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Conference Report: Oral AIDS

# 'Kiss of death' for official line

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A significant crack in the position that AIDS is not transmissible by oral contact, such as kissing, occurred in Montreal, Canada on June 2 and 3. The First International Symposium on Oral AIDS, organized by Canadian dental researcher Drasko D. Pekovic, brought together scientists from around the world to exchange information on the diagnosis and treatment of AIDS-associated oral diseases, as well as to investigate the possibilities of oral transmission of AIDS and examine risk factors faced by dental health care professionals and the safety conditions of dental services.

That the conference even took place is a tribute to the persistence of Dr. Pekovic in the face of direct and indirect obstruction by the World Health Organization (WHO) and other components of the international AIDS mafia. Three groups from the United States who wanted to attend the conference and present their results were forbidden to do so. In one case the leader of a major group working on oral AIDS in California forged signatures of other members of the group on a letter withdrawing from participation in the conference. This after 5,000 copies of an announcement, listing the group as part of the conference committee, had been prepared for distribution at last year's International Conference on AIDS in Stockholm, Sweden.

In spite of this counterorganizing, 50 speakers from around the world participated in the Symposium on Oral AIDS as opposed to only six presentations on the subject at the Fifth International Conference. The symposium consisted of four panels and a poster session. The Panels were 1) AIDS Update, 2) Oral Manifestations of AIDS, 3) Microbiology and Immunology, and 4) Social Aspects, Risks and Preventive Measures.

The conference opened with a welcome from the Director of Public Health of Quebec, Marc Dionne and a welcome from the Honorary Chairman, Armand Frappier, Founder of Institut Armand Frappier, Laval, Quebec. This was followed by an address on "Antibody Response to HIV-1 AND HIV-2 Antigens" by Myron Essex of the Harvard School of Public Health.

The first session discussed recent advances in understanding AIDS and other HIV-1 induced diseases. This was followed by a presentation on the HIV receptor, CD4, and its role in infection and treatment. CD4 is the new hot item being pushed as a potential "magic bullet" for treating HIV infection. Ironically Dr. Pekovic presented evidence at the main AIDS conference which casts doubt on the primary role of CD4 in HIV infection. The final presentation of the session demonstrated that there was a difference between the bacterial population of the mouth of homosexual AIDS patients as opposed to IV-drug-using AIDS patients. This difference may relate to the higher incidence of HIV-associated gum disease in homosexual AIDS patients.

## Oral infections are first symptom!

The second session was entitled "Oral Manifestations of AIDS." This consisted of nine presentations covering the entire spectrum of HIV associated oral disease. The most significant point is that oral infections are the first clinical manifestations of AIDS. Not only that but it is ironic that HIV, which is supposedly a sexually transmitted organism, produces no ulcerations or sores of the genitals but produces a great many such lesions of the lips, tongue, gums, and oral cavity. Anyone sitting through the literally dozens of slides of inflamed, ulcerated and rotting mouths, gums, and even jaws, associated with AIDS would have a hard time believing that contact with such mouths posed no threat of transmission of HIV—especially in light of the well-documented association of transmission of HIV with ulcerated lesions of the genital organs, associated with real sexually transmitted diseases, such as syphilis and gonorrhea.

It was the third session on Microbiology and Immunology which provided the *coup de grace* to the idea that oral transmission, and specifically saliva transmission, was impossible. This session opened with an overview on oral transmission of HIV by Djordje Ajdukovic, of the Institut Armand Frappier, which confirmed that there indeed was active infectious virus in at least some of the inflamed, ulcerated mouths that had appeared in the previous session. This was followed by a presentation on salivary antibodies to HIV in intravenous drug users and homosexual men by D. Archibald, of the University of Maryland Dental School, who was co-chairing the session.

After Dr. Archibald's presentation, things really became interesting. A presentation titled "Lymphocyte Activation by Oral Bacteria As a Factor in Transmission of AIDS by Saliva," by Drs. Q.L. Liu of Shanghai, Pekovic, Ajdukovic and colleagues, demonstrated the presence of HIV-infected lymphocytes in the gingiva and saliva of HIV-seropositive individuals. These HIV-infected lymphocytes had been immunologically activated by bacteria in the mouth which facilitated infection of the lymphocytes by HIV and stimulated the production of high titers of virus by the infected lymphocytes. They concluded that "This activation capacity of oral bacteria may play a significant role in the infection of PBL [peripheral blood lymphocytes] by HIV."



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Dr. Pekovic then presented more evidence of involvement of HIV in human oral diseases. Using sophisticated immunologic techniques and electron microscopy, Pekovic and his colleagues studied 96 patients at different stages of HIV infection. They demonstrated the presence of HIV in blood lymphocytes, gingival epithelial cells (i.e. the surface of the gums), lymphocytes in the gums and saliva, as well as in areas of gingivitis and periodontitis. In fact the number of infected lymphocytes in saliva was higher than in blood!

The kiss of death came in the next presentation, entitled "AIDS Transmission and Microlesions of the Oral Mucosa," by a research group from the Infectious Diseases Clinic of the Medical Faculty of the University of Naples, Italy. By doing studies on the level of hemoglobin, a red blood cell pigment, before and after activities such as eating, kissing, and toothbrushing, they found a significant increase after brushing teeth and kissing but not after eating. They conclude:

> It is generally accepted that the presence of blood in the saliva is indirect evidence that microlesions are present in the oral cavity. During kissing, two mucosae, both of which may contain microlesions, come into close contact. The intense rubbing which occurs during kissing can favor both the formation of microlesions and the passage of blood from one partner to the other. If the blood of one partner contains HIV, the virus can pass into the bloodstream of the other partner. Our study has shown that microlesions are normally present in the oral mucosa and that saliva contains blood. Therefore, we feel that passionate kissing cannot be considered protective sex for the transmission of human immunodeficiency virus infection.

With this background, Dr. Robert Illa of Oroville, California presented the following case:

> A 70-year-old woman who received blood from an HIV positive donor following coronary by-pass surgery in 1979 developed AIDS and died in 1984. Her husband, a 72-year-old man, lost 36 lbs. in 1985. He had a low helper/inducer T-lymphocytes count, became HIV positive, suffered from numerous lung infections and neoplasms and died in 1985 of respiratory failure. The husband was sexually impotent and he denied sexual intercourse with his wife (or with any other woman) since the time of her surgery. He also denied any other risk factor for HIV infection although the couple was affectionate and kissed each other on the mouth often. The CDC officer who interviewed the husband and his children was unable to suspect any other reason for HIV infection. This case may represent the spread of HIV through the oral route via saliva.

Following this presentation, Dr. Pekovic rose and asked Dr. Illa if he had published the case, which had occurred in 1985. Dr. Illa responded that he had been subjected to threats by state and federal health officials and that the laboratory which did the AIDS test on the patient had been closed by the State of California in spite of being one of the major medical laboratories in the state. Before closing, the laboratory sent Dr. Illa a report claiming that the positive test on the husband was an error, the only such error ever made on a positive test and somewhat suspect since a second sample, from the same patient but under a different name, was still listed as positive!

The dénouement to this climactic case came in the final summary of the panel, delivered by Dr. Archibald, who grudgingly conceded that the evidence indicated that salivary transmission might be possible and that Dr. Illa's patient might represent such a case. Afterwards it came to light that his initial formulation was that there was no real scientific evidence for salivary transmission and that the California case was questionable. The next stage in this battle will be to get the conference proceedings published and circulated. But the genie is now out of the bottle and those who hold the line that salivary transmission is impossible will find that line less and less tenable.

The Second International Symposium on Oral AIDS is already scheduled for next year in New York City and in light of the debacle of the Fifth International Conference on AIDS, there are indications that serious scientists are looking to this conference as an alternative forum for presenting their research. Dr. Pekovic is presently committed to maintaining the primary focus on oral AIDS, but his example may well inspire other serious scientists to consider holding alternative conferences to the next Roman circus. The Sixth International Conference on AIDS is presently scheduled for San Francisco in 1990.

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