The last conference of the International AIDS Society (IAS) on HIV Pathogenesis, its treatments and prevention was held in Vancouver (Canada) from 19 to 22 July 2015. It brought together over 6000 participants but became over the years a mercantile fair (sponsored by laboratories) whose almost exclusive promotion purposes with questionable arguments, always toxic treatments and broader populations to increasingly numerous to which the utility is far be demonstrated.

All the information presented in this conference can be found on the site

Abstracts: http://www.ias2015.org/WebContent/File/IAS_2015__MED2.pdf

An impressive amount of information at a fundamental level, clinical, prevention and social, has been provided. Unfortunately, nothing essential in terms of what patients are waiting : efficient preventive or therapeutic vaccine , effective ways to eradicate or reduce reservoirs, non-toxic treatments, ... were made.

Let us recall that the long-term antiviral therapies may cause metabolic disorders (lipid abnormalities, diabetes), toxicities of liver , kidney, heart, bone disorders, peripheral neuropathy and even libido problems (erectile dysfunction) . These side effects of antiviral drugs can lead to serious illnesses and deaths, it is imperative that the patient be informed honestly so as not to undergo a medical and media hype and freely choose and accept treatment.

Pre-exposure prophylaxis (PrEP) was one of the main topics of discussion at the IAS 2015: How to take it, who should be able to take and when it will be available to you-Three studies presented show that for some people in some contexts, a less frequent use of PrEP, with doses determined according to sexual activity, was feasible and that a high number of sex remained protected by PrEP. This could offer people who want to use PrEP, and their physicians, additional options, allowing them to find a way to take PrEP that suits them best.

However our association “Positifs” does not wish this prevention which is very marginal, became the majority, except perhaps on groups at very high risk, such as prostitute (e) s. We maintain that the only prevention, safe, easy to implement and a very low cost (should be free) is the condom, which unfortunately does not sufficiently been campaigns by national health systems. PrEP will not serve if it requires only a majority fatten a little lobbies at the expense of the health of users who consume long-term toxic products and further despoiling a little more bloodless medical coverage systems.

One study, still serving the pharmaceutical lobbies, presented by Myron Cohen, revealed that the partner of a HIV patient, having an undetectable viral load avoids the transmission if he uses a PrEP, while it is known for more than an HIV-positive 10 years with undetectable viral load is not contaminant !! PrEP in this case is unnecessary and criminal for all

HIV-negative partners that condoms can be used for any occasion. We believe that the best way to stop transmission is to test authoritarian way the entire population since over 50% of HIV positive are unaware of their status and thus is the major transmission vector, to make free condoms, and empower HIV-positive patients.

The START study considers provide 'definitive' evidence on the benefits of early treatmentT?
Let us recall that the starting threshold of antiviral treatment was for 20 years, under pressure from the pharmaceutical lobbies, and experimenters of complacent trials systematically raised from 200, where the risk of opportunistic infections very minimal, 350, then 500 and now the announcement of seropositivity (with normal values □□ in the range 500-1000).
Emphasize again that the immediate start of treatment, requires that possible non progressors patients , unidentified, suffer for years (5, 10 years sometimes more) toxic treatments of aggression with their train of 'side effects. For the majority of patients starting treatment at CD4 300-350, allows, with a negligible risk, to live many years without the constraint of a daily treatment and calmly await the arrival of less toxic and **non-treatment day** (which are today possible from the work of
J.Leibowitch, father of HAART
, but not shockingly implemented) or eradication therapy.
According to the results of the much awaited START study, the risk of disease or death are significantly lower among people who start antiretroviral therapy when their diagnosis when their CD4 count is still high, rather than waiting until 'that it falls below 350 cells / mm3. The latest results of the study were presented at the Congress of IAS 2015 and were published simultaneously in the early edition of the American Journal "New England Journal of Medicine" dated July 20, 2015.
“Positifs” does not share the beliefs of the authors of the study on the merits of early treatment . Indeed the START trial is a statistical study of 4685 patients followed for 3 years. Or recall to the uninitiated that more study is about the number the easier it is to demonstrate what we want. This multicenter trial conducted in 35 countries and funded by the American NIH with a huge budget and the results were taken and recommended, without critical analysis by WHO and UNAIDS show collusion NIH, pharmaceutical lobbies, WHO, UNAIDS.
Overall after 3 years, if we consider the non-serious and serious events related to HIV and the deaths were **1.8%** of patients in the early group and **4.1%** in the delayed group representing a 57% reduction. The most common events being tuberculosis and cancer.
These high percentages of events for patients still having a well-preserved immunity seems to us suspect and casts doubt on the conclusions of the START study
If we honestly consider the START study, and which is taken up in detail the results of the test, we realize that there is **no significant difference in the number of deaths** (12 and 21 respectively) . Even if the reasons for these deaths are not explained,
it seems surprising that apart from various accidents and suicides, today we can still die of HIV given the existing therapeutic arsenal. These deaths rather bad sign monitoring patients and poor therapeutic strategies.
Concerning tumoral pathologies were observed 0.20 cases / 100 patients / year in the early group and 0.56 event / 100patients / year in the delayed group, but the difference is significant

after one year. For Kaposi's sarcoma were 11 cases in the delayed group and 1 in the early group. These figures seem overstated us in relation to all the data already published for HIV + patients still having a well-preserved immunity (CD4> 350).

Regarding serious cardiovascular events there is no significant difference between the 2 groups (14 and 12 cases).

In summary, **even assuming that this study has not been tampered with, only the well-informed patient is entitled to decide whether or not to start antiviral treatment as soon as he knows his HIV status when he had CD4 high and normal (600-1000) and low viral load** , taking a risk of 5.6 / 1000par year instead of 2/1000 per year of contracting a tumor pathology.

Note that the only interest to the community of early treatment is the lack of contamination of the partners as soon as viral load falls below 1000copies while condom use has the same effect but with a very low cost and without toxicity. Moreover, it seems to us wanting indecent to treat patients who do not really need, so that we do not have the financial means to deal with tens of millions of HIV around the world that we really need!

For eradication, Asier Sáez-Cirion presented the case of a girl who was infected at birth and was immediately treated with antiretroviral therapy when she was a child. She has not taken antiretroviral therapy for twelve years, since the age of six years, with a viral load well below the limits of detectability of standard tests. People in this type of unusual situation (also called post-processing controllers), represent a **functional model of healing**, one of the objectives of the research on treatment. It appears indecent that such case be presented as a useful model in the search for healing, whereas

healing not only functional but real exists

.This

revolutionary cure

has be presented by

Dr Prakask

in off, at Institut Pasteur in Paris since more than two years

(see on this site C.92- Revolution hidden in the eradication of the virus HIV-treatment of Dr Prakash)

, with some patients cured since 5 years. This work which is known by our scientific authorities (F.Barré-Sinoussi, Luc Montagnier, C.Katlama, JF Delfraissy ...), are beautifully obscured. It is lamentable and criminal Dr. Prakask was not the guest of honor at the conference!

Among the many works presented include:

-the **association Long-term non-progressors and alteration in the metabolism of cholesterol** (MOPEA013 G.Rappocciolo et al)

-the **antibodies against 3S motif of gp41** protects the fall in CD4 (MOPEA014-V. Old Man et al). Indicate that the therapeutic vaccine VAC-3S, which is one of C.Katlama responsible! Is based on this result. - IPROTECT1 MULTICENTRE EUROPEAN TEST VACCINE 6 therapeutically VAC-3S tested on patients with undetectable viral load after 12 weeks it shows an increase in the CD4 / CD8 0,48au starting at 0.49 or 0.57 depending on the dose injected.

- **Zinc Deficiency in HIV +** and inflammatory reaction. Inverse correlation between CRP and

Zn concentration. Interest of supplementation (KC MOPEB184- Poudel et al)
-Interest of supplementation of lactobacillus casei (TUPEB295- H. Ichimura et al). The effect of lactobacillus casei, Shirota strain, was tested on 60 children, 31 on HAART and 29 without HAART for 8 weeks and 20 HIV-. CXCR3CCR6-CD4 and CD4 + significantly increases and the percentage of CD4 in the 3 groups . The activation of CD8 + greatly decreases in HIV + without HAART, weakly in HIV-. Viral load decreases slightly but significantly in the group without HAART .The concentration of lactobacillus and bifidobacterium increases significantly in the stool. It might be recommended to supplement with Lactobacillus casei for HIV for which CD4 capped at an insufficient level, but also to accelerate the fall of viral load.

-the **doravine**, a new NNRTI is as effective as efavirenz but with fewer side effects