Interview by Hans Jochim Ehlers (*Raum + Zeit*) with Heinrich Kremer, M.D., on AIDS and cancer.

"We are Biological Hermophrodites in the Evolutionary Scheme of Life"

Raum + Zeit: Dr. Kremer, you have written a sensational book "*Die stille Revolution der AIDS- und Krebsmedizin*" ("The Silent Revolution in AIDS and Cancer Medicine"). First a question about what AIDS has to do with cancer?

Kremer: The appearance of a rare cancer form, Kaposi's sarcoma, was first reported 20 years ago among homosexual patients in their mid-30s in the USA. This was a sarcoma affecting the inner wall cells of blood and lymph vessels. Other homosexual patients – either with or in most cases without Kaposi's sarcoma – suffered from fungal infections of the lungs and other organs. These were linked to a high fatality rate, since specific chemo-antibiotics proved a failure. Most patients developed cachexia, a loss of body cell volume that could not be offset by nutritional means. The common characteristic of these cancer and infection patients was functional loss of the cellular immune defense against intracellular disease pathogens, while the antibody defense against extra-cellular microbes remained completely intact or even increased. This disease constellation was later called acquired immune deficiency syndrome or AIDS. It was noticeable that this combination of symptoms occurred in exactly the same manner among patients with organ transplants who had been treated since the 1960s with the immunosuppressive agent azathioprin to prevent rejection of foreign organs. Thus the link between cancer and induced cellular immunodeficiency (AIDS) was known to physicians in 1981.

Raum + Zeit: Yet the clinicians reported at the time that previously healthy AIDS patients had not been treated by immunosuppressive measures.

Kremer: These diagnoses were correct superficially, but they were far removed from reality. Up to the present these erroneous diagnoses have led to one of the most absurd mistakes in modern medicine – and one resulting in the most serious consequences. Due to the completely identical symptoms, it would have been absolutely logical to ask if substances with immunosuppressive agents and a cell-toxicity action profile analogous to azathioprin could have been the cause of AIDS before having announced the appearance of a "new fatal sex and blood epidemic". One would naturally have had to search for substances that had not been medically prescribed for immune-system suppression, such as in the case of organ transplants.

Raum + Zeit: Were there any such substances?

Kremer: Yes. Addiction to poppers among homosexuals was rife in the metropolises of the USA and Europe during the 1970s. It involved inhalation of nitrogen gases as sexual doping agents for sphincter muscle relaxation during anal sexual intercourse and for extended penis erection. Nitrogen gases, amyl nitrite, and other agents were found in animal experiments to be extremely dangerous immunosuppressive substances. Anyone can read in medical publications on the first AIDS patients that they were all nitrite users. Nitrites and the aza group of azathioprin have a comparable nitrogen action profile. The substances groups form nitrosothioles and nitrosamines and inhibit certain enzymes in the respiratory organels of our cells, called the mitochondria. The result is blockage of oxygen-dependent cell respiration. The cells die or transfer to energy preparation typical of cancer cells through fermentation independent of oxygen.

Numerous studies during the 1970s also demonstrated that promiscuous gay men had by far the highest infection occurrence among all risk groups in the USA and Europe. Since 1969 the chemo-antibiotic BactrimTM, that contains the substance trimethoprim as well as a sulfonamide, has been viewed as a wonder weapon against multi-infectious incidence. Promiscuous homosexuals were the risk group with the greatest consumption of BactrimTM (Septrin, TMPSMX and cotrimoxazol). According to a statement by the world's greatest BactrimTM producer, the Swiss pharmaceutical concern Hoffmann-La Roche, the drug is regarded as "one of the most successful substances that has ever been developed."

In reality BactrimTM is one of the most dangerous substances. It is prescribed for more than 5% of the population each year. Due to the structural analogy of the nitrogen action profile for azathioprin and trimethoprim, the immunosuppressive characteristics of trimethoprim had already been tested on animals in England during 1970. The result was absolutely clear: trimethoprim, given in comparable doses as BactrimTM treatment among human beings, prevented rejection of skin transplants precisely as long as azathioprin. It was proved in 1971 that one of the most common AIDS indicator illnesses, systematic *candida* fungus infections, appeared after BactrimTM treatment taken according to the usual dosage and length of prescription. It was

demonstrated in 1981 that BactrimTM caused massive DNA damage in human cells immediately after a brief intake period At the outset of the 1980s one administered antibiotics such as BactrimTM along with nitrogen gases in animal experiments. It developed cancer.

Raum + Zeit: Were the necessary conclusions drawn from these findings?

Kremer: Absolutely not. Although the causes of AIDS were obvious, the gay-male AIDS and cancer illnesses were explained as a mystery. Instead it was postulated that there had to be a "new virus" causing the illnesses. Otherwise one would have had to reckon on a pharmaceutical catastrophe with unforeseeable consequences. There were parallels in medical history. During the 1960s a massive outbreak of muscular and nerve damage with high mortality appeared in Japan and was viewed as mysterious. Virus researchers maintained they had discovered a "new virus" as the cause of these illnesses. This disease theory was accepted worldwide in all medical textbooks. Years later a few physicians noted that all these patients suspected to be infected by viruses had been treated with the Entero-Vioform™ preparation from the Swiss pharmaceutical concern CIBA-Geigy. The preparation was withdrawn from commerce after liability suits, and no new cases of the disease appeared. The "new virus" had never existed. The anti-parasite agent Entero-Vioform™ also had an action profile toxic to mitochondria similar to azathioprin, BactrimTM, nitrites, etc.

Raum + Zeit: In your book you document in detail that previous theories on the causes of disease and death involving AIDS and cancer are basically false. Why do virus cancer researchers dominate AIDS research to this day?

Kremer: A crucial clinical phenomena surfaced in cases of Kaposi cancer patients with organ transplants: If azathioprin was discontinued, even tumors the size of chicken eggs receded without leaving a trace. This fact strictly contradicted the cancer theory dominating up to the present that cancer is triggered by an irreparable mutation of the DNA nucleus and that cancerous tumors can only be "combated" by operations, chemotherapy, and radiation. Transformation to the cancer cells is regarded as irreversible. The disappearance of azathioprin-induced Kaposi's sarcoma among organ transplant patients endangered the theoretical structure of the profitable cancer industry. In 1971 then US President Nixon called for a "war against cancer", and set in motion the greatest capital investment in medical history up to that point in time. It was primarily retrovirus cancer researchers who profited from this, though they have been totally unsuccessful to this day. The appearance of Kaposi cancer among homosexuals and patients with immune systems weakened by toxic drugs brought the retrovirus cancer researchers to a simple but extremely viable idea from a commercial standpoint. As in Japan, laboratory techniques had been developed in order to fake the existence of retroviruses that one could indeed demonstrate with electron microscopy in birds and mice but never in human cancer cells. Researchers bred immune cells, which were reduced in the blood of AIDS patients, alongside leukemia cancer cells. In addition, this cell culture was stimulated with highly oxidizing substances and the growth factor Interleukin-2. The stress proteins exported from this cellular mix and a repair enzyme protein were explained exclusively as indirect markers for infection of these cells by a "new retrovirus". Later it was also possible to determine the synthesis of this proteins induced by pro-oxidative cellular stress in other human cells. Thus one produced the assumed "new immune deficiency virus, HIV". In other words, as in the Japanese example, the "new virus" had never existed. However, one brought this human test proteins into contact with human sera, and it logically prompted an antigen antibody reaction, just as with other foreign preoteines, though also in sera of healthy test subjects. Thus one knew that these reacting proteins, stimulated in AIDS and cancer cells with all possible antibodies, also reacted in blood serum of healthy patients who were beyond suspicion of having been infected by the presumably "new fatal HIV". Yet, since one also knew that most AIDS patients showed increased poly-specific antibody levels, the test-reaction threshold was set at a specifically high antibody level. In this way is was seemingly proven in a logical cycle conclusion that only the test subjects from risk groups with more or less pronounced cellular immune deficiencies reacted positively to this "anti-HIV antibody test". That is, they had to be infected with "HIV" according to this topsy-turvy logic. Using this manipulated "AIDS test", millions of human beings were selected as assumed victims of the "fatal sex and blood epidemic HIV" during the past 17 years, and countless people were killed by aggressive cellular toxins based on the medical assertion that one was extending the lives of these patients.

Raum + Zeit: Did these lab tricks suffice to convince the scientific community?

Kremer: No. A seemingly plausible theory was formulated – at least considering the denial of pharmaceutically contributed toxic causes. It held that the apparent virus linked the cause of AIDS to the cause of cancer. Retrovirus cancer researchers postulated from 1983 on that retroviruses were not directly settled cells transformed into cancer cells but that the "HIV retrovirus" would destroy T_4 immune cells responsible for intracellular immunity resistance. The lack of immunity cell monitoring would mean that tumor cell clones that

form in every organism by incidental mutation would no longer be held in check and could increase at will. Hence Kaposi's cancer would develop without substance-induced immunosuppressive agents. Thus a call was made at the 1st International Congress on AIDS in 1983 to carry out a series of human experiments to test this cancer theory. Meanwhile, after use of another immunosuppressive agent for organ-transplant patients, cyclosporin A, not only Kaposi cancer tumors but lymph cell cancer too developed in the brain along with solid carcinomas in a variety of organs.

Raum + Zeit: Your book documents the substances with which these "planned experiments" were or still are being carried out with AIDS patients and "HIV positives". What were the results?

Kremer: All AIDS patients were treated with the immunotoxic chemo-antibiotic BactrimTM of all things and related substances such as long-term prophylactics against the lung fungus infection PCP. From 1987 on azidothymidine (AZT) was also used against "HIV", supplemented from 1989 on by AZT medication for "HIV positives" without symptoms. During the 1990s a complete battery of AZT-related substances plus other preparations toxic to mitochondria were prescribed as "cocktail" or "combined therapy". Sooner or later these substances logically produced AIDS and cancer among the patients. Naturally none of those affected would have taken part in these medical experiments if they had been informed that the goal was to disable the cellular immune defense medically in order to test the immunity monitoring cancer theory. The manipulated fear of death from the "fatal HIV infection" made the patients and parents of newborns and children with "HIV positive" test results willing to cooperate in taking unlimited AZT, BactrimTM, etc.

Raum + Zeit: You are the first researcher who explained the real action mechanism of AZT and BactrimTM based on results of international research on nitric oxide (NO). And you drew the conclusion from published clinical studies with these substances that long-term medication with AZT and BactrimTM is a dangerous bodily harm with fatal consequences.

Kremer: AZT has the identical nitrogen action profile as azathioprin. The azido group in AZT blocks cell respiration in the mitochondria just as the aza group does in azathioprin and the analogous action group in thimethoprim. The inevitable results are with very high probability AIDS, cancer, as well as nerve and muscle cell degeneration, as hundreds of clinical studies on HIV/AIDS medicine have proved beyond doubt. The published evidence is overwhelming.

Raum + Zeit: Have AIDS and cancer virus researchers been able to prove the immune surveillance theory of cancer causation with their perverse experiments on human beings?

Kremer: No, since they were fixated on mutations in the DNA nucleus and viewed cancer cells as foreign bodies, they were investigating the wrong scene of the crime. Nor have they solved the so-called AIDS puzzle. What they could not foresee was the fact that fundamental findings outside orthodox AIDS-cancer medicine were gained from the end of the 1980s, and these have guided virus researchers' theories misled.

Raum + Zeit: Can you brief us on the results' most important findings?

Kremer: All human cells are the genotype of an primeval single-celled organism's settlement about 1.5 to 2 billion years ago with energy preparation not reliant on oxygen but by acquisition of energy through oxidation. The latter, called mitochondria, continue to live as cell colonies in all cells of algae, plants, fungi, animals, and human beings. Genotypes of both single-cell organisms were integrated into a "nucleus". The mitochondria conserved a residual genotype for independent proteins synthesis in cooperation with protein encoded within the nucleus imported into the mitochondria. The more than 1,300 mitochondria existing on average in all human cells possess collectively about 50,000 active genes – a greater number than in the nucleus. Between the mitochondria colonies (that represent 90% of the total energy in the cells' latent and active phases) and the "host cells" there is also a complex import-export system operating through mitochondrial gates for protons and electron flow, ionic exchange, preparation of the universal energy carrier molecule ATP, and various metabolic products.

Since ATP cannot be stored, the mitochondria – amounting to more than 1,000 times the number of our body cells – produce an unbelievable amount of ATP daily. It equals roughly the magnitude of our body weight. The mitochondrial gates – and this is the new finding – are controlled by a mixture of gases consisting of nitric oxide (NO) and peroxide anions. The latter accumulate as a product of the oxidative respiration chain in the mitochondria. NO gas was verified during the mid-1980s as a basic functional gas found in almost all human cells. There is a gas-controlled alternating rhythm in the form of energy preparation between the mitochondria colony and the cells as a whole. During the late cell division phase, the early wound-healing phase, and the embryonic phase, up to the moment of birth, preparation of potential energy is overwhelmingly shifted to

production of non-oxidizing and fermenting ATP. This protects the genome portions of disorganized host cells that during the cell division are more sensitive to oxides and their derivatives than the mitochondrial genome portions. Depending on redox activity, this primordial genome portions express the necessary enzyme protein for alternative switching of oxidizing to non-oxidizing energy preparation. Thus our primeval cell symbiosis possesses a genotype duplicate and a duplicated energy preparation system. We are biological hermaphrodites in the evolutionary sense of life!

All bioenergy and biochemical processes – above all naturally those in the mitochondria too – depend on a varyingly intensive negative redox potential as a biophysical prerequisite for complex proton and electron flow. This is guaranteed chiefly by glutathione, a tripeptide unique to quantum physics, that avails its central molecule, the amino acid cysteine, via the hydrogen sulfide group – especially freely convertible protons for all detoxification services.

Raum + Zeit: What are the consequences of these findings in understanding the causation of cancer, the causes of AIDS, and therapy for cancer and AIDS?

Kremer: The consequences are fundamental. In the case of cancer and "HIV positive" that means increased production of many specific antibodies. In full-blown AIDS (that is, intracellular fungus, protozoa, and mycobacteria infections as well as a few really existing virus infections), it means ulcerative colitis, severe traumas, burns and other systemic and chronic diseases. We have a systemic lack of cysteine and glutathione as the result of excessive cysteine and glutathione use (as with the nitro compounds above) and/or lack of cysteine uptake and/or disturbance of new cysteine synthesis from methionine in the liver (for example, through folic acid inhibitors such as BactrimTM) and/or disturbance of new glutathione synthesis (toxic and pharmatoxic due to a variety of substances). The organism suffers from a striking lack of freely convertible protons. Under current civilization conditions, the organism must cope with more than 60,000 poisons in the glutathione system. Transformation to cancer cells can develop through a shortage of glutatione when the mitochondrial respiration chain's reserve capacity for ATP production is reduced insidiously below a critical level of reserve energy (apparent lack of oxygen, pseudo-hypoxia). The primordial genome portions in the nucleus genotype function in this case as a proton-shortage memory. In genetic and supergenetic terms, it develops into highly complex counter-regulation. Alternating switching with the mitochondria is blocked. The cells can no longer switch back after cell division and remain caught in the division cycle. Nor are cancer cells transformed in this way any longer able to die a programmed cellular death, because the mitochondrial gates that would need to open remain closed due to intense counter-regulated NO gas synthesis. Crucial here too is the circulatory calcium exchange formed between the mitochondria and the cell plasma that is also handicapped. Cancer cells have a striking embryonic character in many respects. Thus it involves a surviving reswitching mechanism on the disorganized gene and energy program – a regression that could not be explained in the past by "malignant" coincidental mutation. From an evolutionary medicine standpoint concerning the cell symbiosis processes, one can comprehend cancer cell transformation if one understands the laws of co-evolution.

Raum + Zeit: Can the blockage of defective alternating switches for cancer cells be reversed?

Kremer: That is the cardinal question for therapy. The disappearance of Kaposi sarcoma after eliminating azathioprin, that caused high use of glutathione as well as all nitro compounds, suggests this. Yet in the meantime we have an abundance of other evidence. It was also possible in animal experiments to prompt tumor cells as well as metastases to disappear completely by stimulating synthesis of NO gas. Undoubtedly the most impressive is the success in healing cancer by balanced high-dosages of cysteine and glutathione to regulate the potential for redox by means of preparations with good bioavailability.

Raum + Zeit: Does glutathione therapy suffice? Or must other measures be combined with it?

Kremer: Cell symbiosis therapy to harmonize redox with equal amounts of cysteine and glutathione is a must as basic therapy. Yet cancer is a highly individualized and highly complex event. Countless studies during the last 10 years have proved the effectiveness of various therapeutic options in counter-regulating cancerous cells by non-aggressive inhibition. The art of healing through counter-regulated cancer cells calls for carefully thought-out interplay between "gas pedal and brake", so to speak. Since basic understanding of cell symbiosis programmed by evolutionary biology was not yet sufficiently advanced, past cancer therapy lacked broad-based testing of a systematically combined and rationally assured overall concept of biological compensation therapy or, expressed in traditional terms, harmonizing of the "yin and yang". In the meantime, however, we did understand why cancer patients died mainly from cachexia's tuberculosis syndrome as the result of a nitrogen and energy imbalance. If you ask cancer specialists how to stop their cancer patients' cachexia, even today you will hear "by supplying high-calorie protein." A study in German clinics found half of the cancer patients to be "undernourished". As one can verify in the standard works of AIDS medical officialdom, therapists treating

AIDS as well as cancer have for decades confused cachexia (called "HIV-related wasting syndrome in the case of AIDS patients) with a chronic state of hunger. They have not understood why the protein was mainly excreted as urea. On one hand, cachexia results from a proton deficit due to lack of cysteine in the liver that leads simultaneously to a lack of glutamine and arginine as well as to an increase of glutamate in the plasma. On the other hand, the recycling in the liver of the glycolysis product lactate resulting from a 20 times higher glucose decomposition by fermentation in the cancer cells, demands an excessive use of protons and higher investment in energy than the energy that was obtained originally from fermentation of glucose. These feedback processes are regulated via type 2 cytokines, communication protein that are synthesized by force due to the gluthation shortage and prevent in the net result protons from splitting out of the cysteine. Thus the primordial anaerobic principle of low-fluid proton fixation also shows up with cachexia in comparison to the high-fluid proton floating of intact cell symbioses. Check the laboratory findings notes of clinics and medical practices. Then it will be clear to you why the causes of systemic amino-acids' dysregulation are usually misunderstood and inadequately balanced.

Raum + Zeit: Can biological compensation therapy dispense with chemotherapy?

Kremer: In principle, yes. Chemotherapy seeks above all to inactivate the cell-division process. Yet it affects the mitochondrial structures primarily. As descendants of eukaryotic bacteria, they possess no protective proteins and no effective repair mechanisms for their genes. However, they are many times more sensitive to peroxide chemotherapy as, for example, genes in the nucleus that are especially protected. During the long course of evolution the mitochondria have functioned very well. Among animals living wild, DNA defects in mitochondria have been detected rarely, while the list of congenital and acquired mitochondrial illnesses among human beings from Alzheimer's to Parkinsonism and severe heart myopathy becomes ever longer. The problem of any chemotherapy is that cells in any tumor are found with variously intensive degrees of counter-regulation. Thus one can use chemotherapy to kill part of the cancer cells. That's called remission. Other cancer cells must encounter intensified counter-regulation. This is due precisely to the intentional simultaneous attack on the mitochondria. It also applies to cells that are not yet transformed and still exist in the compensated state of cell dysymbiosis. As a result, metastatic cells or secondary tumors can be selected. Cancer patients who have been subjected to biological compensation therapy before and during chemotherapy report less side affects and better tolerance to chemotherapy. Yet the problem is the later consequences of chemotherapy: once damaged, mitochondrial DNA is no longer reparable. Defects can build up over the course of years. This cannot be calculated on an individual basis. Based on a long-term study in the German Cancer Center, the average survival period for cancer patients after chemotherapy amounts to 3.5 years, without chemotherapy 12 years. The finding dates back more than a decade, but not much has improved in the meantime in regard to survival odds with most solid carcinomas. In the USA the "War against Cancer" declared in 1971 was considered lost in 1996.

Raum + Zeit: What is your advice for those affected?

Kremer: For those affected and their family members as well as those not yet affected – since every third human being will be diagnosed with cancer during the course of his life – the only advice is not to be driven into panic by the shock of diagnosis. Rather adapt to the basic knowledge about why cancer cells are not foreign bodies but reactions programmed by the evolutionary biology of our cell symbioses that can be reversed in principle if one consistently gives the body what it really needs. Obviously at the end of the day the informed patient can only decide in cooperation with enlightened therapists if he has the necessary mental support. *Raum + Zeit* will surely publish addresses of individual therapists, counseling organizations, patient initiatives, and Internet addresses that already have experiences with biological compensation therapy. Related seminars for those affected and therapists are also offered at the Wolfratshauser Academy. In view of the more than 100 different forms of cancer, there are too many special questions that one can only discuss in individual counseling or in therapy seminars.

Raum + Zeit: What are the consequences for the causes, diagnosis, and therapy in case of "HIV"/AIDS?

Kremer: The crucial thing is the knowledge that the T_4 helper immune cells in the blood are not destroyed by some sort of virus (neither by "HIV" nor by another virus) and that the cellular immunity is capable of recovery. Since the outset of the 1990s, it has been proven in human beings that there are two subgroups of T_4 cells, as with all mammals. These are not differentiated in laboratory measurements by HIV/AIDS researchers. Yet the T_4 cells count in the blood stream is determined by the relationship of these two subgroups called TH_1 and TH_2. Dominant TH_2 cells are formed by lack of cysteine and glutathione. They have migrated from the blood stream and stimulate antibody production in the lymph organs. The number of these T_4 cells in the bloodstream declines automatically. This produces cytotoxic NO defense gas as TH_1 cells against cells that contain pathogens internally. This "switch" in the T_4 cell balance – as in the case of cancer cell transformation – is regulated by type-2 cytokine. If it is lasting, it causes the disposition for AIDS. As has been proved, the really endangered

among the "HIV positives" have type-2 cytokin dominance. This also applies for the dual strategy of immune defense in the cells' interior and in their outer environs. The same programmed evolutionary biology laws of counter-regulation prevail when lacking freely convertible protons as they do with cancer. Since most therapists do not seem aware of these laws – or do not want to know about them – sooner or later they unintentionally kill those stigmatized as "HIV positive" (even those not even primarily endangered by AIDS). This occurs because they measure neither the cysteine and glutathion levels nor other important laboratory parameters. Instead they prescribe unlimited glutathione-consuming chemotherapy and chemo-antibiotics toxic to mitochondria. Or if they do make measurements, the "HIV" fixation prompts them to carry out chemo treatment anyway. A minority resorts to a lazy compromise, treating simultaneously with a half-hearted "supplemental therapy" using L-cysteine or reduced glutathione. But in the long run this cannot compensate for the counterproductive toxic effect of the chemo-substances.

Raum + Zeit: But what happens in the organism of the "HIV-positives" who "feel better" subjectively after beginning the cocktail therapy?

Kremer: This is the so-called "lawn-mower effect". The most frequent opportunistic pathogens, fungi, and protozoa also possess mitochondria whose respiration chain is inhibited by AZT and BactrimTM. But this effect should not be confused with the fictitious "HIV" inhibition. The crucial point is that individual fungi and protozoa can survive the chemotherapeutic target attack just as individual cancer cells can survive by counter-regulation. That is the so-called "resistance problem". The real basic evil is, that the lack of glutathione and the reduced production of NO defense gas dependent on it, are not in balance. Thus the body refuses the surviving means of self-help. Instead, the deficient state resulting from the chemotherapy intensifies, and counter-regulated "resistant" parasites and cancer cells are bred. The detoxifying role of the mitochondria in the immune and non-immune cells is forcefully weakened even more until reaching the point of critical stress. Hence extending survival of the so-called "inevitably fatal infection" really reflects an error in therapeutic approach that maintains the conditions of the vicious clinical circle. Several clinical course studies in the USA in the meantime have confirmed that precisely those patients die whose alleged viral load – measured by the extremely dubious PCR method in this case – was lowered by combined therapy. This was seemingly confirmed by the relative increase in T_4 cells within the blood serum. The relative increase in T_4 cells is based on the reverse current of TH_2 cells that can no longer carry out their helper function for cells producing antibodies, since their maturity is blocked by chemotherapy. The alleged decrease in "HIV" RNA is the result of increase RNA consumption from the serum for DNA repair by genes made defective by the chemo treatment. Therefore, viewed over the long term, these are therapeutic pseudo- successes that deceive both patients and therapists about the favorable effects of chemotherapy and chemo-antibiotics.

Without consistent compensation therapy, it is merely a question of the patient's disposition how long it takes before the point of no return is reached as a result of long-term chemotherapeutic poisoning of respiration in the immune and non-immune cells. But the time-fuse effects should also be taken very seriously among "HIV positive" patients who have taken long-term AZT and BactrimTM, for instance, then distance themselves from it at the critical point, "live healthily" a few years, and suddenly develop fatal organ failure, heart attack, ventricle failure, sepsis, brain or liver coma, etc. These events have nothing to do with "HIV", even if "HIV"/AIDS physicians suggest it. Rather they concern late vascular symptoms of chemotherapy: irreparable mitochondrial DNA defects resulting from absolutely contraindicated "anti-HIV" medication and long-term anti-AIDS prophylaxis. Several orthodox "HIV"/AIDS research groups in the USA have published that the proven damage to mitochondrial DNA after combined therapy "resemble intense inborn mitochondrial DNA damage". We have known for a long time that this damage can accumulate and build up after continued division of the mitochondria and added stress, that cell respiration fails, and that fatal organ failures can appear in tissues and organs with abundant mitochondria or, in case of cellular counter-regulation, cancer transformation. It is crucial that those affected be told how one must check this danger and can compensate for it with biological nontoxic means. This applies regardless of whether primary risks have led to the "HIV positive" test effect.

However those affected are particularly hepatitis patients, whereby the hepatitis C diagnosis is just as false as "HIV", but an autoimmune hepatitis can emerge. Here too many special questions can arise that can only be answered individually or in therapy seminars. In my experience, it is mainly those affected with blood groups B, A, and AB who show an increased disposition for deficiencies of freely convertible protons and are endangered by systemic diseases. Since about 50% of the population has blood group O, this fact is one of many that explains the varying disposition to disease at the same or even higher exposure to risks. The association for increased disposition among human beings with certain blood groups (B, AB, and A) for certain forms of cancer, asthma, etc. (polymorphism enzyme) is known, but very little systematic research has occurred on it. This also applies for the suspicion of later after-effect symptoms after mass vaccinations that can apparently trigger an increased disposition for TH_1-TH_2 switch – particularly among vaccination subjects with blood groups B, A, and AB. During pregnancy, there is a type-2 cytokin status in the placenta, and after birth a natural TH_1 (type-1

cytokin) – TH_2 (type-2 cytokin) balance must be trained in the most natural way possible. Indeed, those affected have strikingly few bacterial infections in childhood. This is due to induced elevation of the TH_2 status. It results from vaccinating against unwanted programming at a lowered sensitivity threshold for the TH_1-TH_2 immune cell switch and the cytokin type 1 – type 2 switch in the sensitive formative phase during early childhood. The advantage is improved antibody production. The disadvantage is reduced NO defense gas synthesis, increased preparedness to react against foreign protein and toxic substances, and increased consumption of glutathione. But asthma, neurodermititis, allergies, cancer, etc. can probably develop with greater frequency later. The striking thing is that AIDS patients stigmatized as "HIV positive" have almost all been born after World War II, *i.e.,* in an era when the human immune system had to cope for the first time with antibiotics and vaccines. Indeed a "HIV infection" supposedly communicable to anybody would hardly have spared older patients. This also addresses the chemo-antibiotics thesis that one first recognized as clinically relevant: the most frequent AIDS indicator illness, lung infections with the airborne pneumocystis fungus (PCP). This occurred at the end of the 1930s as prematurely born babies were treated against bacterial sepsis with the newly developed sulfonamide drugs and developed PCP instead of bacterial infections. Sulfonamide (developed from azo dyestuffs!) inhibits folic acid synthesis in bacteria and in human mitochondria, consuming extreme amounts of cysteine and glutathione. The lung's mucous membrane requires a roughly 100 times higher cysteine and glutatione level than in plasma. Prematurely born babies died 60 years ago of pneumocystose (PCP) after sulfonamide therapy for "white lungs". Long-term medication with the trimethoprim/sulfonamide preparation BactrimTM and other folic acid inhibitors has occurred in exactly the same way since the 1970s. It has become the joint determining cause of disease and death for by far the most frequent AIDS indicator disease, PCP, and other fungus infections dominating in the AIDS disease catalog. After a series of fatalities following BactrimTM treatment of non-"HIV" positives registered during the 1985-1995 period, the responsible officials in England and the USA sharply restricted the indication recommendation for BactrimTM to a half dozen rare infections for a treatment duration of seven days or a maximum of 10 days. Absurdly – one must even say criminally – unrestricted BactrimTM treatment of already immune-deficient "HIV positives" and AIDS patients was the only exeption to this new restriction. In Germany there are still absolutely no restrictions on BactrimTM.

Raum + Zeit: Clinical "HIV"/AIDS researchers have contended for a few years that a protease inhibitor plus drugs such as AZT and one like nevirapine introduced since 1996 had brought about a therapeutic breakthrough in treating "HIV"/AIDS and speak of eliminating "HIV" in three to four years. The media suggests the so-called Lazarus effect by medication with AZT plus nevirapine plus protease inhibitors.

Kremer: The campaign for CRIXIVAN™, VIRAMUNE™, etc. was initiated in 1996 by the multinational public-relations firm Burson-Marsteller, advertising partner for mega pharmaceutical concerns such as Glaxo Smith Kline, Pfizer, Eli Lily, and Bristol Myer Squibb. All healing claims have had to be retracted since 1999. The consequences of a medication like nevirapine plus AZT and protease inhibitors such as CRIXIVAN™ were too obvious this time to be able to project this to "HIV". Drugs like CRIXIVAN™ had caused failure of the liver, pancreas, and kidneys, diabetes, massive lipometabolic disturbances, high blood pressure, heart attacks, strokes, etc. According to clinical studies, it clearly involved the approach of orthodox "HIV" research groups to pharmacotoxically induced mitochondrial diseases. Fatalities by liver failure after medication with drugs like CRIXIVAN™ are not counted as AIDS fatalities, since they often appear before development of the official 29 AIDS indicator diseases, even among patients previously without symptoms. Since then it has been publicized that "HIV" requires a medical elimination period of 10-60 years (!). But regrettably the tolerance of "combination therapy" – for instance, AZT plus nevirapine plus protease inhibitors – is limited to a maximum of two to three years. The collective virus obsession enables "HIV"/AIDS medicine to operate in a lawless sphere without responsibility for the often fatal consequences. Yet ignorance and unwillingness to know can no longer be an alibi for the humiliating helplessness and indifference among officials, professional medical associations, and almost all fellow human beings who face this almost unprecedented lack of scientific and medical ethics. It's worth noting that journalists from DER SPIEGEL have been making passing comments about AIDS for almost 20 years and despite better information on the latest prognoses of unscrupulous propagandists for "HIV", AZT, etc. In the next 10 years the survivors of "combination therapy" are increasingly likely to develop cancer and heart attackes as consequences. What DER SPIEGEL does not report is this: In all studies on "HIV positives" who remain free of symptoms longer than 10 years, it has been determined that these affected are being termed "long-term survivors" or, more to the point, as long-term objectors who never – or among a low number only for a very short term – were treated with drugs such as AZT, BactrimTM, or protease inhibitors.

Raum + Zeit: How do you think your colleagues will react to publication of your book?

Kremer: I think it will be overwhelmingly positive, since the immediate value of the new findings is obvious for survival of the patients affected. I see my role as a mediator independent of the pharmaceutical industry with assured basic knowledge of diagnostic and therapeutic practice. Evolutionary medicine's plausible explanation

for the causes, diagnostics, prevention, and therapy concerning AIDS, cancer, and degeneration of nerves and muscle cells among other maladies can no longer be argued away by yesterday's theories. There is an urgent need for anxiety-free enlightenment among those affected and for rational continuing education available to open-minded therapists. After many years of my own medical experience, I think that knowledge of the elementary laws of cell biology, goal-oriented laboratory diagnostics, and differentiated treatment of biological compensation therapy should be indispensable, fundamental, and helpful for any therapeutic approach rooted in natural science in waging the 30-year "war against cancer" and pursuing the 20-year "hunt for the virus".