



Figure 1 Prevalence of herpes simplex virus type 2 (HSV-2) by sex and age (%)

urealyticum) were identified more often in HSV-2-positive subjects compared with those HSV-2 negative.

This is a first report from Russia on the prevalence of HSV-2 seropositivity in the general population. HSV-2 is common in Russia, with the prevalence rates similar to USA and Scandinavian countries and higher than in other Western European countries. Thus, the sex and age distribution of the infection in Russia resemble the trends in industrialized countries.

We were unable to find differences in HSV-2 seroprevalence among various geographic regions (Western or Eastern Siberia), urbanization level (large industrial city or remote rural settlement), and ethnicity (Caucasian or Mongoloid origin). Possibly, socioeconomic uniformity in the former Soviet Union predisposed similar sexual behaviour standards in the entire population. Interestingly, in a recent study from Australia, rural populations had a lower HSV-2 prevalence (9%) than metropolitan (13%), and indigenous had a higher prevalence (18%) than the non-indigenous populations (12%).⁴

In Siberia, seroprevalence of HSV-2 increased with age until 45-54 years and somewhat declined at 55-64 years with similar rates between men and women at these ages. This may reflect birth-cohort effect with various sexual activity patterns in various age strata. Similarly, in other studies, the risk of acquiring HSV-2 infection seems to increase with age (years) at least till the early 30s, and differences in risk of acquisition for women compared with men become less with age.⁵

In conclusion, HSV-2 is common in Russia with the prevalence rates close to USA and Scandinavian countries. The sex and age distribution of the infection are similar to other populations.

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Response to review of 'The Origin, Persistence and Failings of HIV/AIDS Theory'

Sir: I am indebted to John Potterat¹ for his even-handed treatment of my book, *The Origin, Persistence and Failings of HIV/AIDS Theory*, even as he differs with its conclusions.

Allow me to clarify a possible source of confusion for readers. The book states, 'I have not omitted any contradictory data'. The review says that I 'ignore contrary evidence'. In fact, I did not omit any contradictory data about HIV test results, nor am I aware that any exist; I would appreciate being given the citation to any that I had failed to find. The review no doubt means that I ignored evidence from other aspects than HIV test results; for example, defenders of the orthodox view often cite a claimed efficacy of antiretroviral treatment as proof that HIV causes AIDS. This is consonant with the reviewer's correct characterization of my conclusions as based on ecologic evidence and inferential reasoning, that is, on epidemiology and not on clinical studies.

That I interpret selectively the observations of others is a matter of pertinence. I cite Gisselquist *et al.* for their empirical findings - no difference between the sexual behaviour of Africans and others - and their interpretation that the AIDS pandemic in Africa cannot be explained by sexual transmission, because those are directly relevant to my argument. I neglect their suggestion that unhygienic medical injections could be a major responsible factor because to discuss that would involve a lengthy digression explaining why I disagree, given my conclusion that HIV is not infectious.

I would like to mention, too, that my discussion in the last chapter's section on 'Needed knowledge' is in agreement with the reviewer's statement that collection of more empiric data is needed.

Above all, I am gratified over the consensus that 'HIV/AIDS researchers and health workers ... should take a hard look at the weak quality of evidence supporting the views of HIV propagation appearing in their pages'.

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