The Meaning of AIDS—Then and Now

This month marks the 100th consecutive month of EM editorials. The accompanying editorial was written for EM way back in 1986, when, as a member of EM’s editorial board, I was asked to inaugurate a series of editorial/viewpoints by board members on the issues that “boiled to the surface” at the time. I chose to write about the relatively new and frightening epidemic of HIV infections and AIDS overwhelming EDs across the country. At that time, AIDS was a lethal illness accompanied by fears that it could accidentally spread to health care workers by needle sticks etc.

Predicting the future is a risky exercise but, young and undaunted, I wondered if we would have a vaccine in 3 to 5 years, a cure in 5 to 10 years, and by the latter, “cure cancer.” Though none of these possibilities actually occurred, by the beginning of the 21st century AIDS had been transformed into a chronic and mostly manageable illness—at least in the compliant patient. But in the years since 1986, we have indeed seen rapid scientific advances in identification of causative agents, followed by accurate tests for infection, and effective treatments or vaccines—all of which helped prevent the spread of SARS and other potentially lethal infections. In terms of outcome, not a bad forecast for 1986, though it would be more than 20 years before EM asked me to write another editorial!

Next month, the October issue of EM will be devoted to current ED infectious disease concerns, including the alarming spread of Ebola, a deadly Clostridia perfringens infection, and the current state of HIV and AIDS in the ED.

Also next month, readers will be introduced to several new EM Advisory Board members who have achieved national recognition for their work in newer EM disciplines such as prehospital care, critical care, geriatric emergency medicine, wilderness medicine, and bedside ultrasonography.

Emergency Medicine, the first and oldest publication devoted to our specialty since 1969, continues to be the newest!
We live in a time when the meanings of words often change dramatically—when bad sometimes means good and “cutting up” more often refers to a way of attempting suicide rather than to clowning around. In the 1982 edition of *The American Heritage Dictionary* you’ll find the entry: “aid (ad) v. aid-ed, aid-ing. aids. —intr. To help: assist. —tr. To give help or assistance to. —n. 1. The act or result of helping; assistance 2. One that helps; an assistant or helper …” But who among us will ever again be comforted by the prospect of assistance upon hearing the word “aids”? Today, we immediately think of AIDS, the acronym for acquired immunodeficiency syndrome.

Until very recently, AIDS was neither a word nor a recognized disease. Then—as noted in the article “AIDS on the Frontline” [June 1981 issue of EM], the CDC’s *Morbidity and mortality Weekly Report* described a cluster of cases of Pneumocystis carinii pneumonia, candidiasis, and cytomegalovirus infections occurring in young homosexual men. In November of [1981], the first of many articles on various aspects of AIDS appeared in *EM* and was entitled “The Riddle of Kaposi’s Sarcoma.”

Those initial reports proved to be the tip of the iceberg. Since 1981, both the tip and the iceberg have become much larger. One current estimate suggests that half of the approximately 2,550,000 intravenous drug users in the Northeast may now have a positive HTLV-III (HIV) antibody blood test, indicating exposure to the virus. Another estimate suggests that 5% or more of those with positive blood tests will eventually be stricken with AIDS, while even more may be afflicted with AIDS-related complex, or ARC—another word that used to mean something else.

If one were asked to choose the half-dozen most significant events of [the 20th] century, along with the world at war, the theory of relativity and development of nuclear weapons, the use of antibiotics and vaccines, and the widespread employment of effective birth control methods, one would now have to include the phenomenon of AIDS—“phenomenon” because it remains to be seen whether by the end of the century it will be listed as “the AIDS epidemic and cure.” Whatever the outcome, AIDS is the scientific, clinical, and bioethical challenge to the medical profession in the last quarter of the 20th century.

The challenge is enormous. During our medical school training and clinical practice did we have any real understanding of what is was like to be physicians during an epidemic such as plague, the catastrophic influenza of 1918-19, or smallpox? We will probably learn. Did we consider how to negotiate the impossible demands by the public for the absolute truth—including our admission of vast areas of scientific ignorance—on the one hand, and their equally insistent demands for guarantees and reassurance beyond the limits of current scientific knowledge on the other? We do every day, now.

The ironies of AIDS are incredible. Until a few years ago, we were struggling along “just” trying to come up with a cure (cures) for cancer, when suddenly the struggle became a science-fiction nightmare no one would have believed possible: an infectious disease that causes cancer, spread both sexually and intravenously. And yet while the problem itself has grown, the scientific advances toward a solution have also been progressing in an incredibly short period of time—identification of an etiologic organism followed by a blood test indicating exposure in just a few years.

If we could consider the scientific advances alone, we could all stand around and justifiably congratulate ourselves. But of course, the advances are overshadowed by the disease itself. Will a vaccine be available in 3 to 5 years? A cure in 5 to 10? Will we ultimately cure cancer in curing AIDS? Or will we see a new “Darwinian selection” of the biologically fittest?

To get to the year 2000, we will have to continue to set aside nuclear weapons, effectively balance the world population with the world food supply, and cure or control AIDS and any similar new disease that may develop. To get to 1987, those of us who deal with medical emergencies daily will have to treat the complications of AIDS with the medications and antibiotics available, counsel our patients as best we can, reassure the public to the limits of current scientific knowledge, and neither panic ourselves nor become complacent in handling the needles and biological material that are part of everyday patient care.

It almost makes one long for the “good old days” of the 1970s, when aids were aids and the practice of medicine seemed so much simpler.

—Neal Flomenbaum, MD, New York