

tuberculosis demand that the same type of emergency public health measures now on the books for dealing with tuberculosis and similar communicable diseases be applied to AIDS, before this deadly and untreatable disease devastates our society.

The leadership of the Centers for Disease Control in collaboration with the Soviet-controlled World Health Organization (WHO) in Geneva, Switzerland has explicitly maintained the preposterous lie that the standard of living has improved in the tropics and in America's urban areas over past years, and therefore, there is no immediate threat. The principal control point for the Soviets at the World Health Organization in Geneva is through Sergei Litvinov, the assistant director general for communicable diseases of the World Health Organization, who has the official command position for all AIDS policies globally.

EIR maintains that Soviet attempts to spread disinformation on AIDS must be thoroughly discredited and, in the interest of maintaining the security of the West, embark upon a fullscale global War on AIDS modelled upon traditional Public Health measures for stopping the spread of tuberculosis which we have elaborated in other locations.

The TB resurgence

The implications of an analagous mode of transmission of AIDS and tuberculosis through respiratory aerosol is ominous. As IMF austerity conditionalities have rapidly collapsed standards of living, tuberculosis is currently on a massive global resurgence. In addition to Peru, northern Brazil, and Mexico, TB is breaking out in countries such as France, where 13,000 cases were reported last year. Tuberculosis had been declining steadily in the economically developed areas of the world over the last 100 years, and had become a disease of the urban poor. Now the decline has halted and an ominous increase in cases is occurring in the deteriorating central cities of New York, Chicago, Boston, and others.

Globally, half of the world's population shows evidence of exposure to tuberculosis, and are prime candidates to activate this infection as a consequence of an exposure to AIDS virus. AIDS-associated tuberculosis is a rapidly progressive, lethal process with a potential to wipe out half the world. The potential in the United States is illustrated by the outbreak of drug-resistant tuberculosis in shelters for the homeless in Boston, Massachusetts.

Public Health officials in both Miami, Florida and New York City have done block-by-block studies which demonstrate that there is a direct correspondence to the outbreak of tuberculosis and AIDS in the poorest, overcrowded, and most unsanitary sections of their cities. In the developing sector, some tropical disease specialists believe that many of the cases classified as tuberculosis deaths over the past few years represent clinical AIDS infection.

Thus, several specialists in tropical medicine have commented that TB is the best "marker disease" for actual immune suppression.

AIDS, TB linked in respiratory aerosols

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The following paper, dated Aug. 19, 1985, was entitled by the author, "Chronic Lymphoid Interstitial Pneumonitis and Probable Transmission of Lymphadenopathy-Associated Virus (LAV/HTLV III) by Respiratory Aerosols."

Lymphadenopathy-associated virus (LAV or HTLV III) was isolated a month ago by workers at the Pasteur Institute and at the Pitie-Salpetriere, Laennec and Claude Bernard Hospitals in Paris, from bronchoalveolar lavage fluid of a 30-year-old black Haitian woman with AIDS related complex (ARC).¹ This finding may explain the observation that acquired immune deficiency syndrome (AIDS) affects men and women equally in Haiti and Central Africa. It also raises the ugly possibility that LAV may often be transmitted by respiratory aerosols in the tropics.

The woman had suffered from anorexia, weight loss and intermittent fever for over two years, and from dyspnoea on exertion for one year. The only abnormality detected on physical examination was generalised lymphadenopathy; there were no abnormal pulmonary signs. However, chest x-ray films showed diffuse reticulonodular infiltrates, and lung biopsy revealed lymphocytic and plasma-cell infiltration of the alveolar septa and bronchial walls, characteristic of lymphoid interstitial pneumonitis.

The bronchoalveolar lavage fluid contained 18 million cells per millilitre (comprising macrophages and lymphocytes, evidence of blood contamination. LAV was isolated from the lymphocytes, but appropriate staining and culture of the lavage fluid showed no evidence of pulmonary infection by *P carinii*, fungi or any virus other than LAV.

Other workers have already reported markedly increased lymphocytosis in the bronchoalveolar lavage fluid from patients with AIDS and ARC.² Lymphoid interstitial pneumonitis has been found in infants with AIDS³ and in adults with ARC.⁴ The chest x-rays of large numbers of patients in Zaire with ARC show diffuse reticulonodular infiltrate characteristic of lymphoid interstitial pneumonitis (Quinn T. personal communication).

On 28 June 1985 Centers for Disease Control (CDC) belatedly recognised these observations and redefined AIDS to include histologically confirmed chronic lymphoid interstitial pneumonitis with positive serological tests for LAV/HTLV III.⁵ However, the new CDC definition only applies

to children under 13 years of age; the 30-year-old Haitian woman above, the thousands of her adult compatriots with the same abnormalities in Haiti, and tens of thousands of similarly affected Zairians, still do not have CDC-defined AIDS.

Pulmonary tuberculosis is often the initial clinical manifestation of infection with LAV in Haiti⁶ and Central Africa.⁷ Indeed, it was suggested last month in the *Lancet* that infection with *M tuberculosis hominis* should be included as a manifestation of lesser AIDS or ARC.⁸ CDC remains silent on this absolutely fundamental issue.⁵ A recent study by the head of the U.S. task force against AIDS, and others workers from CDC and NIH, Bethesda, of patients with active tuberculosis in a sanitarium in Kinshasha, the capital of Zaire, showed that 48% were infected with LAV⁷ compared with only 4% of controls.

Pulmonary infection with *M tuberculosis hominis* is characteristically transmitted via respiratory aerosols. If open, cavitating, pulmonary tuberculosis co-exists with chronic lymphoid interstitial pneumonitis caused by LAV, it is inevitable that large numbers of infectious LAV virions, as well

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as tubercle bacilli, will be expelled in aerosols during coughing. LAV spread by the respiratory route would affect men and women equally; spouses and children of index cases would be particularly at risk, as has already been observed in Africa.⁹

It is possible that respiratory transmission of LAV may occur even without the assistance of *M tuberculosis hominis*. It is well known that LAV/HTLV III is a retrovirus genetically very similar to the maedi-visna virus of sheep,¹⁰ that both viruses cause progressive encephalopathy in man¹¹ and sheep¹² respectively. It is less well known that maedi-visna virus also causes chronic progressive pneumonia in sheep,¹³ which is histologically indistinguishable from chronic lymphoid interstitial pneumonitis in man caused by LAV/HTLV III.

An epidemic of maedi-visna in Iceland, spread by respiratory aerosols amongst sheep crowded into shelters to protect them from the long Arctic winters, followed the importation of one infected ram from Germany in 1933. The epidemic built up slowly and unnoticed over several years (just

like the AIDS epidemic has in a thousand cities across the globe) but by 1950 over 100,000 sheep had died from the disease¹⁴ as a direct result of the introduction of just one infected animal.

It seems probable that in the prosperous West LAV is still only transmitted by per-cutaneous inoculation, or by anal intercourse, but that in the tropics it is already being spread also by the respiratory route with, or without, the co-operation of *M tuberculosis hominis*. The prospects for the less prosperous inhabitants of the crowded cities and villages of the world beyond the next decade are bleak.¹⁵

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