

[Sex Crimes – The Hidden Face of HIV part 2](#)

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by Liam Scheff

The last few months have been exciting for the medical industry. First there was the Nevirapine scandal at the NIH, then the FDA falls apart over prescription drugs, and now, with a bang, AIDS 2.0 has arrived in NYC.

On February 12, The New York Times announced that "a rare strain of H.I.V. that is highly resistant to virtually all anti-retroviral drugs and appears to lead to the rapid onset of AIDS was detected..."

The carrier was a New York City man in his mid-40's who "engaged in unprotected anal sex with multiple partners... hundreds of men... in recent weeks while using crystal methamphetamine."

What made this man's HIV different? Simple – he took lots of pharmaceuticals and got sick anyway. Clearly the AIDS drugs, which were supposed to cure his infection, weren't able to, thus allowing the virus to make him very ill.

A New York City health official told the Times that it was the "first time" this had ever happened.

That said, a similar case does appear in the medical record. A 2001 case study in the British Medical Journal tells the story of a "26 year old man who was HIV positive [who] started taking stavudine, didanosine and nevirapine [AIDS drugs].... He was receiving no other treatment...The patient began to experience malaise and pain in the upper abdomen...The symptoms worsened, and three weeks later he was admitted to hospital with severe pain, vomiting, fever, [and] tenderness of the upper abdomen."

The doctors, perhaps not familiar with the benefits of treatment, or unaware that they had a supervirus on their hands, made an unusual choice.

"All drugs were stopped."

The report notes: "The patient made an uneventful recovery with conservative treatment. He is no longer taking antiretroviral drugs" (British Medical Journal, January 2001; 322)

This suggests that AIDS drugs themselves might cause illness – it also implies that you can recover without the life-saving drug cocktail, which is of course, nonsense.

As any good doctor will tell you:

"I have a large population of people who have chosen not to take any anti-retrovirals. They've watched all of their friends go on the anti-viral bandwagon and die." – Dr. Donald Abrams, MD, Director of AIDS Program, San Francisco General Hospital ("Lecture to Medical Students," Synapse, 1996)

Yes, but treatment does improve quality of life:

"One of the major barriers to effectively treating HIV is that most people do not feel sick at the time that they are offered anti-HIV medications. In fact, it is only after starting the medications that they begin to feel sick..." (The Toronto Star, September 24, 1999).

Yes, there are side-effects, but the drugs are the only thing that will keep an AIDS patient alive – this is common knowledge.

"There's no hope for a cure for AIDS with current drugs," the head of the National Institute of Allergy and Infectious Diseases (NIAID) said at the 13th International AIDS Conference. "Eradication is not possible," Anthony Fauci

said.” (Biotechnology Newswatch, July 17, 2000).

Yes, but ...

“There is growing concern about the long-term toxicity and adverse effects of therapy, including liver damage and mitochondrial toxicity....Current research is not directed toward simple long-term survival...The fastest-growing treatment category in my clinic is no treatment or delayed treatment.”

(Annals of Internal Medicine, February 15, 2000; 132)

Fine. Maybe the drugs could have made him sick by themselves. It's possible. But headline for headline, “Drugs Make Drug-Addict Sick” is not nearly as exciting as “New AIDS Supervirus Found in Meth-Sex Addict.” I mean, really. It's not even news.

Robert Gallo, inventor of the Sex-AIDS theory was asked for comment. “My guess is that this is much ado about nothing,” he told the Times.

What a buzz kill.

But thanks to the press coverage, we at last know that if you have marathon sex with hundreds of anonymous partners while high on crystal meth...you might become ill. And if you're HIV-positive, the CDC will make sure you make the evening news, in every country in the western world.

In Washington State, another methamphetamine user, Anthony Whitfield will spend the rest of his life serving a prison sentence for the crime of being extremely sexually active. Whitfield tested positive in prison 12 years ago. Nobody asked why or how he remains alive and well – no AIDS drugs, a meth habit, living from day to day, hook-up to hook-up – but Whitfield's health was not of interest to the judge.

What was of interest was Whitfield's sexual orientation. Unlike the New York super-virus grower, Whitfield practiced heterosexual sex – and supposedly gave his bad HIV test result to five other people.

As we know, sex is the primary vector for HIV transmission, as the Whitfield case ably demonstrates.

From the Seattle Weekly (12/1/04):

“Five of the women tested positive for HIV, but there was little rhyme or reason to the distribution of the misfortune. “Some who had hundreds of incidents of unprotected sex, including anal sex, they're negative,” says Thurston County deputy prosecutor Jodilyn Erikson-Muldrew. “Another woman who had protected sex all but twice, she's positive.”

As we know, this is precisely how STDs work. While it's hard to transmit an STD through hundreds of incidents of unprotected vaginal and anal sex, just two little exposures will always do the trick.

But HIV is, by definition, a sexually transmitted virus. We know this by rote. That said, AIDS researchers have had occasional difficulty proving it. While drug use correlates highly with HIV positivity; sex, outside of drug use, is not such a willing a participant in the HIV cycle.

Take this 1988 review from the Journal of the American Medical Association: “[N]one of the husbands of four seropositive [HIV positive] women were infected despite regular sexual contact for as long as three years. In another study involving 12 couples, no transmission from the infected woman to the male partner occurred after more than 100 sexual contacts. Thus, vaginal intercourse may carry a low risk to the insertive partner, as does anal intercourse. “ (JAMA, 1988; 259(20))

But that's male to female contact – generally considered the least risky. What about female to male?

From the January 17, 2002 Journal of Infectious Disease: “The study...of 17 women who remained uninfected, despite a history of heavy exposure to HIV through repeated, unprotected sexual contact with an infected partner, and 12 of their regular, male HIV-positive partners.”

Well, what about male to male?

An April 1996 study in Nature Medicine focused on 24 hetero- and homosexual men who've remained HIV negative despite “histories of multiple high-risk sexual exposures to HIV-1,” including “sex with multiple HIV-1-infected partners,” or “long-term relationships involving unprotected sexual intercourse over many years [with] predominantly a single HIV-infected partner.” “All subjects were HIV-1 negative,” even though “several [of their] partners succumbed to AIDS.” (Nature Medicine. 1996 2(4))

What about longer studies?

“At Kenyatta National Hospital [Kenya] ...out of 31 couples tested, 23 were discordant [one positive, one negative]. Some of them have stayed in a sexual relationship with the infected partner for more than six years without the infected one passing the virus to the other. And when these discordant couples brought their children for testing, all of them were free of the virus...” (Horizon Magazine, December 18, 2003)

What about larger studies?

“[W]e studied 50 sexually active couples with discordant antibody results [one positive, one negative]...seronegative partners continued to have negative results in all tests for a mean follow-up period of 17 months despite ongoing sexual relations with their seropositive partners....approximately one-half of each group reported some instances of unprotected intercourse...intercourse with outside partners was uncommon in both groups, as was current illicit drug use. (Clin Infectious Disease. July, 1995;211)

What about longer and larger studies?

From a study called “Heterosexual Transmission of HIV in Northern California: Results from a Ten-Year Study”: “We followed up 175 HIV-discordant couples over time, for a total of approximately 282 couple-years of follow up...No transmission [of HIV] occurred among the 25% of couples who did not use their condoms consistently, nor among the 47 couples who intermittently practiced unsafe sex during the entire duration of follow-up...We observed no seroconversions after entry into the study [nobody became HIV positive]”(American Journal of Epidemiology. August, 1997.)

Ten years and no transmission? Huh. Every time I watch Law and Order: Special Victims Unit, HIV tracks like a muddy footprint from the “perp” to the victim.

But studies don’t prove anything. And belief always trumps logic. So in spite of evidence to the contrary, it remains possible that HIV is sexually transmitted. Not probable, but possible.

Of course, when we talk about transmission of HIV, we’re not talking about the virus itself – we’re only talking about what we pick up with HIV tests.

As the CDC Says, “HIV tests look for the presence of HIV antibodies; they do not test for the virus itself.”

But, they add: “The HIV-antibody test is the only way to tell if you are infected. You cannot tell by looking at someone if he or she carries HIV.” (CDC: National HIV Testing Resources; “HIV Test FAQ” 2005)

“The only way to tell” – and fortunately, the tests work extremely well, virtually error-free:

From the University of Michigan Health Service:

“Although the HIV tests are very precise, sometimes the test result can be positive even though you do not have HIV infection (this is called a false-positive test).” (“HIV Antibody Tests” McKesson Health Solutions LLC. 2004)

Okay, fine. There’s an occasional false-positive.

“1991 saw some 30,000 false positives out of 29.4 million tests, with only 66 confirmations...” (“HIV screening in Russia.” Lancet. 1992).

Well, sure, that can happen. But that was in Russia.

“At present there is no recognized standard for establishing the presence or absence of HIV antibody in human blood.”- (Abbot Laboratories HIV Elisa Test. 1997).

Well, that’s just a warning on the test for legal reasons, or something. Of course there are standards. The confirmatory test – the Western Blot – That’s the standard.

“[W]hat constitutes a positive Western blot test has not been standardized (various agencies use different reagents, testing methods, and test-interpretation criteria).” (“AIDS Counseling for Low-Risk Clients”; Max Plank Institute/Aids Care, 10, 1998)

Well then, what is the standard?

“[F]or HIV infection, there is no independent, unequivocal way of identifying a group of individuals who are all assuredly infected or uninfected. “ (JAMA. 1987. 258)”

“There is no reference or ‘gold standard’ test that determines unequivocally the true infection status of the patient...”(JAMA. May,1 1996. 275(17)

“Thus, it may be impossible to relate an antibody response specifically to HIV-1 infection.” (Medicine International, 1988;56)

Alright, I get it.

“Serologic [blood] tests for HIV antibodies appear to be characterized by extra-ordinarily high false – positive results...Furthermore, any increase in false positive rate could turn a screening program into a social catastrophe. A false positive result may label an infant, born to HIV positive mother, as HIV positive where as the same infant may actually be HIV negative.” (“High Frequency of False Positive Results in HIV Screening in Blood Banks” Ayub Medical College, Pakistan. 1999)

Alright, fine. So the tests are crap. Then how do we know that Anthony Whitfield, or any of his partners, is really positive?

The answer is simple. Some tests are more positive than others.

No one asked about false positives with Whitfield because of his lifestyle and skin color. He was in what the CDC calls a high risk group.

That’s how testing works – if you belong to a certain group of people, you’re considered more likely to be positive. If you’re outside of that group, you’re considered more likely to be negative. And your test result is graded against that assumption.

Here’s how the CDC puts it:

“The likelihood that a positive screening test truly indicates the presence of HIV infection decreases as HIV prevalence in the tested population becomes lower. Therefore, false-positive HIV test results are more likely in settings where the tested population prevalence is lower than in settings where the tested population prevalence is higher.” (CDC: “Revised Guidelines for HIV Counseling, Testing, and Referral” November 9, 2001)

In other words – your actual test is less meaningful than the assumed prevalence of HIV positivity in the group the CDC believes you belong to.

Whitfield is a black man and a drug user, and he has unprotected sex. So he is at high risk

As we know:

Sex is unquestionably the primary vector for spreading HIV...

Drug use itself causes a massive antibody production, which is read by the HIV antibody test as HIV positive – so we know that’s accurate.

And finally, the CDC says that HIV positivity is up in the Black community. How do they know this? Because they’re doing more testing in the Black (and Hispanic) communities. And if the CDC is testing them more, then they must be at higher risk.

But why are they at higher risk?

The CDC looks for trends in targeted populations – an increase in STDs, drug use, teen pregnancy – if any of these factors are up, then it’s assumed that HIV prevalence will also be on the rise.

As Dr. Dan Cohen, medical director of Boston’s Fenway HIV test center told me in a 2003 interview:

“The majority of people who are going to be infected [in the Boston area] are in their teens and twenties.

“How do you know that?” I asked.

Dr. Cohen answered, “Because we’re seeing increasing number of other STDs in this young population, and it’s only a matter of time before HIV appears. *That’s especially true among people of color.*”

I pointed out that in 2002, all of Massachusetts recorded 327 AIDS deaths – that included auto-accidents, overdoses and suicides (the state counts all HIV positive deaths as AIDS deaths).

Cohen answered, “Just because we’re not seeing high numbers, doesn’t mean that we shouldn’t pay attention – it’s

lurking beneath the surface.”

“That’s why it’s an emergency,” he said.

And guess what, he was right. Now more Black and Hispanic people are being tested, and because they’re believed to be at higher risk, their test results are considered to be more accurate. That’s statistics at work.

The newest HIV tests are called Rapid Tests. These tests are used for on-the-spot screenings. They take as little as 20 minutes to give you your result. Their accuracy, however, depends mightily on your risk group.

From the industry journal “AIDS Alert”:

“[P]atients who test positive, but who live in a low-prevalence [low-risk] part of the country and engage in no activities that put them at risk for HIV infection, might be told a positive reaction means they “probably” or “very likely” don’t have HIV.

On the other hand, “In higher-risk settings, patients might be told that a positive test means they “probably are” infected.” (“Coming to Your Clinic: Candidates for Rapid Tests.” Aids Alert; March 1998)

And from the CDC’s new guidelines for Rapid Tests:

When a preliminary, positive rapid test is explained to clients, phrases like “a good chance of being infected” or “very likely infected” can be used to indicate the likelihood of HIV infection and qualified based on the HIV prevalence in the setting and the client’s individual risk.” (CDC: “Revised Guidelines for HIV Counseling, Testing, and Referral” November 9, 2001)

The CDC is currently moving into testing all pregnant women with rapid tests, but this will probably only affect those people in public hospitals. You know, the poor.

“[A]ll pregnant women should be recommended HIV testing regardless of setting prevalence or behavioral or clinical risk...HIV prevention counseling and referral should target pregnant women based on risk screening.” (ibid)

[R]apid HIV testing should routinely be made available for the mother or her newborn” (CDC: National HIV Testing Resources; “HIV Test FAQ” 2005)

This is clearly a fantastic idea –as evidenced by this September, 2000 study “False Positive and Indeterminate HIV Test Results in Pregnant Women”:

“As the number of women being screened has increased, the proportion of false-positive and ambiguous (indeterminate) test results has increased....”(Archives of Family Medicine, Sep/Oct 2000)

Well, right... there is the problem of false positives in these women, caused by natural antibodies produced during pregnancy:

“[I]n 1991 alone some 8000 false-positive results were reported in pregnant women, with only 6 confirmations.” (Lancet, 1992;339).

But in a high-risk group, we can be assured that those positives aren’t “false.” They’re accurate – by definition.

In any case, the solution to the problem is obvious. As the Canadian government generously advises:

“One might expect that women found to be seropositive would opt for an elective abortion.” (Screening for HIV antibody. Health Canada, 1994)

The good news is that, for women who keep their babies, whatever the outcome of their rapid test, doctors will enforce a dose of AIDS drugs, like AZT and/or Nevirapine, the official world-wide therapies for mothers who test positive. In fact, the CDC and test manufacturers advise that the test be given at delivery, so drugs can be given during labor:

“For pregnant women who do not know their HIV status at the time of delivery, rapid HIV testing permits [drug] therapy to be initiated for these mothers during labor, and to their infants post partum.” (OraQuick Rapid HIV Test, 2003)

To be fair, there are some concerns about accuracy of tests in newborns:

“Newborns of HIV infected mothers may carry maternal antibodies for up to eighteen months, which may not necessarily indicate the true infection status of the new born.” (MedMira Reveal HIV test. 2003)

But for those at risk – better safe, with a good course of AIDS Drugs, than sorry.

Ironically, the low-risk populations don't need to be tested very much. In fact, testing them is considered to be in bad form:

“Plans to test low-risk populations for HIV antibody generally ignore the possibility of false positive results...How many engagements should end to prevent one infection? How many jobs should be lost? How many insurance policies should be cancelled or denied? How many fetuses should be aborted and how many couples should remain childless to avert the birth of one child with AIDS? (“High Frequency of False Positives...” Ayub Medical College, Pakistan, 1999)

From the journal AIDS Care: “Counseling people at low risk requires paying particular attention to false positives, that is, to the possibility that the client has a positive HIV test even though he or she is not infected with the virus....If clients are not informed about this fact, they tend to believe that a positive test means that they are infected with absolute certainty....Emotional pain and lives can be saved if counselors inform the clients about the possibility of false positives...” (“AIDS Counseling for Low-Risk Clients”; Max Plank Institute/Aids Care, 10, 1998)

In fact, screening low-risk people is considered in such bad form, we simply don't do it:

“The actual risk of transmission between women is unknown....lesbians have been excluded from epidemiological risk groups.” (“A lesbian at very low risk for HIV infection” HIV InSite/UCSF Center for HIV Information. 2004)

“[A]cceptable prevalence rates to justify screening [the general population] have not been defined. (Screening for HIV antibody. Health Canada, 1994)

“[T]here was no information about [HIV] prevalence in men and women with no risky behaviour.” (“AIDS Counseling for Low-Risk Clients”; Max Plank Institute/Aids Care, 10, 1998)

After all, they're low risk. And sex isn't a risky behavior for low-risk folks. Lucky bastards.

The statistical rule being abused here is Bayes rule or law. It states the higher the prevalence, the more accurate the tests. And prevalence is estimated from applying the test to groups that the CDC believes will eventually be at risk (as Dr. Cohen stated – where the new infections “are going to be,” based on targeted screenings of certain communities for drug use, pregnancy, and STDs). We test them more, assume their results are accurate...And voila – prevalence.

The end result of this equation is the “predictive value.” That's the estimated likelihood that your tests are accurate – not positive or negative – but accurate: If you're in a high risk group, your test is believed to have a high predictive value – so your reactive tests are considered to be positive.

For people in the low-risk group, the tests are believed to have a low predicative value – so a reactive test is considered a “false-positive.”

Here's how it breaks down in numbers:

“Most patients (68 to 89%) from low risk groups who show reactivity on screening tests will have false-positive results...The predictive value of a positive ELISA varies from 2% to 99%...” (Mayo Clinic Proceedings , 1988; 63)

“[I]n low prevalence populations the predictive value [of an HIV test] was 11.1%, while in populations with known HIV-1 infection, the predictive value was 97.1%.” (Abbott Laboratories. HIV Antibody Test. April, 1996).

In a high risk group, “The Positive Predictive Value of a home screening test would be 67%; 33 of 100 would be false positives. With a lower prevalence the PPV drops to 17%, and 83 out of 100 positive tests would be false. (“Advances in HIV Testing Technology”- AIDS Education and Prevention – 1997)

The test manufacturers list the following as their high risk group: “Prison inmates, STD clinic patients, inner city hospital emergency room patients... homosexual men [and] intravenous drug users.” (Vironostika HIV Antibody Test. 2003). And these are the groups that they target for testing. For these people, HIV tests are nearly 100% accurate. For everybody else, just 2%.

But all of these numbers are a little confusing. Here's how it looks in practice – from the March, 1998 “AIDS Alert” article on rapid tests:

“Whether the tests will perform as well in the United States as they have abroad is still unknown, experts add. For one thing, using a single rapid test in a low-prevalence population will give a lower positive predictive value....That error rate won't matter much in areas with a high prevalence of HIV because in all probability the people testing false-

positive will have the disease. But if the same test was performed on 1,000 white, affluent suburban housewives – a low-prevalence population – in all likelihood all positive results will be false, and positive predictive values plummet to zero.” (Coming to your clinic: Candidates for Rapid Tests. Aids Alert, March 1998)

So, if you take a test, and are “white, affluent and suburban,” you’ll have a false positive. If you aren’t, even your false positive is a true positive. Gosh, science is wonderful.

One thing’s for sure – if you are in a high risk group, you can never really be negative: “If you have a negative test result but you are in a high-risk group, you may need to have another test 3 to 6 months later. (“HIV Antibody Tests” McKesson Health Solutions LLC.)

“Testing should be repeated after 6 months in seronegative people whose behaviour put them at risk.” (Screening for HIV Antibody, Health Canada, 1994)

In the UK, they don’t even wait that long. (From the 2003 UK National Guidelines for HIV testing) If you test negative but are considered to be at risk, then “clearly, waiting for six months to test is untenable,We would suggest testing using a sensitive [highly reactive] fourth (or third) generation screening test immediately after the exposure [the risky sexual encounter] and then: at one to two months, at three to four months, and six months.”

They’re thoughtful to add: “Some time and care will be needed to explain the reasons underlying the need for follow-up testing ...despite negative results.” (“Towards error-free HIV diagnosis: guidelines on laboratory practice” Communicable Disease and Public Health 2003; 6,4)

But when a low-risk person has a reactive test, the process is quite different.

If a test is reactive “where the strong expectation is of a negative result,” – a low-risk population – the patient is not informed that he or she is HIV positive, or even “very likely infected.” Instead, the process stops – “Reactivity on these specimens needs very careful scrutiny, unhurried by inappropriate ‘turn-around’ targets.”

No rush to a verdict for the low-risk patient. What happens next? The positive result is expunged from the record – through official channels – and the “expected result” is sought: “Further testing is essential, employing several different tests carefully selected to minimize the possibility of each additional test being prone to the same false-positive effect as gave rise to the false reaction in the initial screening test.” (ibid)

How do they minimize false positives? They use less sensitive tests, or interpret them differently. The clinician’s opinion of what the test should be is considerably more important than test result itself: “Checking that the final result is not at odds with patients’ clinical and behavioural characteristics is a key element.” (ibid)

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**Read The Hidden Face of HIV Part 1 – [Knowing Is Beautiful](#)*