The possibility of respiratory transmission of AIDS

by Warren J. Hamerman
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On behalf of the *Executive Intelligence Review* Biological Holocaust Task Force, I am honored to present to our readers the following extraordinary scientific paper on the subject of AIDS transmission by England's John Seale, MA, MD, MRCP. While Dr. Seale's paper is of crucial significance to our understanding of the true nature of the global threat of the deadly AIDS pandemic, nonetheless it has been irresponsibly rejected for publication from normally appropriate journals.

We believe that this was part of an effort to try to suppress the explosive scientific fact that, in the tropics, AIDS is already being spread by the respiratory route. Therefore, we are publishing this paper in *EIR*, despite its somewhat technical nature.

In his paper, Dr. Seale reports on findings of the Pasteur Institute of France that the AIDS virus is carried in respiratory secretions and *"in the tropics it is already being spread also by the respiratory route."*

The French finding signifies that AIDS can spread in a manner analagous to tuberculosis under conditions of crowding and poor sanitation.

In the *EIR* Special Report issued on July 1, 1985, entitled *Economic Breakdown and the Threat of Global Pandemics,* we reported that tuberculosis is "the first of the horseman of death" and:

". . . has classically been associated with malnutrition and crowded, dirty, urban settings which provided for early transmission of the organism from person to person. It is making its anticipated comeback as these conditions continue to spread, in both the underdevloped and advanced sector."

In his paper, Dr. Seale draws the conclusions from the finding of AIDS virus in the pulmonary secretions of a 30-year-old Black Haitian woman with AIDS-related complex (ARC) by the Pasteur Institute. Dr. Seale states:

"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."

An *aerosol* is a collection of droplets containing infectious organisms, spread in the air by mechanisms such as coughing and sneezing. This does not necessarily mean that every time that an infected person coughs and sneezes in another's vicinity, the latter individual will become infected, but chronic exposure or longstanding exposure to such aerosols could result in transmission of the disease in a manner analagous to tuberculosis.

LAV is the name of the AIDS virus used in France; LAV stands for Lymphadenopathy-associated virus. *Lymphadenopathy* is the term for the swelling of infected lymph glands.

In his paper Dr. Seale states:

"Pulmonary tuberculosis is often the initial clinical manifestation of infection with LAV in Haiti and Central Africa. Indeed it was suggested last month [July, 1985—WJH] in the *Lancet* that infection with *M tuberculosis hominis* should be included as a manifestation of lesser AIDS or ARC. CDC [Centers for Disease Control in Atlanta—WJH] remains silent on this absolutely fundamental issue."

M tuberculosis hominis is the scientific term for the germ or bacillus, rather, which causes tuberculosis in man.

The widespread transmission of AIDS is out of control in collapsed, crowded, and unsanitary hell holes created by the conditionalities policies of the International Monetary Fund (IMF) and World Bank in the developing sector, and increasingly also in collapsing urban centers of the United States and Western Europe. Thus, the parallels between AIDS and

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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

by John Seale, MA, MD, MRCP

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-Salpetrière, 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 AIDS[3] 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