CONTINUUM
CHANGING THE WAY WE THINK ABOUT AIDS

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Professor Gordon Stewart
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Dear Gordon,

Many thanks indeed for the excellent piece by fax on Friday. And your swift action much appreciated. It seems you thought enough of Heinrich Kremer's work to warrant the time, and of course I agree. We have now - which I didn't last week - a c.v. of him which I enclose for interest's sake. I met him for three days in Barcelona recently, and he is a member with you of Continuum's Consultant's board. We feel very fortunate here to be associated with the wisdom and experience of the likes of you and him *et al* .

I'm sure you can imagine the care I try to take in structuring the magazine, and using language that is able to support the complexity of the discussion around HIV and AIDS. I hope you'll consider a couple of suggestions I've made in your text (following, underlined), which I'll go through here:

para 2 - concomitant or secondary [infections]: if your sense is, concomitant with or secondary to HIV, I wonder about this phrase. There are a few reasons, but I think you point to a main one when you cite Kremer's objection to an AIDS diagnosis being given when a patient has TB and "if they happen to be seropositive to tests for HIV". Your carefully chosen last four words indicate, rightly, there is good evidence a false-positive HIV test can be obtained through cross-reactions with, for example, even TB antibodies; hence PCP may occur in patients where it is concomitant not with HIV but, for example, with TB. Without validating the specificity of the antibody tests, one can never know. This is to leave aside the large question posed in Eleni's paper in the last issue, of whether we can know HIV exists at all. Until this is answered, we should try use a language that does not take HIV for granted. Your text reads well in my view with the omission of the phrase, and the sense doesn't suffer.

para 3 - I am so sure from the evidence that AZT administered "post-prophylactically" is just as problematic as AZT prophylaxis, I suggest making the distinction here is unrewarding in terms of addressing the problems with AZT. The recent Italian study that showed an initial short-term T-cell increase in 16 HIV-*negatives* taking AZT (which we'll be reporting) goes a long way to confirming that the "post-prophylactic effects" of AZT are clinically distracting - in fact, initial short term T-cell rise in some HIV-positives taking AZT was the only touted benefit I'm aware of that was half credible. For your interest again I enclose that label from an AZT bottle - and will get you the report of the

Italian study. Could we not leave it that, regarding Kremer, you "share his misgivings about AZT..."?

para 3 - I have taken the liberty of suggesting what seems to my non-medical eye a slightly more constructive criticism. Undoubtedly there is as you say room for disagreement in the matter of treatment. From an editorial point of view I must confess I had gladly had it verbally, though now in writing, that the last phrase of Heinrich Kremer's article should read: To be continued...Later next year he will contribute something on KS, and something on treatments. I didn't inform you of this, for which please accept my apology. However, there is a strong thread through his piece (and through the recent Nature Medicine article on mitochondrial toxicity) of the inherent long- and short- term problems with sulphonamides, (for the substantially decreased indication of which in the "non-HIV" population, I recently was given the official reference); and we have the report via the Austrian distributors of pentamidine that it destroys the lining of the lungs after two years. Thus I'm in little doubt that the ideal treatment for active PCP has yet to be available, at least if one considers the future of the host as being as qualitatively significant as the demise of the parasite - a dimension some doctors feel alarmingly free to disregard in "HIV" medicine since it's predicated anyway on an inevitable decline to death. So I am asking whether you could see your way to postponing outright disagreement with Kremer at this stage by issuing a sort of challenge such as I've suggested in the text. I suggest whether Kremer can answer it or not, where are the less problematic treatments is the pertinent question.

para 4 - may we say present readership?

Also, is this the way to credit you: Gordon T. Stewart, Emeritus ~~Mechan~~ Professor of Public Health, University of Glasgow?

Looking forward to hearing from you. Again, many thanks and good wishes.
Yours sincerely,

Huw Christie MA (Oxon)
Editor