❖GAYPOZ IRELAND❖

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CHALLENGE IDEAS NOT PEOPLE.

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"Accountability"

People with HIV/AIDS are concerned about the accountability of the HIV/AIDS professionals who run, and are building careers in, the numerous HIV/AIDS organizations. These organisations survive off the money raised from the community and the government. What value are Positive People getting from these organisations? Has HIV moved from being our crisis to being a way of life inside of these organizations?

HIV/AIDS organisations exist because HIV exists. Though stating the obvious AIDS organizations are moving further and further away from the HIV community involvement in their operation, yet still expecting that community to participate in their funding and operation. Yet failing to invite them to participate in decision making and in determining how the money should be spent.

AIDS ORGANIZATIONS ARE MOVING FURTHER AND FURTHER AWAY FROM THE HIV COMMUNITY

How many positive people will participate in how decisions regarding how benefits are distributed?

GPI is one of the (only) few all-positive-volunteer AIDS groups, a group with no paid staff, receiving no government money, relying exclusively on support from donations and contributions. The denial of funding to GPI, raises a number of questions.

Why is community-raised money flowing to organizations, that receive government money for the services they provide?

Why isn't an up-to-date resource within the HIV/AIDS organisations regarding the current developments in HIV/AIDS set up with the money raised?

Why is relevant information for those living with HIV/AIDS unavailable within these organisations?

Why aren't these organisations doing the work GPI is doing?

These questions might have very good answers but not within the framework of the present organisations. GPI has provided answers to these questions and is surprised at the continual denial of funding from the Department of Health, and other HIV/AIDS organisations.

Unfortunately the kinds of answers available when requesting information are outdated and overly conservative.

Whatever the issue, AIDS organisations generally do not seek community input before decisions are made and are resistant to accountability afterwards.

In order for a HIV/AIDS organisation to effectively thwart community input, it does not need to be deliberately secretive, merely unwelcoming. This has been experienced by GPI. There has been a concern that GPI's resources would somehow highlight their inadequacies.

Those asking for accountability are generally people with AIDS, many with health problems, some with full-time jobs, some without, all with other activist priorities. Those resisting accountability are often paid, HIV-negative, full-time professionals, skilled in the art of media manipulation and spin-control.

Accepting as a given that every individual associated with HIV/AIDS organizations are operating from the purest of motives and the best of intentions, the resistance to oversight and accountability is both completely understandable as human nature, but totally unacceptable.

It doesn't have to be like this. AIDS researchers, charged with a lack of accountability, were forced to respond in the late 1980's with mechanisms allowing any person with HIV to participate in and review decision making. These organisations could reduce the criticism directed at them from throughout the community and insure that they remain in closer touch with the actual needs of people with AIDS in this rapidly changing epidemic by developing regular mechanisms for community input into decision making.

These mechanisms should be an easy means for interested members of the community to gain access to information about the institutions' activities and for community members to provide input and review of those activities. They should emphasize input from people who are not paid staff at particular service organizations. To achieve this, however, will take some courage and a willingness to actually listen to the people the HIV/AIDS organisations purport to serve.

john williams

"Responsibility"

The next several years will be particularly decisive for the future of AIDS. Newly developed drugs do not immediately or completely eliminate the virus from the body. They suppress HIV replication, placing the virus under intense evolutionary pressure. HIV is the most mutable virus we have encountered and there remains a real danger that it will somehow manage to evade the most potent drugs. If we mistakenly believe that the epidemic is over and return to the habits of the past, rapidly **transmitting new, drug-resistant strains of HIV across newly reconstituted viral highways**, the potential for tragedy is almost unthinkable. Our failure to comprehend and modify our preventive efforts could lead to a decisive Second Wave of this epidemic, this time with drug resistant strains of HIV that can never be treated by those drugs which are working at present.

The present generation of gay men that they do not consistently practice condoms consistently. We must culture, one in which people are free destroy the very soul it liberates. tide of HIV lies with us all, positive long the onus of responsibility has turn the tables for a while consider

HIV-negative people must also take responsibility for safer sex

that are becoming infected indicate protected sex, or at least do not use begin to develop a sustainable gay to be gay, but one that does not The responsibility for stemming the or negative gay or straight. For too been left with positive people. To the following points:

How many HIV-negative people have UNSAFE SEX because they wrongly assume their partner is HIV-negative?

HIV-negative people should take responsibility for safer sex and, within a consensual sexual experience, not place themselves at risk.

Another myth is that people become HIV positive in anonymous sexual encounters, anecdotally this was known to be untrue and unfortunately people have become HIV positive within a relationship,wrongly assuming that love would conquer all (it doesn't).This myth is disproved by the following findings.

A recent study involving hundreds of gay men in Amsterdam showed that higher rates of unprotected anal intercourse took place in privatized spaces (i.e., people's bedrooms) as compared to public sex environments.

To develop a new awareness and understanding about HIV will require a belief in our ability to change, and a desire to survive as healthy people, and our rejection of the homophobic myths that we are by nature shameful, diseased and doomed. If we can achieve this tall order is an open question. We will never know the answer until we try, and that attempt will begin with each of us, and proceed one person at a time.

(refer to Sexual ecology. AIDS and the Destiny of Gay Men by Gabriel Rotello published by Dutton)

from page 9

Resistance/Cross-Resistance

But most say it is too soon to understand the relationship between resistance to drugs and how best to treat HIV, because new findings are made every day. For example, researchers studying saquinavir say recent studies suggest that high-level cross-resistance will not be a problem in individuals first treated with this protease inhibitor. And other research shows that viruses that become resistant to several protease inhibitors are still susceptible (not resistant) to some of the newer protease inhibitors being developed. At this point, most experts believe that people will be able to take certain protease inhibitors at the same time--or perhaps one after another with other anti-HIV drugs.

[International Association of Physicians in AIDS Care]

HIV/AIDS WEB SITES

ACT UP/Golden Gate
(http://www.actupgg.org)

Two news collections on this site are particularly useful. The news releases (1996 and 1997) provide a history of the work of this leading treatment activist organization.

American Medical Association
(http://www.ama-assn.org/special/hiv/newsline/newshome)

This site, written primarily for physicians, includes: news briefings, special reports, in-depth articles from major professional sources; and Journal Scan -- postings of abstracts from major journals and related commentaries, sometimes with links to the full-text articles (which often require registration, however, and may not be free).

Critical Path AIDS Project
(http://www.critpath.org/bulletin.html)

Includes treatment and research news, and Federal, state, and local policy issues.

New York Academy of Medicine
(http://www.aidsnyc.org)

This site is host to many AIDS organizations in New York. A "What's New" link tells what has been posted recently on all of the sites, and the date of each posting. You get the benefit of over 20 different AIDS organizations bringing to the public what they feel is important. Also, upcoming AIDS forum announcements (generally for the New York City area) are posted.

Project Inform
(http://www.projinf.org)

Includes treatment and policy news, action alerts, and press releases.

1592: Small Distribution Programs Begin June, July

Glaxo Wellcome announced that it will begin three small compassionate-use programmes for access to 1592, an experimental antiretroviral, in the USA. A paediatric programme is planned to start in June, and dementia and adult programs in July.

1592 is a nucleoside analog -- a drug in the same class as AZT -- but it appears to give much better viral suppression than AZT. Also, its resistance profile is different. About 250 people have been treated with 1592 so far. About 20 additional trials are planned, involving more than 2,000 people.

The three programmes are:

* Pediatric programme (ages 90 days through 12 years):
* AIDS dementia complex (ages 18 through 65):
* Other adults: Patients must have a viral load greater than 50,000 copies, a CD4 count under 100, and they must have previously failed at least two nucleoside analogue drugs and one protease inhibitor.

The adult programme will be conducted at centers in North America, countries in Europe which are currently running trials of 1592, and Australia. The list of centres is not yet final.

2,500 slots will be available in all three programs together worldwide.

Comment

There is widespread concern that 2,500 slots will be entirely inadequate -- that the adult programme could fill up quickly. In that case the drug will be available to those with luck and first in line.

There is also concern that the development of this drug has proceeded too slowly Current plans are to apply for FDA approval well into 1998. Glaxo hopes to have a larger expanded access programme starting in early 1998.

The company has given two reasons for the small size of the current programme: (1) some supply limits due to unexpected difficulties in scaling up the production process to make large batches, and (2) concern about distributing a drug very widely when it has been tested on a few people so far.

1592 is expected to be most useful to people who have limited treatment options and need to find a combination which works for them to suppress HIV replication.

cautious optimism

"AIDS Drugs Showing Dramatic Results"
Washington Post (05/97) "**Three studies published in the journal Nature reaffirm the power of new treatments for AIDS, indicating that the touted triple therapy using protease inhibitors kills HIV even faster than originally thought. The studies, moreover, show that the new drug combinations can successfully battle HIV in the lymph nodes, tonsils, and other organs, parts of the body where the virus appeared to become relatively entrenched, compared to the blood....**"

THERE IS A WORLD OF DIFFERENCE BETWEEN KILLING A VIRUS AND SUPPRESSING A VIRUS.

The above commentary is brought back to reality in the May issue of Nature Medicine, which cautions these assertions. That the triple combination drugs "kill" any virus anywhere in the body has not been proven -- the qualified term used to describe the effect of these drugs is "viral suppression". There is a world of difference between killing a virus and suppressing a virus.

This view may seem a little pessimistic in the face of all the current optimism but the danger of the hype is that it is giving people a false sense of security and could encourage unprotected sex. It is far safer to err on the side of caution, for now because:

1. hitting hard isn't a cure
2. people are still dying
3. there are limited choices of combination therapies
4. women with HIV are dying at faster rates than ever
5. there is a large increase in HIV among young people in certain urban areas.

David Ho has communicated to Dr. Giuseppe Pantaleo, at the Laboratory of AIDS Immunopathogenesis in Lausanne, Switzerland, that "discontinuation of antiviral therapy after prolonged treatment (up to 1 year) also results in a rapid 10 to 14 days) return of viraemia to basal levels, despite the fact that during the period of antiviral therapy, plasma viraemia was persistently (up to 1 year) found below detectable levels, that is, 200 to 500 HIV RNA copies per milliliter of plasma (D.D. Ho, personal observation). "

Pantaleo offers two possibilities to explain this: "First, the rapidity with which viraemia returns to basal levels after discontinuation of therapy indicates the presence of persistent, although at very low levels, virus replication rather than a reactivation of virus replication from a pool of latently infected cells." and -

"Second, these findings suggest that there is a different susceptibility to antiviral therapy of the two pools of HIV-infected cells that are mostly responsible for virus production. These include cells that support high levels of virus replication (high replicating virus cells), that is, CD4+ T lymphocytes, which account for most (up to 99%) of the viraemia detected in the absence of antiviral therapy, and cells that support low levels of virus replication (low replicating virus cells), that is, tissue macrophages and/or possibly dendritic cells, which are responsible for less than 1% of the total viraemia."

Does this study show the triple-drug therapy is also getting into the CNS (Central Nervous System) or is the jury still out on that one?
Given these disclosures, one should reconsider the goal.

HITTING HARD WITH COMBINATION THERAPY CAN LOWER THE VIRAL LOAD, TO UNDETECTABLE LEVELS, BUT STILL ISN'T PROVIDING A CURE.

Therefore, despite impressive reductions in plasma viraemia, treated patients who have been taken off triple therapy soon see viraemia rebound to earlier levels. Although there is, of course, a role for antiviral therapy in managing the infection, Pantaleo notes there is now more than ever a need to develop longer term immune-based interventions to eradicate the virus.

HIV ADULT STANDARD OF CARE WHEN THE CD4 (TCELL) COUNT IS LESS THAN 100.

THE FOLLOWING TESTS AND EXAMINATIONS SHOULD BE PROVIDED BY YOUR DOCTOR OVER A SERIES OF CONSULTATIONS IF YOUR CD4 (TCELL) COUNT IS LESS THAN 100.

< LESS THAN
> GREATER THAN

HIV Infection

Continue triple therapy with a protease inhibitor (indinavir or ritonavir or nelfinavir), or a drug trial. High dose (800 TID) acyclovir may be considered for survival benefit at these levels (unproven).

Fungal prophylaxis

Fluconazole (Diflucan) 200 mg three times a week may be considered, but consider the possibility of developing resistance.

Cryptococcal meningitis

This is treated aggressively with Amphotericin B (liposomal formulations may be less toxic--less "shake and bake") + 5FC; prophylaxis with fluconazole to prevent crypto (but there is a risk of resistant fungi).

Toxoplasmosis

If positive, prophylax with pyrimethamine, Septrin or combo.

CMV retinitis or gastrointestinal

See Volume 2 Issue 1.

Candidiasis

Treat aggressively with fluconazole (Diflucan).

MAI/MAC

Consider prophylaxis with Klacid (Clarithromycin) (500 mg PO bid) at lower dosage or azithromycin (1200 mg PO weekly, if counts are <75 CD4). Rifabutin (300 mg PO daily) as second line defense.

Kaposi's sarcoma or lymphoma

See Volume 2 Issue 1.

PCP (recurrent--moderate or severe)

After conventional treatment failure, use trimetrexate with (calcium folinate) leucovorin rescue as effective salvage protocol.

Finding a competent doctor with AIDS treatment experience may be the single biggest factor in survival according to recent studies.

Cryptosporidiosis

Aggressive testing and treatment. Humatin works in some cases. But NTZ available at some buyers' clubs seems to be much more effective. Consider new garlic treatment. Food/water, diaper-changing, and sex safety precautions.

Pap smear (women)

Every six months. If abnormal (including atypia) follow with colposcopy and treatment. Treat any STDs.

Wasting (10% body weight loss)

Serum albumin <3.0 is prognostic for wasting. Men should be on testosterone +nandralone therapy. Use medicinal marijuana (or Marinol--less effective) as appetite stimulant or for control of nausea. Check for undiagnosed infections, look for experienced specialist. Oxandrolone or deca-durabolin may be good options for women. Office visits monthly to bimonthly. Treat all other problems aggressively.

Delayed Hypersensitivity Skin Tests (DTH Anergy panels) are useful as functional test of immune system competence.
The following, while not part of the actual Standard of Care, can be useful to persons with HIV disease wishing to take some control of their health .

Finding a competent MD with AIDS treatment experience (and a "Just Do It" attitude) may be the single biggest factor in survival according to recent studies. Stick with a medical clinic with backup, so you can get care on evenings or weekends. Get second opinions. Review all medications taken to help minimize side effects. Plan ahead.

SAQUINAVIR

SAQUINAVIR UPDATE

What is saquinavir?

Saquinavir (also called Invirase) is an antiviral drug that slows the reproduction of HIV. It does not treat illnesses associated with AIDS but reduces the amount of HIV in your body. It works by blocking the action of an enzyme that the virus makes called a protease. This enzyme is necessary for the virus to reproduce and infect new cells. Saquinavir is one of three drugs called protease inhibitors; the other two are ritonavir and indinavir. It was approved by the Food and Drug Administration (FDA) in early 1996 for the treatment of advanced HIV disease.

What are the reasons my doctor might prescribe saquinavir?

Saquinavir in combination with other antiviral agents may slow disease progression, raise the T-cell count, and decrease the level of virus in the blood in people with HIV infection. Studies are underway to determine the possible long term benefits and risks of taking this medication.
Saquinavir in combination with nucleoside analogue drugs, including zidovudine (AZT), didanosine (ddI), zalcitabine (ddC), stavudine (d4T), or lamivudine (3TC), may be given as initial therapy for HIV disease. It may also be prescribed for HIV-infected persons who: 1) have developed side effects from other drugs; 2) have failed to respond to other therapies; or 3) have received other drugs for a prolonged period of time, generally several months to years.
Saquinavir does not appear to be as potent an antiviral drug as the other two protease inhibitors, and it has only been shown to be effective when taken in combination with other agents. If you are starting a protease inhibitor, your doctor should discuss the differences between these medications with you.

How do I take it?

Three 200 mg capsules taken three times a day within two hours after eating a full meal preferably high in fat. Invirase must be taken on a full stomach to be effective. Some healthier foods that are high in fat include; lean red meat, peanut butter, avocado, cheese, bread with butter, whole or 2 percent milk products. Unlike other protease inhibitors, Invirase has been shown to be effective only when used in combinations with other anti-viral drugs, including AZT, ddC, or AZT/ddc. Talk with your doctor about which combination and at which dose is best for you.
Clinical studies have shown that Invirase is not as potent as other protease inhibitors in lowering the level of virus in the blood. This may be due in part to the fact that Invirase is not absorbed or metabolized very well by the body. A new, improved version of Invirase will be available over the next year. Studies have shown that development of cross resistance between Invirase and Crixivan or Invirase and Norvir may occur more slowly than with the other protease drugs. Although more studies need to be done, this is good news for people already taking Invirase who may wish to switch from Invirase to Crixivan or Norvir. Invirase in combination with Norvir or Crixivan has not been tested and the safety is not known. Screening for an upcoming trial with Invirase and Norvir is occurring now.

Storage

Keep capsules in their bottle at room temperature.

Side Effects

Invirase has fewer side effects than the other protease drugs. Side effects might include diarrhoea, stomach upset and nausea. However, most people in the clinical studies did not develop these problems.

Drug Interactions

Invirase should not be taken with: rifampin or rifabutin (Mycobutin), terfenadine (Seldane), astemizole (Hismanual), phenobarbital, phenytoin (Dilantin), dexamethasone (Decadron), carbamazepine (Tegretol). Speak to your doctor about other possible drug interactions.

Homophobia in Health Care

John Williams

Proof (if needed) of homophobia among the medical profession in Ireland was given voice recently in The Irish Medical News by a Blackrock GP, Dr. Fleetwood Jr. This GP effectively blamed gay people for their disease (HIV). He went on to comment how record numbers of gay men are falling victim to the HIV virus. This overt homophobia is easy to confront. GPI printed a reply article in the Irish Medical News, and has made complaint of Dr. Fleetwood Jr. to the Fitness to Practice Committee of the Medical Council. GPI has received confirmation of receipt of this complaint. GPI has accused Dr. Fleetwood Jr. of incitement to hatred of gay people.

The rather sad fact that a number of supportive medical professionals and gay groups have not commented on this attack, will allow this overt homophobia room to develop, and ensure that the more insidious homophobia retains credibility.

Recently in Massachusetts USA, the Department of Public Health launched a new "Equal Access to Health Care" campaign. This included posters of gay and lesbian people which read “Homophobia in Health Care is Unhealthy. Gay, lesbian, bisexual, and transgender people deserve the same care as everyone else. Thousands of healthcare providers in Massachusetts agree. They're working to eliminate barriers to healthcare access, so everyone can be treated well. And STAY well.”

What is disappointing in Ireland is that we don’t even imagine that this is a problem, hence no one is looking for a solution!



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RESISTANCE/CROSS-RESISTANCE

Resistance is the ability of HIV to change its chemical (or "genetic") structure so that it resists the effects of drugs. All viruses and bacteria can change themselves in this way. Resistance may develop to every anti-HIV drug in use today when given as "monotherapy" (one drug at a time). With some drugs it happens very quickly, and with others it takes longer.

CERTAIN PATTERNS OF RESISTANCE CAN BE A PLUS INSTEAD OF A MINUS

Resistance is a complicated problem. Resistance to a drug may not necessarily mean that a person should stop taking that drug and will never be able to take it again. Some studies of reverse transcriptase inhibitors show that certain patterns of resistance can be a plus instead of a minus.

Also, all of the viruses in an infected person's body don't suddenly become resistant to a drug at the same time. So a drug can continue to be effective against the many nonresistant viruses still in the body. If a protease inhibitor is taken with other anti-HIV drugs-AZT and 3TC, for example-those other drugs might be able to attack the viruses that are resistant to the protease inhibitor. And the protease inhibitor could attack all the other viruses that are not resistant to it.

As with other drugs, each protease inhibitor differs in how quickly resistance to it develops. And everyone with HIV will differ in how quickly their HIV viruses will become resistant to different protease inhibitors. Resistance will develop more slowly in people with only a little virus in their body and with relatively high CD4 counts. In people with a lot of virus in their body, resistance will probably develop more quickly. Protease inhibitor experts agree that the best way to avoid or delay resistance to a protease inhibitor is to take the drug exactly as recommended by the drug manufacturer, to be especially careful not to skip taking the drug, and to take the protease inhibitor in combination with one or more reverse transcriptase inhibitors (AZT, ddI, ddC, d4T, and 3TC).

But the most important thing to remember about taking protease inhibitors is that, if you're already taking one or more reverse transcriptase inhibitors and not doing well, it's best to start taking a protease inhibitor with reverse transcriptase inhibitors that you have never taken before or at least have not taken in a long time.

What is cross-resistance?

HIV can become resistant to two or more drugs at the same time. When it does, HIV is said to be cross-resistant to those drugs. Researchers studying the protease inhibitor indinavir found that HIV in some people first became resistant to the drug and then became resistant to several other protease inhibitors when they were tested later. AIDS experts agree that cross-resistance is a problem that must be studied closely.

continued on page 3

GayPoz Ireland

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 continues to fall below 200.

Learn about preventive therapies for MAC and CMV infections.

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

MEDIA ROUND 1

Bristol-Myers Buys Rights to Potential Drug for HIV

Investor's Business Daily (06/97)

Bristol-Myers has bought the marketing and development rights for two HIV protease inhibitors from Novartis for an undisclosed sum. The drug maker plans to conduct additional clinical tests of one of the compounds while continuing pre-clinical research on the other.

Injected Gel Zaps Genital Warts

United Press International (04/97);

New research presented at the annual meeting of the American College of Obstetrics and Gynecology suggests that an injectable gel spiked with a cancer drug may clear most or all genital warts for the majority of people who have failed other therapies. The gel, which contains fluorouracil (5-FU), a blood vessel constrictor epinephrine, and a biodegradable gel, was effective in eliminating all the warts in 61 percent of the 270 subjects and clearing more than half the warts in another 30 percent of patients. Matrix Pharmaceuticals, the maker of the gel, expects it to receive FDA approval by the end of this year, says Elaine Orenberg, a Matrix scientist.

A 26-Year Emergence From the Closet

USA Today (04/97)

The long and uneven televised path that has led finally to the first homosexual lead character--Ellen DeGeneres' character on the ABC show "Ellen"--has often included homosexual characters grappling with the issue of HIV and AIDS. In 1985, "An Early Frost" was the first network AIDS movie, featuring Aidan Quinn as a young homosexual returning to his parent's house. In 1983 on "As the World Turns," Hank Eliot, played by Brian Stracher, had an HIV-positive lover. Lee Mathis, who played "General Hospital's" recurring gay character Jon Hanley, died of AIDS in 1996, as did his character on the show. The 1984 Showtime series "Brothers," which had been rejected by ABC and NBC, featured a homosexual major character, Clifford (Paul Regina), and confronts issues including AIDS and coming out. In addition, Peter (Peter Frechette), one of two recurring gay characters on "thirtysomething," tests positive for HIV in a 1991 episode. In 1994, moreover, Pedro Zamora, a gay cast member on MTV's "The Real World," lived with AIDS, both in real life and in front of the cameras.

Where Have All the [Red] Ribbons Gone?

U.S. News & World Report (04/97)

The popularity of the red AIDS ribbon among celebrities has apparently dwindled, evidenced by their absence on the tuxes and gowns worn at the Academy Awards ceremony. "It became a cliché," suggested AIDS Project Los Angeles's Gerry Ansel. Other reasons for the AIDS ribbon's decline include advances in AIDS treatment, which have diminished the urgency previously felt about the disease, and the fact that celebrities that support animal rights may have realized they cannot pledge allegiance to both causes, since AIDS researchers often use animals for tests.

Frankie Trull, president of the Foundation for Biomedical Research, also suggested that celebrities may not be as inclined to display their support of AIDS because "they don't want animal rights people protesting outside their movies."

A SECOND LOOK

POZ (06/97)

In his new book "Sexual Ecology: AIDS and the Destiny,"author Gabriel Rotello lends urgency to the possibility of a second wave of AIDS. According to reviewers Dr. Joseph Sonnabend and Richard Berkowitz, Rotello believes that homosexual men cannot practice safer sex consistently enough to prevent a second epidemic, and he urges an end to promiscuity via sexual restraint, monogamy, and marriage. To prove his point, Rotello cites an "alarming" increase in the number of cases of rectal gonorrhea in the state of Washington in 1989. However, Sonnabend and Berkowitz note that changes over one year are not indicative of a steady trend. Moreover, they point out that after 1989, Washington saw a continuous decline in the number of rectal gonorrhea infections. Sonnabend and Richard Berkowitz argue that safer sex has played a key role in preventing the spread of HIV and that it is now important to encourage those men at risk to practice it. Forcing monogamy denies homosexuals their ability to express themselves sexually and can result in guilt, shame, and disease, the critics conclude.

MEDIA ROUND 2

A Drug From DuPont Merck Fights AIDS in Study

Investor's Business Daily (05/97)

New research shows that DuPont Merck Pharmaceutical's DMP 266, when used in combination with Merck's Crixivan, reduced HIV below measurable levels in four out of five patients; at the same time, it also raised CD4 counts. Merck and DuPont formed DuPont Merck Pharmaceutical six years ago.

American Medical News (05/97) Vol. 40, No. 9,

Hope on Hold

With the ever-increasing number of treatments for AIDS and HIV, it is becoming more difficult for doctors to be sure that their HIV/AIDS patients are receiving the proper medications. Many hospitals are, therefore, establishing "protease inhibitor rounds," special committees dedicated to finding solutions for individual problems related to the development of new therapies. Because of rigorous pill regimens and special conditions required to keep medication fresh, for example, some patients of lower socioeconomic status would be considered a high risk of not being able to keep up with treatment. Another factor to consider is the psychological effects of taking numerous--in some cases up to 20 pills a day--medications. As Jeanne Carey, a physician at the HIV Comprehensive Care Center at Beth Israel Medical Center in New York, notes, "A person who takes 18 pills a day is reminded 18 times a day that they have HIV. ... It's psychologically difficult, and it's hard to rearrange your life around medicine, and having to take medications wherever you go, and not being able to eat whenever you want to." For patients unwilling to adhere to their regimens, treatment is often deferred, which thus creates an ethical dilemma related to denying care. Health care professionals note that directly observed therapy, which is used to monitor the treatment of some tuberculosis patients, is too time-consuming and expensive for HIV. Doctors are thus advised to thoroughly counsel patients about their various medications before prescribing them, including the possible benefits and their chances of developing resistance if they do not follow their schedule.

A Hepatitis Drug That May Cure Glaxo

Business Week (05/97) No. 3526

In 1990, Glaxo Wellcome acquired the marketing rights to the AIDS drug 3TC, which it sells under the brand name Epivir. Epivir produced $315 million in revenues in its first year of availability and analysts estimate that the drug could reach sales of up to $840 million by the year 2000. Now, it seems the chemical compound, renamed lamivudine, could be the most effective treatment available against hepatitis B, a disease that kills some 2 million people each year. Data from a trial in Hong Kong, Taiwan, and Singapore show that 96 percent of patients who received a 100mg dose of lamivudine reported significant suppression of the hepatitis B virus (HBV) with few side effects. About two-thirds of the subjects also had decreased liver inflammation. The discovery of lamivudine's hepatitis-suppressing potential will likely provide Glaxo with a needed boost, since the patent for the anti-ulcer drug Zantac, its No. 1 product, will soon expire. Lamivudine "will be the gold standard" for treatment of hepatitis B, predicts Timothy M. Block, chief scientific advisor of the Hepatitis B Foundation. However, others argue that the drug's marketing potential is being overestimated, because the drug is not a "cure" and only 16 percent of patients taking the drug showing no sign of HBV in their blood.

More Effective Therapies Needed to Cure AIDS

Xinhua News Agency (05/97)

Dr. David Ho, director of the Aaron Diamond AIDS Research Center in New York, said recently that it will be difficult to eliminate HIV. "The therapies can kill 99 percent of the HIV virus in the patients' blood during the first two weeks, but it is very difficult to get rid of the rest of it," he noted. Ho added that more effective therapies are still needed. "I will do my best to invent a vaccine for HIV and develop cheaper drugs to treat the disease," he said.

testosterone: A naturally occurring male hormone. Levels are often reduced in HIV.

thalidomide: A drug that reduces the level of TNF. It is being used in the treatment of wasting.

th 1 response: An acquired immune response. It is promoted by CD4+ "Th1" T-helper cells.

3TC (epivir): A nucleoside analogue with anti-HIV and anti-HBV activity.

thrombocytopenia: A condition in which platelets, a type of blood cell, fail to help blood clot. Treatment is either with drugs (prednisone), removal of the spleen, or by platelet transfusion.

thrush: See candidiasis.

thymus: The organ of the body that trains T cells to be part of the immune system.

T-killer cell (cytoxic T cells): A type of white-blood cell that kills foreign organisms after being activated by T-helper cells.

TNF: See tumor necrosis factor.

total parentral nutrition: A method of supplying nutritional supplements by intravenous infusion.

toxic reaction: A poisonous or unwanted reaction to a vitamin, drug or other substance. A toxic side effect is when a helpful medicine also causes some damage to the blood or body. Toxicity is a measurement of how much damage may be caused.

toxoplasmosis: An inflammation of the brain caused by toxoplasma gondii, a parasite. Frequently causes inflammation of the brain. It may also involve the heart, lung, adrenal glands, pancreas and testicles. This disease is usually mild but it can cause fever and swollen glands, as well as severe headaches. Fifty percent of Americans have been exposed to toxoplasma gondii at some point in their lives.

transaminase: An enzyme measurement that indicates the health of the liver.

transfusion: The process of giving blood, or parts of the blood from one person to another.

trimethoprim: Sometimes abbreviated to TMP - it is an approved antibiotic which is used most frequently in conjunction with sulphamethoxazole (SMX) in the form of the drug c0-trimoxazole. Co-trimoxazole is the first line therapy for the prevention and treatment of PCP.

trisodium phosphonoformate: See Foscarnet

T-suppressor cell: A type of white blood cell that helps control the body's response to an infection.

tuberculosis (TB): An infection caused by Mycobacterium tuberculosis. Treatment consists of the administration of a combination of antibacterial drugs, usually for at least nine months.

tumor necrosis factor (TNF): A protein produced by macrophages. By itself, TNF destroys cancer cells. TNF can cause fever, chills, fatigue, headache, and inflammation. TNF causes weight loss and probably helps HIV to grow.

V

vaccine: A shot or shots that prevent(s) a disease. Another kind of vaccine, treatment vaccines, are in development and being studied. Treatment vaccines may help fight HIV even after someone has been infected.

vaginal candidiasis: Infection in the vagina with thrush. Presents with pain, itching, redness and white patches in the vaginal wall. Much more common and more difficult to treat in women with HIV infection.

valaciclovir (Valtrex): This is a prodrug of acyclovir i.e. it is broken down into acyclovir in the body.

varicella virus: See herpes zoster virus.

vertical transmission: Transmission of a pathogen such as HIV from mother to foetus or baby during pregnancy or birth.

Viracept (nelfinavir) : A protease inhibitor distributed by Roche Pharmaceuticals. It is showing promising results to date. (see Vol.2 Issues 3 & 4)

viraemia: The presence of virus in the blood stream.

viral load: The number of viral particles (usually HIV) in a sample of blood plasma. Viral load is used as a surrogate marker for disease progression. It is measured by PCR and bDNA tests and is expressed as the number of copies of HIV per millimeter. Decisions on instituting combination are made using viral load test results along with CD4 counts.

Viramune (nevirapine): A non-nucleoside reverse transcriptase inhibitor (NNRTI) that is showing anti-HIV activity. Possible side effects include severe rash and fever. (see Vol.2 Issues 3 & 4)

virion: A complete virus particle existing outside a cell.

virus: The smallest known infectious organism. A group of infectious agents characterized by their inability to reproduce outside of a living cell. They are unable to live or multiply outside of a host cell since most do not possess the means to synthesize protein.

vitamin: Organic chemicals essential in small amounts for normal metabolism, growth and development of the body.

vx-478: A protease inhibitor which was developed by Vertex and has been licensed to Glaxo-Wellcome. It is known by the codename 141W94. It is presently in combination trials with AZT and 3TC.

W

wart: A benign growth on the skin caused by infection with the human papillomavirus (HPV). Common warts are usually seen on the backs of the hands and tend to resolve spontaneously. Genital warts are frequently associated with other genital infections and affected women have an increased risk of developing cervical cancer. Treatment includes cryotherapy (freezing) but can cause spreading to the immediate surrounding area. Laser treatment is used. Also topical solutions including lactic and salicylic acid and podophyllotoxin (Warticon).

wasting syndrome: Severe weight loss involving depletion of muscle mass in people with AIDS and HIV positive individuals which can occur even in the absence of other infections. Unwanted weight loss of more than 10% of body weight plus either chronic diarrhea or chronic weakness and fever for more than 30 days. Treatment is required.

white blood cells: Part of the immune system that protects the body against foreign substances such as disease-producing microorganisms.

Y

yeast: Any of a group of fungi consisting of individual cells which may occur singly or in groups of two or three, or in chains. Yeasts that cause disease in humans include *Candida, Cryptococcus* and *Pityrosporum.*

yeast infection: See candidiasis.

Z

zerit (d4T): an anti-HIV nucleoside analogue, used in combinations with other drugs e.g. AZT, 3TC. Possible side effects may include peripheral neuropathy.

Zidovudine: See AZT.

Zinamide (pyrazinamide): An oral anti-tuberculosis drug used in combination regimens.

zinc: A component of many enzymes. It is important in protecting the cells against oxidation.

zinc fingers: These help to package HIV's genetic material into whole new virus particles (virions). They may also play a role in an earlier stage of the HIV replication process.

zintevir (AR-177): An integrase inhibitor, presently in trial development.

Zovirax: See acyclovir.

GLOSSARY T - V

GLOSSARY V - Z

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SHINGLES

(Herpes Zoster)

WHAT IS SHINGLES?

Shingles is a very painful disease caused by the same herpes virus that causes chicken pox (varicella zoster virus). Like other herpes viruses, the varicella-zoster virus has an initial infectious stage, (chicken pox) followed by a dormant stage. Then, with no warning, the virus becomes active again. Older people are more likely to develop shingles. Shingles is not one of the infections that leads to a diagnosis of AIDS, but people with lower T-cell counts seem to develop shingles more often than healthy people of the same age. Herpes zoster lives in nerve tissue. Outbreaks of shingles start with severe pain in a belt-like pattern on the chest, back, or in the eye and forehead. These outbreaks are almost always on just one side of the body. A day or two later, a rash appears on the skin area related to the inflamed nerve. Small blisters form, and crust over. The virus can be transmitted to other people when the blisters break open.

TWO NEW DRUGS HAVE BEEN APPROVED FOR THE TREATMENT OF SHINGLES: FAMCICLOVIR AND VALACICLOVIR

In rare cases, shingles can spread throughout the skin or internal organs, and can cause serious complications. In most cases, the rash goes away in 10 days to two weeks, but severe pain can last for months or years.

HOW IS SHINGLES TREATED?

The standard treatment for shingles is the drug acyclovir, which can be given orally (in pill form) or intravenously in more severe cases.

Recently, two new drugs have been approved for the treatment of shingles: famciclovir and valaciclovir. Both famciclovir and valaciclovir are taken three times each day, compared to five times for acyclovir. All of these drugs work best when they are started within the first three days after the shingles pain begins.

Because the pain of shingles is so intense, some researchers have looked for ways to block the pain. When nerves become inflamed by the herpes zoster virus, they pump out a chemical messenger called glutamate. Glutamate then lands on receptors on nearby cells, which transmit pain signals to the brain.

Shingles triggers such a flood of glutamate that some cells stop functioning while others become hypersensitive. This probably explains why shingles patients can feel great pain even when skin is touched only lightly.

There are drugs that can block the receptor sites where glutamate lands, and researchers are studying whether these drugs will help relieve shingles pain.

CAN SHINGLES BE PREVENTED?

Currently, there is no way to predict an outbreak of shingles, and there is no medication approved to prevent it.

But researchers have shown that giving older people the chicken pox vaccine - the same vaccine used for children - boosts the type of immunity believed necessary to hold the virus in check.

The researchers hope to show that this increased immunity will result in a lower risk of shingles in later life.

THE BOTTOM LINE:

Shingles is an unpredictable, very painful disease. It is caused by a re-activation of the virus that causes chicken pox. Although not directly linked to HIV, shingles seems to occur more frequently in people with AIDS.

Although shingles may disappear within a couple of weeks, severe pain may continue for several months.

There is no known way to prevent outbreaks of shingles.

The disease has been treated with acyclovir, taken five times daily, or given intravenously in severe cases.

Two newer drugs, famciclovir and valaciclovir, seem to be more effective against the pain of shingles and need to be taken only three times each day.

SHINGLES IS NOT ONE OF THE INFECTIONS THAT LEADS TO A DIAGNOSIS OF AIDS, BUT PEOPLE WITH LOWER T-CELL COUNTS SEEM TO DEVELOP SHINGLES MORE OFTEN THAN HEALTHY PEOPLE OF THE SAME AGE.

A BALANCED VIEW

John Williams

With any complex issue it is all too often attempted to narrow the questions to two choices: right or wrong, left or right, etc. In playing this game the choices are reduced down to one of two alternatives. With the question, who is responsible for the spread of HIV, it is wise to think of the answer in terms of "everyone" rather than in terms of any individual or individual group. This avoids the extreme danger of isolating any portion of society, who when catered to by simplistic alternatives, are made to feel immune to HIV, thus leaving them exposed to that very risk. According to a new study conducted by the University of California, San Francisco's Centre for AIDS Prevention Studies, they have found that lack of communication is one of the main factors contributing to the spread of HIV through sexual intercourse. It is only through open, frank and non-judgmental discussion that we can come to the correct and prospective management of HIV/AIDS.

Recent Figures for HIV/AIDS cases

The European Commission report (COM/96/720) released at the end of January 1997 indicates that the number of reported new AIDS cases is down in most European countries except Spain, Italy, and Portugal. But figures from the Centre for Disease Control (CDC) in Atlanta Georgia, USA show that there are about 60,000 new AIDS cases a year in the USA. David Satcher, M.D, Ph.D., Director, Centers for Disease Control and Prevention (CDC) stresses "Moreover, we estimate that at least 40,000 Americans are becoming infected with HIV each year---- there is clearly more to be done." AIDS cases in the USA are now increasing most rapidly among women and minorities. Furthermore, there has not been a significant decline in new infections among young people. This year, for the first time, the CDC reported a drop in the AIDS death rate - but an increase in the rate of AIDS deaths in women. Helene Gayle, M.D., M.P.H., Director of CDC's National Centre for HIV, STD and TB "Women account for an increasing proportion of newly reported AIDS cases in the United States," says Gayle. "These trends point to the urgent need to identify female-controlled HIV prevention methods.". While the AIDS death rate in men in the USA dropped by 15% in the first six months of 1996, deaths in women increased by 3%. Contrary to published reports, the CDC has announced that AIDS is no longer the fourth but the third leading cause of death among American women as of December 1996. Since 1993, AIDS has been the most common cause of death in African American women ages 25-44.

HIV does not discriminate by race, gender or sexual preference.

Cause and Transmission

AIDS is caused by a virus called the human immunodeficiency virus or HIV. HIV is found in the blood, semen, and vaginal secretions of an infected person. The virus is spread by unprotected sexual intercourse with an infected person, by needle-sharing among injecting drug users. Babies born to HIV-infected women may become infected before, during, or shortly after birth through breastfeeding. To reconsider, there are three important facts about HIV transmission :

1. The virus is mainly spread by unprotected sex and sharing needles with an HIV- infected person.
2. Babies born to HIV-infected women may become infected.
3. You do not become infected by casual contact or insects.

HIV does not discriminate by race, gender or sexual preference.

Confidentiality

To assign blame to an individual for contracting a viral infection only serves to weaken an already fragile HIV/AIDS treatment system. Unwarranted breaches of confidentiality imposed on HIV-infected patients within a clinical setting have the potential to undermine the critical patient education message that treatment is safe when universal precautions are followed. (see note 1) While any intentional transmission of HIV is staunchly repudiated, any right a doctor may consider he/she has to inform another party of that pa-

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tient's HIV status, and to be able to make that decision alone is too volatile a position to safely adopt. Breaches in confidentiality have occurred with devastating effects. These breaches were unwarranted and unprofessional. They have only served to diminish the medical profession's integrity and their patients' trust. Patients whose confidentiality has been breached have little or no recourse to litigation, as the pursuit of such a litigious position only serves to breach their confidentiality still further. These breaches of confidentiality have generated an amount of fear among HIV positive patients who have expressed grave concerns about attending their GPs for treatment. One patient has recently been told that it is his own fault that he is HIV positive, by his GP. This has destroyed his present medical support system. It will be a difficult task to reassure patients of the integrity and non-judgmental position of their treatment providers if some practitioners continue to adopt this stance. The engendering of fear and blame will encourage patients not to test for HIV and subsequently preventing status disclosure. This will force HIV underground, a position from which it will be impossible to manage, and from where we are all at risk.

ENGENDERING FEAR AND BLAME WILL ENCOURAGE PEOPLE NOT TO TEST FOR HIV

Note 1.**"Universal precautions,"** as defined by CDC, are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other bloodborne pathogens. Universal precautions apply to blood, other body fluids containing visible blood, semen, and vaginal secretions. Universal precautions also apply to tissues and to the following fluids: cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.

Universal precautions do not apply to faeces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. Universal precautions do not apply to saliva except when visibly contaminated with blood or in the dental setting where blood contamination of saliva is predictable. Universal precautions involve the use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear, which can reduce the risk of exposure of the health care worker's skin or mucous membranes to potentially infective materials. In addition, under universal precautions, it is recommended that all health care workers take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices.

Cáirde

Cáirde is a voluntary organisation which provides a range of services for people infected and affected by HIV and AIDS. These services include:

- Befriending
- Crisis Intervention
- Children and HIV
- Dementia
- Art Workshops
- Video Library
- Counselling.

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Statement of Purpose

GPI reports on experimental and standard treatments, especially those available now. We interview physicians, scientists, other health professionals, and persons with AIDS or HIV; we also collect information from meetings and conferences, medical journals, and computer databases around the world. Long-term survivors have usually tried many different treatments, and found combinations which work for them. GPI does not recommend particular therapies, but seeks to increase the options available.

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GPI WILL RETURN TO A MONTHLY FORMAT FROM THE SEPTEMBER ISSUE WHICH WILL BE AVAILABLE ON 20 TH. AUGUST 1997