

This article was first published in the German scientific magazine *raum & zeit* 121, 50-64; Jan. / Feb. 2003

### **Foreword of the editor:**

In July 2002 the “Congreso Mundial por la Vida” was organized in Barcelona from more than 60 Spanish and international groups parallel with the official 14th International AIDS Congress. The main theme of this congress was the critical working through of 20 years of “HIV”/AIDS medicine. Dr. Kremer, one of the main lecturers of the “Congreso Mundial por la Vida”, summarized the important manipulations which have led to vaccination techniques of high risk with “naked DNA”.

## ***The Perversions of AIDS-Medicine***

*After the planned experiments with toxic medications now the hunt for the phantom virus “HIV” with “naked DNA” vaccination.*

*Mundus fraudiatur ( The world wants to be betrayed). An old roman saying.*

### ***Dr. med. Heinrich Kremer, former medical director. Barcelona***

What is AIDS? This clinical artificial term was established in 1982 and it means: acquired immunodeficiency syndrome. In this term lies a striking imprecision, because “deficiency” can mean lack, weakness or defect. But it is clinically and therapeutically crucial which concrete findings are used as a basis.

Lack of certain immune cells normally measured as quantitative distribution in the blood stream, can be an expression of a poor ripening of the many cells of the immune-cell-network. In contrast, the weakness of immune cells can be a reduced functional ability of certain immune cells. While defect can mean that ripe, sound immune cells can be prematurely and continually destroyed due to one or more factors which first have to be investigated.

The ambiguity of the term AIDS has, from the beginning, reflected and at the same time veiled the fact that important processes in the complex interplay of the components immune function was not yet understood 20 years ago. This circumstance favoured fundamentally arbitrary fixing to propagate a deadly mass epidemic through “a new agent”, as the alleged cause of a certain disturbance of the immune cell balance.

The historical starting point for AIDS-medicine was the report of the US authority for the surveillance of epidemics (CDC) in June 1981 about 5 disease cases in Los Angeles. The patients suffered from a typical non-bacterial pneumonia with the known agent “Pneumocystis Carinii”, a fungus microbe, which is normally inhaled by breathing. Against this fungal agent there are normally demonstrable antibodies in more than 90% of the examined blood sera of children and adults.

What made these cases so spectacular, to raise an epidemic alarm? The patients were treated routinely with the chemoantibiotic “Septrin” (in Germany the trade mark for the same substance is “Bactrim”). Two of the five patients, all of which were around 35 years old, died.

It should have been logically obvious to think that the deaths could be led back to the failure of “Septrin” and also further to ask whether the Pneumocystis fungal agents had developed a resistance to “Septrin”.

In 1969 “Septrin = Bactrim” came to the pharmaceutical market as a “wonder medicine” especially against opportunistic agents, also against microbes which establish themselves within cells. “Septrin ” contains 2 substances Trimethoprim and Sulfamethoxazole. The researchers were euphorically convinced that the antimicrobial effect would be so increased through the double effect of the combined substances that a “Septrin” resistance could never be developed by bacteria and opportunistic agents.

In the beginning this idea seemed to have proven itself, but already in 1970 it was proved through animal experimentation that one of the substances in “Septrin”, Trimethoprim, next to its property as an antimicrobial substance also showed a potential to suppress the cellular immune function (immunosuppressive effect) as well as a comparable potential with Azathioprin, the substance which since the 1960’s patients received after organ transplantation in order to suppress the cellular immunity for the purpose of preventing the rejection of the transplanted organ.

It was therefore not surprising, that with prolonged and/or repeated “Septrin” therapy against intracellular agents, and at the same time the suppression of the cellular immunity of the patients, even though not wanted from doctors, the survival of resistant agents (like the intracellular fungal opportunists) was also brought on. The reason is that chemoantibiotics can relieve the cellular immunity but they cannot replace it. This is especially the case with the handling of opportunistic agents.

As a matter of fact the first cases of resistance against “Septrin” were already published in 1974. Therefore a vicious circle developed: Resistant-made opportunistic agents survived and subclinically irritated the cellular immunity, without, at first, the manifestation of symptoms. This was the case not only for the carriers of resistant opportunists which survived, for example, a Pneumocystis-phase but also for the receivers of airborne resistant pneumocystes.

The risk of a manifest opportunistic infection under these conditions comes about naturally, especially for people who are disposed to (be it from a disposition from birth or acquired) toxic, traumatic, mental, radiative, dietary and other manifold concrete causes due to the prolonged stress burden upon the cellular immunity. It is a fundamental medical professional error of doctors to attribute serious disturbances of the cellular immunity exclusively to a primary infectious cause in every case. As a rule microbes are the profiteers and not the primary causes in the processing of disturbances in the balance of the cellular immunity. A classical example is the microbial sepsis after serious trauma and operations. Highly significant with these patients are anomalies of the immune cell status, identical with those of AIDS patients, without having spoken about AIDS. The death rate is also very high until today in spite of the massive working of the most modern antibiotics.

There was however no mention of the obvious law-governed interaction of the individual dynamic between disposition and exposition in the first clinical publications about the disease cases which were later named AIDS. It was instead simply stated that the 5 Californian patients “had been up until then healthy”. It was therefore suggested that vital young men in their middle thirties suddenly developed from rather mysterious causes, a life threatening pneumonia. We must have this hard core of the medical thesis from 1981 clearly in mind in order precisely to follow why, from these in no way puzzling disease cases, this alleged dangerous threat to the whole of humanity could have been deduced, through a plain ignorant denial of the biological-medical facts of the historical burden these young men suffered.

It was diagnosed, without comment, in the first publications that : One patient was a heroin addict, two patients were hepatitis B-positive, and that all 5 were habitual nitrite users.

Anamnestic case histories of the antibiotic usage of these patients, whether prescribed or self-prescribed, were not published. This fact has not changed in medical publications even up to the present day.

Since 1981 hundreds of thousands of clinical publications have reported on the effects and follow-up effects of substances against supposed or actual disturbances of the cellular immunity. These publications have concentrated solely on the results of the prescribed arsenal of provable immunotoxic antimicrobial medications. It is however a forbidden thought to ask whether these immunotoxic medicines have pathogenetic effects in themselves in the sum of stress factors which bring about and keep the process of disturbed immune balance going.

However, one who becomes as a onesided socialised doctor, and that goes for the vast majority of doctors in the world, and associates the causes of anomalies of the cellular immunity, arbitrarily and chiefly with known or unknown infectious agents, will be blind to the perception of the biologically programmed laws of evolution of the human immune reaction. These laws prove clearly that the human immune-cells react as sensors and effectors to many different prooxidative stressors and not only to structural elements and metabolic products of microbes. These processes are ongoing in a uniform way.

In the case of the first 5 historical AIDS patients, (not the actual AIDS disease cases, these were already present but were not so named) the immune cells which ripened in the thymus gland (the so called T immune cells) were examined in the test tube in the laboratory. Thereby a newly developed technique was employed: through the use of monoclonal antibodies a central subgroup of the T cells ( T4 or CD4 cells ) were differentiated. These T4 cells were proportionally greatly reduced in the blood stream and reacted, after the usual stimulation with strong oxidising substances, without heightened division. The researchers deduced from these isolated results the leading speculation to date : the T4 immune-cells must have been infested and destroyed by a “new agent”.

This statical momentary result of the dynamic of the immune-cell network was however misleading, because another striking contradictory result was ignored because it did not match the hypothesis that the T4 cells were destroyed by a “new agent”. The T4 cells were also described as T helper cells, because they not only receive molecular signals from so called antigen presenting cells, but also, for themselves, send out, after stimulation, activating molecular signals to other unspecified and specified immune cells. Under antigens is to be understood, amongst others, foreign molecules from microbes, which are presented as stimulating signals amongst others by the B cells (which ripen in the bone marrow) for the T4 immune cells. B cells are antibody producing immune-cells, which migrate into the lymph organs and catch the invasive agents and present certain parts of these agents to the T4 helper cells as antigen signal, which for themselves send back a stimulation signal to the B cells to stimulate more antibody synthesis. Therefore the term : T4 helper cells.

The first AIDS patients had however normal and even increased antibody levels. The helper function of the T4 cells must have therefore been intact. The decrease of T4 cells in flowing blood and their unwillingness to ripen after stimulation in the test-tube must not be explained, in any way, through an infectious defect of the T4 cells. Much closer was the supposition, that the T4 cells had made a transformation of function, and many had travelled outside of the blood-flow, into the lymph organs as the real place of interaction, in order to give needed help for the production of antibodies.

In fact it was clinically striking, that the AIDS patients developed no extra cellular, bacterial infections, which could be effectively blocked through antibodies. The logical consequence then was, that the AIDS patients merely suffered from a lack of T4 immune-cells whose specialized job it is to send out signals, after specific stimulation, to other immune-cells whose function rather is to destroy cells which are colonized by intracellular so called opportunistic agents (ie, fungi, protozoa, mycobacteria (agent of tuberculosis), some real existing viruses). These T4 cells are named, in order to

make the distinction from T4 helper-cells, inflammatory T4 immune-cells (because these immune cells set off inflammations).

AIDS, the clinical appearance of opportunistic infections is then nothing more than the consequence of a transformation in function and a balance shift in favour to one of the two subgroups of the T4 immune cells, namely of the T4 helper cells at the expense of the inflammatory T4 immune cells.

This model of double strategy of the T4 cells can be well established evolutionarily. The equivalents of inflammatory T4 immune cells can be proved already with simple animal forms such as sponges, while the antibody immunity appears much later, in the development of types of bony fish. At this point in evolution, the development of the antibody immunity was necessary because among other things, through the better developed circulation system of fish, worms, as an extra cellular class of parasite, become extremely dangerous. Because of their size, these worms could, furthermore, not be held in check solely by the inflammatory T4 cells. We know today that every corresponding stimulation of the inflammatory T4 cells is answered with a corresponding counter-regulation: a balance shift to the increased stimulation of the antibody synthesis. This shift is, typically after some 7 days, balanced out again. This is the case after trauma or operation. If the balance is not brought about after 7 days, a danger becomes evident, namely the already mentioned microbial sepsis (at first line a bacteraemia). With every kind of infection, the specific cooperation between the inflammatory T4 cells, (also named: T-helper-cells of type 1 = TH1) and the actual T4 helper-cells, (also named: T-helper-cells of type 2 = TH2) can be non-effective in the elimination of intra-cellular agents. The result can be a chronic sub-clinical reaction from the infection and a long lasting shift of the TH1-TH2 balance, as has been proved for many illness stimulators. Clinical symptoms like those of AIDS (long lasting balance-shifts of the TH1-TH2 synthesis with opportunistic infection and many accompanying symptoms) can, in these cases, manifest themselves much later after the primary events. The helper-construction of a virus-based infection of the T4 cells, as in the construction of the theory: "HIV" is the cause of AIDS, is for the understanding of such a symptom-development neither necessary nor sufficient. On the contrary these constructions have led to fatal therapeutic results through mistreatments with immunotoxic cell poisons and to the averting of treatment of the actual illness connections through biological-compensatory-therapy. According to the latest knowledge drawn from the fundamental research of animal experimentation, the T4 immune cells react, time limited, with an evolutionary biologically programmed strategy not only to strong but also to weaker stimulation. The course of the reaction is therefore not dependent upon the successful turning off of the triggering immune stressors. The stimulated T4 cells ripen very fast and divide identically (they make clones, to use the term of molecular biology). After a time period of about ten days 90% of the cloned T4 cells are already dead.

The same process, the fixed balance-shift between the TH1 and TH2 immune cells can develop itself under the influence of many immunotoxic factors, especially also immunotoxic medicines with patients for example, who are treated for leukemia or other cancer illnesses with certain cytostatic drugs. Regular opportunistic infections occur and the same characteristic lack of the T4 cells in the blood flow (decreased TH1 immune cells) has been seen. The same symptoms have also occurred with organ transplant patients who were treated with immunotoxic medicines (Azathioprin, Cyclosporin A, Corticosteroids) for the specific "switching off" of the cellular immunity. With kidney transplant patients the added manifestation of Kaposi sarcomas, as in the case of the AIDS patients, the cancer-like transformation of the cells in the inner walls of blood- and lymph-vessels, was also observed. These Kaposi sarcomas occurred with 6% of kidney transplant patients, often years after the beginning of the continuous treatment with Azathioprin, and disappeared again often after this treatment was ended. The appearance of Kaposi sarcomas was unequivocally brought about through the immunotoxic treatment with Azathioprin.

The unambiguity of the proof of primary provocation of the combination of symptoms from secondary opportunistic infections and from Kaposi sarcomas (with a minority of affected patients) through the

reduction of the TH1 immune cells, induced through immunotoxins, would, even through a moderate rational analysis of the immunotoxic burdening profile of the first AIDS patients, have unmasked the false speculation of a “new agent” claimed to cause a (high hypothetical) defect in the T4 immune cells as being arbitrary construction from the beginning. Shortly after the first publication of the five cases in California of Pneumocystis-pneumonia it was reported, from the same US epidemic authority backdated to 1978-1981, that a further twenty cases had occurred, with and without opportunistic fungal infections, by the onset of Kaposi sarcomas. The common denominator between the immunotoxic burdening profile of the Californian Pneumocystis Carinii Pneumonia (PCP) cases and the 20 Kaposi sarcoma cases was the fact that all the patients were homosexual men from US metropol who were also chronic nitrite “users”.

Nitrites are nitrogen gases, which since the 60's have been used by many homosexuals in the west as a sexual doping agent for the easing of anal-sex. Nitrites are inhaled and very quickly reach the blood circulation through the lungs. They change into nitric oxide (NO gas) in the cells in the inner walls of the blood vessels. NO gas diffuses from the cells in the inner walls of blood vessels into neighbouring smooth muscle cells. NO stimulates in these muscle cells an enzyme which contains iron (Fe<sup>2+</sup>), and helps in this way to reduce the calcium 2+ content of the cells. Therefore the NO gas is involved in the regulation of the blood pressure. NO gas induces the same effect in the smooth muscle cells of the anus. That brings about the relaxation of the anal muscles, so sought after by homosexuals.

The first case of death from inhalation of nitrite gases was already published in the 60's in the USA. The pinnacle of nitrite misuse by homosexuals is stated in medical literature to be the middle of the 70's. Many animal experiments clearly proved, before the appearance of the first AIDS cases in homosexuals, the high immunotoxic effects on T4 immune cells from nitrite gas. NO-gas builds itself out of nitrite gas in the cell metabolism. Through chronic nitrite abuse it binds with iron containing enzymes of the cell respiration process, part of the respiration chain in the cell organelles. The result is the inhibition of the oxygen dependent synthesis of adenosine triphosphate (ATP), that is the essential life energy and information carrying molecule for all cells. The ATP synthesis is quickly inhibited, so starts the programmed death of the cell (Apoptosis). On the other hand the cell dies through “sudden” death (Necrosis), if the decrease in ATP synthesis is very abrupt. If the inhibition of the ATP synthesis draws on chronically, the cell can change over to an oxygen independent ATP synthesis, then the danger can occur of a transformation into a cancer cell. In this case the programmed or sudden cell death is inhibited. While through usual nitrite inhalation nitrite gas chiefly transforms itself in the cells in the inner walls of the blood vessels into NO gas, a risk can occur of the development of the Kaposi sarcomas. The immunotoxic substance Azathioprin can cause, through the same mechanism as NO gas, the Kaposi sarcoma, because it contains a marked nitrogen grouping (N<sub>3</sub>). This grouping can also in the same way as NO gas closely bind to the iron containing enzyme cytochrome oxidase in the respiration process occurring in cell organelles named mitochondria, and can inhibit the oxygen dependent ATP synthesis.

In summary: Trimethoprim, Azathioprin and nitrite / NO show the same immunotoxic working profile and can, dependent on cell type, dosage and time-span of influence, as well as the disposition of the patient, bring about, due to immunotoxic potency, especially through an accumulation effect, cell transformation as in Kaposi sarcoma. This carcinogenic potential showed itself with animal experiments done in the 80's: after the administration of nitrites + “Septrin”, a development of cancer was seen to have taken place. In western AIDS patients the Kaposi sarcoma occurred up to the present day, practically only in connection with the misuse of nitrites by homosexuals. After the prevention, in the US and Great Britain, of marketing inhalation substances based on nitrite gas (known as “poppers” in the homosexual world) the cases of Kaposi sarcoma were drastically reduced. The carcinogenic potential of these nitrogen derivatives rests, among other things, with their ability to bind to heme groups containing iron in the respiration complexes of the mitochondria and the ensuing inhibition of the oxygen dependent ATP synthesis which is connected to the respiration chain.

The unambiguous causal connection between the toxic burdening profile and the occurrence of so-called AIDS indicator diseases (opportunistic infections and Kaposi sarcoma) could only, from 1981 onwards, be arbitrarily denied, in favour of the illness hypothesis of the supposed emergence of “a new strain of retroviral agent”. Well informed insiders spoke of “the American illness”. Thereby was meant the puritanical double moral of the opposition to pleasure on the one side, together with the definite market interests. A few months before the first reports from the US epidemic authority (CDC), Ronald Reagan, the former Hollywood actor, had ousted Jimmy Carter, the outgoing “liberal“ democratic president, thereby bringing about the transition to conservatism. Reagan had, in his post as governor of California, distinguished himself as an action-taker against the homosexual scene in Los Angeles and San Francisco. The arbitrary, stage managed, mass hysteria through a “deadly sex-epidemic”, allegedly primarily put about by promiscuous homosexuals, and the economic exploitation of the induced epidemic fear, together with the denial of the causes of the illness through toxic industrial products, mirrors the spirit of the times and the political climate in the States.

The reports of the US epidemic authority (CDC) in connection with the first AIDS cases in the homosexual community were published by the infections disease department of the CDC. The co-workers of this department were, under the Reagan administration, (with the exception of an older sociologist) young virologists roughly the same age as the AIDS patients. They spoon-fed the media with all sorts of thinkable and non-thinkable global epidemic fantasies about the deadly dangers of a probable new viral agent, which could, through unprotected sex, be transmitted to everyone. The media had proclaimed until then, since the introduction of the “pill” in 61, sexual liberation, and public life was overflowing with “things sexual”. Without proof and with an uncritical lack of restraint the media turned its attention to the mirrored sexual threat of the freely fantasised “AIDS agent”. At the behest of the assumed “scientific authority” of state virologists at the CDC and the state doctors of the elite Uni-clinics in the gay centres of California and New York, the media dragged the sexual life of homosexual men under the crassest spotlight of world publicity. Since the middle of 1982 a new “gay-plague” has been propagated. Using the proven media device: The worse the prognosis, the more the people believe, it was suggested: The absolute deadliest sex-epidemic, against which there is no medicine, would be passed on from homosexuals through bisexuals onto the women of the world and from these onto the unborn and living children who, once infected from the “AIDS agent”, could look forward to a life span of two years and then certain death. The actor-president Reagan declared, with pomp and circumstance, the “new agent” to be the no. 1 enemy of humanity.

That at the time, and ever since, no AIDS agent could be proved, disturbed practically no one. The unbridled driving-force of the association between sex and epidemic robbed every rational controlling force of energy. It was the birth of the epidemic dictatorship without epidemic stimulators, who’s discovery was awaited any minute after the freeing of the biggest capital investment in medical history through the Reagan administration.

What sort of nature must the “new agent” be?. It must destroy the inflammatory T4-cells but spare the sub-group of T4-helper-cells which bring about anti-body synthesis. At the same time it must be the cause of the opposite: namely to bring about the uninhibited division of the cells in the inner walls of the blood vessels in order to bring about the Kaposi sarcoma. Such an agent was not imaginable. On the contrary the toxic illness hypothesis fulfilled exactly these conditions. Azathioprin blocked selectively the inflammatory T4-cells (TH1 cells) in the case of kidney transplants but not the TH2 cells, the helper cells for antibody producing cells, thereby causing, through extended use, opportunistic infections and Kaposi sarcoma (Transplantation AIDS). Added to that, kidney transplant patients were also handled with “Septrin”, symptomatically for the avoidance and treatment of infection of the urinary tract. The proof for the toxic causes of AIDS were furnished a decade later through fundamental research results outside of AIDS research. It became cognised that many cell systems in man, for the regulation of the flow of energy and information in the cell metabolism, synthesise gas-like nitric monoxide (NO) and, especially the inflammatory T4-cells and other immune

cells as well as non-immune cells, produce a cell destroying (cytotoxic), long working NO gas. It became obvious that without sufficient cytotoxic NO gas production, opportunistic (intracellular) microbes could not be effectively destroyed. At the same time it was proved by many research groups that, with too much or overextended stimulation of the inflammatory T4-helper-cells, an automatic switching-off of the cytotoxic NO gas production occurs and actually the synthesis of the inflammatory T4-cells (TH1 cells) was switched to the predominant and over-extended production of those T4-helper-cells (TH2 cells) which synthesise no cytotoxic NO gas and in place of it disappear from the blood stream and help the extended production of anti-bodies in the lymph organs.

The switch-over from inflammatory to T4 helper cells is again dependent on the glutathione content of the cells which present antigens. Glutathione is, in all cells, the central regulatory molecule for the transfer of protons and electrons. The molecule is synthesised out of 3 amino acids. The decisive role is played by the amino acid cysteine. Cysteine contains a sulphur-hydrogen grouping, which easily transfers electrons and hydrogen to oxidised substances which is indispensable for countless biosyntheses and detoxification functions. Glutathione and cysteine also bind the radical NO-gas molecules, if they are in surplus due to over-stimulation, for example through microbe toxins in the case of acute or chronic infection, through the inhalation of nitrite, the taking-in of poisons in food, environment etc, as well as medicines with metabolic NO-gas synthesis, influx of contaminated blood products and multi-transfusions as well as countless other bio-physical, bio-chemical and psychological stress-factors. When the result is over-extended glutathione and cysteine exhaustion, especially compounded in the wake of bad diet, the body's protective answer is an evolutionary, biologically-programmed counter-regulation. The immune-cell network switches over, in this vital emergency situation, from the evolutionary-biological older inflammatory immunity (for protection against self-destruction through too high cytotoxic NO-gas content) predominantly to the evolutionary biologically younger anti-body immunity. The biological price is the risk of opportunistic infections (AIDS), if the balance of the TH1-TH2 displacement remains fixed.

Lack of glutathione also causes the increased production of nitrogen and oxygen radicals in the respiration chain of the mitochondria and thereby, amongst other things, the forced decomposition of heme molecules containing iron, which lead to the synthesis of carbon monoxide gas (CO). CO is in concurrence with NO and binds, in cases of surplus, amongst others with the iron of the enzyme that synthesises NO gas. Because NO is involved in the exchange of calcium between the respiration chain and the cell plasma, through the production of peroxinitrite, there occurs, due to the CO related inhibition of NO synthesis (in spite of the appearance of enough molecular oxygen) a disturbance of the flow of energy and information between the mitochondria and the cell as a whole. The consequence is (when this process is going on gradually and not very quickly or abruptly, see above page 5) an inhibition of the oxygen dependent ATP synthesis and, at the same time, an inhibition of the programmed death in the cell due to the disturbance of Ca<sup>2+</sup>-exchange. Therefore the cells switch-over to an archaic survival strategy. The cell energy is then won predominantly from the breakdown of glucose in the cell plasma through enzymatic non-oxygen dependent production of ATP. Normally silent genes which are evolutionary biologically preserved, are activated. If this condition is prolonged, the cells can transform the won cell energy, which is as a matter of priority invested in cell division, into cancer cells.

This pioneering cognition, which can be here only outlined, has, in principle solved the problem of the development of AIDS and/or Kaposi sarcoma. As a matter of fact many research groups have been able to prove a significant lack of cysteine and glutathione in T4-cells and other cells actually in the early, still symptom-free, stages of AIDS threatened patients and at the same time an unambiguous dominance of the TH2 immune-cells in relation to the inflammatory T4 cells. In cancer cells with the highest rate of division as well as in metastatic tumor cells (wandering daughter cells) the lowest NO gas level was measured. Added to that, many research studies have showed that cancer-cell transformation is associated with a dominance of the TH2 immune cells. Clinical studies, conducted

over long periods of time in AIDS therapy, have demonstrated that patients with extremely low inflammatory T4 cells, through the substitution of high dosage cysteine have had their disease and death rates , in the words of the clinical AIDS researchers at Stanford University in the USA, “dramatically” reduced.

How is it then possible that armies of laboratory researchers, now as then, uninhibited, propagate the “new type of agent”, the alleged “human immune weakness virus (HIV)”, “discovered” in 1983, to be the cause of AIDS? How is it possible that millions of doctors in the world ignore the overwhelming evidence of the real cause of AIDS and maltreat their patients, with assumed or actual cellular immune weakness, with massive cocktails of glutathione-exhausting, mitochondria-toxic cell poisons right up until the point of death, with the “alibi”, that failure of experimental chemotherapy is the outcome of the deadly “HIV”-infection, unfortunately a “sooner or later” outcome. How is it possible that the experts and mass-media, in unison, declared that the South African state president Mbeki (who as host of the World AIDS Congress 2000 in a rousing appeal to the political leaders of the world, declared that he was not prepared to give his people over to death through pharmaceutical poisons on the basis of an unproven virus theory) was crazy or criminal, without one single word of the actual scientifically published state of cognition being reported. President Mbeki is under great pressure of US investors, whose capital help for poverty in Africa, he desperately needs. The answer to the question before us is in principle very simple: the alleged “isolation of the human immune deficiency virus” rests on deliberate scientific forgery. The lions share of the huge capital already invested , more than 400 billion dollars for “HIV” research, is used to delay, with new laboratory tricks, the uncovering of the failings of modern medical history. The profiteers of this organised scientific swindle fear that, alone the legal-process avalanche after the uncovering of the scientific truth, in relation to the experiences with the compensation paid by the tobacco industry in the USA, could bring about compensation claims which would outstrip the capital outlay. The abrupt loss of trust in relation to the medical institutions, science, politics, media and by no means least of all the pharmaceutical industry would be unimaginable.

Because the scale of intensity of the organised scientific deceit defies the imagination of the average man not to mention the doctors, it is necessary to give now a flash-back to the minutes of the 1st International AIDS Congress in New York in march of 1983. The main themes of this congress were not the predominant opportunistic infections but Kaposi sarcoma. The lecturers were predominantly from Retro-virus cancer-research rather than infection researchers. WHY? Since the 50’s it has been proved in tests from tumor tissue in (inbred) birds and mice and through the use of the electron microscope that viruses of the RNA type are present. Research, long standing and intensive, could not however in one single case demonstrate, also through the use of electron microscopes, RNA viruses in human tumor tissue. In the middle of the 60’s the serious cancer researchers started down the road to find the cancer virus. In 1970 US researchers, however, discovered an enzyme, which transcribed the genotype of the RNA virus into the stable DNA form, as it appears in the cell nucleus of all autonomous self multiplying organisms. It was wrongly believed that this transcribing enzyme (named reverse transcriptase = RT) occurred exclusively in tumor RNA viruses. They were then “baptised” as “retroviruses”. It was euphorically proclaimed, that with RT the key had been found, how retroviruses alter their RNA genotype into human DNA and thereby trigger-off the cancer cell transformation. In 1971 the republican president Richard Nixon, in light of the Watergate scandal and under immense political pressure, called for the war on cancer and set the wheels in motion of the (up to that time) biggest capital investment in medical history. Within 10 years cancer should be humbled. But already in 1971 several researchers had published the fact that RT in no way was exclusive to retroviruses, on the contrary it was provable in all manner of single and multi-celled organisms, and also in differentiated human cells. For the provability and isolation of supposed retroviruses in human tumor cells, Dr Montagnier of the Pasteur Institute in Paris codified exact rules. Therewith not only the unspecific proof of RT and other “replacement markers” as isolation criteria could be validated. In 1975 Dr. Gallo from the National Cancer Institute in the USA published pictures, taken with an electron microscope, of the alleged, “initial isolation of retroviruses” in human leukemia cells. The

later examinations of colleagues showed that Gallo in no way followed the laid out rules for the actual isolation of human retroviruses. The EM pictures emerged, through precise examination to be transporting particles, which, after corresponding stress stimulation, ripened out of the membrane of the leukemia cells and contained nothing other than stress protein and cell waste from the transformed lymph-cells. Because the ripening-out of such transport particles (Engl. = budding) with analogous stimulation techniques in all possible types of cells could be observed, the safeguards of the Pasteur institute would hinder the possible mixing of the “budding” of transport particles with the possibly real retrovirus particles in human tumor cells. Dr Gallo stood as “scientific-forgery” in the stocks and quickly took back his “ERROR”. In 1980/81 towards the end of the Nixon project (costing billions) and as the retrovirus cancer research showed no tangible results and after asking after the sense of the furthering of the project, Dr. Gallo published anew the alleged “isolation of human retroviruses” in 2 rare human leukemia cell lines. Again the Gallo team had nothing to offer apart from RT and budding as well as 2 unspecified “replacement markers” for the presence of retroviruses. In fact, the rules of the Pasteur Institute of true isolation of retroviruses were not met. The Gallo team probably wished themselves a betterment of fortunes with election of the republican Ronald Reagan as well as a prolonging of the Nixon project. The Gallo team presented anyway exactly these two new laboratory products from the human leukemia cells, as the “first isolated human retroviruses”. The event being the historic first AIDS congress in march 1983. This time however they “isolated” the “retroviruses” in T4 lymph-cells from the blood serum of open AIDS patients (homosexuals) in New York. Also in this case, the unspecified “replacement-markers” had been seen. Why the “retroviruses”, which until then had been allegedly leukemia stimulators, suddenly mutated into “AIDS stimulators”, which should destroy the T4 lymph-cells instead of transforming the T4 lymph-cells into leukemia cells, was not forthcoming from the Gallo team. The results of these laboratory manipulations were published in the same month in the leading scientific magazine “Science” as “retrovirus isolates” from the above mentioned T4 lymph-cells of the AIDS patients in New York. In the same edition of “Science” however the team of Dr Montagnier in Paris chipped in with “the isolation of a retrovirus” from the T4 lymph-cells of a pre-AIDS patient with swollen lymph nodes. The French retrovirus / cancer researchers seemed however to suffer from a sudden case of scientific amnesia. They had somehow forgotten the rules set out in 1972 for the correct isolation of retroviruses, rules they themselves had laid down. As proof for the “successful isolation” they merely published the unspecific “replacement markers”, just like the Gallo team. A female worker in the French team had studied the isolation techniques of the Gallo team in his laboratory. The fact that the French team published an EM photo of the “budding” of a particle from the umbilical cord and not from a T4 lymph cell of an AIDS patient did not seem to bother the experts too much. From one point of view the French researchers were cleverer than their American counterparts. They sold their “retrovirus particle isolation” disregarding their own self-defined standard-rules not as leukemia retrovirus but as “a new human retrovirus” under a new name and did not claim up to that point that they had found the “AIDS agent”. This apparent modesty brought Dr Montagnier the scientific recognition, valid even to this day, as the first discoverer of the “human immune deficiency virus HIV”. In 1997 Dr Montagnier was asked in an interview why he had not used the standard rules for his “isolation of the retrovirus”. He answered that it was not possible because in spite of heroic efforts so few virus particles with the EM examination were recognisable. He agreed that he had merely seen the four unspecified “replacement markers” but he emphasized that he had actually “encountered HIV”! These absurd declarations were given to posterity by Dr Montagnier in the same year and 14 years after the alleged first discovery of “HIV”, the first time (!) two research teams had actually applied the standard rules for the proving and isolation of “HIV”. The published result was shocking for the experts. The electron microscope photos of the cleaned-up “HIV” concentrate showed much cell waste and a few cell particles (blister like vesicles) of absolutely different size and form, which moreover did not accord with the long held characteristics of “HIV” held by Gallo and Montagnier. There has been up until today in the scientific literature no other EM photos of a pure alleged “HIV” concentrate in accordance with the standard rules of retrovirus-isolation!

The consequence is that for millions of people the medical diagnosis of the sentence for death due to the alleged “deadly HIV infection” is established through the “encounter” with a budding cell particle whose actual nature could not be cleared up because Dr. Montagnier and his colleagues –greedy for cash and credit- lost their memory of their own rules for the true isolation of retroviruses. But why had these “savers of mankind” also 20 years after the alleged discovery of “HIV” not received the Nobel Prize for medicine? The answer is simple: All insiders know that neither Dr. Montagnier nor anyone else had really discovered “HIV”, they all know that “HIV” is a laboratory construction. However, almost all of them think that it is better to stay silent in times of global scientific dictatorship and to profit from, rather than swim against, the tide.

At the first international AIDS congress in 1983 the research strategy was laid down. The prominent retrovirus cancer researcher Prof. Thomas, one of the main profiteers of the Nixon project, postulated the theory that the AIDS agent brought on cancer indirectly through the destruction of the inflammatory T4 cells and the loss of the immune cell monitoring of cancer cells. A reason for the primary cancer cell transformation which must come before the immune cell control according to his theory, was not forthcoming from him. He demanded however that it is necessary to conduct a series of planned human experiments in order to observe whether, after medical blocking of the cellular immunity, cancer would develop or whether tumors already in place would develop themselves further. Against this proposition devoid of humanity ie. the misuse of these AIDS patients, who allegedly through a deadly virus infection within two years would be dead, as human test subjects through the use of immunotoxic chemotherapy in medical experiments for cancer research, there arose no voice in the publication about the first international AIDS congress, either in the forward of the editors nor in the following lectures. The retrovirus cancer researchers who dominate, through the control of the research monies, the present “HIV”/AIDS research, were probably quite sure, that due to the previous mass psychological brain washing of humanity in regard to the existence of an “AIDS agent” which threatens the whole of humanity, no resistance was to be expected. The following events up until the present day would prove this assumption to be correct. Nevertheless, this fact is just a scientific, medical, political, economical and, last not least, ethical scandal.

In order to realise the planned medical experiments two other extra pre-conditions must be declared:

1. An “ANTI-HIV”-antibody test must be developed in order that a person allegedly “infested with HIV” is stigmatised as a candidate for death. Further, due to the induced death panic, the patient can be motivated to co-operate in a treatment with alleged “HIV inhibiting” medicine.
2. The authorisation of a substance as “ANTI-HIV” medicine must be given from which it would be known that it is not only provable as a cancer producer but also that it has immunotoxic qualities. The carcinogenic and immunotoxic properties of such a potential “anti-HIV”- substance should not be known before by practising doctors.

To point 1.: The construction of an “ANTI-HIV”antibody test.

The laboratory experiments with T4-cells from AIDS patients had showed clearly that these T4-cells synthesised stress proteins by over-stimulation. These were transported out of the inner cell through transport vesicles into the area outside of the T4-cells. One could draw from that, that high stress burdening on cellular immunity in patients from risk groups causes an analogous process becoming evident in the channeling-out of stress proteins into the extra cellular space. It was known that a particular cell protein, which normally is hidden from the antibody producing cells behind the membrane of the cell, would, upon being releasing from the inside of the cell into the extra-cellular space, be recognised by antibody producing cells as foreign protein and would be dealt with by the production of antibodies against such “intruders”. Consequently it could be awaited that human stress proteins from the cell waste of the alleged “pure HIV-isolation-concentrate” would react with the antibodies in the blood sera of risk persons, which had formed themselves against the analogous stress

proteins in the organism of the test patients in risk groups. In trial tests Dr Gallo equipped the “ANTI-HIV” antibody test, initially construed by him, with human cell proteins from the alleged “HIV-isolation-concentrate” and let this test substrate react with the antibodies in the blood sera of the AIDS patients. In fact the tests showed a “positive” antigen-antibody reaction. That said, the same “positive” reaction showed itself when he let his test substrate react with control sera from fully healthy blood donors. These test control patients then must, according to the “HIV”-infection theory of Dr Gallo and Dr Montagnier, also be infected with “HIV” if the test substrate actually consisted of “HIV”-proteins. Consequently Dr Gallo so calibrated the test substrate that he raised the “HIV” positive threshold result for the test reaction. In this case 80% of the blood sera of AIDS patients still reacted “positive”. As expected, the AIDS patients built significantly higher antibody levels (on the grounds of the fixed TH1 / TH2 balance switch) against the freed cell stress proteins than the healthy control persons did. No one could further distinguish whether the “positive” test reaction was a response to the alleged “HIV” proteins or the human cell stress proteins.

The T4 cells of the AIDS patients were however not, because of their short life-span, suitable for the mass production of the “ANTI-HIV” antibody tests. Dr Gallo, who for many years had experimented with leukemia cells, fell on a simple trick. Normally antigens were won for antibody tests from cell components from real existing agents. Because Gallo isolated no real retrovirus “HIV”, he co-stimulated and co-cultivated potentially immortal human leukemia cells together with T4-cells from AIDS patients and maintained that the “retrovirus HIV”, allegedly isolated by himself, sprang from the T4-cell structure over to the leukemia cells. In this way he could produce as many human stress proteins to be used as “HIV” proteins (as test antigens, which are in reality human stress proteins from the cultivated immortal leukemia cancer cells), as he wished.

In order to perfect the deceit, he published in his original publication from 1984 for the construction of the “ANTI-HIV” antibody tests, also the alleged proof for the presence of his alleged “isolated leukemia retroviruses” in the blood sera of AIDS patients. Of these “leukemia retroviruses” there came no word later, also no AIDS patients became ill through leukemia. Dr Gallo patented his “AIDS-test” and in the spring of 1985 the “Anti-HIV” antibody test was marketed by 5 pharmaceutical firms. The trick with the human leukemia cells gave Dr Gallo a decisive lead on his opponent Dr Montagnier, who had experimented with umbilical cord cells and who could not mass-produce alleged “HIV” antigens for a corresponding antibody test. After a long smear campaign over the right to be called the “discoverer” of “HIV”, the two notorious scientific forgers were praised by the worlds press as the savours of mankind from the deadly sex and blood epidemic “HIV”. In 1987 they were promised 1% of the costs of every “HIV” test under the political management of Reagan and Chirac. The rest of the patent money flowed into the World AIDS Foundation, whose president, Dr Montagnier (through the delivery of capital into the research labs of over 10,000 “HIV” researchers and the world wide army of clinical specialists in “HIV”/AIDS medicine) can be quite sure of his position in view of dishonourable suspicion, at least until the money-tap is turned off.

To point 2: Experimental chemotherapy as research tool of retroviral cancer research.

After the “discovery” of the “Anti-HIV”-antibody tests a few considerations were logically necessary. How could one reach the experimental research goal, to provoke the possible cancer-genesis through suppression of the cellular immunity of the “HIV-positive” and AIDS patients? The laboratory experiments of the Gallo team with the T4 lymph cells of the AIDS patients and the human leukemia lymph cells had showed that the alleged “replacement markers” for the proof of “HIV-infection” of the T4 immune cells would be called forth when these cells, at the same time, were over-stimulated with the growth factor of inflammatory T4 lymph-cells (TH1-immune cells) namely interleukin-2 and with highly oxidizing substances for the stimulation of the division rate described as mitogens. A substance was needed, which inhibited the “HIV”-replacement, which was provoked in the T4 immune cells in the test-tube through the introduction of interleukin-2 + mitogens, in order to maintain that this

substance could be effective as an “anti-HIV” medicine. This first step was important in order to receive the go-ahead for the clinical pilot studies with the AIDS patients, who were, through the “ANTI-HIV” antibody tests, stigmatised as “HIV positive”. At the same time it had to be made certain that this “ANTI-HIV” medicine also had the qualities needed for the goals of the research: namely cancer genesis through the suppression of the cellular immunity. On the other hand the AIDS patients should not die too quickly from their opportunistic infections, before cancer could develop itself. Therefore the “ANTI-HIV”-substance must prove itself at the same time as an effective anti-microbial substance against opportunistic agents. Such an effect must be demonstrable in clinical studies with the usual control groups, at the very least temporarily. A recognisable therapeutical benefit must be there for the treated AIDS patients in contradistinction to the untreated control patients, because the opportunistic infections (AIDS), due to the simultaneous antimicrobial effect by the alleged “anti-HIV” substance, for a limited time, parallel with the immunotoxic effects, would be inhibited. In other words: The transient benefit by the “anti-HIV” substance is not the action against the non-existing “retrovirus HIV” but the action against intracellular fungi and protozoa, because these microbes have also a respiratory chain in their mitochondria and therefore treatment by the “anti-HIV” substance can inhibit (for a limited time) these agents. Consequently, this effect has nothing to do with the supposed “inhibition of HIV”. However sooner or later there is a price to be paid for it: the patients treated by “antiretroviral therapy” lose their still available ability of cellular immunity and simultaneously of their antibody induced immunity. These patients can acquire then a complete immunodeficiency syndrome (full blown AIDS = severe combined immunodeficiency). In other words: The planned and thereby the planned concealing of the immunotoxic and cancer producing effects of that “anti-HIV” substance should only occur with a certain time-fuse effect.

We must be quite clear that, in medicine, such different working mechanisms dependent on time factors and dose of the substance are well known. For example with the treatment with chemotherapy in cancer therapy which is still today thought of as experimental, or with treatment through certain chemoantibiotics. A substance was to be brought -out, which was until then not introduced in the pharma market but which proved to have a biochemical working profile analogous to Azathioprin, that inhibits interleukin-2 and mitogens, at the same time which had antimicrobial and immunotoxic working profile and with long lasting medication would show cancer producing qualities. Such a substance was there. Azidothymidine (AZT). The AZA-group of Azathioprin and the Azido-group of Azidothymidine are analogous (3 Nitrogen atoms = N<sub>3</sub>). Azidothymidine was found in 1961 in herring-sperm. In 1964 it was synthetically produced and in 1965 was tested in leukemia carrying rats as an anti-cancer substance. The rats developed, as by-product, lymph-cell (immune cell) cancer, so the product was banned from human clinical tests. In 1985 colleagues of Dr Gallo at the National Cancer Institute in the USA publicised the assertion that in cell cultures with “HIV-infested” T4-immune cells (T4 lymph-cells which were over-stimulated according to the methods of Dr Gallo) Azidothymidine (AZT) had proved itself to be an inhibiting substance against “HIV”. At the end of 1985 AZT was investigated in the test tube in a short pilot-study, and used as phase-1-study as “Anti-HIV”-therapy on AIDS patients. In 1986 in many US clinics double-blind studies with the AZT medication on AIDS patients were carried out with the usual placebo controls. As expected, there showed in the early phases of AZT prolonged medication in the treatment group a relatively smaller rate of opportunistic infection and death rate in contradistinction to the AIDS patients in the control group who were not treated with AZT. The clinical studies were therefore stopped on “ethical” grounds after 17 weeks and AZT was offered to all of the study participants. In the spring of 1987 AZT was admitted for all AIDS patients from the US medicine administration authority (FDA) and in record time under the greatest political pressure, as openly reported by commission members. The warning of the toxicologist of the FDA (who in a routine test for cancer causing (carcinogenic) substance characteristics (Ames test), established an unambiguous raising of the carcinogenic potential by AZT) was ignored.

The whole world wondered at the research capabilities of the US laboratories, who, in the shortest time, had “isolated” “public enemy no.1” (Ronald Reagan), developed an “Anti-HIV”-antibody test for the identification of the patients “infested with HIV” and who found an effective “Anti-HIV”-medicine.

In 1989 AZT was freely given out in the USA also for the prophylactic treatment of symptom-less “HIV positive” patients. The same occurred after in Europe. In 1990 the first clinical study was already published, which showed that under AZT medication the rate of lymph cell cancer had increased 50 fold. Innumerable studies demonstrated that AZT in the bone-marrow caused serious ripening problems in the blood and immune cells. Further experimental and clinical studies proved that AZT brought about irreparable defects in DNA in the respiration chain of the mitochondria, especially in the heart and skeleton muscle cells as well as in the central and peripheral nerve cells. In a huge European AZT treatment study it came out that the sooner the “HIV” positive babies, children, women and men were treated with AZT, “Septrin = Bactrim” etc, the quicker opportunistic infections occurred and the shorter the life expectancy became. These AZT studies were conducted with earlier diagnosed patients at the start of the 90’s. The T4 cell numbers of these patients were in the beginning of the AZT treatment still relatively stable. It must be emphasised that the necessary distinction of the T4 cells into TH1 and TH2 cells in clinical “HIV/AIDS” medicine, then as now, was not practised. Many studies showed clearly, that children, whose mothers were treated with AZT during pregnancy, came into the world with terrible birth defects.

All of these undoubtable results of the AZT-medication had in no way the result that the illness theory “HIV is the cause of AIDS” was critically analysed. On the contrary the results of the medical intoxication excesses were ascribed to the refined nature of “HIV”. The “HIV conditioned” catalogue of AIDS indicator illnesses was extended to 29 known symptom characterisations and the alleged mechanism of the “HIV” illness received many new definitions.

In the last decade the planned experiments with the immunotoxic treatment of “HIV” positive and AIDS patients was extended by a round dozen AZT analogous and other substances, described as cocktail or combi therapy. Because therapeutic successes were not forthcoming, despite new bombastic promises of healing in the expert and mass media, the “HIV”-theory was abruptly changed. It was now maintained that “HIV” increased quickly by the day and that “virus-burden” in the blood serum could be measured (ie increase of the tiniest amounts of DNA sequences, which were designated as transcribed “HIV”-RNA, without actually being able to also isolate a single retrovirus “HIV” in spite of the allegedly “speedy increase” in the blood serum).

As addition to the cocktail therapy a new substance class of the protease inhibitors was brought in and proclaimed, in 4 years “HIV” would be beaten. The media fantasised over the “Lazarus-effect on the condemned”. In 1999 however this propaganda crashed. Leading “HIV”-researchers publicised that the eradication time of “HIV” would take 10-60 years, according to the calculations done on the basis of the HAART treatment (High active antiretroviral therapy). In other words, the actual research goal, to provoke cancer through the immune toxic treatment, had not realised itself in the awaited measure nor in the calculated time-span. In 1999 however “HIV”-AIDS researchers publicised the fact that an outcome of HAART, next to massive liver damage, fat metabolism disturbance, diabetes and other forms of multiple organ dysfunctions, was that a major DNA defect in the mitochondria had developed itself. This defect was similar to noticeable mitochondria-DNA defects at birth. This is the case foremost in muscle cells and central and peripheral nerve cells. Because these cell systems are not anymore division-active, they could degenerate under toxic influences but they could not transform into cancer cells. On the other hand, division-active cell systems which are able to transform into cancer cells can produce flexible counter-regulations for protection against extreme pro-oxidative cell stress which the division-inactive cells cannot. From this the retrovirus-cancer researchers now calculate apparent longer intoxication times, before they can study the consequences of cancer from

the “Anti-HIV”-therapy on condition, naturally, that the “HIV” and AIDS patients have survived the medical cell poison experiments. Several US research teams have, at any rate since 2000, prognosticated a rise in cancer rates with HAART treated patients and children of mothers who were treated with HAART in pregnancy.

The background is the proof that the “maintained” mechanism of AZT, namely the incorporation into the “HIV-DNA”, is biochemically impossible, as in every type of DNA, because the coupling of 3 phosphate groups to AZT, needed for this goal, only succeeds to a very small degree. The opposite has been demonstrated by French research groups. AZT chiefly binds itself to the enzyme cytochromoxidase in the respiration chain of the mitochondria. The inhibition thereby brought about in the ATP synthesis is, chiefly with the symptomatic lack of cysteine and glutathione in “HIV” and AIDS patients, a possible effective mechanism for the starting phases of cancer cell transformation from division-active cell systems.

At the World AIDS Congress 2002 it was declared, from these results, that “HIV” could not be “beaten” through the strategy of experimental chemotherapy used up to date. The end result, after the nearly 20 year chemo-therapeutical “hunt for the virus”(Dr. Gallo), may have depressed medical doctors, who, due to lack of foundational knowledge and through the ignorance of the biotechnical lab-trickery of the inventors of the “HIV”-epidemic theory, did not see-through the real intention. This news from the 2002 congress in Barcelona meant however in consequence that the hidden research goal of the retrovirus cancer researchers, could still not be reached to the awaited extent and time interval. The worst was feared, namely that instead of a thorough reversal in thinking, the original strategy of the denial of doubtless biological-medical facts would be developed and taken further. Due to “the flight from the evil deed, which must continually bear evilness”(Shakespeare), it was therefore proclaimed at the 14th World AIDS Congress in Barcelona, by the protagonists of the virus hunters, that a new chance “in the fight against the dramatically rising HIV-infection” could be awaited through the “encouraging results” of the new technique of vaccination with “naked DNA”. On the one side it was said that the research was still in its infancy, on the other side however it was reported that the first vaccination-tests with “HIV-RNA/DNA” had been “tolerated well” by apes and voluntary test persons chiefly in 3rd world countries. What is to be understood by the concept “vaccination with HIV-RNA/DNA” is demonstrated in an inclusion in the German doctor’s newsletter (Deutsches Ärzteblatt 13. 7. 2002), the organ of the German doctor’s community, which came out in the week after the conference in Barcelona. The title picture is, due to the lack of the actual isolated “HIV“, a free fantasy-full computer graphic. Next to it, it was suggested; “HIV, on the trail of the vaccination substance”. What doctors, who have not specialised, do not recognise whilst reading this inclusion is the fact that the “HIV”-glycoproteins and “HIV-RNA/DNA” sequences, whose working was described in clinical studies as “immune stimulating “HIV”-foreign molecules”, in no way come from original isolation. It is much more the case of laboratory constructions which, after the fine-tuning of the techniques, were given the fictitious “HIV” label. These techniques were used by Gallo and Montagnier in the alleged “HIV-isolation”. In the technical sense one can call the injection of such foreign molecules, vaccination. The difference however with a classical vaccination, lies in the fact that with these components, actual isolated agents or parts of agents are vaccinated which can stimulate the building of specific antibodies and / or T memory cells, which answer future specific infections with a quick specific immune reaction against antigens of wild-type-agents. With vaccination with “naked DNA”, this “pure DNA” must however reach the cell nucleus DNA strands of antigen-presenting cells of the vaccinated persons. The foreign DNA must next be translated into the RNA message, which becomes, as the last act, translated into corresponding proteins in the cell plasma (cytoplasm). Fragments from proteins which have been so formed must then be presented to the T immune cells from these antigen-presenting cells. In this way the cellular immunity could be stimulated. Of what use this procedure should be with the existing fixed balance shift between TH1 and TH2 („HIV“ and AIDS status), when so to say, the inflammatory TH1 cells are missing, which could react on the signal of the antigen-presenting cells (and also the fact that the TH1 cells cannot be induced through such antigen signals for the synthesis of TH1 cells as long as the cysteine-and/or

glutathione deficiency, as cause of the disturbed synthesis of the TH1 cells, is not compensated for) stays the secret of the “HIV”-vaccine researchers.

The other scenario could, with correspondingly disposed persons, bring about the balance alteration of the TH1-TH2 immune cells on the grounds of provocation with foreign-DNA, provoking the condition for AIDS, namely the development of opportunistic infections following too weak, or missing, immune-response through the decreased inflammatory TH1 immune cells. It is therefore not surprising in the light of this that the disinformation article for the German doctors community, after the presentation of all possible vaccination variants (in the usual style of confused ambiguity), finally concluded: “Not one of the tested vaccination substances, either by animal or human experimentation, seemed to be able to really stop infections with the immune weakening virus. It is therefore questionable, whether an immune protector, which wholly stops the HIV-infection (“sterilising” immunity), or after a short time eliminates it through vaccination, can be induced at all”. For the record: The results of the first vaccination tests with “HIV-DNA” were given out at the end of 2002. Then, sadly, there was the disaster with cancer genesis in infants with inherited immune deficiency in France after gene therapy. My warnings before about the danger of development of cancer due to manipulation of DNA, owing to triggering heat shock proteins in the human cells, was confirmed very quickly. In consequence, the health authorities and pharmaceutical companies give no more information about the results of trials with “naked DNA” vaccinations against “HIV”.

But what is the goal of such vaccination strategies which have already reached phase 3 study, that means practised on large collectives of vaccination test subjects, mostly in the 3rd world countries? Naturally it turns on the conquering of new global markets. Therefore the holding of the epidemic fears in the consciousness of humanity, in order not to stop the huge in-flow of capital into the research labs. The smuggling-in of “naked DNA” could provoke effects which have not been discussed. No researcher really knows what really happens when foreign DNA molecules find their way into the DNA strands of the human cell nucleus. At the most it is not calculable into which region of the cell nucleus-genome the “HIV-RNA/DNA” will be integrated, “HIV-RNA/DNA” which, by such vaccination techniques for example, is coupled with adeno- or bird-viruses as transportation vehicles. According to the previously ruling theory of the virus-cancer researchers, as one can reference in all cancer study books, the integration of the virus-DNA from supposed retroviruses (after the transcription of the virus-RNA into the virus DNA form as condition for integration in the host-DNA) which is needed by the virus for its own multiplication, should be causal for cancer cell transformation. One imagines the process so: that the viruses should bring about a mutation of proto-onkogenes, which do not cause cancer, into onkogenes, which do. This process should set the uninhibited cell division in motion. Retroviruses especially, should thereby take away the proto-onkogenes and should plant them into more sensible regions of human DNA, as a switch mechanism, for cancer cell transformation. One can therefore assume that the “HIV-RNA/DNA” transfer should promote the research goal of retrovirus-cancer researchers, to re-test the theory of unproved retroviral cancer-genesis. It has been stated with the usual safeguards, that the “HIV-infections” can not be hindered with this vaccination procedure. The alibi, that it was intended to “weaken” the “HIV-infection” through the “HIV-RNA/DNA” vaccination is not convincing. Weaken from what? It was maintained that the “HIV-RNA/DNA” vaccination lessened the virus burden in the blood serum, ie. the level of RNA-sequences in the blood serum, which was ascribed to “HIV” due to the lack of an actual “HIV” isolation, after theoretical imaginations. Fluctuating RNA levels are however the expression of the induced DNA-repairing process which is called forth through the “HIV-RNA/DNA” transfer as well as through experimental chemotherapy. Attention is diverted away from the actual central research interest of the retrovirus-cancer researchers which involves human experiments with “naked DNA” (applied gene technique) in order to find out under which conditions, (for the sake of the most fashionable theory of cancer research) the cancer genesis can be provoked.

For such experiments with human test subjects one needs, of course, a therapeutical pretext the same as for human experiments concerned with the research question: whether the immunotoxic blockade of the cellular immunity causes cancer or increases it. The combination of both experimental strategies (the experimental test subjects, who, in spite or because of the “HIV-RNA/DNA” vaccination, were selected as “HIV-positive”, will be, naturally, further treated with immunotoxic “Anti-HIV” cell poisons) makes available an extended research setting for the retrovirus-cancer researchers and creates, at the same time, pharmaceutical markets which are uncontrollable. The “American illness” is called “business as usual“. The knowledge about the adequate researched, real causes of the development of human cellular immune deficiency syndrome and the knowledge about the effective, biological compensatory therapy (orthomolecular cell symbiosis therapy) is thereby, with all available means, suppressed. In the place of this, vaccination for the world population as thoroughly as possible with “HIV-DNA vaccines” will be worked towards. For this purpose, the people of 3rd world countries have been stigmatised with the sweeping label: collective “HIV”/AIDS risk-group. The reality is that contact with tuberculosis, malaria, fungi, protozoa- and worm-infections is endemic for people in these countries, beginning at the time of pregnancy and birth. This raised frequency of agent-contact leads to quantitative and qualitative raising of antibody levels. Demonstrably, the antigens in the test-substrate of the „Anti-HIV“ antibody tests react with polyvalent antibodies (which react with diverse antigens) and cause a “positive” test result a reason, among others, for the allegedly high “HIV-positive” test rate with pregnant women in Africa. After mass vaccinations with “HIV-RNA/DNA” vaccines it is foreseeable that there will still be many “vaccination-failures”, and these persons will be further treated with the whole spectrum of experimental chemotherapy. For the “predator-capitalism” a sure, calculable double business perspective.

**Recommended literature** with the most detailed documentation of the basic and clinical research and the non-toxic therapy measures (Orthomolecular Cellsymbiosis Therapy):

- **Kremer, H.:** Die Stille Revolution der Krebs- und AIDS-Medizin. Neue fundamentale Erkenntnisse über die tatsächlichen Krankheits- und Todesursachen bestätigen die Wirksamkeit der biologischen Ausgleichstherapie. (The quiet revolution of cancer and Aids medicine. New and fundamental cognition about the actual causes of illness and death, prove the effectiveness of the biological balancing therapy). (Pub. Ehlers Verlag, Wolfratshausen 2 ed. 2002. Edition in Italian language at Macro Edizioni 2003)
- **Kremer, H.:** Die Hintergründe der angeblichen AIDS-Seuche in Afrika. raum & zeit Nr.113, September/Oktober 2001 (Kremer, H.: Background to the alleged AIDS epidemic in Africa. raum & zeit No.113 sept/oct 2001)
- **Kremer, H.:** Die tödlichen Irrtümer der AIDS- und Krebsmedizin. raum & zeit Nr. 114, November/Dezember 2001 (Kremer, H.: The deadly errors of the AIDS and cancer medicine. raum & zeit No.114 nov/dec 2001)
- **Kremer, H.:** Die Natur der Krebszelle und die Logik der natürlichen Krebsheilung. raum & zeit Nr. 116, März/April 2002 (Kremer, H.: The nature of cancer cells and the logic of natural cancer-healing. raum & zeit No. 116 mar/apr 2002)

The book and the publications in the magazine raum & zeit are available at:

Ehlers Verlag

Geltinger Str. 14e

D-82515 Wolfratshausen

Germany

Internet: [www.raum-und-zeit.com](http://www.raum-und-zeit.com)

E-mail: [vertrieb@ehlersverlag.de](mailto:vertrieb@ehlersverlag.de)

Tel: +49 / (0) 8171 / 418461; Fax: +49 / (0) 8171 / 418466

The book and other publications in Italian language are available at:

Macro Edizioni

Via Savona, 66

47023 Diegaro di Cesena (FC) – Italy

Internet: [www.macroedizioni.it](http://www.macroedizioni.it)

E-mail: [produzione@macroedizioni.it](mailto:produzione@macroedizioni.it); Tel: +39 / 0547 / 347424

Contact for organizing seminars about basic research and orthomolecular cellsymbiosis therapy (OCT) in the fields of “HIV”/AIDS, cancer, immune regulation, long-term effects after conventional vaccinations and other chronic and systemic disease states as well as preventive and curative nutrition:

E-mail: [DOCTORKREMER@terra.es](mailto:DOCTORKREMER@terra.es)

Fax: +34 / 933248046

Further publications from H. Kremer about “HIV”/AIDS and cancer medicine in English language:

[www.virusmyth.com](http://www.virusmyth.com)

Therapeutical recommendations from H. Kremer for orthomolecular cellsymbiosis therapy (OCT) of pre-AIDS and AIDS disease states in English language:

E-mail: [felix.defries@bluewin.ch](mailto:felix.defries@bluewin.ch)