Tropical Institute physicians refute CDC coverup report

In May 1986, the Atlanta-based Centers for Disease Control’s (CDC) Morbidity and Mortality Weekly Report (MMWR) threatened to publish a fraudulent report to explain away the overwhelming pattern of “No Identifiable Risk” (NIR) AIDS cases in Belle Glade, Florida. Belle Glade has the highest percentage of AIDS cases, and of NIR cases of AIDS, in the country. The CDC report was not based upon any scientific study, but was nothing more than a continuation of their “opinion” that there could not be such a pattern of cases in Belle Glade because of how they, the CDC, have arbitrarily defined the “only possible” routes of AIDS transmission.

Dr. Mark Whiteside and Dr. Caroline MacLeod of the Tropical Disease Institute in Miami, who have courageously led a campaign to reveal the true scientific facts about AIDS and collapsed environmental factors in the tropics, produced a stinging rebuttal of the CDC report at the time, in the form of a letter to CDC officials. In response, the CDC withdrew its faulty report from publication. Nonetheless, four months later, in late September, the CDC published its lying draft. Dr. Whiteside therefore released his rebuttal to EIR on Oct. 7, along with a prefatory statement. Below is Dr. Whiteside’s statement of Oct. 7, followed by the full text of the letter:

It is clear to me that the CDC officials had already reached their conclusions before they ever came to Belle Glade. James Mason stated in a letter to Warren Hamerman, dated Aug. 27, 1985, that “Most of the patients reported from Belle Glade have known risk factors for AIDS, such as homosexuality or intravenous drug use.” Harold Jaffe reaffirmed this position and predicted that the hypothesis that “mosquitoes, poverty, or the environment” contribute to AIDS would be “laid to rest.” This MMWR report reflects an overwhelming bias toward sexual transmission of AIDS, and the conclusions are not warranted by the available data. It is evident to a growing number of scientists and concerned citizens that there is, in fact, a direct relationship between environment and disease in Belle Glade, Fla. It is most unfortunate if this report allows us to neglect the conditions of economic squalor that allow the uncontrolled spread of such diseases as AIDS and tuberculosis.

The Whiteside/MacLeod letter to CDC

We reviewed the May 13, 1986 MMWR draft entitled, “Acquired Immunodeficiency Syndrome (AIDS) in western Palm Beach County, Florida.” This document is unscientific, and a gross misrepresentation of the pattern of AIDS in the ‘glades area. The conclusion that AIDS can be explained in this region by the classic “risk factors” with an increase in (bidirectional) heterosexual transmission is not supported by available data. It is outrageous that such sweeping conclusions are drawn when the studies are incomplete and the possible role of environmental factors have not been examined. This clumsy attempt to blame the AIDS epidemic in the Tropical setting on “sex and dirty needles” with environmental factors neatly sidestepped, is particularly unfortunate when Belle Glade is perhaps the best barometer of the changing pattern of AIDS in south Florida. The following point-by-point critique of this MMWR document explains why we believe it should not be published in the present form.

The article addresses western Palm Beach County, but certainly the vast majority of AIDS cases (even those listed with current residence in South Bay or Pahokee) in the Glades area, lived in or had an important link to Belle Glade. What are the facts? Independent surveys (by CDC and the Institute of Tropical Medicine in Miami) document a 9-11% seroprevalence of antibodies to HTLV-III/LAV among a largely heterosexual control population from one of the two central depressed—that is, southwest—neighborhoods of Belle Glade. Over 50% of “official” AIDS, and 60-70% of HTLV-III/LAV antibody positive individuals do not have an identifiable “risk factor.” Considering that the southwest neighborhoods contain approximately 40% of Belle Glade’s 20,000 population, at least 1 in 10 has been “exposed” and 1 in 200 already has AIDS. These rates are indeed comparable to those observed in Central Africa.

The “official” figures cited in the MMWR draft do not accurately reflect the true numbers of sick individuals in Belle Glade or the changing pattern of disease in this community, the increasing percentage in the “no identifiable risk” (NIR) category. Lack of diagnostic facilities (for example bronchoscopy-endoscopy) and few autopsies in this isolated, rural community have meant that AIDS is under-reported by a
factor of at least 3 to 1. A tropical disease clinic operated by
the Palm Beach County Health Department maintains a list
of over 200 persons with AIDS, presumptive AIDS (most of
whom are already dead), ARC, and HTLV-III/LAV antibody
positive (sick) individuals.

Clinicians, including ourselves, caring for these individu­als
realize the majority of new cases of AIDS are no identi­fi­able
risk (NIR) men and women, born either in the Carib­bean
or in the Southeastern United States. A physician, who
recently visited the Tropical Disease Clinic, asked, "Don't
you have any patients who are in one of the usual risk groups?"

On page 1 of the MMWR draft, it states that, "An addi­tional
four AIDS cases initially placed in this (NIR) category
were reclassified as transfusion-associated or heterosexual
contacts of intravenous drug users based on further infor­ma­tion." CDC officials reclassified these individuals without
consulting the primary care physicians, and by using second­hand or undocumented sources of information. A male who
(questionably) had sexual contact with a female drug user,
was considered to be "at risk" in this study. Finding evidence
of sexual contact in a few cases may mean nothing more than
shared environmental exposures.

The CDC table of AIDS by patient characteristics and sex
would indicate that 20% of AIDS occurred among persons
born in Haiti. Our own records indicate that 30% of AIDS
now occurs among persons born in the Caribbean. The
majority of these individuals do not have identifiable risk factors
for AIDS. The CDC, however, continues to overlook the
problem of AIDS among Caribbean immigrants to south
Florida. The federal investigators do not evaluate AIDS among
Haitians in Belle Glade, apparently satisfied by their own
limited data suggesting that AIDS is spread by heterosexual
means (or "promiscuity") in this group. How, we asked, do
they explain that 16% of AIDS in Florida occurs in individu­als
born in the Caribbean or that the rate of AIDS among
Haitians living in Miami is four times the rate of AIDS of
Haitians living in New York City?

Newly diagnosed cases of AIDS and ARC increasingly
follow the "Tropical pattern" of men and women without the
usual pre-existing "risk factors." They represent nearly all
age groups, with a growing number of persons from the 50-to
60-year-old age group. Although not yet diagnosed with
AIDS, several children with severe Failure to Thrive Syn­dromes and multiple infections are being followed prospec­tively in the Tropical Disease Clinic.

Although the age and sex distribution reported in the
MMWR do not reflect the current trends, the predominance
of the adult male cases actually support an environmental
exposure (for example, more field work, mechanical injuries,
fishing on canals, etc.) and argue against heterosexual trans­missions, as female-to-male AIDS is unproven, and has rarely
been reported in the United States. The lack of AIDS in
children is unconvincing as an argument against environmen­tal spread of AIDS, since we believe AIDS is a disease of
repeated exposure over time (enhancement) and one would
expect, as seen with insect-borne viruses (for example, yel­low fever), a gradually increasing instance of antibodies with
age. It is puzzling why CDC finds it difficult to accept NIR
AIDS, since they readily accept hepatitis B (serum hepatitis)
as a model for transmission. In the Tropics, hepatitis B is a
disease of the general population living in an environmentally
poor, overcrowded condition. Several studies implicate in­sect transmission of hepatitis B in this setting. It is only as
the standard of living improves, that hepatitis B becomes a
disease of "risk groups" with transmission by parenteral or
indirect parenteral means, i.e., shared needles, direct intro­duction, sexual practice, at least to break some skin and
mucosa. It is apparent that investigators from CDC have
spent little time reviewing modes of transmission of hepatitis
B in the Tropics, or the known modes of transmission of
animal retroviruses. Mechanical transmission by large
bloodsucking insects is a major mean of spread of bovine
leukemia virus and equine infectious anemia ("swamp fe­ver") in conditions of crowding and abundant insect popula­tions. These retroviruses are rarely sexually transmitted
from male to female animal.

No identifiable risk and female-heterosexual-contact
AIDS, as well as infant cases, are concentrated in black and
Hispanic (often Puerto Rican) populations living in poor envi­ronmental conditions along the Southern and East Coast of
the United States. There has been a notable absence of
female-heterosexual-contact AIDS in regions of high inci­dence of homosexual/bisexual men, for example, San Fran­cisco, Calif. and Key West, Fla. All reported cases of AIDS
from Belle Glade, Fla. have long-term residence in the slums

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of the southwest neighborhood.

We repeat our premise that an untreatable sexually transmitted disease does not confine itself to geographical regions or a single poor neighborhood. There is no mention in this report of the concurrent epidemic of tuberculosis limited to the same poor neighborhoods in Belle Glade.

The reference to the CDC Fort Collins arbovirus survey on p. 40 of the MMWR draft, indicates that the Atlanta group has decided not to investigate vector transmission of AIDS, or our hypothesis that repeated exposures to Bunyamwera serogroup arboviruses lead to immunosuppression and activation of retroviruses such as HTLV-III/LAV. This paragraph omits the following critical information: 1) It was only at our urging and direction that antibodies to these arboviruses were tested; 2) Antibodies to arboviruses were measured by plaque reduction neutralization; all antibodies to HTLV-III/LAV were measured by ELISA and Western Blot procedures. It is well known that most patients with AIDS lack neutralizing antibodies to HTLV-III/LAV! 3) The survey showed a remarkably high seroprevalence of antibodies to one of these arboviruses in the HTLV-III/LAV negative control group; and 4) 17% (versus 15% in our own survey) showed antibodies to Maguari, a Bunyamwera serogroup virus endemic to the Caribbean and South America, and not previously reported in the United States.11

Our own data using indirect immunofluorescence (IFA), a serologic test comparable to ELISA for HTLV-III, has shown a highly significant association between antibodies to Maguari and AIDS.12 There was an inverse correlation between neutralizing antibodies to Bunyamwera arboviruses (Tensaw, Maguari) and antibodies to HTLV-III, supporting our hypothesis of sub-neutralizing (but enhancing) concentrations of antibody to the arbovirus in persons with AIDS. The CDC has steadfastly refused to test AIDS patients for arboviruses by other serologic methods, including the IFA technique we have used for several years. It would be a miracle, if the CDC found a link between AIDS and insect vectors, considering their closed-mindedness and refusal to seriously study the subject.

One of the fundamental problems of the ongoing CDC/Florida HRS Cross-Sectional Study of AIDS in Belle Glade is that it assumes HTLV-III/LAV is the only "cause" of AIDS, and it focuses on sexual transmission of AIDS to the virtual exclusion of environmental factors. It has been noted that many people have antibodies to HTLV-III/LAV, but with no evidence of immune dysfunction, and conversely, some AIDS patients have no evidence of HTLV-III/LAV infection. Bidirectional heterosexual contact has not been proven to be the primary mode of transmission of AIDS in tropical regions (for example, Africa, Caribbean); we already know that the majority of NIR AIDS in south Florida are not explained by this mechanism. This report implies that only when CDC interviews patients is the data valid, whereas, in fact, even early (now deceased) NIR cases of AIDS in Belle Glade were independently interviewed by ourselves, public health physicians, and epidemiologists.

There is intense national and international scrutiny of the ongoing studies of AIDS in Belle Glade, and we believe the lessons learned have major public health significance, not only in south Florida, but for other communities worldwide. The MMWR is a greatly respected format for dissemination of accurate information. Unfortunately, there is no mechanism for rebuttal.

We never thought it would be necessary to debate with public health officials, the importance of the environment in relation to health and illness. We should have prevention and control of AIDS as our primary goal. If we wait to act until all causes and all modes of transmission of AIDS are proven, then millions will continue to be infected and die from the disease. It will be a sad day for public health in south Florida, if this document is published in the same tone as presented in the draft of May 13, 1986.

(Signed)

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References


3. Case Records, Tropical Disease Clinic, Palm Beach County Health Department, Glades Health Center, Belle Glade, Fla.


