehow not doing its job, however, to maintain a balanced internal environment, which is the first line of defense, not immunity, against tissue destruction and infection. This is because infection can come from within. And it bears repeating that the fundamental misconception of the germ theory is that infection must be invasion, rather than an endogenous morbid change in chemistry or micromorphology.

Compromised or weakened by fungal infestation (evidence for which is obvious and strong) or by drugs and chemicals such as mycotoxins, the immune system may weaken and fail to be efficient, but it will not attack healthy cells. There is a situation where this may appear to be so-when free radicals produced by the immune system in response to mycotoxins and morbidly evolved microforms damage local cells and tissue by the “shotgun” effect - but it is not a direct attack on “self,” and is frequently an overreaction to the alarming situation.

What constitutes AIDS in 1998?

HIV/ET responds to the question of why the syndrome hasn't spread into the general population with the reply that it just needs a little more time. To accomplish this, however, the situation requires a little massage as well. On occasion, the definition of AIDS has been expanded (along with the latency period), with more indicator diseases being added to the list. In 1987, purportedly for surveillance purposes, a major change was made to the definition, which not only added diseases to the list, but removed, in the presence of a positive HIV test, exclusions for *other known causes* of immune suppression. The rationale was to provide consistent statistical data for public health purposes. Thus, a person could now be diagnosed with a *surveillance* case of AIDS.

In the CDC guideline, the caveat was given that clinicians would not rely on this definition alone to diagnose serious disease caused by HIV. Good medical practice, which was apparently expected to be employed later, could be expected to catch cases that somehow slip through the vast surveillance net because they have either a negative HIV-antibody test or, in the presence of HIV antibody, an

opportunistic disease not listed in the definition. With the new rules, in the case of diagnosis of any one of several indicator diseases by a “definitive method,” AIDS had to be diagnosed even if the patient were HIV negative.

One question would seem to be: Why not employ good medical practice at the outset? Also, with the vast range of conditions listed, one is hard pressed to imagine what might not be included, except perhaps the common cold. But the overall effect of this change was to boost statistics and bring more people into the web of fear surrounding the syndrome. In 1992 another statistic-bumping revision was handed down. Today the AIDS-indicator list includes, but is not limited to, Pneumocystis pneumonia, Kaposi's sarcoma, non-Hodgkin's lymphoma, Candidiasis, cryptococcosis, tuberculosis, herpes simplex, cryptosporidiosis, coccidioidomycosis, toxoplasmosis, wasting disease and dementia. And symptomologies such as syphilis, chronic fatigue, anemia, arthritis, nephritis, pneumonitis, diarrhea, cervical cancer, and a T-cell count of less than 200 cells per microliter, or less than 14% of the expected level, have been added to the diagnostic list. It appears that when a higher rate of new AIDS cases is needed “for public health data,” the CDC expands the definition. With the stroke of a pen an illusion of the spread of AIDS is created. To include the major symptoms of malnutrition (wasting) as an AIDS indicator, especially in Africa and the Third World, is to ensure a burgeoning statistical picture.

Nor is this the first time such statistical manipulation has occurred in medical history, polio being an excellent example. According to Dr. Herbert Ratner, former public health officer for Oak Park, Illinois, prior to vaccine introduction, doctors were being paid \$25 apiece by the National Foundation for Infantile Paralysis for polio case reports. Also, Ratner indicated, it was known that paralytic polio went away in 50 percent of cases within 60 days. After the arrival of the Salk vaccine, the case definition for polio was changed to require symptoms for 60 days before a diagnosis could be reported. Thus, if someone had it and it went away within that time, it was never counted, making the vaccine look better.⁴⁸ After vaccine introduction, cases previously reported as poliomyelitis were differentiated as aseptic meningitis. Despite this subterfuge, case incidence increased dramatically after vaccine introduction (80 percent from 1958 to 1959) but the Public Health Service manipulated statistics and made statements to give the opposite impression.²⁵

Should anyone question the idea that the CDC at any time “needed” a higher case rate, consider the following: In the early years of AIDS syndrome, while this supposed epidemic was developing, the CDC stood back and did nothing to identify and help the sexual contacts of AIDS syndrome patients. It was a departmental “do-nothing” policy. This has been documented and published by a former Public Health Adviser and AIDS researcher who worked at the CDC at the time.²⁶

A final thought

To prove that HIV is the cause of AIDS and make HIV/ET more than a speculative hypothesis, it would be necessary to show the presence of HIV among patients with AIDS diseases whose personal history did not include:

- I. Chronic, abusive, male homosexual activity with associated chronic drug abuse and antibiotic dependency;
- II. Massive ingestion or injections of recreational drugs; and
- III. Use of toxic prescription medications, including AZT and antifungal.

Likewise, one would have to show HIV absent among groups of healthy, asymptomatic individuals. In spite of the millions which have been spent on AIDS research, such a study has never been undertaken, although we have seen instances of long-term HIV presence with no correlated illness.

In my research, I can see only minor differences among dried blood samples of people with cancer, dementia, MS, and diabetes on the one hand, and the person with AIDS on the other. They all show excess fermentation processes and disseminated intravascular coagulation. They are all rotting from the inside out. There seems to be one model that makes sense and consistently validates clinical observation and research: *There is only one physiological disease-terrain imbalance seen as acidification*, due primarily to an inverted way of eating and living. *Acidification leads to the one sickness, or primary symptom of disease-morbid microzymian response*, or the overgrowth of microforms whose poisons result in secondary symptoms (commonly called “diseases”), these being produced in or by the body in keeping with the uniqueness of each individual. Forms of toxicity such as environmental chemicals and heavy metals also play a role, but in most cases will also disturb the central balance of the microzymas, thus complicating the situation with morbid microzymian evolution.

There are no “diseases” created by “microbes” invading from without. Viruses are not even symptogens. HIV has no causative connection with disease, and no new epidemic exists.²⁷⁻³¹

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