

MEDITEL

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Dear David and Fran,

Oct 4th, 1996

Thank you for your letter, full of its customary challenges and acuity!

In response to your point about our discovering "a slightly higher margin of error", we have revealed a margin of error (even in our small samples) of 4 out of 68 samples, or 1 in 27. This represents a 120 fold increase in the admitted error rate. This rate would be unacceptable in any other field of science and must be made public.

The orthodoxy accepts only 1 in 3,300 false positives. We asked five diagnosed HIV positive young men, one gay man leading a high risk life style, and five volunteers who were vaccinated to join our study - total 11. (The rest of our samples were frozen serum samples donated by research institutions). We filmed our 11 volunteers giving blood for our tests.

Out of those 11 (who donated fresh blood) we found one false positive result with the same blood sample tested on three different test kits. Interestingly this young man, Peter Nicholls, went from positive to negative. That is, he was positive on the Organon, Pasteur and Wellcome test kits and later negative on the new Abbott kit at St Mary's Hospital and negative at the Royal Free on the Wellcome test. (All of these test kits are widely used in the UK and internationally).

In a separate phase of our testing we sent the blood of ten people with very high gammaglobulin count to be tested, we had another false positive. This patient had an inflammatory autoimmune condition and no AIDS -defining disease.

ON LIFESTYLE/BIAS

It is true to say that the five diagnosed positives in our tests remained consistently positive both in our lab tests at UCL and when we took them (with a female partner) to HIV clinics in London and Scotland. This means that our attempts to find out if bias comes into play (when a person is known to be gay etc) in diagnosing results was unsuccessful.

However, this is where the importance of the indeterminates comes in. Remember that two of our test kits in the experiment, Organon and Wellcome, gave negative results for 30 specimens that were found to be indeterminate by the widely used Pasteur test - some were verging on full positives. Normally an indeterminate has to be tested again, and this is where bias can come in.

As you know, all requests from doctors for HIV tests state whether or not the person concerned is from a risk group. We have a statement from the PHLS at Colindale that says,

"Blood specimens are treated by methods appropriate for an accurate diagnosis. For example, a negative HIV result in a person in a high risk group is likely to be subject to further confirmation before reporting a negative result to the physician. Similarly, a positive HIV result in someone not known to exposure to HIV would be subject to careful confirmation."

We can therefore conclude that an *indeterminate* result in a person in a high risk group is highly likely to be declared positive, whilst an indeterminate in a person with "no known exposure to HIV" is more likely to be declared negative.

Given that the baseline for each HIV test kit worldwide is set individually by the manufacturer and the lab has to establish the practical implementation of these standards with each series of assays. The chance of an indeterminate creeping into the positive or negative range is high. This is why our high rate of indeterminates through the Pasteur kit (but not through the other two) are significant.

You ask "Did we do something wrong?"

Yes, I think we should have tested all our samples for high gammaglobulins IGg and IGm *before* sending our samples off. However, it was incredibly difficult to persuade people to let us have the samples for TB, malaria, lupus, and candidosis. When we eventually did swing it, the professors assured us that their specimens *ought* to have a high gammaglobulin count. These specimens were non-reactive on two test kits and produced 30 indeterminates on the third.

Later, when we approached the problem "from the other end" and just looked for specimens with high IGg and IGm, but no AIDS-defining diseases, we found one false positive within a day through a Wimpole Street lab using the Bio-Merieux kit.

Now that we have a good relationship with Professor Pam Riches at the protein lab, St George's Hospital, Tooting, it would be exciting to put another set of these high gammaglobulin samples through a variety of labs during production of the programme. We are confident we would get more false positives, because, as Eleni says, it is this high gammaglobulin (protein) count in the body that is being wrongly identified as HIV antibodies.

Huw Christie is enclosing a letter describing his views on the current scientific debate surrounding the HIV test and the existence of HIV. He and his journal CONTINUUM are at a very exciting stage.

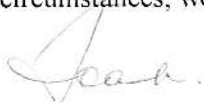
I know I should not mix personal with professional, but I think these are special circumstances which I would like to explain.

If, after our meeting, we have satisfied you and Fran that our findings are indeed important, and after taking on board your views on our main line of approach, I would like to go into production straight away. This is because the surgeons at the London Hospital Whitechapel have told me that I need to get my hip replaced again (third time in 20 years!) because there has been some deterioration in my femur. This time they will give me a bone graft which requires organising donors. They know about Dispatches and how important it is for me to get the programme made first, so are willing to wait until Jan-Feb next year but I need to inform them of my situation as soon as possible because of bed availability etc. This is why Huw and I would like to be able to finish the Dispatches for you by the end of December. I do hope this will be possible.

In the meantime I am fine and mobile and ready to go!

Given these circumstances, would it be possible to book in to see you next week?

Yours,



PS Enclose piece from San Francisco Chronicle to show how the AIDS myth message is spreading!