AIDS patient in North America: white, middle class, educated, and homosexual.

Because I'm well-known locally as a sexually transmitted diseases investigator, he insists on discussing AIDS exposure information in a discreet location. There, he tells me that he often travels to the Caribbean—specifically Haiti—to relax, and that he likely picked up this virus from a Haitian prostitute. My reaction: convenient, cop-out explanation. Not only do I know that older North American gay men frequently travel to the Caribbean to pick up young locals at bargain prices, but that his explanation is unlikely to account for other positive blood tests done by his doctor: hepatitis-B (HBV) and cytomegalovirus (CMV). At least he's providing some truthful information: where he likely picks up infection and by what means; it's just that I think he's reporting the wrong sex for his sexual partner(s). Yet no amount of motivational coaxing or ironclad guarantees of confidentiality (even vis-à-vis his doctor) applied during nearly two hours of discussion makes him recant.

What does finally make him change his story is the last card I play. I scribble, on the back of a paper

napkin, the mathematical probability of a heterosexual person having all 3 blood markers (AIDS, HBV, CMV) combined: 0.000008 (8 out of 1,000,000), whereas in a homosexual man, the combined proportion is 0.15 (15 out of 100), for a difference in odds of triple infection of nearly 19,000 to 1.[5]

Patients may lie, but blood doesn't.

(JJP)

Hoping Against Hope

Keith is in his early 40s and has just tested for HIV in our public health clinic. It's a good thing he does, because he's recently been exposed to HIV. After hearing about our study on how people recall their sex partners, he volunteers to participate.

Although affable, he's clearly distressed when talking about his sexual partners. He confides that most

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[5] This mathematical argument is considered worthy of dissemination and appears in Potterat JJ, Muth JB, Markewich GS. Serological markers of sexual orientation in AIDS-virus infected men. *Journal of the American Medical Association* 1986; 256: 712.

take advantage of him. His trusting nature repeatedly puts him in danger, as he's a prostitute, servicing both men and women.

Some of his male clients are HIV-positive but nevertheless engage him in very high-risk sex, such as unprotected anal intercourse. One recently tricked him, claiming to have used a condom when, in fact, he didn't. His other male clients are mentally ill, alcoholic, drug-addicted, and/or physically abusive.

Keith tells me he's even suffered multiple attempted or completed rapes by clients and other men. One client rapes him at gunpoint. Another time, he goes to a restroom to relieve himself and is sodomized by a stranger in a surprise attack.

Keith often does things professionally that make him uncomfortable, particularly when he tries to accommodate client fantasies. For example, he endures bondage, receives oral sex from a demanding woman in an outdoor parking lot, has vaginal sex with a woman half his age who wants his baby (he withdraws before ejaculation), and has sex with disgusting clients, such as an aggressive woman who reeks of unbearable body odor.

Being optimistic, Keith vows that from now on he'll accept only safe, sane and sober clients who share his values (family values in particular, ironically enough). To my ears, it sounds like he's hoping against hope.

(**DDB**)

Not Investigated Rigorously (N.I.R.)

The national Centers for Disease Control classifies AIDS cases by major risk factor, such as male homosexuality, injecting drug use, or blood transfusion, and also by risk marker, such as Haitian origin. When a newly-reported case reaches the local health department with none of the known risk categories checked it's categorized as N.I.R. (No Identified Risk). It's our job as infectious disease sleuths to contact the medical facility making the report to find out if the missing information is an oversight or if the risk category is truly unknown. That's the passive approach and the one most often used by health departments, especially when there are many N.I.R. cases. Since it's usually done by telephone in the comfort of your office, it can be viewed as the lazy AIDS epidemiologist's approach.