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VOLUME 3 ISSUE 2

A HEALTHY MIND

HIV RELATED FATIGUE

AFTER YOU'VE TESTED POSITIVE

TREATMENT STRATEGY PART II

HIV & AIDS AND HUMAN RIGHTS

LIPODYSTROPHY

CHALLENGE IDEAS NOT PEOPLE.
GPI PO BOX 5187 DUBLIN 6.

HEALTHY MIND

IMMUNE POWER

The adage "Healthy Mind - Healthy Body" has long been considered to be true. Research has shown that stress (beyond everyday stress) reduces CD4 counts and the branch of medicine called PNI (psychoneuroimmunology) has established links between the nervous and immune systems.

The book entitled 'The Immune Power Personality' is an exploration of scientific research linking personality traits with a stronger immune system and explores how and why some personalities are so resistant to disease while others are more vulnerable. Psychologists have documented the role of healthy traits in maintaining a healthy state of mind in this book. Several factors, have been identified which can contribute to immune health. These are:

1. **The ACE Factor**:
Attention, Connection, Expression: research has shown that people who are tuned to mind-body signals of discomfort, pain, fatigue, distress, sadness, anger, and pleasure cope better psychologically, have a better immune profile, and a healthier cardiovascular system.

2. **The Capacity to Confide**:
demonstrates that individuals who confide their secrets, traumas, and feelings to themselves and others, have livelier immune responses, healthier psychological profiles, and far fewer incidences of illness. This gives credence to the proverb *'a problem shared is a problem halved'*.

3. **Hardiness**:
Hardiness includes the "three C's": Commitment, Control, and Challenge. A sense of control over one's quality-of- life, health, and social conditions; a strong commitment to one's work, creative activities, or relationships; and a view of stress as a challenge rather than a threat. People who exhibit the three C's suffer far fewer chronic illnesses and symptoms that those who don't. Other investigators have found that hardy individuals have stronger immune systems.

4. **Assertiveness:**
studies have shown that people who assert their needs and feelings have stronger, more balanced immune responses. They more readily resist and overcome a range of diseases associated with dysfunctional immunity - from rheumatoid arthritis to AIDS. Research has found immune-power connections to other traits as well, including the ability to find meaning in stressful life circumstances.

5. **Affiliative Trust:**
The Motive of Unconditional Love: it has been discovered that individuals who are strongly motivated to form relationships with others based on unconditional love - rather than frustrated power - have more vigorous immune systems and reduced incidence of illness.

6. **Healthy Helping:**
a large survey showed that people committed to helping others get a "helper's high" that is not only mental and spiritual, it is physical as well. These individuals, displaying the personality trait of altruism, suffer fewer illnesses than others who are not similarly motivated or engaged.

7. **Self-Complexity:**
research has demonstrated that people who explore many facets of their personalities - called "self-aspects" - can better withstand stressful life circumstances. Studies have shown that people with many "self-aspects" were less prone to stress, depression, physical symptoms, and bouts of flu and other illnesses in the wake of stressful life events. They also had higher self-esteem. It was found that individuals high in "self-complexity" have strengths to fall back on when one part of themselves is lost or wounded.

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HIV RELATED FATIGUE

Fatigue impacts significantly on the psychological well-being and quality of life of people with HIV & AIDS.

Fatigue is one of the most relevant and most undertreated problems experienced by patients with HIV infection and AIDS. Yet many doctors tend to ignore HIV & AIDS-related fatigue, even though fatigue can be as disabling as pain. Studies have shown that as many as 54% of people living with HIV & AIDS have experienced fatigue. Fatigue can be a treatment-related side effect. An analysis found that fatigue was more prevalent in women and in people with a greater number of AIDS-related symptoms, particularly persistent or frequent pain. Studies have shown a strong correlation between depression and fatigue. However not all the fatigue symptoms can be accounted for by psychological factors. It cannot be determined how frequently depression results from fatigue rather than the other way around.

Causes of Fatigue

HIV & AIDS-related fatigue has no single cause, but rather a range of interactive causes, of which psychological distress and depression are just one aspect. Physical symptoms, drug side effects, sleep disturbances, malnutrition and wasting, AIDS dementia, hormonal insufficiency (due to low adrenal gland output, for example) and muscular weakness (HIV- or AZT-related myopathy) all contribute to fatigue. One study noted a small, but statistically significant association between fatigue and anaemia (low oxygen transport by the blood). Opportunistic infections (such as Mycobacterium avium and B19 parovirus) decreases red blood cell (RBC) production.

Nutritional deficits: Gastrointestinal infections can lead to malabsorption and deficiencies in folic acid and especially vitamin B12 which are necessary for RBC formation. Iron deficiency can arise from chronic blood loss, for example as a result of intestinal KS or CMV. PCP and CMV and other active opportunistic conditions directly trigger fatigue. Part of this fatigue results from the increase in inflammatory cytokines as a response of the immune system, but also PCP lowers oxygen levels in the blood by interfering with lung absorption, and CMV can reduce hormonal levels by infecting the adrenal glands.

Treating the medical causes of fatigue, which may be as simple as switching to alternative drugs, can have a rapid, positive effect A better diet and special nutritional supplementation to combat malabsorption or the special needs in the management of chronic infection can be useful in combating fatigue.

Raising haemoglobin levels by administering blood transfusions, recombinant erythropoietin or nutritional therapy also gives people improved energy levels and greater functional capacity. Red blood cell transfusions are a quick fix for treatment-associated anaemia, but they do carry a small risk of immune reactions and transmission of blood-borne infections.

Psychostimulants: Two psychostimulants (U.S.), Ritalin and Cylert, are being studied to reduce fatigue in HIV- positive people. These drugs can also interfere with sleep and cause loss of appetite, which might cause further fatigue.

Coping with fatigue.

The first steps you can take is to **pace your daily life,** altering activity/rest patterns, including frequent rest breaks, and delegating activities to others. **Working out at the gym** or jogging is a form of natural psychological and physical stimulation, but more moderate exercise, like walking, can be helpful, too. People have also found **meditative exercise** such as yoga or tai chi to be very restorative. **Massage, therapeutic touch, acupuncture** and other alternative therapies that claim to restore the body's "energy balance" may have a role to play, if only for their meditative aspects, which relieves mental tension and depression.

Psychosocial counseling and support groups can be important for helping to cope with emotional stress or anxiety. **Occupational therapy** can be a valuable strategy for distraction from focusing on disease symptoms and emotions. (Antidepressant medication can be used in cases of depression.)

Based on an article by L. Delmonte, D.Sc

After You've Tested Positive

Treatment Strategy Part II

This document is provided by Project Inform & by GPI.

Part I Volume 3 Issue 1.

III. Intervention Against HIV

There are several types of intervention which you can take against HIV. All are useful, but no one of them alone is sufficient. Unfortunately, some of these approaches are promoted with religious fervor, to the exclusion of the others. The best overall approach may be one which is inclusive, combining the best of each of the five types of intervention.

5. Opportunistic Infection Strategy

Once the immune system has failed to a significant degree, it becomes necessary to try to prevent the occurrence of the most common opportunistic infections, (OIs) or prevent their return after a first occurrence.

OI prevention or "prophylaxis"is recommended when CD4+ counts are in or nearing a danger zone (for example, the risk of PCP becomes high at CD4+ count of 200 or below, and the risk of MAI increase rapidly when the CD4+ falls below 50).

Careful and timely use of medication can prevent PCP. As the incidence of tuberculosis (TB) rises among HIV+ people, testing and possibly preventive treatment is recommended. Similar preventive treatment is rapidly becoming available for other infections as well. Using this approach alone, however, would be misguided because it does nothing to slow or stop the decline of the immune system. Even though a person may successfully avoid PCP or MAI, he or she is still at risk for many other HIV-related infections.

In advanced HIV disease, an infected person often must try to treat or prevent several different opportunistic infections at the same time.

The key to successful intervention is comprehensive inclusion - doing all of the things that makes sense in your individual situation. The biggest mistake we can make is to dogmatically choose one approach over the others. HIV is not a political debate or simply a matter of opinion - it is a life threatening illness. Every decision about treatment has consequences. Each infected person has little room for mistakes. It makes no sense to bet your life on any single philosophy of medicine.

Combination Therapy

The last three types of interventions against HIV are usually made with pharmaceutical drugs. Researchers have shown that HIV is treated with combinations of these drugs: combinations of antivirals, antivirals plus immune modulators, and any needed treatments for infections. Most studies of antivirals suggest that any one drug used alone has a relatively short period of usefulness. This can be extended by using such drugs in combinations.

When to Start Treatment?

The earliest possible treatment is recommended for just about every known illness. There is little reason to think that HIV is any different. In fact, early treatment may be even more important because of the seriousness of the disease.

Starting points for antiviral, immune modulating, and OI medications are the subject of disagreement. Many believe that antiviral medication is appropriate immediately upon learning of the infection, whether or not the CD4+ count is falling or whether symptoms are evident. Waiting longer might only let the infection progress as it slowly damages the immune system. Many researchers now believe that viral load tests give the best indication of when it is appropriate to begin treatment.

Recent evidence, however, shows that the virus is always active and that damage to the immune system is always taking place, perhaps at levels too low for current tests to detect. Thus they feel antiviral medication is appropriate at the earliest possible moment, when it can perhaps prevent further spread of the virus. They also note that people who are healthy and have no symptoms of HIV infection have

far less trouble with the side-effects of such drugs as AZT, d4T and ddI.

The other argument against beginning treatment very early is the fear that it may "use up" the medicines before they are really needed, or that people may experience long-term toxicity from the drugs. The only way we will ever get clear answers to these questions is when additional clinical trials are completed. Such trials are now underway. In the meantime, the question will remain a matter of personal choice. However therapy at all stages is favoured, assuming the person is ready and willing to begin treatment.

There is no argument about the need to start antivirals when symptoms are present, the CD4+ count is falling, or the viral load is high. (Early treatment may avoid these complications).

The starting point for using immune modulators may someday be based on CD4+ counts or measure of CD4+ cell function. When the count or level of function is sufficiently high, there are enough useful CD4+ cells for effective immune response and for replenishing the immune system. The natural chemicals which sustain the growth of CD4+ cells, called growth factors, are made by the CD4+ cells themselves. Thus, when the count or function falls too low, it is very difficult to get it back up again. In short, you must have an immune system to rebuild one. These treatments are currently unavailable.

CD4+ Cell Ranges

- **High - 500 plus**
- **Middle - 200-500**
- **Low - 200-50**
- **Lowest - Under 50**

High Range: In general, a CD4+ count above 500 suggests no immediate danger. The 500 level is often cited as the bottom of the "normal" range, but this can be misleading. While an occasional drop to 500 may be normal, a steady or falling count of 500 or even 600 is not normal and indicates suppressed immunity. At the very least, dietary counseling, nutritional supplements, CD4+ cell and viral load monitoring, are recommended in this range, whether or not treatments are used.

Middle Range: CD4+ counts in this range generally indicate decline of the immune system. However, serious symptoms are uncommon in this range.

Lowest Range: CD4+ counts below 200 indicate the greatest risk of infections and according to the 1993 definition of AIDS, a CD4+ count of 200 or less constitutes an AIDS diagnosis, in the U.S. A person with counts below 200 CD4+ may remain stable for many years, especially with careful health management. There are exceptions, but even people in this range who seem healthy have greater difficulty combating infections when they occur. While some people have warning signs in the form of symptoms before major infections occur, this is not always the case. Some progress directly from apparent health to serious OIs.

It is standard practice to put people with CD4+ counts below 200 on preventive treatment against PCP (for example, Septrin or dapsone) , along with all people who have already suffered an initial bout of pneumocystis. Prevention strategies for all of the most common opportunistic infections are described in the 'HIV & AIDS Treatment Directory'. Regardless of CD4+ cell count, yearly monitoring for tuberculosis is becoming increasingly important.

IV. Available Treatments

GPI can help provide information on the use of HIV treatments. These and any other treatments should only be used under the care of an experienced physician. We encourage patients and physicians to enter into collaborative relationships with shared responsibility for achieving and maintaining health. Treatment should always be accompanied by monitoring which evaluates the success or failure of treatment. Both patient and physician should be prepared to adjust strategy based on the results of the monitoring process. This model of flexible, monitored treatment used in the context of a collaborative doctor/patient partnership is the key to managing HIV as a chronic illness.

This document is provided by Project Inform & GPI. Part II has been edited by Dr. M. Horgan MD FRCPI MRCP(UK).

A full copy of Parts I & II are available from

GPI, PO Box 5187, Dublin 6.

LIPODYSTHROPHY

Lipodystrophy:

Any disturbance of fat metabolism or of the distribution of fat in the body. (Oxford Medical Dictionary).

What does it look like?

A fat belly and facial wasting are the main features of lipodystrophy. The word itself means a disturbance in the way the body produces, uses and distributes fat. These changes in body fat have not been scientifically and statistically proven to be a result of protease inhibitors. Observations have shown that a person may retain muscle and weight, especially if they work out regularly, while experiencing substantial facial wasting. Loss of fat stores in the limbs - that is, the arms and legs, has been seen. The loss of tissue seems to be predominantly fat versus muscle. Anecdotes that have been reported include increased fat around the belly. Some people are saying they have lost fat in one or more places elsewhere in the body; arms, legs, face and bum are all common places for people to lose fat.

What's happening?

Protease inhibitors are associated with a number of chemical changes in the body. People taking protease inhibitors may have higher levels of sugars and fats in the blood and raised cholesterol levels. At this stage it is unclear how the changes in the blood relate to the body fat changes.

HIV infection often causes high blood sugars and high triglycerides, however HIV tends to be associated with low cholesterol. Protease inhibitors may cause increased triglycerides, sugars and cholesterol. These changes may be linked to the wasting and fat accumulation seen with lipodystrophy. High cholesterol is associated with hardening of the arteries in the presence of other risk factors such as hypertension, diabetes, obesity and smoking. High triglycerides, cholesterol and sugar can all be treated.

When does it occur?

Anecdotal reports suggest that facial wasting and stomach fat gain appear at some stage during the first twelve months on protease inhibitors. The fat changes have been described as a slow and progressive change. Minor changes appear at two to three months, with more significant changes developing at six to nine months. It then seems to reach an equilibrium. Anecdotal reports suggest that the fat changes are slowly reversed if a person stops taking protease inhibitors.

Do all PIs cause lipodystrophy?

At this stage, experts believe that all the protease inhibitors cause lipodystrophy. Research is currently being undertaken to compare the effects on body fat of the individual protease inhibitors, as well as double combinations of protease inhibitors. There is speculation that a double protease combination is more likely to cause lipodystrophy, however no published data is available. (This should not be a reason to discontinue PIs).

`Crix belly'

In the United States, lipodystrophy is commonly referred to as `Crix belly' where a majority of people on protease inhibitors are taking indinavir (brand name Crixivan). There is also some debate about whether or not saquinavir causes lipodystrophy, because most people on saquinavir are also on another protease inhibitor. All protease inhibitors are thought to cause some degree of lipodystrophy. There has been no specific discussion of ritonavir and nelfinavir to date.

Continued on page 10

HIV & AIDS and Human Rights

HIV continues to spread throughout the world at a rate previously underestimated. Close in the wake of the epidemic is the widespread abuse of human rights and fundamental freedoms associated with HIV.

The protection of human rights is essential to safeguard human dignity in the context of HIV & AIDS and to ensure an effective, rights-based response to HIV & AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards.

Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, less people become infected and those living with HIV & AIDS and their families can cope better with HIV & AIDS

In the context of HIV & AIDS, international human rights norms and pragmatic public health goals require countries to consider measures that may be considered controversial, particularly regarding the status of women and children, sex workers, injecting drug users and men having sex with men. It is, however, the responsibility of all countries to identify how they can best meet their human rights obligations and protect public health within their specific political, cultural and religious contexts.

Guidelines and declarations on HIV & AIDS and human rights have been adopted without being known to community groups - although they could so well use them in their lobbying for responses to HIV & AIDS that respect the human rights of those affected by or living with HIV/AIDS.

The following guidelines which consider the human rights and action-oriented measures to be employed by Governments as aiming to ensure the protection and fulfillment of the human rights of people affected by HIV & AIDS are worth our attention.

1 Ireland should review and reform public health laws to ensure that they adequately address public health issues raised by HIV & AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV & AIDS and that they are consistent with international human rights obligations.

2 Ireland should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV & AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies

3 Ireland should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV & AIDS to understanding and acceptance.

4 Ireland, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

5 Ireland should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV & AIDS, their families and communities.

6 Ireland should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV & AIDS at international level.

NEWS FROM THE FRONT

INFORMATION FROM PEOPLE LIVING WITH HIV & AIDS

THIS INFORMATION IS SUPPLIED BY PEOPLE LIVING WITH HIV AND AIDS.

IT IS THEIR EXPERIENCES. THIS INFORMATION IS NOT A SUBSTITUTE FOR MEDICAL CARE.

PLEASE SPEAK TO YOUR DOCTOR BEFORE YOU CONSIDER ANY OF THE TREATMENTS MENTIONED.

non-Hodgkin's lymphoma

Nearly two and a half years ago, I had non-Hodgkin's lymphoma, which had progressed to stage III. To treat it I had chemotherapy, radiation and some surgery. This all happened two months after starting triple combination therapy. Now everything seems to have settled and doing well.

VITAMINS & SUPPLEMENTS

I have been diagnosed HIV positive since 1987 and I am on combination treatment. I also take the following vitamins and supplements, which I find helpful.

MultiVitamin (LifePlan / Health Craft or any good one) - 2 a day divided doses
Beta Carotene (10,000 IU) - 4 a day
Vitamin C (500 mg) - 2 a day
B12 (250 mcg) - 1 a day
B6 (100mg) - 1 a day
Glutamine (500 mg) - 1 a day
NAC (600 mg) - 2 a day
CoEnzyme Q10 (60 mg) - 2 a day
Strong Garlic tabs. (600 mg) 4 a day.

CMV Retinitis

I had CMV Retinitis for 22 months and I lost a lot of the sight in my left eye & some in my right eye. This was treated with IV ganciclovir, given through a catheter, which was under the skin of my left arm. This catheter was taken out 2 years ago. I was very restricted in my activities when I was hooked up to this daily IV, and the idea of holidays or going away for a weekend seemed impossible. Thank God that's all over now!

Cidofovir is now being used (which can cause kidney problems) to treat CMV and only needs to be infused every other week. I was on it for 6 months & it did wonders.

I now take oral gancyclovir, 4.5g daily (18 pills). The studies have shown good results with daily dosages varying from 3g to 6g for maintenance therapy. There has been no signs of the CMV re-activating in my eyes now for over 2 years.

DRUGS FOR 1998 (NEW COMBINATIONS)

Available via expanded access programs are **abacavir** (Glaxo-Wellcome's new reverse transcriptase inhibitor); **efavirenz** (Sustiva, Merck's NNRTI); and the first representative of a new subdivision of reverse transcriptase inhibitors known as the nucleotide analogues Gilead's **adefovir** (Preveon).

In development are new protease inhibitors by Glaxo-Wellcome (**amprenavir**, formerly 141W94) and Abbott (**ABT-378**) and another nucleotide analogue known currently as **PMPA**.

New target sites for anti-HIV activity are also being sought out with HIV binding inhibitors (e.g., **TP-20**) and the ongoing development of integrase inhibitors (e.g., **zintevir**).

DRY SKIN

I have had dry skin for some time, and it seems to have become worse since I began taking indinavir. My skin was sore and itchy, and flaky in patches. Bathing in an emollient (Balneum Plus) alleviated the itching & dryness. It only takes a 10 minute soak in a capful of this stuff. I try not to use harsh and perfumed soaps on my skin, instead I use a mild anti-septic moisturising shower gel (Sanex). I use moisturisers after bathing to help prevent irritation and dryness. I tried a number of moisturisers and found Clinique's to be great, but too expensive. E45 lotion at a quarter of the price is equally good.

I now pay attention to good skin hygiene and use medicated, unperfumed, moisturising soap; hypoallergenic washing powders (M&S do one) and moisturisers; and try to avoid wearing artificial fabrics and stick to cotton.

1997 to 1998 ?

1996
Viral Load Testing
1997
Eradication theory
1998?

HIV & AIDS is in its 17th year. A number of breakthroughs in 1997 will pave the way for those developments this year. Looking back at what 1997 gave us and may indicate what 1998 will bring.

1. Change All

1997 showed that adding a single drug to a failing regimen is inadvisable. A patient is more likely to fail a new protease-containing regimen if the accompanying two reverse transcriptase inhibitors are not changed as well. This increased the use of the d4T/ddI combination, to replace AZT/3TC.

2. Resistance

Resistance received considerable attention at medical conferences throughout 1997. While viral resistance is the main reason why drug regimens fail, it's important to remember that other factors such as poor absorption, poor intracellular metabolism or poor compliance play a part. Nevertheless, there is significant overlap of resistance patterns (so-called "cross-resistance") between indinavir and ritonavir, or nevirapine and delavirdine. Genotype testing which may help to indicate a virus' mutations are being used more frequently, thanks to computer technology. However these testing techniques are not anywhere near approval.

3. Eradication

The current combination therapies can suppress most viral replication. However a reservoir of infected lymphocytes (so-called CD45RO memory cells), perhaps only 0.1% of the total, still harbor the virus after prolonged administration of treatment (HAART - highly active antiretroviral therapy). New ultrasensitive assays (tests) which read down to 50 copies/ml showed evidence that viral replication was occurring, albeit very slowly. The use of these ultrasensitive tests will become more widely available this year.

4. HAART

While HAART has demonstrated clinical and ultimate survival advantages, 1997 saw the development of new cases of diabetes and abnormalities in lipid levels (such as triglyceride elevations) in some patients on protease inhibitors. The possible development of cumulative toxicities must be carefully considered in patients on long term HAART

This year may see more convenient drug doses such as ddI (Videx) dispensed at 300-400 mg once daily, nevirapine (Viramune) at 400 mg once daily, Combivir (which contains AZT plus 3TC) and the more bioavailable form of saquinavir, Fortovase.

5. Supplementary medicine

Lower levels of B12 were associated with lower rates of survival and trials of NAC (N-acetylcysteine) therapy for HIV, showed that it restored depleted glutathione levels, and was associated with improved survival in a study. Another study of seropositive drug users found that deficiency of the trace mineral selenium was associated with shortened survival.

6 Post-Exposure Prophylaxis (PEP)

Should persons who sustain a potential or actual exposure to HIV through unprotected sex or needle-sharing be treated with the same triple antiviral drug combination offered to health care workers who sustain a potential exposure? This question will continue to be debated long into this year, and will raise a number of questions such as: Should partners be treated as well? What if patients continue to relapse, i.e., continue to have unprotected sex and ask for subsequent antiviral treatment? PEP is being used for victims of sexual assault and for persons in emergency departments and clinic settings more frequently in the U.S. However its benefits in this situation has not been proven.

John Williams

1994
AZT Reduces Transmission in Pregnancy

1995
Protease Inhibitors

GPI. The Basic Message

Get Tested - Anonymously

If you test positive, **get informed,** get a good doctor who will give you a full immune health workup.
Get baseline CD4 counts and viral load tests done and repeat every 3 months. **Watch your counts.**

If your CD4 count is already below 500 and your Viral Load is above 5,000, or if your viral load is 30,000 - 50,000 regardless of other factors, consider carefully combination treatment options.

Learn about drug interactions.

Consider preventive therapies against PCP if your CD4 count falls below 200.

Learn about preventive therapies for MAC

You are not alone, GPI is here to help -
phone 087 - 436502.
e-mail: gpi@poz.iol.ie

GayPoz Ireland

(GPI) are HIV positive people working to improve access to and information about HIV and AIDS. GPI reports on experimental and standard treatments, especially those available now. We interview health professionals, and persons with HIV or AIDS, we also collect information from meetings and conferences, medical journals, and computer databases around the world.

GayPoz Ireland

does not advocate particular treatments but seeks to increase the options available. GPI's guiding principle is that all people affected by HIV in Ireland can understand enough about HIV itself and about HIV treatments to make informed decisions.

Lipodystrophy From page 6

How people respond

Some people are so thrilled with how their viral load has come down to undetectable and their CD4 count has risen, they're quite willing to accept it as a side effect. Others are very self conscious. Inquiries suggest that people on protease inhibitors who have experienced these fat changes believe that reductions in viral load and improvements in health justify the ongoing use of protease inhibitors. However, anecdotal reports suggest that some people on protease inhibitors are finding they are faced with the dilemma that a low viral load comes with a body that is seen to be HIV positive, at least within gay community networks. Unusual weight gain and wasting may also damage a person's self-esteem and confidence.

Who will get lipodystrophy?

Not everyone on protease inhibitors will develop lipodystrophy, although at this stage no one knows how common lipodystrophy will be. Estimates range between "a small proportion" and "50 percent" of people on protease inhibitors developing wasting and excessive stomach fat.

Implications for combination therapy

Community organisations and medical professionals clearly do not want to overstate the commonality or implications of lipodystrophy when so little is known. Lipodystrophy should not deter people from combination therapy.

The implications of lipodystrophy for the widespread use of proteases in combination is unclear. If lipodystrophy proves to be relatively common, the appeal of protease inhibitors, especially in early HIV disease, may be reduced. In addition to the impact of lipodystrophy on size, shape and self image, the health consequences of the changes in fat, cholesterol and sugar levels are unknown.

The need for open discussion of lipodystrophy and further research is emphasised

Treatment and diet

Doctors emphasised that the process which produces the wasting and fat redistribution is not understood, so there is no current remedy to this side effect of protease inhibitors.

[HIV Herald, (ΔΕΛΟ). GPI]

MEDIA ROUND
Volume 3
Issue 2

AIDS Deaths Drop 60%

SAN FRANCISCO CHRONICLE, 1/98

AIDS deaths in California dropped an astonishing 60 percent in the first six months of 1997. More than 37,500 Californians now have AIDS, and 150,000 more have been found to be HIV-positive, the Department of Health Services reports.

Dr. Steve Morin, director of public policy research at UCSF's AIDS Research Institute, said the availability of the new AIDS drugs varies dramatically from state to state. ``California and New York probably have the best programs in the country,'' said Morin. ``The worst states are those with the poorest Medicaid programs,'' like North Carolina, Mississippi and Florida.

Doctors' Guidelines urged for living wills

Irish Medical Times 1/98

The introduction of new guidelines to help doctors deal with 'living wills' should be given careful consideration, according to a leading medico-legal expert.

Dr. Denis Cusack said that many people made advance directives outlining their wishes in the event of their becoming mentally disabled as a result of illness.

Experience of these anticipatory decisions was not universally good and there was no guidelines as to how doctors should respond to such directives.

People made advance directives to outline their wishes with regard to treatment if they were facing debilitating ailments such as Huntington's or motor neurone disease.

At present the cases are dealt with on the basis of common law and best medical practice and it was time to consider whether that was good enough.

Dr. Cusack who lectures in medico-legal medicine in UCD, said it was an appropriate time to consider the introduction of guidelines as the Medical Council was currently reviewing its ethical guidelines.

He added however, that it was important to be clear on the parameters within which the guidelines would work. They should include proper safeguards, which recognise the patient's right to make decisions within the law and ethically.
He said that decisions should always be taken in the best interest of the patient but on occasions there were disagreements between families and doctors.

Dr. Cusack added that he did not believe that it was a matter which needed to be dealt with by way of legislation. It was also important to point out that this was not a debate about mercy killing. "It has absolutely nothing to do with euthanasia. Advance directives deal with matters that are lawful and ethical. They are not about assisted killing," he said.

T-20: Entirely New Antiretroviral

AIDS Treatment News 9/97 John S. James

A drug which works against HIV by an entirely new mechanism of action has shown clear antiviral activity in a small proof-of-concept human trial.

T-20, developed from virology knowledge gained through influenza research, is a 36-amino-acid peptide designed to block a critical step in the process by which HIV binds to and enters cells. The data showing antiretroviral activity in humans was first presented at the Infectious Disease Society of America 35th Annual Meeting in San Francisco (IDSA '97) .

Volunteers received the drug in four different doses, 3 mg, 10 mg, 30 mg, and 100 mg, every 12 hours, for 14 days. The highest dose group had a viral load decrease of at least 1.5 logs. (But all four patients who received this dose had their viral load go below the 500-copy limit of the test, so the actual decrease was probably greater.) A dose response was found, with the next lower dose (30 mg) having only a 0.48 log viral load decrease. The high-dose group had a CD4 count increase of 52 -- but the real improvement may be larger, since this change was measured after only 14 days, not enough time for the counts to fully recover. All four volunteers at the high dose had increased appetite and felt better. No side effects are known. T-20 has one important disadvantage: it must be injected, either twice a day or continuously (which would probably be better, judging from the 2.7-hour half life of the drug in the body). Today patients can use a small electronic pump, like wearing a pager, which provides continuous or other programmed drug injections.

What is still not known is whether T-20 will be tolerable and effective in long-term use.

NAME _____

ADDRESS _____

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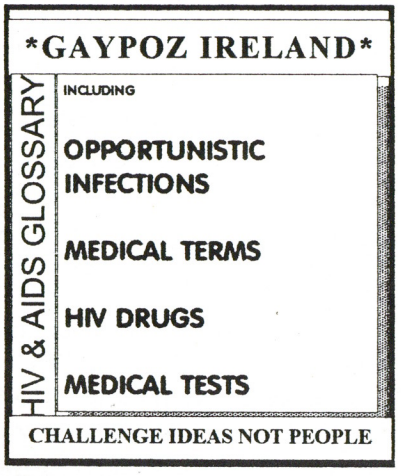
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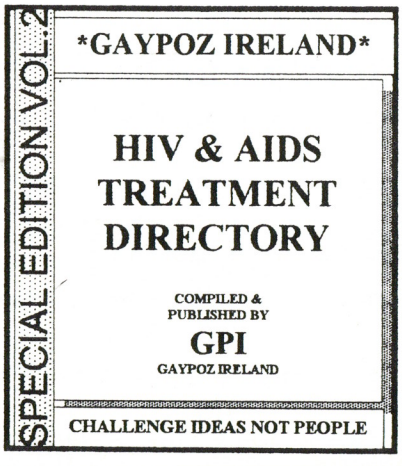
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MEDICAL ADVISORY PANEL

Dr. Mary Horgan MD FRCPI MRCP(UK) is a consultant in infectious diseases at Cork University Hospital. She trained at Washington University Medical Centre, St. Louis, Missouri.

Dr. Fergus O'Kelly MICGP is a GP working in Dublin's South West Inner City with people with HIV since its first appearance. "Good, accessible and informative.....I am happy to be associated with same" - Dr. O'Kelly.

Other members of the advisory panel will be introduced in future issues.

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