

This is a freely translated and abbreviated version of three articles published by Dr. Juliane Sacher in 2006 in *Raum & Zeit*.

Sacher is a physician who has been in private practice since 1983. She worked with the German Federal HIV Study between 1987 and 1993; served in 1988 on the Parliamentary HIV/AIDS Commission; was co-recipient in 1990 of a prize of 100,000 Deutschmark for work with HIV/AIDS patients. Between 1975 and 1993 she served under contract with Lufthansa. From 2000 to 2002 she worked part-time in the biostatistics unit of Wuppertal University. She has a special interest in all aspects of chronic illnesses, and in complementary as well as mainstream medicine.

### **I. AIDS---Chronology of the mistakes, 141: 34-38**

[Editorial introduction: The AIDS-Myth has remained entrenched despite indefatigable attempts to debunk it; and celebrity galas raise funds that benefit the pharmaceutical industry. Here, Dr. Juliane Sacher describes the results of her work which reveal the official HIV/AIDS theory as false. Sacher's findings have been suppressed even though the work was instigated and financed by the government.]

For the first time in 1983, Sacher read about AIDS, Acquired Immune Deficiency Syndrome, formerly called GRID, Gay Related Immune Deficiency. It was supposedly a new disease that spread among gay men and that led rapidly to death. It was asserted that the cause must be a virus, for which a search was made.

Sacher wondered why the first 5 AIDS patients in the US were not known to one another: this indicated a lifestyle cause rather than a sexually transmitted one. What illness-inducing factor might be common to homosexuals?

### **Significant blood phenomena**

Sacher worked for Lufthansa beginning in 1975 and was privy to much information from blood tests on homosexuals. Sacher had noted already in the 1970s that male Lufthansa personnel were often homosexual, and a number of the first AIDS patients in Germany were Lufthansa employees. Male flight crews often had reduced lymphocyte counts, which Sacher at first attributed to work-related stress and constant jet-lag. Later Sacher learned that frequent receptive anal intercourse (RAI) was associated with immunosuppression, presumably the result of reaction against the foreign sperm-associated protein, and decreased lymphocyte count. (Only later, in the 1980s, were studies begun of different classes of lymphocytes, e.g., T-cells, studies made possible by the introduction of monoclonal antibodies.)

Much was being reported in the 1970s about epidemics of STDs among homosexuals, e.g. syphilis and herpes. Among the latter, cytomegalovirus was prominent and was at first speculated to be the cause of Kaposi's sarcoma.

The reports of multiple partners in a single night made Sacher realize that such activity was hardly possible without resort to drugs.

### **Gallo's virus myth**

At a press conference on 23 April 1983, it was announced that Dr. Robert Gallo had discovered the new virus HTLV-III---later named HIV---that supposedly killed T4-cells and was thereby responsible for the illnesses of AIDS. Never before in medical history had such a discovery been proclaimed at a press conference before publication in professional journal.

It turned out later that Gallo had lodged a patent application for an HIV-test on the very same day. AIDS patients showed a progressive decline of T4-cells. Following availability of the test, AIDS was defined as either Pneumocystis carinii pneumonia (PCP) or Kaposi's sarcoma (KS) or both, plus a positive HIV-test.

## **Illogicalities**

After the HIV test had been introduced, drug addicts and hemophiliacs were soon identified as additional risk groups. Hemophiliacs were a well studied group: 80% were HIV-positive. Sacher noted the discrepancy between that and the HIV-positive rate among blood donors, which was only 0.01%.

Sacher needed no new virus to explain the individual cases of AIDS that she encountered, she needed no new virus. And the official figures did not point to an epidemic spread of AIDS. Still, she could hardly deny the discovery of a new virus; at that time she knew little about how viruses are isolated and identified, and learned more only in the late 1980s and early 1990s.

At the Frankfurt Clinic (“Frankfurter Uniklinik”) in the mid-1980s, a small group led by Prof. Eilke Helm took a special interest in AIDS; for the first couple of years, just 4 or 5 established practitioners [“niedergelasse Ärzten”, an obscure phrase, probably some typo]. None could answer what Sacher saw as a decisive question: AIDS patients had high, sometimes extreme amounts of gammaglobulins (immunoglobulins, antibodies), 35-40, even 45% as against the normal 18%. But Sacher had learned long ago that T4-cells are called “helper” cells because they enable B-cells to become plasma (?red-blood?) cells which produce gammaglobulins. How could it be that patients supposed to be low in T4-cells were producing excess gammaglobulins? (And Sacher even had patients with zero T-cells who were nevertheless fit enough to work!) The answer, shown by research in later years, is that the T4-cells are not destroyed, they merely absent themselves from the blood and move elsewhere.

## **New explanations**

In the late 1980s and early 1990s it was realized that there are two kinds of T4-cells, namely, Th1 and Th2. In HIV/AIDS patients, the balance was shifted toward Th2 and away from Th1, i.e. a lack of Th1 and an excess of Th2. Those Th2 cells move into the lymph system to assist B-cells to produce gammaglobulins. Hence the oft-noted swelling of lymph nodes in HIV/AIDS patients, reflecting chronic and rather intractable inflammation.

This also explains why “cocktail” HIV/AIDS therapy works. It is cytostatic---it kills cells---, and thereby attacks the processes that caused the inflammation. When the lymph-node inflammation subsides, the count of T4-cells in the blood increases again as they move back into the blood. Recent work [[HB--references??]] has indeed shown that these are not newly generated; they were never destroyed in the first place. To this day no one has shown how HIV is supposed to kill T4-cells.

## **Why Africa?**

It was generally assumed already at the beginning of the 1980s that AIDS had come from Africa, even though all the early cases were in the USA, plus a few in Europe---none in Africa.

Researchers in Africa in 1985 found no *Pneumocystis carinii* pneumonia; the same Kaposi’s sarcoma as had been known there for centuries; and lack of resources for HIV tests. Hence the Bangui definition allowing diagnosis of AIDS from clinical observations without HIV-test. Sacher cites details from Quinn et al., “AIDS in Africa: an epidemiological paradigm”, *Science* 21 November 1986. These criteria are so non-specific, so like symptoms of many other illnesses, that it’s readily conceivable who gets classed as AIDS patients under this definition and without an HIV test.

## **New bottles, old wine**

At the “Alternative World AIDS Congress”, Amsterdam 1993, Sacher met African physicians who explained that they knew that “AIDS” patients there actually suffered from the same old illnesses of malaria and TB; but they got much more money from WHO to treat AIDS than to treat malaria and TB, so it made sense to record all patients as AIDS patients.

The Perth Group, and Christine Johnson's article in *Continuum*, are mentioned regarding the many conditions that can produce a positive HIV-test, including syphilis, alcohol-related hepatitis, multiple pregnancies, vaccination against flu.

### **A German study doesn't fit**

A study was begun in 1987 in Germany of infection via dirty needles in prisons. An average of 20,000 drug addicts are in prison at any given time. The study, planned for ten years, was halted after two-and-a-half years because not a single instance of infection via needle had been observed. This was not published since it didn't fit the prevailing dogma.

Note that Padian's study (*American Journal of Epidemiology*, 1997) reported no single observed instance of sexual transmission either, among 442 discordant couples (one HIV-positive, the other not). Note Christian Fiala's report to the Mbeki Panel, "Epidemiologic disproof of heterosexual transmission of HIV". Note Gisselquist et al., 2002, "HIV infections in sub-Saharan Africa not explained by sexual or vertical transmission".

### **Alternative theories**

An alternative explanation for the cause of AIDS (as well as of cancer) is by Heinrich Kremer, "Die stille revolution von Krebs- und AIDS\_Medizin", Ehlers Verlag, Wolfratshausen 2005.

An official HIV Project led by Prof. Hans Brede started in 1987, directed in Frankfurt at Georg-Speyer-Haus by Prof. Helga Rübsamen-Waigmann, who reputedly was the first in Germany to isolate the virus. (for more about this, see the book by Michael Leitner, "Mythos HIV", Videel, Niebüll, 2001.) The Project enabled studies to assess the efficacy of AZT (azidothymidin, Retrovir) therapy. After Berlin, Frankfurt had the highest number of AIDS patients in Germany, and there Dr. Sacher had the largest or second-largest group of HIV/AIDS patients in Germany; all enrolled in the Project. Most of these patients had full-blown AIDS, though a few were HIV-positive but asymptomatic and showing little abnormality on laboratory tests.

Results published after one year showed that in patients treated with AZT the T4-cell counts had decreased by 70%, whereas those treated by Sacher using alternative treatments--80-90% of all her patients--had experienced a decrease of only 7.5%! The T4-cell count is the accepted criterion for how seriously ill a patient is and how the illness is progressing, and a count below 200 is still taken in the USA as defining AIDS. Only one other physician beside Sacher was using alternative treatment for AIDS, quite successfully, in that case homeopathy.

Though the Project had been funded and re-funded through 1996, it was discontinued at the beginning of 1994 without explanation. There was no further publication of results, and some of the data have disappeared. Federal sources deny knowledge of the Project and of Dr. Sacher, though she has a letter from the President querying her invoice for the expense of preparing a report to him about the Project.

The article includes a photo of the publication whose translation is:

Ärzte-Zeitung (Physicians Newsletter), 6/7 October 1989, #189, page 15  
Frankfurt HIV Project---Treatment of HIV-positives

#### **In early stages, alternative treatments rather than AZT?**

Frankfurt (sos). At the opening of a new high-security laboratory in the AIDS Research Institute of the Georg-Speyer-Haus in Frankfurt, Dr. Helga Rübsamen Waigmann warned against the use of AZT in the early stages of HIV infection.

Professor Dr. Hans Dieter Brede, director of laboratories at Georg-Speyer-Haus, said that comparative studies on small numbers of HIV-positives showed that, within the short compass of a year, alternative treatments were superior to AZT. Some 50 patients had been treated with a variety of alternative methods, including immunoglobulin, Echinacin©, Padma 28, Hypericin or

Wobenzym© and did better than 56 patients treated with AZT for 6 or 10 months. Six patients treated with immunoglobulins did especially well.

Rübsamen Waigmann added that resistance to AZT increased 10-fold in the first year and 100-fold in two years. So if AZT is used with HIV-positive people, they will be left without effective medications when full-blown AIDS sets in.

Brede said that nearly 800 seropositive but asymptomatic HIV-carriers, referred by established physicians, had enrolled in the project since November 1987. Typically 4 times a year they were given standard blood tests in addition to antibody tests and measurement of T4 and T18 cells. The treatment they had received, progression of illness, and probable source of infection were also recorded.

## **II. AIDS---The virus that doesn't exist, 142: 18-23**

Part 2: The true biological background of the myth

The immune system has two arms: #1 kills microbes by means of the gas NO; #2 binds and destroys foreign substances by means of antibodies.

### **The two human immune systems**

#2 has been known for 50 years. Electrophoresis permits detection, separation, and measurement of proteins, including antibodies. All antibodies detected by the usual viral-antibody tests are immunoglobulins. Exposure to a viral disease can be detected via the nature and amount of antibodies. HIV tests are of this sort.

The mechanism of #1 has been elucidated only in recent years, though the system itself is much older in evolutionary terms; it's used already by unicellular life forms. #2 evolved 50 million years later, in bony fish. #2 employs particular proteins, immunoglobulins, which bind to foreign invaders; in creatures as large as fish, invaders can't be killed by NO because so much of that gas would be needed as to harm or even kill the fish itself. So the antibody system evolved: antibodies bind to and destroy invading germs and foreign substances without harming the host.

The two systems are interconnected via T4-cells which became well known because of AIDS. Only 15 years ago was it realized that there are two sorts of T4-cells, Th1 and Th2. Th1-cells produce NO, Th2-cells assist B-cells to produce antibodies, and the two sorts of Th cells exist in an equilibrium.

Both systems react against viruses. [Specific] antibodies show whether a particular virus has been encountered. For an HIV test one needs whole virions or bits of viral chromosome to detect or identify antibodies in the patient's blood. Presence of antibodies is taken to indicate exposure to the virus.

### **How HIV tests work**

The ELISA test requires whole virus. The Western Blot requires eight components of HIV (e.g., core or envelope) placed in 8 bands on a strip, and one observes with which of these the patient's blood reacts.

The trouble is that a whole array of different antibodies, generated by inflammation or rheumatic conditions, react positive on ELISA. Therefore a positive ELISA requires a WB confirmation.

Unfortunately, many doctors don't heed this necessity and scare patients needlessly. A young woman whose doctor had told her she was HIV-positive was sent to the HIV clinic but by chance came to Dr. Sacher instead. The test result stated "WB missing; positive result is not valid", but the "not" had been blacked out, as were the four following lines. Sacher phoned the lab, asked

about the WB, and was told the patient was negative since only one band had reacted, and only weakly at that, and the HIV-core p24 antigen was negative.

### **Virus test without virus**

Since HIV tests require virus, what's really being tested, since HIV has never been purified? What is actually meant by isolation of HIV?

Electron microscopy of virus-containing tissues can reveal virus budding from cells, but normal metabolic processes also cause cells to eject similar-looking vesicles containing cellular debris. So virus-containing extracts are centrifuged to separate the components by density. The virus-containing band is photographed to confirm the gold standard of virus purification. ***No such photograph exists for HIV!***

Thirteen years after the discovery of HIV, results of such purification were published for the first time by a French-German team, revealing "HIV-like particles"; but how could that "likeness" be known, given that HIV had never been isolated?

### **Stress, not AIDS**

To prepare pure virus, one needs to isolate it in order to extract the genome. Then one can separate the individual bits and use them to validate WB or PCR tests and perhaps use the genetic material as a basis for an eventual vaccine. But without isolation and purification, one can't do any of those things.

What starting materials have researchers, doctors, and drug companies used for their investigations and test materials? They took blood from patients and cultured it with various substances (hydrocortisone, interleukin, interferon), which stimulated the blood cells to produce stress proteins that emerged in the mentioned vesicles. So all investigations have been based on genetic material corresponding to stress proteins. In other words, HIV tests identify people whose physiology has been stressed by something or other--stressed lightly or moderately over a longer period of time or through some acutely traumatic event.

Many AIDS patients in Sacher's practice had experienced a tragic event; she hadn't encountered such cases among her other patients at anything like that frequency.

### **AIDS patients in Germany**

In Germany and other industrialized countries, still--after 25 years--95% of HIV/AIDS patients are (1) gay men, (2) drug addicts, and (3) hemophiliacs. Why?

1. 85% of AIDS cases are gay men, but only an estimated 1% of gay men have AIDS: those who have experienced exceptional stress--because of sexually associated drugs (e.g. poppers), other commonly used drugs, or frequent infections with classic STDs.
2. Drugs themselves cause damage. Needle-sharing is less significant, though it can also transfer all sorts of microbes that can over-stimulate the immune system.
3. Hemophiliacs are medically well characterized. Their need for blood products exposes them to foreign microbes and proteins that strongly stress the immune system. They are the most highly affected group, at 80%, but they are small in absolute numbers. Noteworthy is that very few wives of hemophiliacs are HIV-positive despite unprotected sex.

Patients often know exactly who their sexual partners were. A newly HIV-positive young man had an HIV-negative partner, and his only other two sexual contacts were also negative. But he used poppers copiously. In such a case it doesn't suffice to stop using poppers. If the cellular stress from popper use has brought about the "Th1-Th2 switch" toward Th2, leading to antibody production that triggers a positive HIV-test, that state may be so entrenched as to require a year's treatment to reverse it. As a matter of fact, we are not sure that it can always be reversed.

However, treatment can stabilize the condition, ward off serious illness, and make a decent lifespan possible.

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SIDE BAR: Poppers

Amyl or butyl nitrites, which release NO, increase blood flow, stimulate sometimes hour-long erections, and relax the anal musculature--ideal for regular and frequent sexual activity. But they release copious amounts of NO, which is normally produced by Th1 cells. The body tries to restore the balance by accentuating Th2, producing the resulting imbalance that characterizes HIV/AIDS patients. Large amounts of NO are also cytotoxic.

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### **Treatment**

Sacher's therapy owes much to Dr. Heinrich Kremer. The main objective is restoration of the Th1-Th2 balance, via diet and exercise.

Diet emphasizes dealing with deficiencies in proteins and amino acids that are typical in HIV/AIDS patients. Orthomolecular therapy also has a role. Food should be as fresh as possible, rich in vegetables, with more fish than meat, little sugar, and much still (not carbonated) water. As well as proteins and amino acids, Sacher uses minerals, trace elements, vitamins and particular fats (omega 3).

**Glutathione** is the most important detoxifying agent, which also regulates the Th1/Th2 balance; deficiency of glutathione shifts the balance in the direction of Th2. HIV-positive patients invariably show glutathione deficiency, and their health improves when this is rectified. Glutathione occurs particularly in egg yolk, and is administered as SAG (S-acetyl-glutathione), 200-1000 mg per day.

**Cysteine** is a component of glutathione and has been used since the early '90s, 2-3 capsules per day, each capsule containing 600 mg acetyl-cysteine. Preferably not the tablets of acetyl cysteine sold in drug stores because they contain too much sugar.

### **MAP (Master Aminoacid Pattern):**

Only 25-30% of animal protein is usable; 48-50% of egg protein; but 99% of vegetable protein from lentils and beans.

**Alpha-lipoic acid** regenerates glutathione that has been oxidized and facilitates NO production. Inflammation produced by stress can be treated with extracts of algae, herbs, and root vegetables as antioxidants, containing e.g. polyphenols. According to Kremer, the physiology of the animal kingdom never evolved to synthesize benzene rings (the basic structure of phenols) because these substances were so plentifully available in the algae omnipresent in natural waters. Increasingly since industrialization, humans drink algae-free water; together with a diet lower in greens and high in refined foods, this contains too little in the way of polyphenols.

Sacher prescribes vitamins, minerals, and trace elements only as indicated by lab tests on each patient.

The already mentioned B-cell stimulation in presence of excess Th2 leads to overabundance of proteins and antibodies and possible blood-thickening, which can be treated with thinning agents (e.g. Ginkgo) and proteolytic enzymes.

Dr. Sacher also recommends exercise (light and aerobic), relaxation techniques, and magnetic field therapy as ways of counteracting the production and presence of stress proteins. Psychotherapy in circumstances of chronic or acute stress can also be helpful.

These treatments were used by Dr. Sacher both for HIV-positive patients and for those with manifest AIDS-defining illnesses.

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SIDE BAR: PCR TEST

In the '80s it was persistently observed that T4-cell counts in blood do not correlate with patients' state of health. Even HIV/AIDS specialists recognized this. So PCR tests were

introduced to measure viral load, even though the inventor of PCR has testified that the technique cannot be used quantitatively.

Nor is PCR suited to detection of an unknown virus, since one needs to know the sequence of bases in the genome in order to choose the “starter” material for the Polymerase ***Chain*** Reaction of successive amplifications. Moreover, PCR is designed to amplify DNA, while HIV is an RNA virus.

In reality, “HIV” PCR involves bits of proteins and nucleic acid released by cells under oxidative stress. One should then be able to detect these also in HIV-negative people experiencing physiologic stress. Dr. Sacher wanted to carry out a controlled study comparing her patients with, as controls, their partners; but the only lab available to her refused to participate in such a study. So Sacher sent a sample of her own blood labeled as from one of the HIV-positive patients for PCR testing, and another sample under her own name for HIV (antibody) testing. For 20 years, Sacher has suffered a rheumatic condition and associated chronic inflammation. Her HIV test was negative, yet the PCR reported 1800 “HIV copies”. Of course, one is healthier if HIV-PCR returns a negative result, but a high viral load has nothing to do with viral infection, rather it signifies chronic inflammation and not anything life-threatening.

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### ***III. “AIDS”--How alternative therapies can help, 143: 60-62***

Though AIDS is not a viral disease, people do suffer tangible symptoms. There are less onerous and more effective treatments for these than the mainstream chemotherapies.

The previous article described a basic general therapy. Here Sacher discusses alternative treatments for some of the acute conditions experienced by HIV-positive people and AIDS patients.

**Acute diarrhea**: In most cases, these suffice: charcoal and “Heilerde” (“healing earth”, mainly silicates and minerals containing mainly calcium, aluminum, iron, potassium); also glutamine powder.

**Acute bronchitis**: acetyl-cysteine; in capsule form, mustard and volatile oils that have antibacterial as well as antiviral properties.

If necessary, injections of glutathione, acetyl-cysteine, B vitamins, folic acid, selenium, and homeopathic lymph- and cough-remedies. As with diarrhea, injections are sometimes necessary because existing intestinal disturbances may interfere with absorption of orally administered substances.

**Acute bladder and kidney problems**: berberis (barberry) and solidago (goldenrod) are very effective.

In all these cases, probiotics are a useful adjunct to help with intestinal healing, since 80% of T4-cells subsist in the intestine. The intestinal mucous membrane is like a “lawn” inhabited by beneficial bacteria that protect against harmful bacteria. Destruction of the beneficial bacteria-- e.g. by antibiotics--allows harmful bacteria (fungi, say) to proliferate. Probiotic treatment brings subjective feelings of improvement and stabilizes the bronchial and intestinal illnesses. The efficacy of the treatment can be assessed by specific stool tests that cost about 150-200 € (not reimbursed by standard insurance programs).

Questions frequently asked by patients:

***How can I prevent the inflammation that brings a Th1-Th2 switch and production of “HIV” antibodies?***

All the things described in Part II: light exercise, proper diet, magnetic field therapy. Dietary supplements of algae, hops, spices (Gewürze).

### ***Why do you sometimes still use antiretroviral drugs?***

If the alternative treatments fail and the patient's health deteriorates, Sacher uses the antiretrovirals not as specifics against a virus but because they are cytotoxic. It's analogous to treating a fever. The fever itself results from the body's resistance to illness, and it doesn't make sense to immediately apply antipyretics because that inhibits the body's response to the disease. Only if the fever becomes life-threatening should antipyretics be used as temporary expedients before attacking the cause of illness.

Similarly, the alternative treatment takes care of chronic inflammation and the organisms responsible for the inflammation are then killed by the cytotoxic drugs. A period of recuperation ensues, followed by the usual "alternative" approaches. Then the administering of the cytotoxic drugs is halted to limit their harmful side effects; "Tri-O-Acetyl-Urinphosphat" helps repair some of the damage done to the mitochondria.

### ***Besides T4-cell counts and PCR, what blood tests can reflect state of health?***

- An annual check of minerals and trace elements: sodium, potassium, calcium, magnesium, copper, iron, zinc, selenium (total cost 50€).
- Also check vitamins A, E, B6, B12, folic acid (cost for each, 20€).
- The Th1/Th2-cells are estimated via their products (cytokines).
- Stool tests including of beneficial and harmful microflora.
- Estimation of how well food is utilized.
- Parameters indicative of inflammation.
- A biodynamic protein profile (CEIA) of the 53 proteins known to be found in blood. In AIDS but also already with HIV-positive cases there is a massively increased presence of immunoproteins which are involved in intercellular communication. Though Dr. Sacher has studied this for a decade in all sorts of illnesses, she has never seen so massive a shift as in HIV/AIDS. This test is therefore an outstanding reflection of overall health. Should be looked at at least annually (cost 105€).
- Level of homocysteine is a good measure of inflammation and deficiency of B vitamins.
- Macrophage activity in the blood. Macrophages devour germs, fungi, viruses, poisons, and tumor cells. After consuming a given quantity they send out chemical signals---TNF-alpha,  $\beta$ 2-microglobulin, noepterin. Measuring the latter indicates when something is going wrong in the body.