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Università degli studi di Firenze

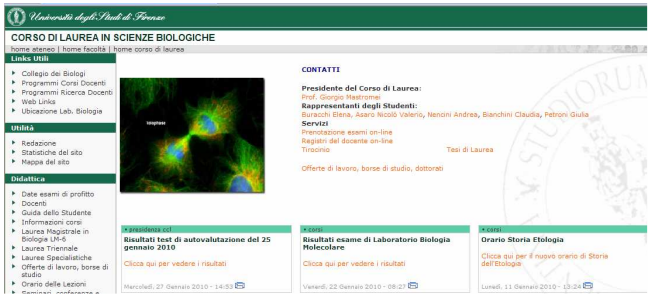
DOTTORATO DI RICERCA IN SCIENZE CHIMICHE

The Chemical Bases of AIDS

Università degli Studi di Firenze, Aula Magna

Marco Ruggiero MD PhD

www.marcoruggiero.org



PhD Program in Chemical Sciences

DOTTORATO DI RICERCA IN SCIENZE CHIMICHE
XXIII ciclo: III anno; XXIV ciclo: II anno ; XXV: I anno

Febbraio- 2010 Aula 37 Dip. Chimica

Time	1 Lun	2 Mar	3 Mer	4 Giov	5 Ven	8 Lun	9 Mar	10 Mer	11 Gio	12 Ven
9.30-11.30	Guarna	Guidelli	Ruggero	Spina	Guidelli	Neto	Spina	Ruggero	Sessoli	Neto
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Time	15 Lun	16 Mar	17 Mer	18 Giov	19 Ven	22 Lun	23 Mar	24 Mer	25 Giov	26 Ven
9.30-11.30	Neto	Sessoli	Ruggero	Sessoli	Neto	D. Giomi	Guarna	Ruggero	Sessoli	Guidelli
14.30-16.30	D. Giomi	D. Giomi	Minunni	Chimichi	Chimichi	Guidelli	Chimichi	Chimichi	Guarna	D. Giomi

(BIO/11) Prof. M. Ruggiero Le basi chimiche dell'AIDS
(FIS/03) Prof. G. Spina Spazi di Liouville in spettroscopia

C. Organica
Prof. S. Chimichi Spettroscopia NMR: aspetti teorici e pratici delle moderne tecniche bidimensionali di correlazione scalare.
Organocatalisi asimmetrica: un nuovo tipo di catalisi in condizioni metal-free
Prof. A. Guarna Stereochimica: dai principi di base alle nuove metodologie

C. Inorganica
Prof. R. Sessoli / Dr. C. Sangregorio Materiali Magnetici Nanostrutturati e Molecolari

C. Analitica
Dr. Minunni Immobilizzazione di biomolecole si superfici e realizzazione di dispos innovativi

C. Fisica

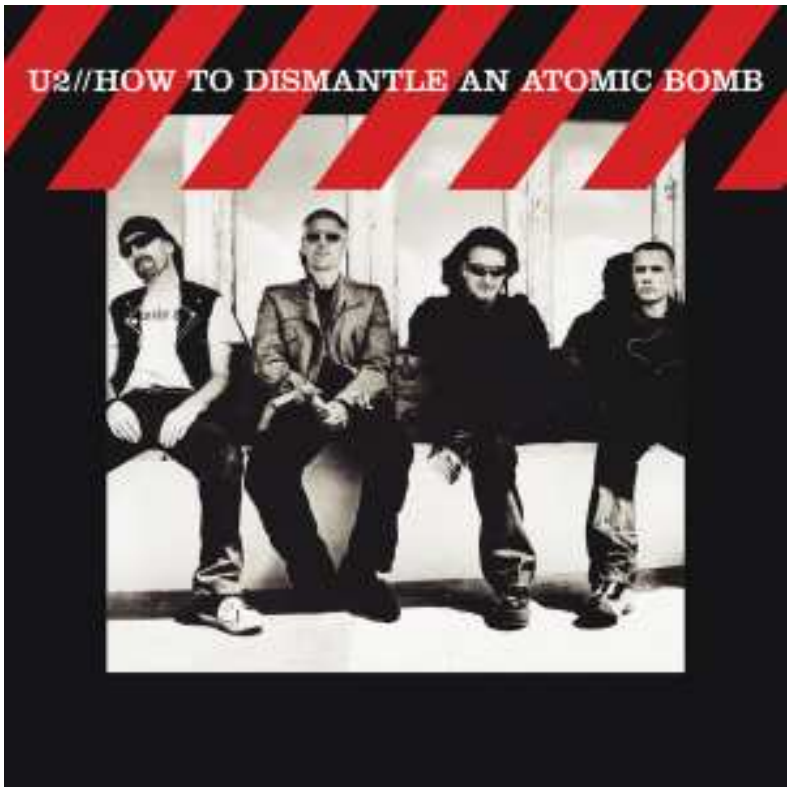
Dr. G. Aloisi Le microscopie a scansione di sonda *(pomeriggio escluso giovedì)*
Prof. R. Guidelli Trasporto ionico attraverso le biomembrane (qualunque orario)
Prof. L. Neto Introduzione ai tensori e loro applicazioni

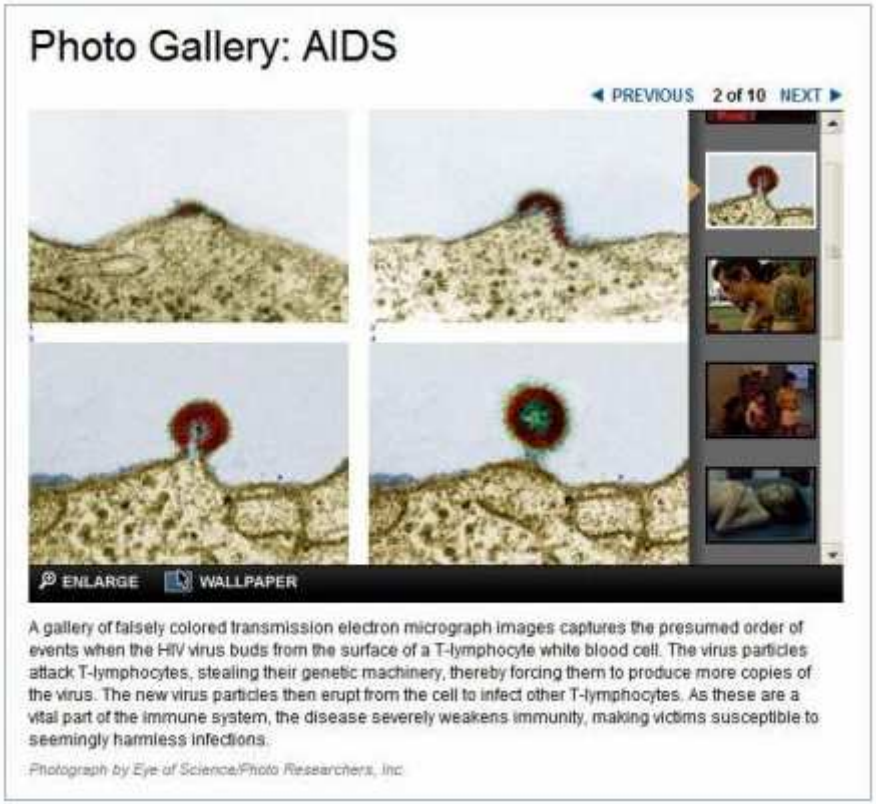
C. Fisica/ C. Inorganica
Prof M.Romanelli/ Dr. F. Di Benedetto Risonanza Paramagnetica Elettronica in stat

Altri settori		Febb
Ruggiero	C. Ghedini XXIV P. Nicolini XXIV S. Scarano XXIII D. Fibbi XXIV L. Misuri XXIII M. Giannoni XXIV R. Gualdani XXIV Guerriero XXIII L. De Lellis XXIV Silvia Pappini XXIII V. Mirabello XXIV E. Ravera XXV Y.Balachandran XXV Lastraioli XXIII Neri Sara XXIV M. Toccafondi XXIV G. Gabrielli XXIV Laura Bartali XXV Luca Giustini XXIII Andrea Casini XXV	
20		

Part I

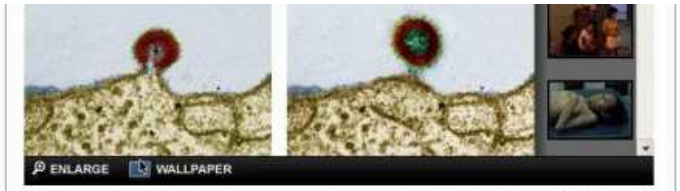
HIV=AIDS? How to dismantle a flawed hypothesis





I guess that it is

- difficult to dismantle an atomic bomb. However, to dismantle a flawed hypothesis is easy, just ask. Or better, do not stop questioning!



A gallery of falsely colored transmission electron micrograph images captures the presumed order of events when the HIV virus buds from the surface of a T-lymphocyte white blood cell. The virus particles attack T-lymphocytes, stealing their genetic machinery, thereby forcing them to produce more copies of the virus. The new virus particles then erupt from the cell to infect other T-lymphocytes. As these are a vital part of the immune system, the disease severely weakens immunity, making victims susceptible to seemingly harmless infections.

Photograph by Eye of Science/Photo Researchers, Inc.

I was surprised that one of the HIV/AIDS groupies had not already dumbfounded me with this conclusive evidence of the veritable existence of echt "HIV". But then I remembered some of what I used to know about electron microscopy: specimens to be examined by that technique are ultra-thin sections of material "fixed" in some manner to withstand the nearly absolute vacuum that allows electron beams to serve as the "light" source to illuminate the specimen. You can't do electron microscopy *in situ*, *in vivo*. Ergo, those 4 pictures cannot be an ***echt*** sequence. Moreover, the odds would be impossibly against capturing such a sequence by preparing a series of specimens: how lucky would you have to be to catch the "budding virus" at just the right moments?

I sent an inquiry to the National Geographic website and was referred to Photo Researchers, who are credited for these images. They responded:

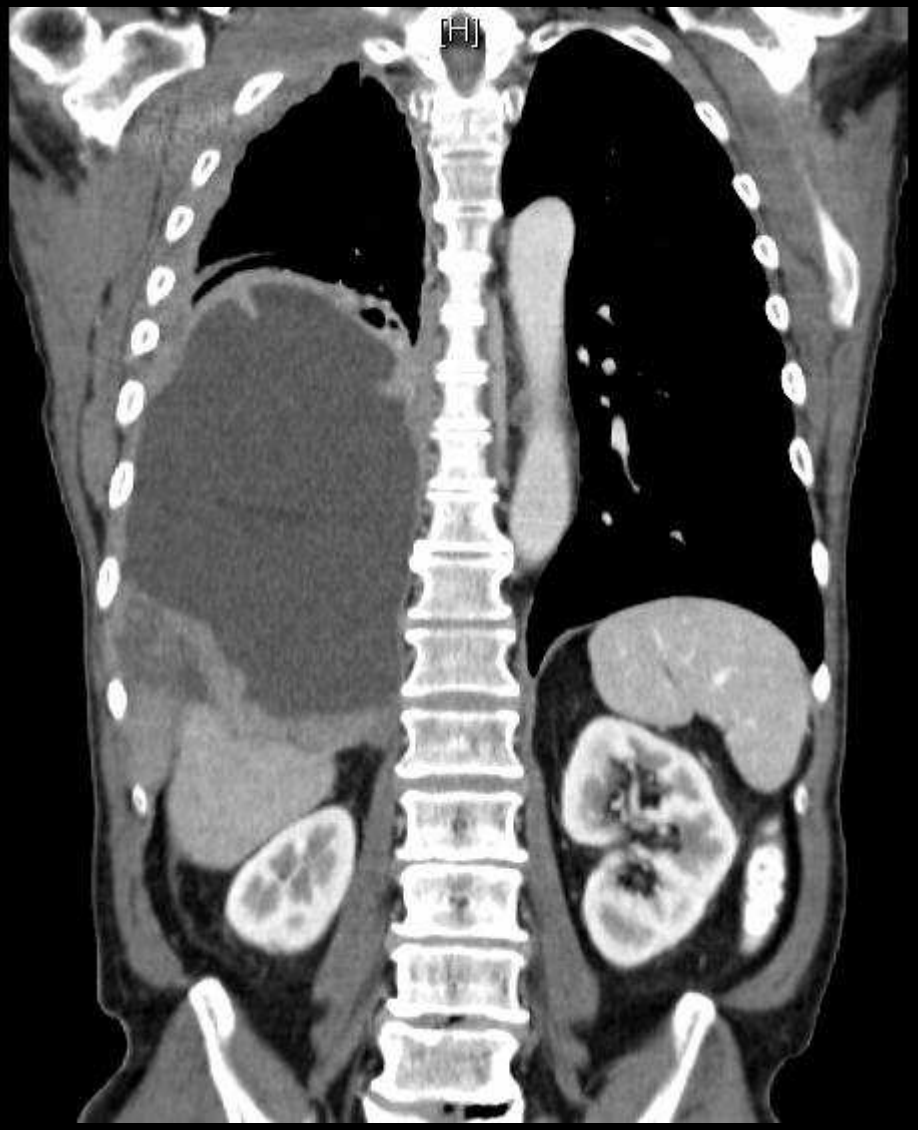
"The photo you listed is represented by our stock agency here in the US. The copyright owner is actually based in Germany and they have many agents selling the piece worldwide.
The only sales we have here in the US have been the Nat. Geo. you linked to and a sale to 'Junior Scholastic' back in 2006. Due to the vast distribution of the image there is the distinct possibility that this image has been used in a wide variety of places."

and

"These are certainly TEM's [transmission electron micrographs]... but with a few caveats. First, they have been (obviously) colorized from the original B/W. Second, this is not a true sequence in that we are not seeing the same virus particle. And third, the cell was repeated in the bottom two frames to create the effect of a sequence.

Before AIDS, an appetizer

Is the AIDS scam the first case of industrial interests killing people?



Germany, 1930-40

- In 1938 lung cancer was recognized in Germany as an occupational disease of workers who had been exposed to asbestos (Nordman, Der Berufkrebs der Asbestarbeiter. Z. Krebsforsch 47:288–302, 1938).
- In 1942, in Germany, lung cancer associated with asbestosis was recognized as a compensable occupational disease (Proktor, 1999).

United States 1940-50

(from Wikipedia)

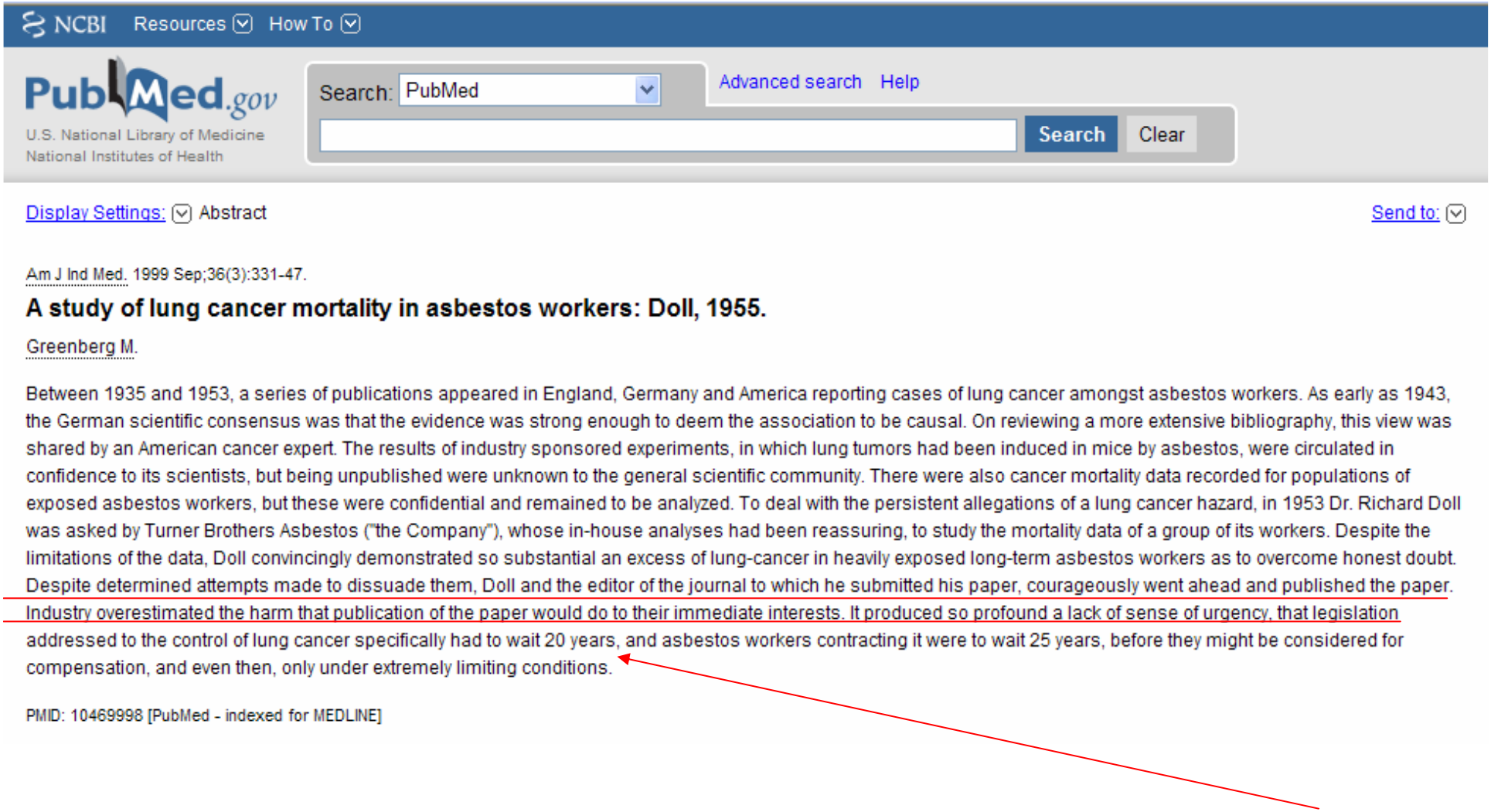
1940s [edit]

In 1942, an internal Owens-Corning corporate memo referred to "medical literature on asbestosis.... scores of publications in which the lung and skin hazards of asbestos are discussed."[39] Either in 1942 or 1943, the president of Johns-Manville, Lewis H. Brown, said that the managers of another asbestos company were "a bunch of fools for notifying employees who had asbestosis." When one of the managers asked, "do you mean to tell me you would let them work until they dropped dead?" the response is reported to have been, "Yes. We save a lot of money that way."[41] In 1944, a Metropolitan Life Insurance Company report found 42 cases of asbestosis among 195 asbestos miners.[39]

1950s [edit]

In 1951, asbestos companies removed all references to cancer before allowing publication of research they sponsored.[42] In 1952, Dr. Kenneth Smith, Johns-Manville medical director, recommended (unsuccessfully) that warning labels be attached to products containing asbestos. Later, Smith testified: "It was a business decision as far as I could understand...the corporation is in business to provide jobs for people and make money for stockholders and they had to take into consideration the effects of everything they did and if the application of a caution label identifying a product as hazardous would cut into sales, there would be serious financial implications."[43] In 1953, National Gypsum's safety director wrote to the Indiana Division of Industrial Hygiene, recommending that acoustic plaster mixers wear respirators "because of the asbestos used in the product." Another company official noted that the letter was "full of dynamite" and urged that it be retrieved before reaching its destination. A memo in the files noted that the company "succeeded in stopping" the letter, which "will be modified."[44]

However …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Send to:
Am J Ind Med. 1999 Sep;36(3):331-47.
A study of lung cancer mortality in asbestos workers: Doll, 1955.
Greenberg M.
Between 1935 and 1953, a series of publications appeared in England, Germany and America reporting cases of lung cancer amongst asbestos workers. As early as 1943, the German scientific consensus was that the evidence was strong enough to deem the association to be causal. On reviewing a more extensive bibliography, this view was shared by an American cancer expert. The results of industry sponsored experiments, in which lung tumors had been induced in mice by asbestos, were circulated in confidence to its scientists, but being unpublished were unknown to the general scientific community. There were also cancer mortality data recorded for populations of exposed asbestos workers, but these were confidential and remained to be analyzed. To deal with the persistent allegations of a lung cancer hazard, in 1953 Dr. Richard Doll was asked by Turner Brothers Asbestos ("the Company"), whose in-house analyses had been reassuring, to study the mortality data of a group of its workers. Despite the limitations of the data, Doll convincingly demonstrated so substantial an excess of lung-cancer in heavily exposed long-term asbestos workers as to overcome honest doubt. Despite determined attempts made to dissuade them, Doll and the editor of the journal to which he submitted his paper, courageously went ahead and published the paper. Industry overestimated the harm that publication of the paper would do to their immediate interests. It produced so profound a lack of sense of urgency, that legislation addressed to the control of lung cancer specifically had to wait 20 years, and asbestos workers contracting it were to wait 25 years, before they might be considered for compensation, and even then, only under extremely limiting conditions.
PMID: 10469998 [PubMed - indexed for MEDLINE]

A brief history of AIDS-research

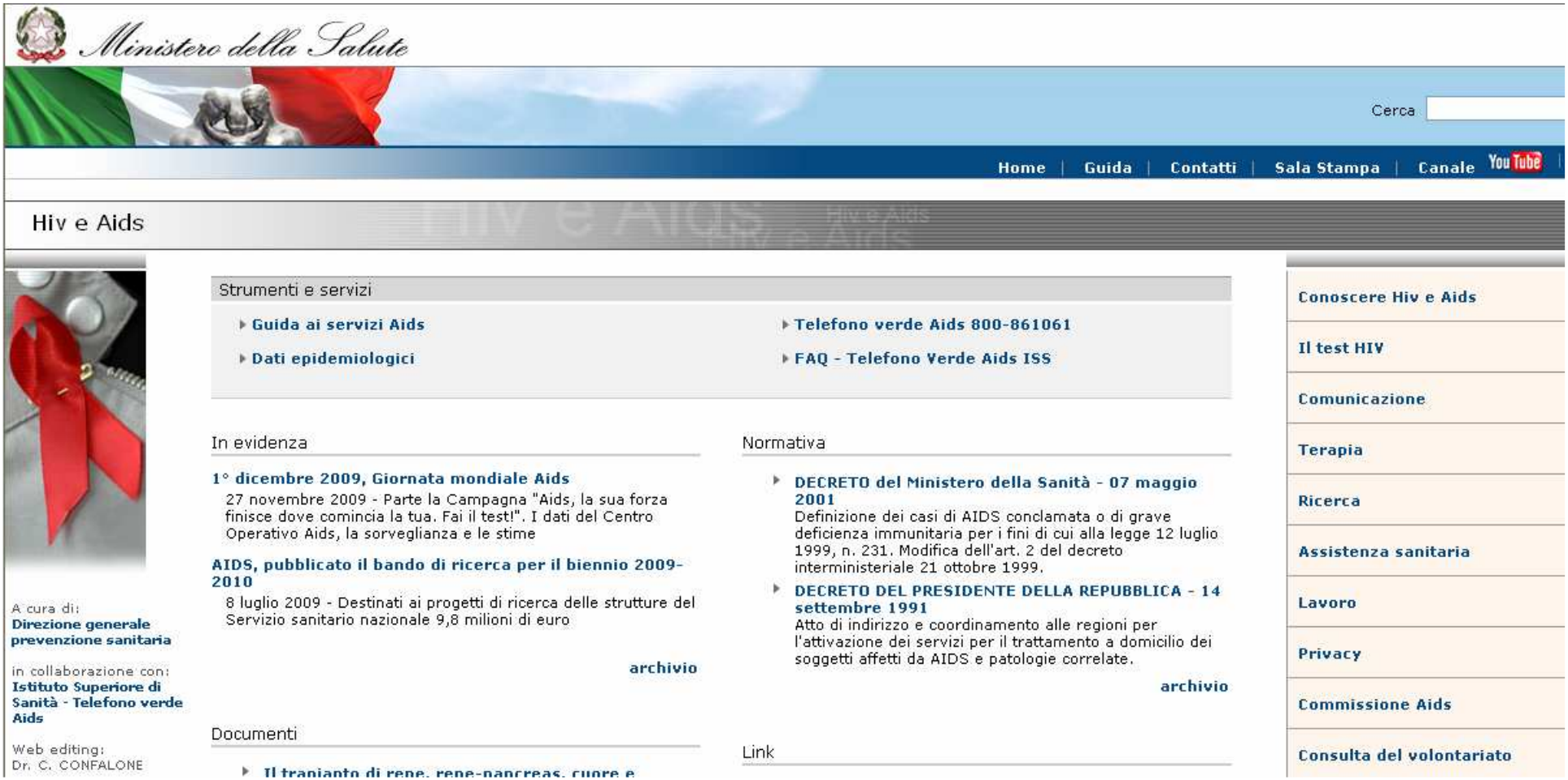
- The birth of Aids research dates back to the beginning of the Eighties. Starting from 1980 a new mysterious pathological condition killing previously healthy persons was observed in the United States and soon recorded by the epidemiological surveillance federal agency CDC (Centers for Disease Control).
- First patients suffered from an unusually severe form of Kaposi's sarcoma and from opportunistic infections, such as *Pneumocystis Carinii* pneumonia. They especially included young homosexual males from big urban areas (Los Angeles and New York City) and intravenous drugs users, but soon other populations were identified as involved in the epidemic (such as hemofiliacs and infants).

A syndrome rather than a disease: the GRID before the AIDS

- Susceptibility to opportunistic infections suggested a pathological lack of immunocompetence and was readily associated with lymphocytopenia observed in patients' blood.
- This connection guided the first official definition of the newly observed clinical phenomenon as a *syndrome*, *i.e.*, a condition which manifests itself as a collection of symptoms due to an underlying pathological condition, *immunodeficiency*, which is *acquired*, namely non-congenital.

Definitions

- from the Italian Ministry of Health



DIAGNOSIS

- Candidiasis of bronchi, trachea, or lungs;
- Candidiasis esophageal;
- Cervical cancer, invasive;
- Coccidiodomycosis, disseminated or extrapulmonary;
- Cryptococcosis, extrapolmonary;
- Cryptosporidiosis, chronic intestinal (greater than 1 month's duration);
- Cytomegalovirus (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis;
- Encephalopathy, HIV-related;
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis;
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (greater than 1 month's duration)
- Kaposi's sarcoma
- Lymphoma, Burkitt's;
- Lymphoma, immunoblastic;
- Lymphoma, primary, of brain;
- Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary;
- Mycobacterium tuberculosis pulmonary;
- Mycobacterium tuberculosis extrapulmonary;
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary;
- Pneumocystis carinii pneumonia;
- Pneumonia, recurrent;
- Progressive multifocal leukoencephalopathy;
- Salmonella septicemia, recurrent;
- Toxoplasmosis of brain;
- Wasting syndrome due to HIV;
- CD4+ T- lymphocyte count of less than 200 cells/ uL*;
- Karnofsky Index of 50 or lower*.

HIV+

*since 2001 (DECRETO MINISTERIALE 7/5/2001)

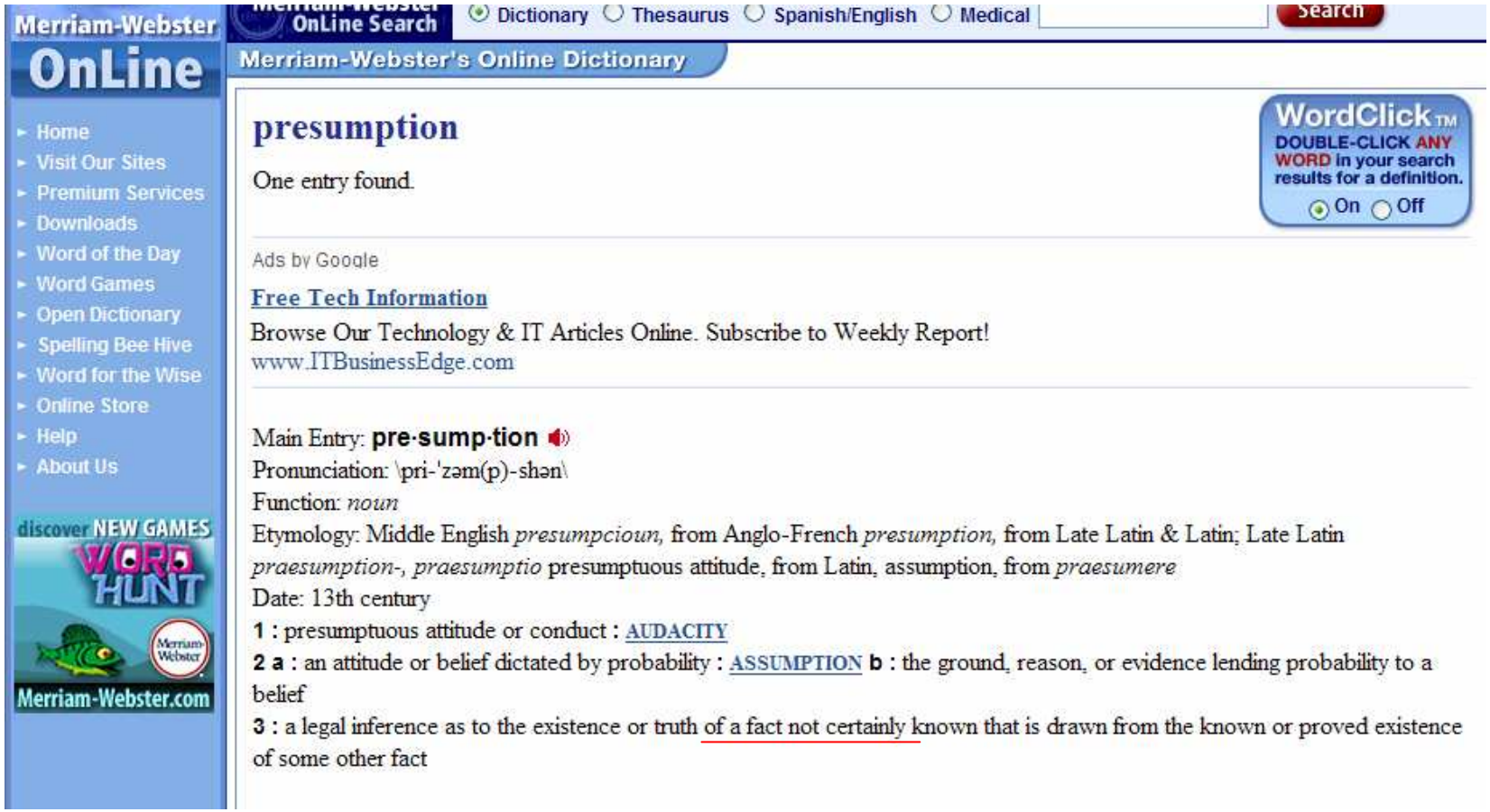
CIRCOLARE 29 aprile 1994, n.9
Revisione della definizione di caso di AIDS ai fini della sorveglianza epidemiologica.

Articolo 9998 vai all'articolo precedente - vai all'articolo successivo

ALLEGATO 4
La notifica dei casi conclamati di sindrome da immunodeficienza acquisita (AIDS) e' obbligatoria in base al decreto ministeriale 28 novembre 1986 del Ministero della sanita'.
La notifica deve essere effettuata tramite compilazione ed invio della presente scheda che sostituisce tutte le precedenti.
Le informazioni contenute nella scheda hanno carattere CONFIDENZIALE e saranno utilizzate ai soli fini di sorveglianza epidemiologica: l'attuale legislazione garantisce la riservatezza delle informazioni.
La presente scheda deve essere compilata in triplice copia a ricalco in caratteri stampatello in ogni sua parte.
La prima pagina della scheda va inviata a:
Centro operativo AIDS - Laboratorio di epidemiologia e biostatistica - Istituto superiore di sanita' - Viale Regina Elena, 299 - 00161 ROMA (Tel. 06/4940602 - Fax 06/4468380).
La seconda pagina della scheda va inviata a:
Assessorato alla sanita' della regione dove il caso e' stato diagnosticato.

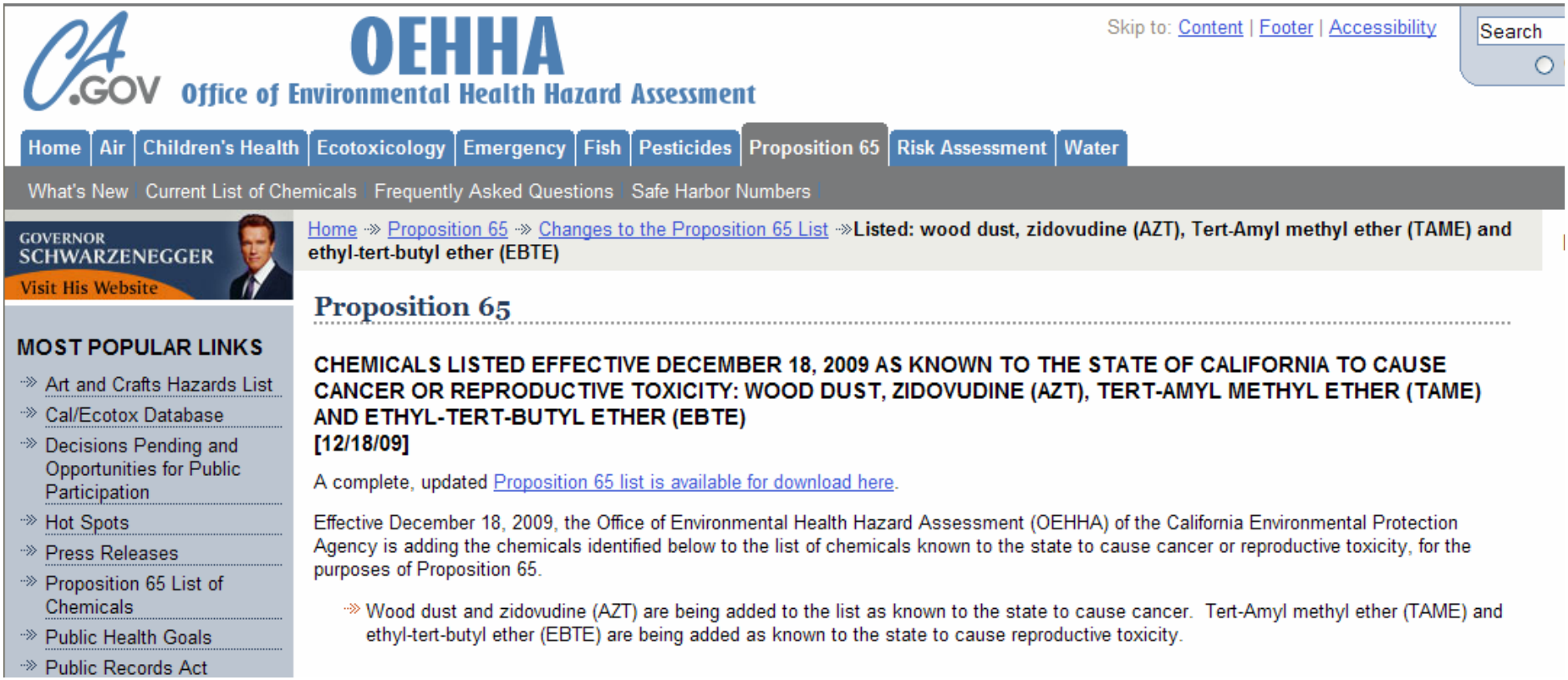
Then a *strange* word appears

presumption



Presumed diagnosis

- *i.e.* no certainty about the presence of the disease.
- But certainty of deadly side effects.



CA.GOV OEHHA Office of Environmental Health Hazard Assessment

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- Press Releases
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- Public Health Goals
- Public Records Act

Home » Proposition 65 » Changes to the Proposition 65 List » **Listed: wood dust, zidovudine (AZT), Tert-Amyl methyl ether (TAME) and ethyl-tert-butyl ether (EBTE)**

Proposition 65

CHEMICALS LISTED EFFECTIVE DECEMBER 18, 2009 AS KNOWN TO THE STATE OF CALIFORNIA TO CAUSE CANCER OR REPRODUCTIVE TOXICITY: WOOD DUST, ZIDOVUDINE (AZT), TERT-AMYL METHYL ETHER (TAME) AND ETHYL-TERT-BUTYL ETHER (EBTE)
[12/18/09]

A complete, updated Proposition 65 list is available for download here.

Effective December 18, 2009, the Office of Environmental Health Hazard Assessment (OEHHA) of the California Environmental Protection Agency is adding the chemicals identified below to the list of chemicals known to the state to cause cancer or reproductive toxicity, for the purposes of Proposition 65.

- Wood dust and zidovudine (AZT) are being added to the list as known to the state to cause cancer. Tert-Amyl methyl ether (TAME) and ethyl-tert-butyl ether (EBTE) are being added as known to the state to cause reproductive toxicity.

CIRCOLARE 29 aprile 1994, n.9
Revisione della definizione di caso di AIDS ai fini della sorveglianza epidemiologica.

Articolo 9996 vai all'articolo precedente - vai all'articolo successivo

ALLEGATO 2
Linee guida per la diagnosi presuntiva delle tre nuove malattie indicative di AIDS.

Malattia	Criteri presuntivi
Polmonite ricorrente	Polmonite ricorrente (due o piu' episodi in un periodo di 12 mesi) acuta (nuova evidenza di alterazioni radiografiche con quadro negativo nel periodo intercorrente fra i due episodi) diagnosticata su base clinica o radiologica dal medico del paziente
Tubercolosi polmonare	Tubercolosi polmonare diagnosticata su base clinica e radiologica dal medico del paziente

CIRCOLARE 29 aprile 1994, n.9
Revisione della definizione di caso di AIDS ai fini della sorveglianza epidemiologica.

Articolo 9997 vai all'articolo precedente - vai all'articolo successivo

ALLEGATO 3
Metodi per la diagnosi definitiva delle tre nuove malattie indicative di AIDS.

Malattia	Metodi diagnostici
Carcinoma cervicale	Microspia (istologia o citologia)
Tubercolosi	Coltura
Polmonite ricorrente	Episodio di polmonite ricorrente (due o piu' episodi in un periodo di dodici mesi), acuto (nuova evidenza radiologica con negativita' tra i due episodi) diagnosticato da: - evidenza radiologica di polmonite; - coltura (o altri metodi diagnostici specifici) di un patogeno in grado di causare polmonite (diverso da Pneumocystis Carinii o Mycobacterium Tubercolo-sis). I casi che non hanno la conferma di laboratorio del microorganismo in causa per uno degli episodi vanno considerati diagnosticati presuntivamente.

La diagnosi presuntiva e' con QUALSIASI ALTRO METODO, quale il reperto delle seguenti combinazioni:
a) recente insorgenza di dolore toracico retrosternale alla deglutizione
E
b) candidosi orale diagnosticata dall'evidenza di macchie bianche o placche su un fondo eritematoso o evidenza microscopica di ife in un campione non coltivato prelevato dalla mucosa orale;

Early aetiological hypotheses

- The first series of publications linking homosexual AIDS with drugs, particularly aphrodisiac nitrite inhalants was published in the *New England Journal of Medicine* in 1981 together with an editorial by AIDS researcher David Durack suggesting that drugs are the causes of AIDS.
- The CDC conducted epidemiological studies, which confirmed that male homosexuals at risk for AIDS and with AIDS were using batteries of recreational and aphrodisiac drugs, Not even one male homosexual at behavioural risk for AIDS or with AIDS was found to be drug-free by the CDC.

Chemical AIDS and lifestyle in Western world

- The perfect correlations between recreational drug use and AIDS became the basis for the hypothesis that drugs, or the drug use,“lifestyle” is the cause of AIDS.
- Moreover, the findings that specific drugs, as for example nitrite inhalants, correlated with specific AIDS diseases, such as immune suppression and Kaposi’s sarcoma, directly supported the lifestyle hypothesis.

AIDS and malnutrition in Africa

- The African epidemic had been reduced right from its presumed origin in 1984 to the consequences of malnutrition and lack of drinkable water, alias poverty, consistent with its random distribution in the population.
- As Professor Montagnier said: “ … it is malnutrition that makes the immune systems of Africans weak and the diseases of TB, malaria and parasitic infections. Water is key”, clearly meaning clean water, without parasites and pollutants.

AIDS before April 23, 1984

- All clinical and epidemiological data available on AIDS in 1984 made a coherent case for lifestyle, or chemical AIDS, caused by recreational drugs and/or malnutrition.

The viral hypothesis

- On that day, government researchers from the NIH claimed that they had found in some AIDS patients antibodies against a new retrovirus closely related to a hypothetical human leukemia virus. The virus was introduced as fortunate fallout of the failed War on Cancer.
- The next day the new virus was already termed, the “AIDS virus”, by the *New York Times*. Overnight nearly all AIDS researchers dropped the lifestyle-AIDS hypothesis to work on the new “AIDS virus”, which was already endorsed by the US government.

Why did the viral hypothesis fail?

- Despite its spectacular birthday the HIV-AIDS hypothesis has remained entirely unproductive to this date: there is as yet no anti-HIV-AIDS vaccine, no effective prevention and not a single AIDS patient has ever been cured – the hallmarks of a flawed hypothesis.

Predictions *vs* facts

- An analysis of the defects of the HIV-AIDS hypothesis based on its failure to predict AIDS facts is shown in the following slides.

No.	Prediction	Fact
1.	Since HIV is "the sole cause of AIDS", it must be abundant in AIDS patients based on "exactly the same criteria as for other viral diseases."	But, only antibodies against HIV are found in most patients (1–7)**. Therefore, "HIV infection is identified in blood by detecting antibodies, gene sequences, or viral isolation." But, HIV can only be "isolated" from rare, latently infected lymphocytes that have been cultured for weeks *in vitro* – away from the antibodies of the human host (8). Thus HIV behaves like a latent passenger virus.
2.	Since HIV is "the sole cause of AIDS", there is no AIDS in HIV-free people.	But, the AIDS literature has described at least 4621 HIV-free AIDS cases according to one survey – irrespective of, or in agreement with allowances made by the CDC for HIV-free AIDS cases (55).
3.	The retrovirus HIV causes immunodeficiency by killing T-cells (1–3).	But, retroviruses do not kill cells because they depend on viable cells for the replication of their RNA from viral DNA integrated into cellular DNA (4, 25). Thus, T-cells infected *in vitro* thrive, and those patented to mass-produce HIV for the detection of HIV antibodies and diagnosis of AIDS are immortal (9–15)!
4.	Following "exactly the same criteria as for other viral diseases", HIV causes AIDS by killing more T-cells than the body can replace. Thus T-cells or "CD4 lymphocytes . . . become depleted in people with AIDS".	But, even in patients dying from AIDS less than 1 in 500 of the T-cells "that become depleted" are ever infected by HIV (16–20, 54). This rate of infection is the hallmark of a latent passenger virus (21).
5.	With an RNA of 9 kilobases, just like polio virus, HIV should be able to cause one specific disease, or no disease if it is a passenger (22).	But, HIV is said to be "the sole cause of AIDS", or of 26 different immunodeficiency and non-immunodeficiency diseases, all of which also occur without HIV (table 2). Thus there is not one HIV-specific disease, which is the definition of a passenger virus!

6.	All viruses are most pathogenic prior to anti-viral immunity. Therefore, preemptive immunization with Jennerian vaccines is used to protect against all viral diseases since 1798.	But, AIDS is observed – by definition – only after anti-HIV immunity is established, a positive HIV/AIDS test (23). Thus HIV cannot cause AIDS by "the same criteria" as conventional viruses.
7.	HIV needs "5–10 years" from establishing antiviral immunity to cause AIDS.	But, HIV replicates in 1 day, generating over 100 new HIVs per cell (24, 25). Accordingly, HIV is immunogenic, i.e. biochemically most active, within weeks after infection (26, 27). Thus, based on conventional criteria "for other viral diseases", HIV should also cause AIDS within weeks – if it could.
8.	"Most people with HIV infection show signs of AIDS within 5–10 years" – the justification for prophylaxis of AIDS with the DNA chain terminator AZT (§ 4).	But, of "34·3 million . . . with HIV worldwide" only 1·4% [= 471,457 (obtained by substracting the WHO's cumulative total of 1999 from that of 2000)] developed AIDS in 2000, and similarly low percentages prevailed in all previous years (28). Likewise, in 1985, only 1·2% of the 1 million US citizens with HIV developed AIDS (29, 30). Since an annual incidence of 1·2–1·4% of all 26 AIDS defining diseases combined is no more than the normal mortality in the US and Europe (life expectancy of 75 years), HIV must be a passenger virus.
9.	A vaccine against HIV should ("is hoped" to) prevent AIDS – the reason why AIDS researchers try to develop an AIDS vaccine since 1984 (31).	But, despite enormous efforts there is no such vaccine to this day (31). Moreover, since AIDS occurs by definition only in the presence of natural antibodies against HIV (§ 3), and since natural antibodies are so effective that no HIV is detectable in AIDS patients (see No. 1), even the hopes for a vaccine are irrational.
10.	HIV, like other viruses, survives by transmission from host to host, which is said to be mediated "through sexual contact".	But, only 1 in 1000 unprotected sexual contacts transmits HIV (32–34), and only 1 of 275 US citizens is HIV-infected (29, 30), (figure 1b). Therefore, an average un-infected US citizen needs 275,000 random "sexual contacts" to get infected and spread HIV – an unlikely basis for an epidemic!

11.	"AIDS spreads by infection" of HIV.	But, contrary to the spread of AIDS, there is no "spread" of HIV in the US. In the US HIV infections have remained constant at 1 million from 1985 (29) until now (30), (see also The Durban Declaration and figure 1b). By contrast, AIDS has increased from 1981 until 1992 and has declined ever since (figure 1a).
12.	Many of the 3 million people who annually receive blood transfusions in the US for life-threatening diseases (51), should have developed AIDS from HIV-infected blood donors prior to the elimination of HIV from the blood supply in 1985.	But there was no increase in AIDS-defining diseases in HIV-positive transfusion recipients in the AIDS era (52), and no AIDS-defining Kaposi's sarcoma has ever been observed in millions of transfusion recipients (53).
13.	Doctors are at high risk to contract AIDS from patients, HIV researchers from virus preparations, wives of HIV-positive hemophiliacs from husbands, and prostitutes from clients – particularly since there is no HIV vaccine.	But, in the peer-reviewed literature there is not one doctor or nurse who has ever contracted AIDS (not just HIV) from the over 816,000 AIDS patients recorded in the US in 22 years (30). Not one of over ten thousand HIV researchers has contracted AIDS. Wives of hemophiliacs do not get AIDS (35). And there is no AIDS-epidemic in prostitutes (36–38). Thus AIDS is not contagious (39, 40).
14.	Viral AIDS – like all viral/microbial epidemics in the past (41–43) – should spread randomly in a population.	But, in the US and Europe AIDS is restricted since 1981 to two main risk groups, intravenous drug users and male homosexual drug users (§ 1 and 4).
15.	A viral AIDS epidemic should form a classical, bell-shaped chronological curve (41–43), rising exponentially via virus spread and declining exponentially via natural immunity, within months (see figure 3a).	But, AIDS has been increasing slowly since 1981 for 12 years and is now declining since 1993 (figure 1a), just like a lifestyle epidemic, as for example lung cancer from smoking (figure 3b).

16.	AIDS should be a pediatric epidemic now, because HIV is transmitted "from mother to infant" at rates of 25–50% (44–49), and because "34·3 million people worldwide" were already infected in 2000. To reduce the high maternal transmission rate HIV-antibody-positive pregnant mothers are treated with AZT for up to 6 months prior to birth (§ 4).	But, less than 1% of AIDS in the US and Europe is pediatric (30, 50). Thus HIV must be a passenger virus in newborns.
17.	"HIV recognizes no social, political or geographic borders" – just like all other viruses.	But, the presumably HIV-caused AIDS epidemics of Africa and of the US and Europe differ both clinically and epidemiologically (§ 1, table 2). The US/European epidemic is highly nonrandom, 80% male and restricted to abnormal risk groups, whereas the African epidemic is random.

*All quotes are from The Durban Declaration, the most authoritative edition of the HIV-AIDS hypothesis to date, which was signed "by over 5000 people, including Nobel prizewinners" and published in *Nature* in 2000 (The Durban Declaration 2000). **Numbers

These “predictions vs facts”

- Were published in 2003 and were based on data available until then (mostly from the 1980-1990). In order to check whether they are still “true” and to check the *viability* of the viral hypothesis, we matched some of them with the most recent data from Italy and Tuscany.

[Duesberg P, Koehnlein C and Rasnick D 2003 The chemical bases of the various AIDS epidemics: recreational drugs, anti-viral chemo-therapy and malnutrition; *J. Biosci*. **28** 383–412]

2. Since HIV is "the sole cause of AIDS", there is no AIDS in HIV-free people.

But, the AIDS literature has described at least 4621 HIV-free AIDS cases according to one survey – irrespective of, or in agreement with allowances made by the CDC for HIV-free AIDS cases (55).

DEFINIZIONE EPIDEMIOLOGICA DI CASO ADULTO DI AIDS
PER CUI E' RICHIESTA LA NOTIFICA
(> 12 anni di eta')

1. In assenza di risultati positivi circa l'infezione da HIV, ed in assenza di altre cause note di immunodeficienza, ognuna delle forme cliniche di seguito elencate e' indicativa di AIDS se diagnosticata in modo definitivo (per la definizione di diagnosi accertata vedi le successive istruzioni della sezione 2 della scheda):

candidosi esofagea, tracheale, bronchiale o polmonare;
criptococcosi extrapolmonare;
criptosporidiosi con diarrea persistente da oltre un mese;
infezione da Cytomegalovirus polmonare o del S.N.C.;
infezione da Herpes simplex ulcerativa e persistente; o bronchite, o polmonite, o esofagite;
sarcoma di Kaposi in un paziente di eta' superiore a 60 anni;
linfoma cerebrale primitivo in un paziente di eta' inferiore ai 60 anni;
micobatteriosi atipica (da M. avium o M. kansasii) disseminata (con localizzazione diversa o in aggiunta a quella polmonare o dei linfonodi ilari o cervicali);
polmonite da Pneumocystis Carinii;
leucoencefalite multifocale progressiva;
toxoplasmosi cerebrale (S.N.C.).

8. "Most people with HIV infection show signs of AIDS within 5–10 years" – the justification for prophylaxis of AIDS with the DNA chain terminator AZT (§ 4).

But, of "34·3 million . . . with HIV worldwide" only 1·4% [= 471,457 (obtained by substracting the WHO's cumulative total of 1999 from that of 2000)] developed AIDS in 2000, and similarly low percentages prevailed in all previous years (28). Likewise, in 1985, only 1·2% of the 1 million US citizens with HIV developed AIDS (29, 30). Since an annual incidence of 1·2–1·4% of all 26 AIDS defining diseases combined is no more than the normal mortality in the US and Europe (life expectancy of 75 years), HIV must be a passenger virus.

And in Italy, how many HIV-positive people do develop AIDS?

Or, is AIDS a relevant disease in Italy?

Not really, according to the Ministry

Ministero della Salute (Italia)

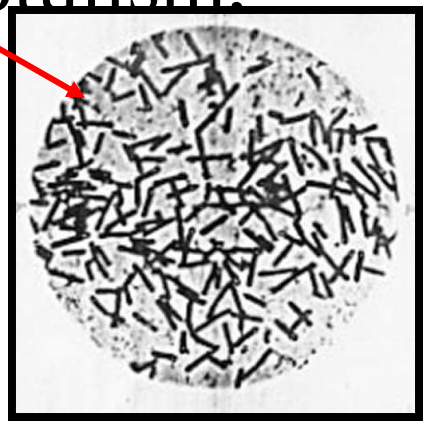
della Repubblica Italiana

Ministero della Salute

Istituito nel:	2001
Istituito da:	Governo Berlusconi II
Soppresso nel:	2008
Soppresso da:	Governo Berlusconi IV
Competenze oggi di:	Ministero del Lavoro, della Salute e delle Politiche Sociali
Sede	Via Giorgio Ribotta n. 5

Infectious diseases are classified into five classes, in order of importance for the threat to public health

The first class is defined as “diseases for which immediate notification is required either because under international health rule or because they are of particular interest”. In this class there are 13 diseases including, *e.g.*, cholera, botulism, tetanus, influenza and rabies.



The second class is defined as "diseases that are relevant because at high frequency and/or susceptible of control interventions". In this class there are 25 diseases including, *e.g.*, hepatitis, measles, mumps, scarlet fever and whooping cough.

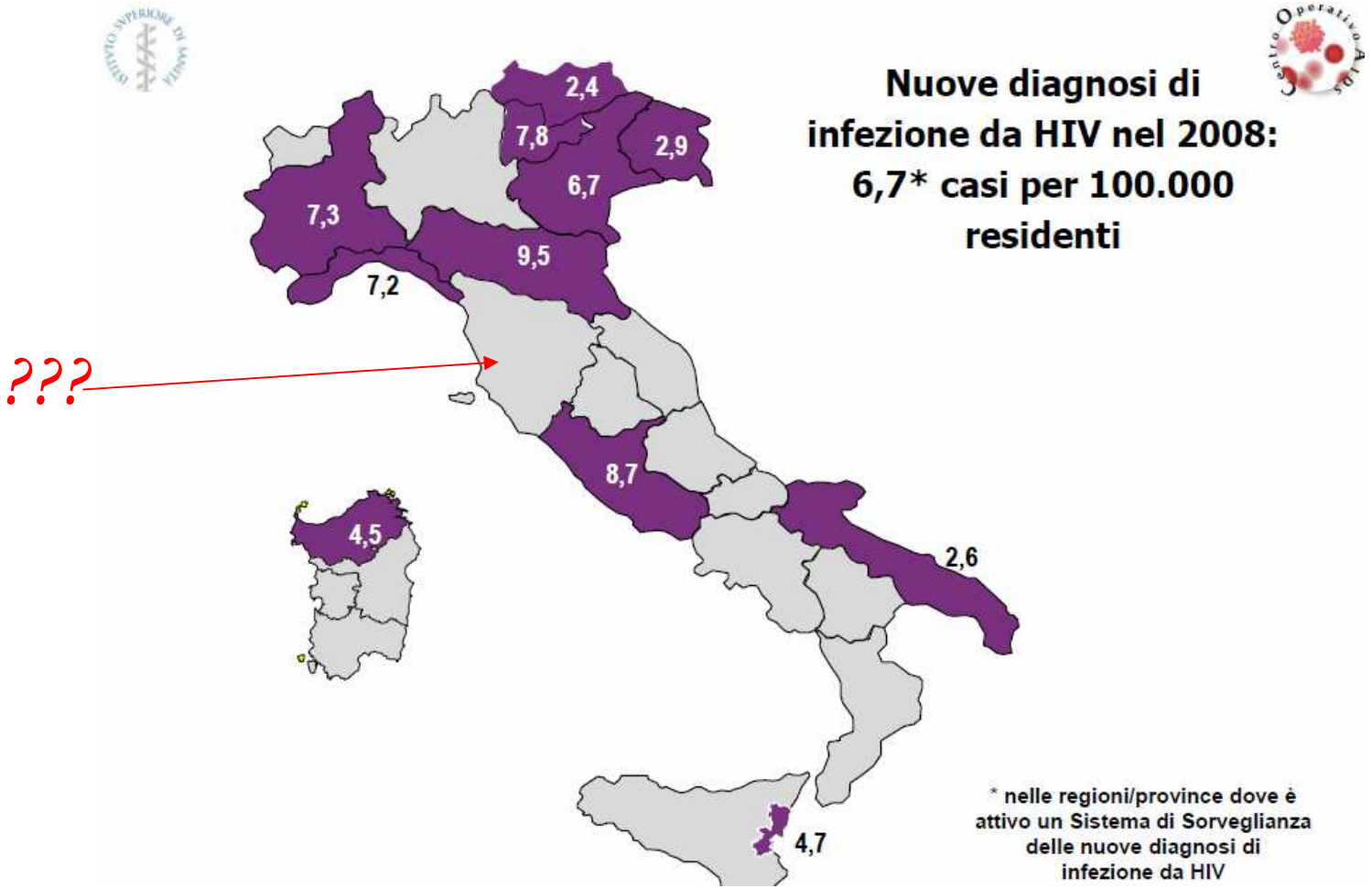
AIDS is in a third class (not of particular interest, not relevant, not at high frequency, nor susceptible of control interventions).

La suddivisione in classi risponde anche a criteri di rilevanza epidemiologica e a esigenze differenziate di profilassi.

Classi	Tempi di segnalazione del medico alla Azienda Sanitaria Locale	Malattie
Prima - Malattie per le quali si richiede segnalazione immediata o perché soggette al Regolamento sanitario internazionale o perché rivestono particolare interesse	12 ore Modulo classe I	Colera, botulismo, febbre gialla, febbre ricorrente epidemica, influenza con isolamento virale, febbri emorragiche virali (febbre di Lassa, Marburg, Ebola), rabbia, peste, tetano, poliomielite, trichinosi, tifo esantematico, difterite
Seconda - Malattie rilevanti perché ad elevata frequenza e/o passibili di interventi di controllo	48 ore Modulo classe II	Blenorragia, brucellosi, diarree infettive non da salmonella, epatite virale A, B, NANB, epatite virale non specificata, febbre tifoide, legionellosi, leishmaniosi cutanea, leishmaniosi viscerale, leptospirosi, listeriosi, meningite ed encefalite acuta virale, meningite meningococcica, morbillo, parotite, pertosse, rickettsiosi diversa da tifo esantematico, rosolia, salmonellosi non tifoidee, scarlattina, sifilide, tularemia, varicella
Terza - Malattie per le quali sono richieste particolari documentazioni	48 ore Modulo classe III	AIDS, febbra, malaria, micobatteriosi non tubercolare, tubercolosi
Quarta - Malattie per le quali alla segnalazione del singolo caso da parte del medico deve seguire la segnalazione dell'unità sanitaria locale solo quando si verificano focolai epidemici	24 ore Modulo classe IV	Dermatofitosi (tigna), infezioni, tossinfezioni ed infestazioni di origine alimentare, pediculosi, scabbia
Quinta - Malattie infettive e diffusive notificate all'unità sanitaria locale e non comprese nelle classi precedenti, zoonosi indicate dal regolamento di polizia veterinaria di cui al decreto del Presidente della Repubblica 8 febbraio 1954, n. 320, e non precedentemente menzionato	Le notifiche di classe V vengono comunicate annualmente, in un riepilogo, al Ministero. Solo quando assumano le caratteristiche di focolaio epidemico, devono essere segnalate con le modalità previste per la Classe IV.	

The numbers of HIV and AIDS in Italy

- About HIV: only a vague idea.



Should we fear AIDS in our beautiful Region?

Differenze territoriali

L'incidenza per Azienda USL presenta differenze territoriali (**Tabella 1**). Nell'ultimo triennio (2006-2008) il tasso di incidenza più basso si registra nell'Azienda USL di Siena (0,6 per 100.000 abitanti), mentre quello più elevato è segnalato nell'Azienda USL di Livorno con 4,7 nuovi casi ogni 100.000 abitanti.

Nel contesto nazionale (ISS), nel 2008, la Toscana si colloca al secondo posto assieme all'Emilia Romagna come regione più colpita (con un tasso di incidenza pari a 2,9 per 100.000 abitanti), preceduta da Liguria e Lombardia (3,4 per 100.000).

Tabella 1. *Tasso di incidenza (per 100.000 abitanti) per Azienda USL di residenza. Trienni 1994-96, 1997-99, 2000-02, 2003-05, 2006-08*

Az. USL di residenza	94-96	97-99	00-02	03-05	06-08
AUSL 1 Massa-Carrara	16,9	5,0	4,4	3,2	3,1
AUSL 2 Lucca	6,3	3,8	2,0	2,8	3,4
AUSL 3 Pistoia	8,2	6,0	2,4	3,6	2,8
AUSL 4 Prato	7,1	4,6	3,1	3,4	4,0
AUSL 5 Pisa	5,4	2,5	2,9	2,9	3,0
AUSL 6 Livorno	12,4	6,1	4,5	4,0	4,7
AUSL 7 Siena	5,6	3,3	1,2	1,0	0,6
AUSL 8 Arezzo	3,9	2,1	1,5	1,9	1,2
AUSL 9 Grosseto	14,0	6,0	3,9	2,5	3,0
AUSL 10 Firenze	11,9	5,8	3,7	3,0	3,1
AUSL 11 Empoli	8,2	4,5	3,8	2,2	2,3
AUSL 12 Viareggio	13,7	9,0	6,1	4,3	4,4
Regione Toscana	**9,6**	**4,9**	**3,3**	**2,9**	**2,9**

Tabella 3.1 *Distribuzione dei casi di AIDS di soggetti residenti in Toscana e ovunque notificati per anno di diagnosi e stato in vita al 31 dicembre 2006*

Anno di diagnosi	Totale residenti in Toscana	Viventi	Deceduti	Tasso di letalità x 100*
1985	12	0	12	100,0
1986	29	0	29	100,0
1987	55	1	54	98,2
1988	103	2	101	98,1
1989	165	5	160	97,0
1990	213	8	205	96,2
1991	217	9	206	95,8
1992	254	6	248	97,6
1993	284	16	267	94,3
1994	349	38	310	89,1
1995	368	85	279	76,6
1996	294	122	165	57,5
1997	214	119	85	41,7
1998	140	86	48	35,8
1999	161	93	64	40,8
2000	119	75	39	34,2
2001	110	65	42	39,3
2002	115	73	36	33,0
2003	109	74	26	26,0
2004	108	79	24	23,3
2005	90	83	7	7,8
2006	85	81	4	4,7
Totale	**3.594**	**1.120**	**2.411**	**68,3**

* il tasso di letalità è calcolato come il rapporto tra i deceduti al 31 dicembre 2006 per anno di diagnosi e i casi diagnosticati nello stesso anno (esclusi i casi "persi di vista")

hopes for a vaccine are irrational.

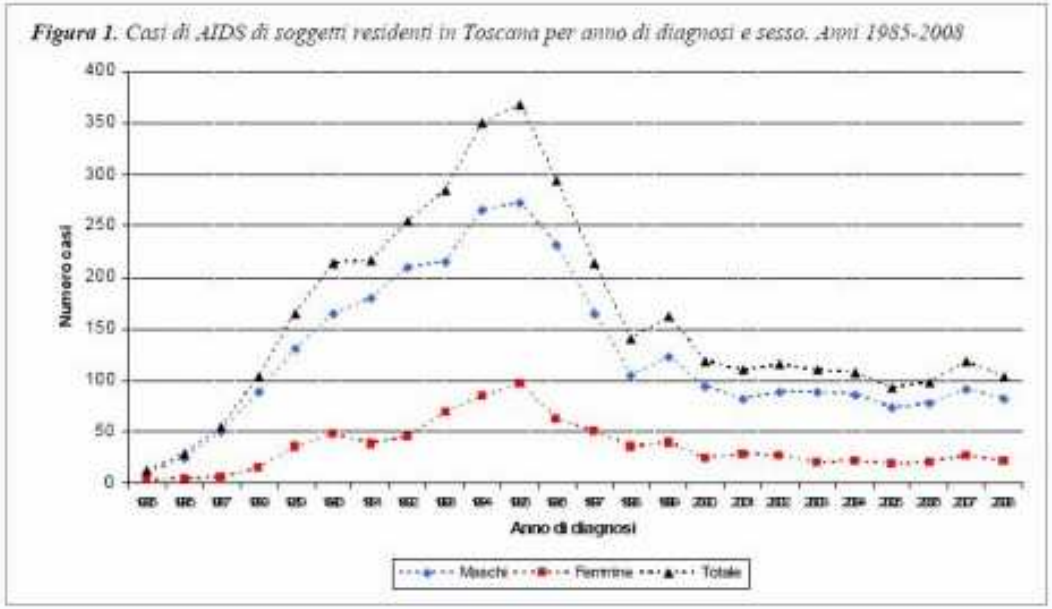
10. HIV, like other viruses, survives by transmission from host to host, which is said to be mediated "through sexual contact".

But, only 1 in 1000 unprotected sexual contacts transmits HIV (32–34), and only 1 of 275 US citizens is HIV-infected (29, 30), (figure 1b). Therefore, an average un-infected US citizen needs 275,000 random "sexual contacts" to get infected and spread HIV – an unlikely basis for an epidemic!

14. Viral AIDS – like all viral/microbial epidemics in the past (41–43) – should spread randomly in a population.

But, in the US and Europe AIDS is restricted since 1981 to two main risk groups, intravenous drug users and male homosexual drug users (§ 1 and 4).

For example, in Tuscany the male-to-female ratio for the incidence of AIDS has been essentially constant from 1985 to 2008 at ~3.6:



whereas the purported mode of transmission changed drastically: from ~8% of "HIV" being transmitted heterosexually to ~44% being transmitted in that way — see red curve in figure below:

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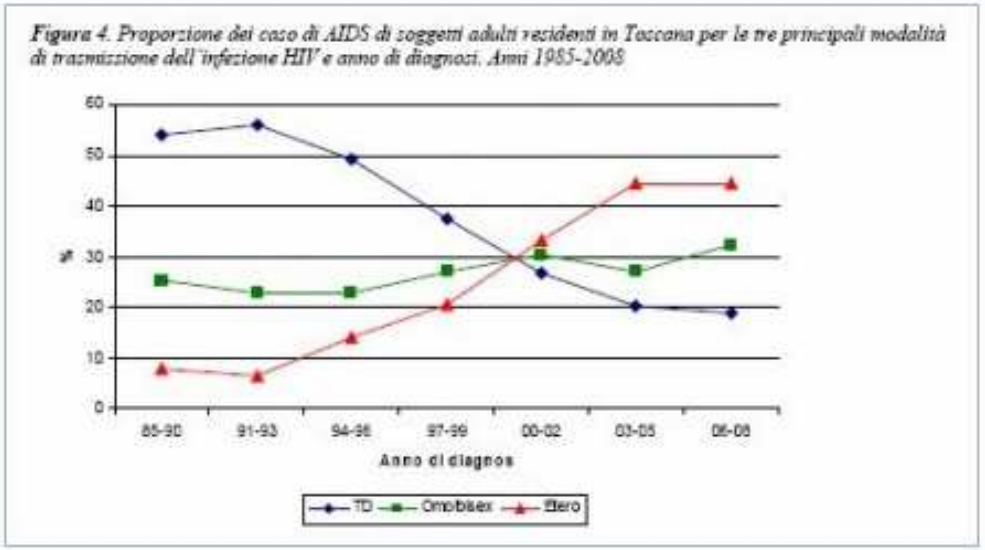
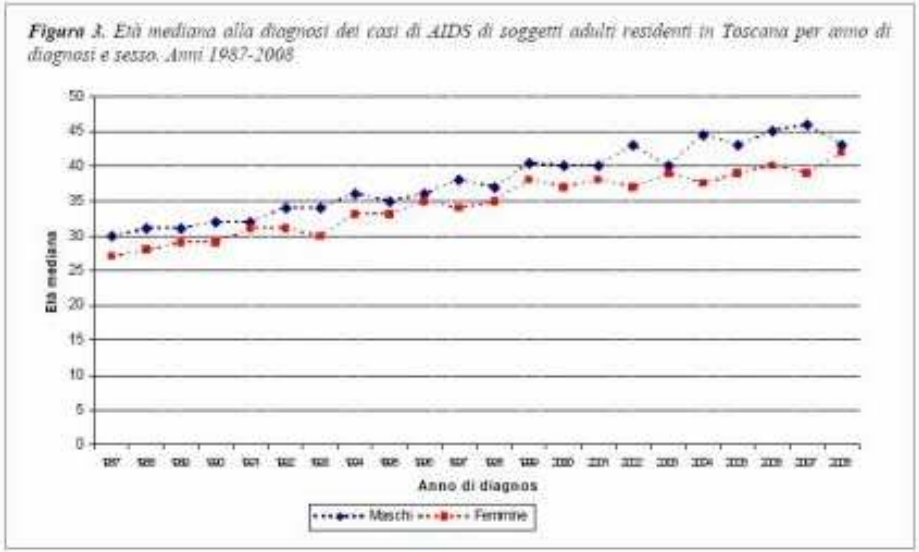


Those data place a very curious constraint on how infection via dirty needles occurred in males and in females respectively: it must occur in precisely the same relative manner as sexually transmitted "HIV infection" occurs in males relative to females. Otherwise the M/F ratio for the consequences of "HIV", namely AIDS, should have changed in some manner.

Another remarkable phenomenon in the Tuscan data is the upward drift in the median age for an AIDS diagnosis:



The stochastic fluctuations reflect the small numbers involved in each year but do not mask that the difference in median ages between men and women was seemingly constant at about 3 years, while both increased from 1987 to 2008 by about 2/3 of a year per year.
Such an upward drift of the median age of AIDS diagnosis (as well as of the median age of first "HIV-positive" test and median age of AIDS deaths) is also present in US data, albeit of somewhat smaller magnitude (**Deaths from "HIV disease": Why has the median age drifted upwards?**, 18 February 2009). The drift in the US data is partly explainable by a changing racial composition of those affected by AIDS. In Tuscany, the drift may be associated with the shift away from predominantly drug abusers (from ~54% to ~19%, see above): "HIV-positive" is a very non-specific indication occasioned by a wide variety of physiological conditions, certainly by serious illness and by drug abuse, and it seems plausible that serious drug abuse brings illness at an earlier age.

14. Viral AIDS – like all viral/microbial epidemics in the past (41–43) – should spread randomly in a population.

But, in the US and Europe AIDS is restricted since 1981 to two main risk groups, intravenous drug users and male homosexual drug users (§ 1 and 4).

In addition, other epidemiological data have to be considered. In Italy, more than 25 years after its onset, AIDS is still confined to intravenous drug (mainly heroin) users and male homosexuals. Thus, according to the official data, in the years 2006-2007, AIDS incidence in general (heterosexual) population was 1/100.000, in homosexuals, almost 5-fold higher, and in intravenous drug users, about 100-fold higher (Suligoi et al., 2008; Eurispes, 2003; EMCDDA, 2006). Furthermore, estimates from data provided for by Regione Lazio (that includes Rome) demonstrate that AIDS in Italy still shows a preference for male patients. At the beginning of the epidemic, the number of males with AIDS was 4-fold higher than that of females, but since then, the ratio changed very little: during the first years, the ratio male/female grew to 5/1, then it decreased, fluctuating around 2.5-3/1 between 1995 and 2006, just to rise again, in 2007, to more than 3.5/1 (Pezzotti et al., 2008). The percentage of affected males is not decreasing, but just fluctuating. Furthermore, the decrease in 1995 can be explained with the fact that in 1994 the list of conditions used for the diagnosis of AIDS was modified by adding invasive cervix cancer: adding a women-only disease forced the female patient count to go up (Ministry of Health, circular No 9 of 29th April, 1994). This point is also consistent with the conclusions of a recent paper (Duesberg et al., 2003) stating: " … in the US and Europe AIDS is restricted since 1981 to two main risk groups, intravenous drug

But, cervix cancer is the most common neoplasia in women! And it does not occur because of immunodeficiency!

Although cancer does not discriminate between the male and female, their different sex, and the secondary sex structures makes women more prevalent to certain type of cancers.**The most common among them are the breast and cervical cancer than in other organ cancers**. Of these,cancer of the cervix is the most common one. Even-though the probable factors responsible for the above cancer is many the actual cause of cervical cancer is still not established, the causative factors can be discussed. **That the disease is more closely linked to sexual activity was established by researchers. Other causes are the beginning of sexual intercourse at a young age and multiple sexual partners.** A big help in lessening risks of this cancer is keeping clean of the private parts and not involving in the above said factors, and this applies to both the male and female.

16. AIDS should be a pediatric epidemic now, because HIV is transmitted "from mother to infant" at rates of 25–50% (44–49), and because "34·3 million people worldwide" were already infected in 2000. To reduce the high maternal transmission rate HIV-antibody-positive pregnant mothers are treated with AZT for up to 6 months prior to birth (§ 4). But, less than 1% of AIDS in the US and Europe is pediatric (30, 50). Thus HIV must be a passenger virus in newborns.

Aggiornamento dei casi di AIDS in Toscana al 31 dicembre 2008

a cura del Settore Epidemiologia dei Servizi Sociali Integrati
Osservatorio di Epidemiologia dell'Agenzia Regionale di Sanità della Toscana

La Regione Toscana dispone di un proprio Registro Regionale AIDS, la cui gestione è stata affidata dal giugno 2004 all'Osservatorio di Epidemiologia dell'Agenzia Regionale di Sanità della Toscana.
La presenza di una sorveglianza regionale, seppure esiste un registro nazionale, permette di descrivere realtà territoriali di maggiore interesse dal punto di vista sanitario consentendo di presentare analisi anche per Azienda USL. Inoltre, grazie alla presenza in Toscana di un Registro Regionale di Mortalità e alla possibilità di effettuare indagini presso le anagrafi comunali, è possibile disporre di dati di prevalenza più precisi.

Incidenza e prevalenza

Dall'inizio dell'epidemia al 31 dicembre 2008 in Toscana sono stati diagnosticati 4.013 casi di AIDS, di cui il 90% residente in Toscana. I soggetti residenti in Toscana malati di AIDS risultano essere, per lo stesso periodo, 3.834 e dal 2001 non si registrano casi di AIDS in età pediatrica (<13 anni).

… HIV must be a passenger virus in newborns". In the years 2007-2008 there were only five pediatric cases of AIDS in Italy (Suligoi et al., 2009). It is also interesting the fact that, according to the data from the Italian National Institute of Health, in certain years (for example in the years 1999-2000 and 2000-2001) a significant percentage of pediatric AIDS cases (25% in the years 1999-2000; 29.2% in the years 2000-2001) could not be attributed to mother-son (vertical) transmission. The causes of these apparently non-transmissible cases of AIDS in newborns are not known at present. In total, from the beginning of the epidemic there have been 28 newborn babies with AIDS of unknown origin (*i.e.* not attributable to vertical transmission, haemophilia or blood transfusions). In fact, no pediatric AIDS cases were reported as associated with haemophilia or blood transfusions, thus indicating that adoption of safe working practices produced valuable results in preventing AIDS by transfusion.

Tabella 11 - *Distribuzione dei casi pediatrici di AIDS per modalità di trasmissione, per anno di diagnosi e per sesso*

Modalità di trasmissione	Periodo di diagnosi							Totale	Sesso	
	<1995	1995-96	1997-98	1999-00	2001-02	2003-04	2005-06		Maschio	Femmina
Trasmissione verticale	466	135	49	18	17	12	12	709	341	368
	94,1	*97,8*	*92,5*	*75,0*	*70,8*	*80,0*	*92,3*	*93,0*	*90,5*	*95,6*
Emofilico	15	0	0	0	0	0	0	15	15	0
	3,0	*0,0*	*0,0*	*0,0*	*0,0*	*0,0*	*0,0*	*2,0*	*4,0*	*0,0*
Trasfuso	11	1	0	0	0	0	0	12	5	7
	2,2	*0,7*	*0,0*	*0,0*	*0,0*	*0,0*	*0,0*	*1,6*	*1,3*	*1,8*
Altro/ Non determinato	3	2	4	6	7	3	1	26	16	10
	0,6	*1,4*	*7,5*	*25,0*	*29,2*	*20,0*	*7,7*	*3,4*	*4,2*	*2,6*
Totale	**495**	**138**	**53**	**24**	**24**	**15**	**13**	**762**	**377**	**385**

13. Doctors are at high risk to contract AIDS from patients, HIV researchers from virus preparations, wives of HIV-positive hemophiliacs from husbands, and prostitutes from clients – particularly since there is no HIV vaccine.

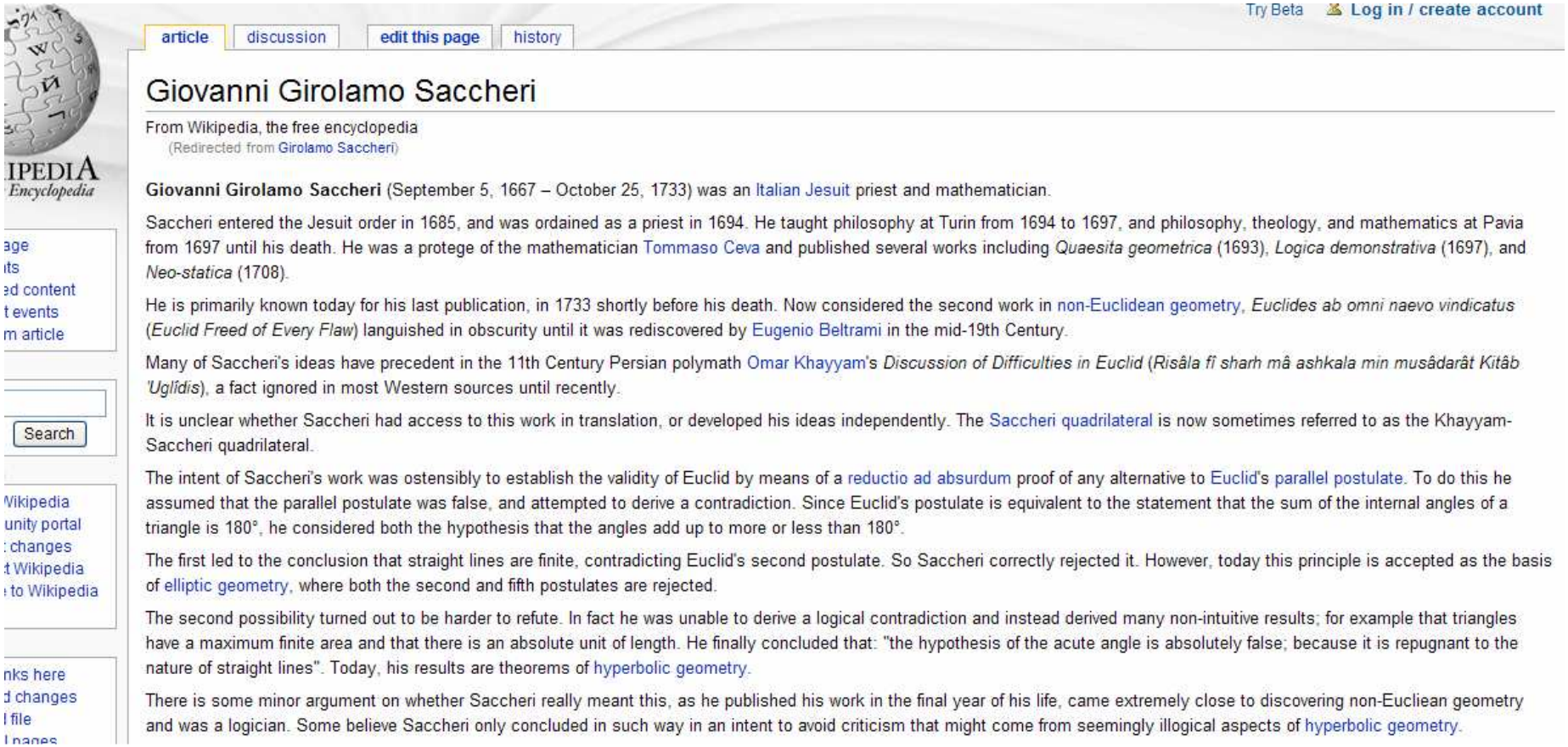
But, in the peer-reviewed literature there is not one doctor or nurse who has ever contracted AIDS (not just HIV) from the over 816,000 AIDS patients recorded in the US in 22 years (30). Not one of over ten thousand HIV researchers has contracted AIDS. Wives of hemophiliacs do not get AIDS (35). And there is no AIDS-epidemic in prostitutes (36–38). Thus AIDS is not contagious (39, 40).

synovial, pleural, and peritoneal fluids (Bell, 1997). However, occupational exposure to HIV is uncommon, and the overall risk of seroconversion after contact with HIV positive blood is extremely low (seroconversion rate, 0–0.42%). It is calculated that, on average 99.7% of health care workers, who are exposed to HIV, will not be infected (Ippolito et al., 1993; Marcus, 1988). As far as pathologists or anatomists are concerned, there is only one well-documented case of autopsy-acquired HIV infection in a pathologist who sustained a scalpel wound to the hand (Johnson et al., 1997). In general, most health care professionals found to be HIV-positive have a history of behavioural (male homosexual contact or intravenous drug use) or transfusion exposure (Chamberland et al., 1995; Duesberg et al., 2003).

I. There is only one well-documented case of an autopsy acquired HIV infection in 1992, with isolation of the virus nineteen months later. However, the infection was not associated with the development of AIDS, and repeated attempts to isolate HIV from the wounded pathologist after the first, positive test were unsuccessful (Johnson et al., 1997).

After all these contradictions

- Could we still consider HIV as the cause of AIDS?



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Giovanni Girolamo Saccheri

From Wikipedia, the free encyclopedia

(Redirected from Girolamo Saccheri)

Giovanni Girolamo Saccheri (September 5, 1667 – October 25, 1733) was an Italian Jesuit priest and mathematician.

Saccheri entered the Jesuit order in 1685, and was ordained as a priest in 1694. He taught philosophy at Turin from 1694 to 1697, and philosophy, theology, and mathematics at Pavia from 1697 until his death. He was a protege of the mathematician Tommaso Ceva and published several works including *Quaesita geometrica* (1693), *Logica demonstrativa* (1697), and *Neo-statica* (1708).

He is primarily known today for his last publication, in 1733 shortly before his death. Now considered the second work in non-Euclidean geometry, *Euclides ab omni naevo vindicatus* (*Euclid Freed of Every Flaw*) languished in obscurity until it was rediscovered by Eugenio Beltrami in the mid-19th Century.

Many of Saccheri's ideas have precedent in the 11th Century Persian polymath Omar Khayyam's *Discussion of Difficulties in Euclid* (*Risâla fî sharh mâ ashkala min musâdarât Kitâb 'Uglîdis*), a fact ignored in most Western sources until recently.

It is unclear whether Saccheri had access to this work in translation, or developed his ideas independently. The Saccheri quadrilateral is now sometimes referred to as the Khayyam-Saccheri quadrilateral.

The intent of Saccheri's work was ostensibly to establish the validity of Euclid by means of a reductio ad absurdum proof of any alternative to Euclid's parallel postulate. To do this he assumed that the parallel postulate was false, and attempted to derive a contradiction. Since Euclid's postulate is equivalent to the statement that the sum of the internal angles of a triangle is 180°, he considered both the hypothesis that the angles add up to more or less than 180°.

The first led to the conclusion that straight lines are finite, contradicting Euclid's second postulate. So Saccheri correctly rejected it. However, today this principle is accepted as the basis of elliptic geometry, where both the second and fifth postulates are rejected.

The second possibility turned out to be harder to refute. In fact he was unable to derive a logical contradiction and instead derived many non-intuitive results; for example that triangles have a maximum finite area and that there is an absolute unit of length. He finally concluded that: "the hypothesis of the acute angle is absolutely false; because it is repugnant to the nature of straight lines". Today, his results are theorems of hyperbolic geometry.

There is some minor argument on whether Saccheri really meant this, as he published his work in the final year of his life, came extremely close to discovering non-Euclean geometry and was a logician. Some believe Saccheri only concluded in such way in an intent to avoid criticism that might come from seemingly illogical aspects of hyperbolic geometry.