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ADMINISTRATIVE CONFIDENTIAL

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Update on the Epidemic of Acquired Immunodeficiency - Kaposi Sarcoma -  
Opportunistic Infection

Director, NCI  
Through: Acting Director, DCT, NCI \_\_\_\_\_

On June 30 I attended a meeting at the New York City Health Department concerned with this epidemic syndrome. (Monthly meetings are being held at the Health Department involving representatives from all of the New York hospitals seeing these patients.) At this time, half of all patients reported to the CDC have come from New York City.

I am attaching my report from the June issue of Cancer Treatment Reports which was current as of May 1 of this year. The June 30 meeting provided significant new information, as follows: Four hundred and thirty cases have now been reported nationally. The rate has gone from one new case per day to 2-3, and in the past month, 90 new cases have been reported to the CDC. The character of the epidemic has also changed in that more heterosexual men and women with no history of drug use are being reported. As before, Kaposi's sarcoma has been infrequent in the non-homosexual cases, with heterosexuals primarily manifesting the opportunistic infections. Two hemophilic patients, both older men, with no history of homosexual contact or drug abuse, have the immune abnormality and opportunistic infections. Although these cases have not yet been completely worked up by the CDC, it is possible that their immunological deficiency was induced by donor plasma. This possibility brings up the question as to whether homosexual men should be permitted to serve as blood donors. It also raises a question about hepatitis B vaccine, since the donors for this vaccine were mainly homosexual men.

Another new observation is that a number of recent patients have been monogamous homosexuals whose sexual contact was with apparently healthy men who in turn had had contact with patients involved in the epidemic. Moreover, clustering has been observed in California as reported in a recent issue of MMWR (attached). This cluster involves patients who had sexual contact with one another at sometime during the past five years, with mutual contacts, and/or with contacts from New York City. The probability of this cluster occurring due to chance alone approaches zero. Finally, it is evident that Haiti is in some way involved in the epidemic. It has been known that the syndrome is occurring in Haiti, and now it has become clear that a number of Haitians in New York City and elsewhere in the U.S., both recently arrived and having been

here for some years, are involved. An attached table describes nine patients recently treated at the Downstate Medical Center. Twenty-two Haitians are currently under observation in Miami, all with the inverted T lymphocyte helper/suppressor ratio characteristic of the syndrome. There are also a few such Haitian patients in New Jersey, Cleveland, and elsewhere. The Haitian patients will be reported in the July 15 issue of MMWR. It is unclear just how Haiti may be involved. In addition to the wave of emigration, it is known that Haiti is a popular vacation spot for American homosexual men, and it cannot be excluded that a transmissible vector of this syndrome, long present, has now been introduced from that country. (This is obviously explosive politically). Could there be a connection with HTLV - also endemic in the Caribbean?

All of this new information led most physicians at the June 30 meeting to believe that the cause of the syndrome is "biological", i.e., a parenterally or sexually transmissible infectious agent. The roles of nitrite exposure, host genetics, CMV, etc., have not been proven nor disproven; nitrite experiments in mice at the CDC are, however, so far negative.

With regard to the earliest immunological abnormality, it now seems likely that this occurs in natural killer cell activity. With respect to treatment of the infections, the most prevalent of which remains pneumocystis pneumonia, the results are very unsatisfactory. In general, patients are not responding well to Bactrim and the usage of pentamidine is increasing as a consequence. With regard to treatment of the Kaposi's sarcoma, it is evident that combination chemotherapy does induce regressions, but it worsens the immunological abnormalities and leukopenia, and probably hastens death due to infection. A small number of patients have been treated with interferon with apparently good results; these data will be presented at the July 13 symposium at Mt. Sinai. [A number of these patients are not synthesizing endogenous interferon (in vitro) and they may be the ones who develop the sarcoma.] Two patients have received marrow transplants, but neither engrafted. It seems evident that definitive treatment for both the sarcoma and the infections will have to include reconstitution of the immune system (as well as elimination of any continuing cause), as in the case of children with congenital immunological deficiency syndromes.

Other tumors besides Kaposi's sarcoma continue to appear, and there are now approximately 15 patients reported with non-Hodgkin's lymphoma as the primary or secondary diagnosis.

It is apparent that this epidemic is growing by the day, no longer involves homosexual men exclusively, and in fact, is spreading to other subsets of the population. It is also becoming increasingly likely that there is a transmissible, infectious vector and that transmission may be parenteral as well

as sexual. It seems to me that this problem should involve all of the NIH, not just the NCI, and that monies should be identified (in excess of our one million dollars) to facilitate a most urgent response. I believe that an NIH/CDC Task Force should be appointed at once, and that whatever funds are required by these agencies to pursue this epidemic properly should be made available now.

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Attachments

cc:

Dr. Adamson  
Dr. Fraumeni  
Dr. Gallo  
Dr. Henney  
Dr. Rabson