DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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National Cancer Institute
Bethesda, Maryland 20205

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Dr. Harold Varmus
Professor, Department of
Microbiology and Immunology
University of California
at San Francisco
San Francisco, California 94143

Dear Harold,

As you know, NCI has had extensive basic research and clinical investigations in AIDS since the very beginning of this disease. Since its inception, I have served as the overall Director of NCI's AIDS Task Force, which correctly focused on retroviruses as a probable cause of AIDS. I am also a member of the NIH Executive Committee on AIDS. A number of our interacting colleagues worldwide have pointed out that the pending discussions and possible decision regarding nomenclature by your Subcommittee of the ICTV Groups will have a global impact.

Let me raise a few issues that may have a bearing on your deliberations. The designation of an official name for this causative agent will not be trivial, but will directly affect hundreds of thousands of people already infected with this virus. The advent of the blood antibody test will identify (and therefore "label") positive individuals. The implication that virus antibody-positive status implies a potential infectious status is true, although quantitatively not clear-cut. The continued rapid spread of virus and the various projections of disease have kindled an extraordinary sense of anxiety and many irrational fears. As you well know, the psychosocial ramifications of AIDS have been profound.

As we know AIDS today, it is still an evolving perspective. The full spectrum of diseases is not as yet well defined. The current $\sim$10% projections of developing clinical AIDS after virus seroconversion must deal with the remaining individuals as well. The disease, like feline leukemia, may be initially demonstrable as AIDS, but the possible late timeframe effect of neoplastic disease in long-term virus-positive survivors is unknown in man.

The patients and their families turn to the medical community for information, especially to doctors who specialize in infectious diseases and oncology. It is the clinician who will be compelled to use the name for the virus that your committee will suggest. It is also the clinician who can now point out that a currently used term like lymphadenopathy-associated virus is inappropriate

because dozens of unrelated syndromes can cause this phenomenon. The clinician also is the person who will have to define and interpret the impact of virus-positivity to the individual in the most sensitive terms possible. Based on these considerations, I would strongly urge that you include several clinicians in your committee's deliberations.

In considering possible candidates, one would like to have clinicians with the widest possible experience in both infectious diseases and immune deficiencies, as well as oncology, and who command respect from their peers in these subspecialties. There are outstanding individuals who meet these criteria by virtue of their extensive scientific publications and hands-on experience in treating human retroviral diseases. Dr. Samuel Broder, the Deputy Clinical Director of NCI and the head of our Clinical Oncology Program, has had major experience with both AIDS and adult T-cell leukemia. He also has many ressearch publications dealing with both sets of viruses, and has worked in immune deficiencies for over a decade. Dr. Anthony Fauci, as Director of the NIAID, has an outstanding grasp of immunology, and has had extensive involvement with practical and investigative aspects of AIDS. Other key clinicians who come to mind are Drs. Jerome Groopman, Bijan Safai, and Mark Kaplan. Of course, there are many others who deserve consideration.

As a minor addendum, you may find it helpful to include an expert in the biology and molecular biology of bovine leukemia. As you consider the lentivirus group with interested experts, the bovine leukemia virus also has obvious similarities with the human T-cell leukemia virus. Based on recent observations, cross-reactive epitopes seem to exist on several of the constituent viral proteins. As a primary choice, Arsene Burny comes to mind as a reasonable, highly-regarded scientist.

Based on the above considerations, it is our feeling that, unlike in the nomenclature of many infectious agents, here the most serious disease aspect not become a part of the name. Perhaps a more emotionally neutral and generic name could be considered which adequately encompasses and describes the agent. You are empowered with a weighty and unenviable task, and your collective decision will have a profound impact on many. Should you have any questions or comments, I would be amenable to further interactions.

Sincerely yours,

Peter J. Fischinger, M.D., Ph.D.
Associate Director
National Cancer Institute