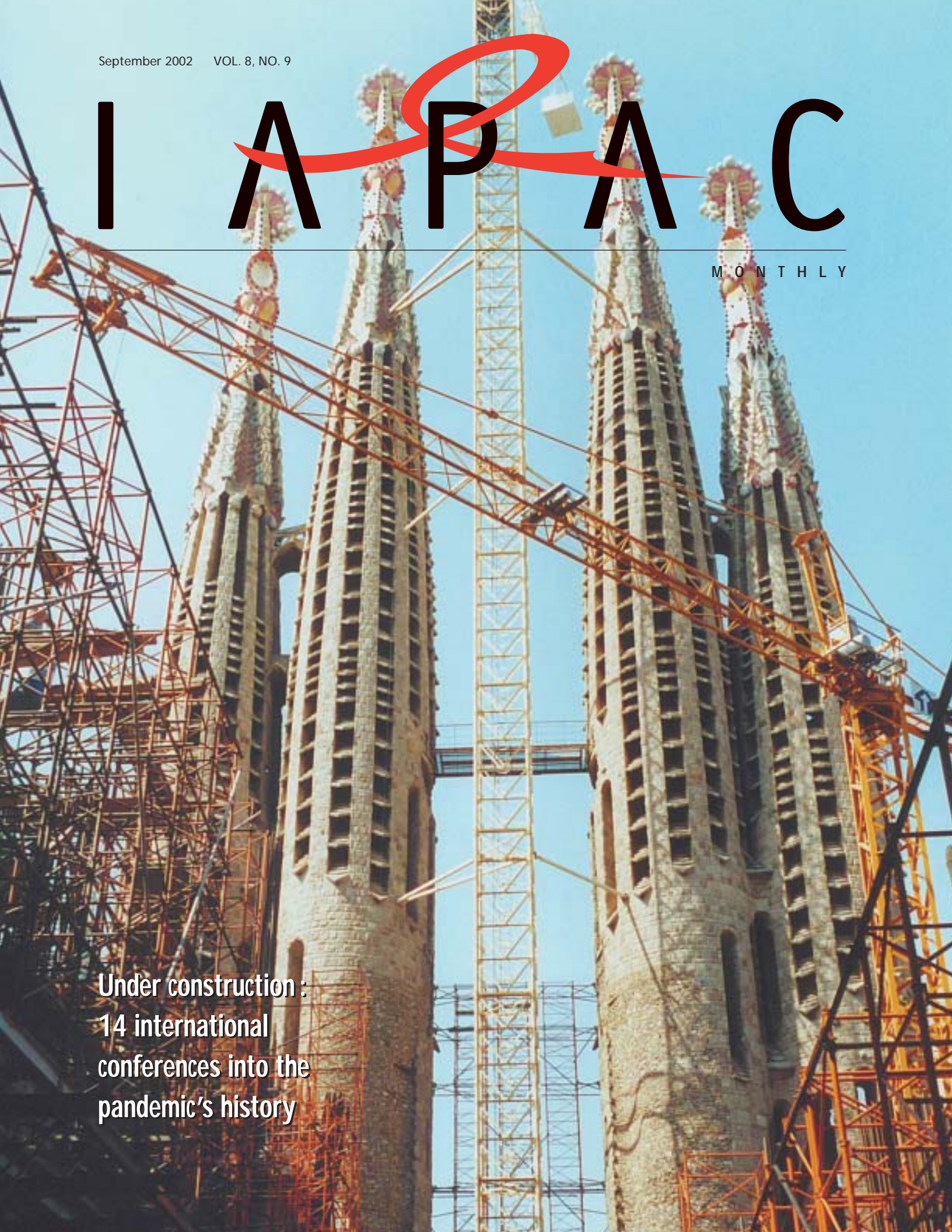


September 2002 VOL. 8, NO. 9

# I A P A C

M O N T H L Y

Under construction :  
14 international  
conferences into the  
pandemic's history



# 260

## Under construction: 14 international conferences into the pandemic's history

*David S. MacDougall*



More than 15,000 delegates gathered for the XIV International AIDS Conference held July 7-12, 2002, in Barcelona. What they found was that much like Antonio Gaudi's unfinished La Sagrada Família (a Catalan cathedral now more than 100 years under construction), the clinical and social landscape has changed in some ways by ongoing construction.

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## Let's not waste another minute...

*José M. Zuniga*

July 2002 marked the fourteenth international gathering of the HIV/AIDS community. After the first ever developing-country staging of this biennial event two years ago in Durban, South Africa, the world set its gaze upon Barcelona this year as the conference returned to the more affluent North. As such, 15,000-plus attendees gathered in the Catalonian capital to gauge what progress had been made in the meantime and to determine what the next two years of activity will hold in store for both those living with and affected by HIV/AIDS and the collective of researchers, clinicians, advocates, and policy-makers entrusted with the responsibility of redressing the AIDS pandemic.

It was anticipated in advance of the Barcelona conference that little of clinical novelty would be forthcoming throughout the week's clinical sessions. For the most part this prediction proved true. With the exception of intriguing data suggesting hope for enhanced options via a new class of drugs—HIV entry inhibitors—as well as clinical trial results further confirming a number of suspicions concerning preferred antiretroviral drug combinations and sequences, the greatest flurry at this conference again surrounded increased access to screening, counseling, and treatment for HIV. As in Durban two years prior, the global community of HIV care advocates insisted that priority must finally be given to ensuring that HIV-positive men, women and children in every country of the world have affordable access to life-preserving HIV treatment. This would come by way of both increased global spending for HIV prevention and care as well as either reduced prices for patented antiretrovirals or increased availability of generic drugs.



With yet another promise that an effective HIV vaccine will become available within the next five years—the same promise having been made two years ago—and the aforementioned lack of truly significant clinical news, it became clear by the end of the weeklong gathering in Barcelona that there is little of competing significance at this point in the struggle against HIV disease to warrant us further postponing highest prioritization of universal access to treatment. Given both the moral imperative inherent in the drive to provide care where it is most needed and the absence of groundbreaking clinical advances on the horizon, the International Association of Physicians in AIDS Care (IAPAC) continues to adamantly support the call for immediate increases in international funding and programs designed to augment access to treatment throughout the world.

The difference between access to care,

which distinguishes the respective lots faced by those living with HIV in the countries of the industrial North versus those in resource-poor countries, remains stark and unjust. As with so many other infuriating differences that arbitrarily befall us along the chain of humanity, it is typically the difference between life and death. Therefore, where science has yielded the possibility of saving life it is critical that we balance our quest for further scientific advance with universal application of what is known and available to us at present. It is incumbent upon us not only to ensure that antiretroviral therapy be made affordable and available in those settings hardest hit by the AIDS pandemic, but that physicians and allied health professionals who work tirelessly to care for HIV-infected patients be provided with the appropriate training and physical environment to effectively treat their patients.

The XIV International AIDS Conference was by no means a watershed event. Its greatest outcome should in the end be the signaling of a long overdue opportunity for us to calibrate our activities and to finally address the dire reality faced by the vast majority of this world's inhabitants: that just beyond a given border or across a given sea the world's few are currently taking advantage of clinical infrastructure and drugs that mean not merely a more plentiful life, but life itself. In order that we may give hope that life is truly meaningful across all demographic categories, it is crucial that we ensure fulfillment of commitments to such international initiatives as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund).

The potential impact of our quick and deliberate commitment to increase access to care throughout the world would be difficult to over-estimate. Not only will our success in this respect be measured by the sheer number of lives that stand to be

salvaged, but also by the extent to which these lives restore vital components to healthy families and communities and thereby translate into productive local and national economies. Lest we take swift action to set in further motion this positive chain of reactions, the potential impact of future drugs and vaccines will be completely lost on populations by then too far decimated to truly derive benefit from them.

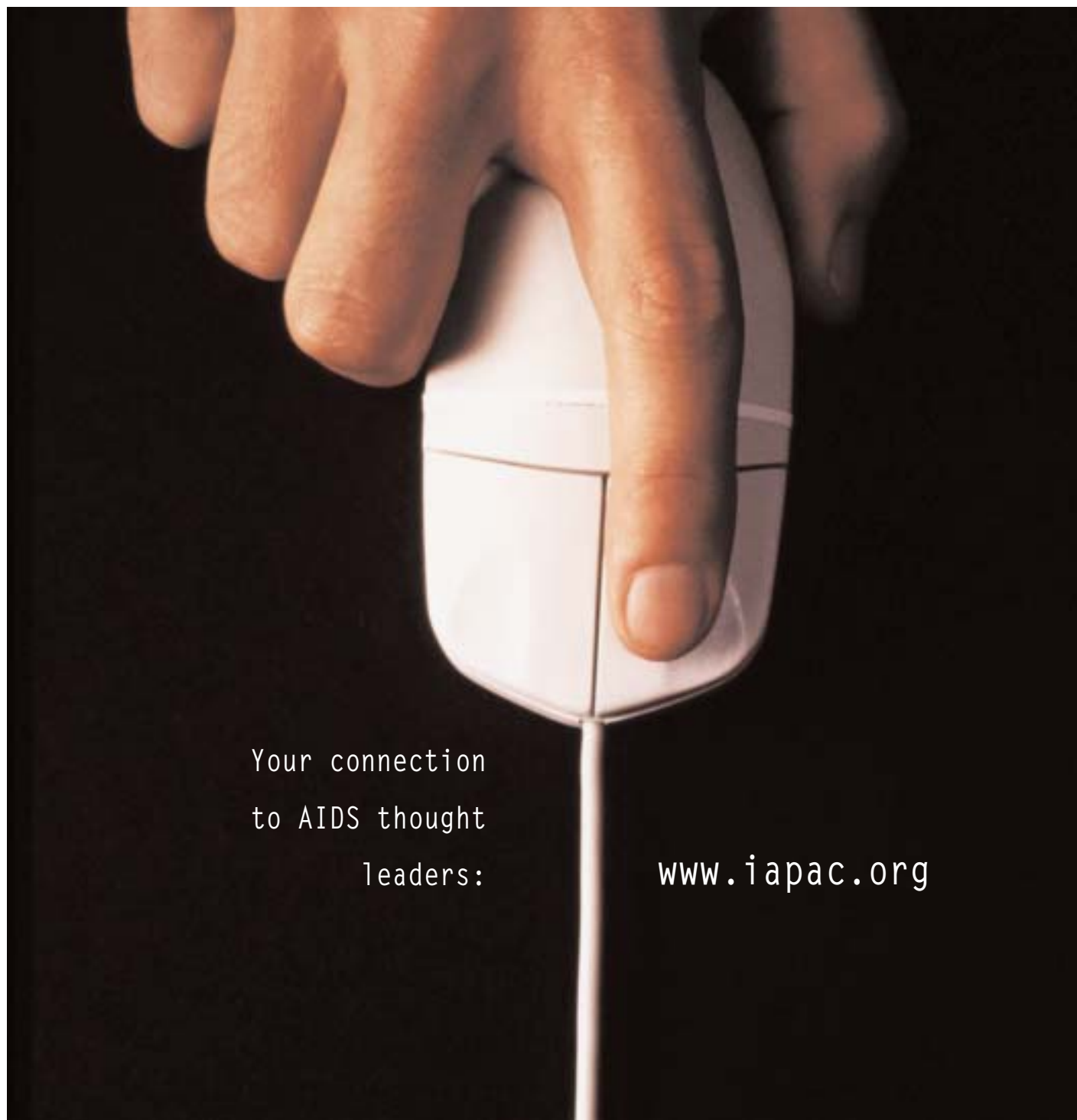
It is critical that we not let one more minute be wasted without our firm com-

mitment to working toward equal access to care and treatment. For our part, IAPAC will remain vigilant in its effort to provide HIV-treating health professionals with the tools and environment necessary to have a lasting influence on the lives of their patients the world over, facilitating the introduction and scale-up of antiretroviral therapy. Toward this end we will continue to harness the collective insight and energies of our global membership to the benefit of partner institutions, governments, and

policy-makers working to ensure care for the world's citizens.

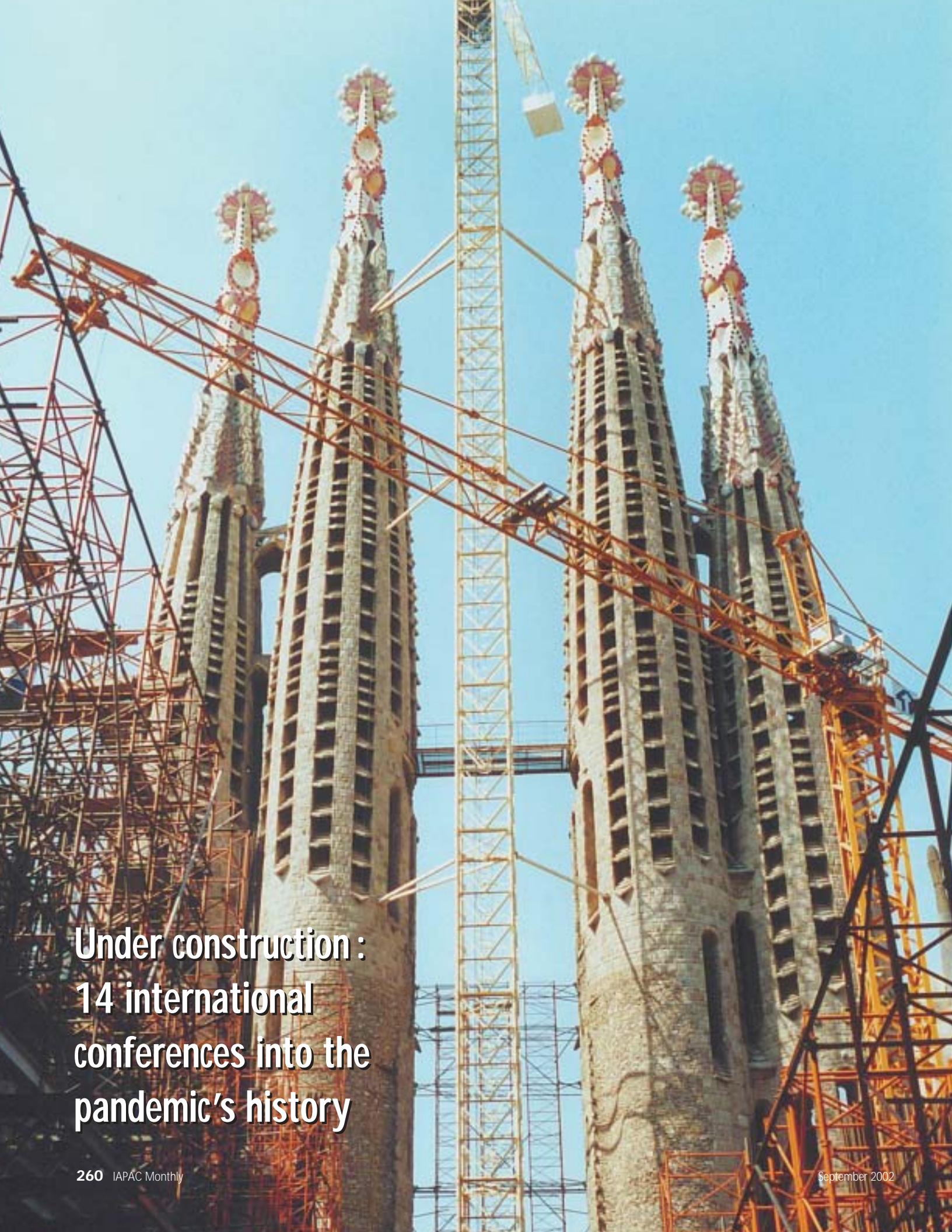
I look forward to the opportunity for IAPAC to assist and/or lead where and whenever possible, and welcome an enhanced role for our global membership in this collective struggle. ■

*José M. Zuniga is President of the International Association of Physicians in AIDS Care and Editor-in-Chief of the IAPAC Monthly.*



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**Under construction :  
14 international  
conferences into the  
pandemic's history**

David S. MacDougall

If the XIII International AIDS Conference in Durban, South Africa, served to focus the world's attention on the devastating impact of HIV disease on the fragile socioeconomic fabric of sub-Saharan Africa and other struggling regions disproportionately affected by the AIDS pandemic, the XIV International AIDS Conference in Barcelona was the place to take measure of the world's actions, or lack thereof, over the span of two years. Delegates attending the XIV International AIDS Conference held July 7-12, 2002, arrived with hopeful anticipation of word that the stark realizations of Durban had provided a foundation for some signs of progress. What they found was a landscape changed in some ways by ongoing construction. They also found a healthy dose of encouraging news around clinical issues expected to be featured at a biennial international conclave of researchers and clinicians—issues such as “when to start?” and “when to interrupt?”



### Under construction: Addressing global HIV/AIDS

In the two years since Durban, signs indicate that the world has awakened to the realization that a meaningful response to the AIDS pandemic calls for much more than a massive scale-up of efforts and massive infusions of funding. One of the most significant events that helped shape this realization was the landmark United Nations General Assembly Special Session on HIV/AIDS (UNGASS) held in

**Editor's Note:** This article is Part I of a two-part series featuring clinical coverage and analysis of the XIV International AIDS Conference. In Part I, the author focuses on access to HIV care in resource-limited settings, the debate around initiation of antiretroviral therapy, continued follow-up on structured treatment interruption (STI) in HIV clinical management, and HIV/tuberculosis coinfection. Part II, which will be published in the October 2002 issue of the IAPAC Monthly, focuses on clinical trial updates, new additions to the antiretroviral armamentarium, salvage therapy, opportunistic infections, and the prevention of vertical HIV transmission.

June 2001. The UNGASS was a welcome indication that world leaders were at last coming to terms with the fact that real progress against HIV/AIDS would require the recruitment of businesses, finance ministries, international development agencies, and other sectors into a battle that had been left previously to public health agencies and affected communities. The UNGASS concluded with the establishment of a series of ambitious goals, including a 25 percent reduction in the global prevalence of HIV in young men and women by 2010, and the commitment of US\$10 billion to low- and middle-income countries for HIV/AIDS prevention and treatment efforts by 2005. [The difference between this committed amount and that currently spent annually on HIV/AIDS interventions in developing countries—about US\$3 billion, according to UNAIDS—remains a source of frustration and undoubtedly provided the *raison d'être* for the hundreds of ubiquitous orange and black “WHERE IS THE \$10 BILLION?” stickers posted by HIV/AIDS activists throughout the Barcelona conference venue.]

Another sign of a global awakening was the June 2001 establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) by G-8 leaders successfully lobbied by United Nations Secretary-General Kofi Annan. The Global Fund is a unique public-private partnership that includes donor and recipient country governments, multilateral agencies, private sector organizations, and other groups with the mutual goal of attracting, managing, and distributing resources to combat the three largely endemic diseases. The first round of grants for the prevention and treatment of HIV/AIDS, tuberculosis, and malaria in developing countries was announced in April 2002 with the awarding of US\$1.6 billion over five years, with funding after the second year based on performance during the first two years.

At a press conference in Barcelona, Richard Feachem, the Global Fund's incoming Executive Director, announced that the initial multiyear grants would result in a six-fold increase in the number of HIV-infected African men, women, and children receiving antiretroviral therapy over the next five years. According to

Feachem, the funding would expand the availability of antiretroviral therapy to more than 220,000 people living in Africa, Latin America, the Caribbean, and other regions, as well as provide support for anti-malarial and anti-tuberculosis initiatives.

“Never before has the world been so poised to dramatically prevent sickness and death from AIDS, [tuberculosis], and malaria,” Feachem said to a crowd of reporters and activists who wished to hear how the Global Fund intended to goad developed world economies to increase their contributions. Unfortunately, no plan of action was forthcoming from the Global Fund or any developed world country representatives at the conference, including US Secretary of Health and Human Services Tommy Thompson—although one was promised no later than year's end.

The World Health Organization (WHO) took its share of the spotlight in Barcelona with the announcement of the launch of Scaling Up Antiretroviral Therapy in Resource-Limited Settings: Guidelines for a Public Health Approach. Developed by a committee of international researchers, clinicians, public health specialists, and patient advocates, the guidelines are intended to reduce technical barriers to antiretroviral therapy through the use of standardized and simplified antiretroviral regimens designed for ease of administration and reduced toxicity. [Editor's Note: See the June 2002 issue of the *IAPAC Monthly* for an Executive Summary of the WHO guidelines.]

A vital component of the WHO strategy is the inclusion for the first time of antiretroviral medications on the WHO Essential Medicines List, which represents a compendium of minimum medicines necessary for the treatment of priority conditions in basic healthcare systems. The list had previously included nevirapine (NVP) and zidovudine (ZDV) exclusively for the prevention of mother-to-child transmission (MTCT) of HIV. Both drugs are now included in the revised list for the treatment of HIV infection in adults and children, along with abacavir (ABC), didanosine (ddI), efavirenz (EFV), indinavir (IDV), lamivudine (3TC), lopinavir (LPV), nelfinavir (NFV), low-dose ritonavir (RTV), saquinavir (SQV), and stavudine (d4T). “The long-sought inclusion of anti-

retroviral [drugs] in the WHO's Essential Medicines List will encourage governments in hard-hit countries to further expand the distribution of these viral drugs to those who need them," explained UNAIDS Executive Director Peter Piot.

Only time will tell if these and other forward-thinking initiatives, such as the International Association of Physicians in AIDS Care (IAPAC) Global AIDS Learning & Evaluation Network (GALEN), will have the desired effects of reducing HIV transmission and improving the treatment of millions of HIV-infected patients worldwide. A major impediment remains that antiretroviral drugs continue to be unaffordable for the vast majority of people living with HIV/AIDS. Data compiled by UNAIDS indicate that of 40 million HIV-infected people worldwide, only about 730,000—less than 2 percent—are receiving antiretroviral therapy. Of those, more than two-thirds live in developed countries. And, only about 0.1 percent of the 28 million HIV-infected people living in sub-Saharan Africa received antiretroviral therapy in 2001.

These stark statistics reinforced the message communicated in Durban two years earlier: the spread of HIV disease is fueled not only by the biological characteristics of HIV and the host immune response but also by a multitude of sociologic factors including poverty, ignorance, sexual violence, discrimination against high risk groups, and failure to integrate HIV/AIDS treatment and prevention into broader development efforts. The message of Barcelona with regard to global HIV/AIDS was: let's do more than listen to statistics and launch pilot initiatives.



### **Under construction: Access to treatment**

Several reports presented at the conference described the establishment and performance of initiatives designed to increase access to antiretroviral therapy among HIV-infected patients living in developing world regions. One such program is the Senegalese Initiative on Access to Antiretroviral Therapy, a government-subsidized program launched in August 1998 with the establishment of a pilot program, to be followed by performance evaluations and scale-up for nationwide implementation.

A total of 470 patients were enrolled in the pilot phase of the program, reported Salif Sow and colleagues from the Fann

Hospital in Dakar, Senegal. The majority of patients who entered the program were treatment-naïve and severely immunosuppressed. The mean HIV RNA and CD4 count at enrollment was 81,650 copies/ml and 105 cells/mm<sup>3</sup>, respectively. Standard treatment consisted of triple antiretroviral therapy, and follow-up monitoring included viral load and CD4 cell counts after the first month of antiretroviral therapy and every six months thereafter, as well as serum biochemical parameters measured every four months.

During the three-year conduct of the pilot, 86 percent of the enrolled patients reported taking at least 80 percent of their prescribed medications. One month after the initiation of antiretroviral treatment, HIV RNA <200 copies/ml was achieved in 84 percent of patients. The mean CD4 count increased to 230 cells/mm<sup>3</sup> at 18 months and 280 cells/mm<sup>3</sup> at 36 months. Polyneuritis and anemia were the most common pathological events observed. According to Sow, the results of this pilot demonstrate the feasibility of subsidized programs for increasing access to antiretroviral therapy in resource-limited settings. Challenges to the nationwide implementation of such programs are multiple and coincide with resource availability and the capabilities of the region's health infrastructure.

Increasing access to antiretroviral therapy is a primary objective of many government and private sector HIV/AIDS programs in developing regions, but few studies have examined the impact of increased access to antiretroviral therapy on risk behaviors among HIV-positive persons. Factors influencing sexual behaviors in 711 persons seeking antiretroviral therapy in the context of a drug access initiative in Côte d'Ivoire were described by Jean-Paul Moatti and colleagues at the Observatoire Regional de la Santé in Marseille, France. Overall, 44 percent of the study participants reported at least one episode of unprotected sex. In multivariate analysis, sexual abstinence was associated with female gender, age greater than 35 years, being illiterate or unemployed, not having a primary sexual partner, and being unaware of the availability of highly active antiretroviral therapy (HAART). Unprotected sex was associated with not receiving HAART, knowledge of HIV serostatus for less than nine months, ignorance of HIV serostatus of the main partner, and high depression scores. Patients with access to HAART were sig-

nificantly less likely than those without such access to practice high-risk sexual behaviors (37 percent versus 50 percent;  $p=0.02$ ). The findings contradict the belief that greater access to antiretroviral therapy may be associated with increased likelihood of high-risk sexual practices and HIV transmission among persons in resource-limited settings.

HIV-infected patients receiving antiretroviral therapy are more likely than those not receiving therapy to practice safe sexual behaviors, reported Yves Souteyrand and colleagues at the Agence Nationale des Recherches sur le SIDA (ANRS) in Paris. The finding was based on a study of 800 HIV-infected patients in Chile who were interviewed and completed questionnaires on sexual and other behaviors. Patients on antiretroviral therapy were sexually active less frequently than were those not receiving antiretroviral therapy (66 percent versus 77 percent;  $p=0.002$ ). The likelihood of having sexual activity more than once a week was lower in persons receiving antiretroviral therapy than in those not receiving therapy (43 percent versus 53 percent;  $p=0.03$ ), and the rate of consistent condom use was higher in treated than in untreated persons (92 percent versus 69 percent;  $p=0.01$ ). Among those receiving therapy, the proportion reporting a reduction in the frequency of multi-partner sexual relationships since the initiation of therapy was greater than the proportion reporting an increase. The researchers concluded that increased access to antiretroviral therapy is not associated with increased rate of high-risk sexual behaviors.

Many HIV-positive persons in developed regions remain untreated despite universal access to medical care and antiretroviral therapy, noted Evan Wood of the University of British Columbia in Vancouver, Canada. In a study of 1,036 patients who died of HIV-related causes in British Columbia between January 1995 and December 2000, 422 persons (or 41 percent) never received treatment with antiretrovirals. Factors associated with not receiving antiretroviral treatment included female gender, non-white ethnicity, residing in a neighborhood in which injection drug use is common, and residing in a low-income neighborhood. The likelihood of having access to antiretroviral therapy prior to death decreased overall during the six-year study period. Among those with access to therapy prior to death, only 45

percent received 75 percent or more of their prescribed medications.

Factors other than cost may limit access to antiretroviral treatment in resource-limited settings. According to Alison Balaba and colleagues at the Joint Clinical Research Centre (JCRC) in Kampala, Uganda, stigmatization is a major obstacle to HIV/AIDS treatment in Uganda and other underdeveloped regions. In an observational study of 60 HIV-positive adults receiving treatment at the JCRC, 13 patients (26 percent) used false names, nine patients (18 percent) always sent another person to pick up their antiretroviral drugs, seven patients (14 percent) preferred to use a segregated facility when receiving their HIV counseling and treatment, and four patients (8 percent) pretended they were seeking help for HIV-positive relatives. The researchers concluded that stigmatization may result in unnecessary delay or avoidance of HIV/AIDS treatment, thus requiring increased efforts to ensure confidentiality in HIV/AIDS treatment.

Victoria Orekhovskiy and colleagues of the Canada AIDS Russia Project in Toronto reported that stigmatization also results in suboptimal treatment and increased risk of transmission of HIV and other blood-borne pathogens among intravenous drug users (IDUs). In a study of 69 IDUs in Russia who completed questionnaires and participated in discussions that explored access to HIV/AIDS services and other healthcare issues, 33 participants (48 percent) were HIV-positive and 39 (57 percent) were infected with hepatitis C virus (HCV). The study participants reported experiencing pervasive stigmatization in accessing healthcare services and medical care, including treatment that was delayed, inadequate, or refused. Some care providers displayed open contempt, the participants claimed. Contempt took the form of verbal expressions of negative perceptions, refusal to provide pain medications, breaching of confidentiality, and demanding payments for free services. The stigmatization of IDUs in Russia and elsewhere prevents many HIV-positive IDUs from seeking testing and medical treatment, the researchers said, and contributes to the spread of infectious diseases among both IDUs and non-IDUs.



**Under construction:  
When to start?**

The XIV International AIDS Conference

drew attention to the realization that recommendations for initiating antiretroviral treatment based primarily on immunologic status and other patient-related factors may be inadequate in settings in which the costs of such treatment are prohibitive and access to monitoring and other medical care is limited.

The need to develop setting-specific guidelines for the initiation of antiretroviral treatment was highlighted in a study by Sujata Lalla-Reddy and colleagues from the Unison Medicare and Research Centre in Mumbai, India. In this study, 44 patients attending a comprehensive AIDS treatment clinic in rural India received HIV RNA testing at baseline and were followed for five years. Overall, 28 patients (64 percent) were eligible for the initiation of antiretroviral treatment at study-entry based on current guidelines developed by the US Centers for Disease Control and Prevention (CDC). During follow-up, 16 patients died. The mortality rate was similar in patients with HIV RNA <50,000 copies/ml at baseline and in those with HIV RNA between 100,000 and 500,000 copies/ml at baseline. Initiating antiretroviral treatment in all patients eligible at baseline would have exposed a large proportion of patients to unnecessary expense and toxicity, explained Lalla-Reddy. The findings may have implications for the accessibility of antiretroviral treatment in settings in which the availability of such treatment and follow-up care is limited.

In developed regions, debate centers on the optimal HIV RNA level and/or CD4 cell count at which antiretroviral therapy should be initiated, and the relative contributions of these parameters to prognosis in treatment-naïve patients. According to Jonathan Kaplan and his colleagues at the CDC, antiretroviral therapy should be initiated in most patients at CD4 counts >200 cells/mm<sup>3</sup> and in those with high baseline load at CD4 counts <350 cells/mm<sup>3</sup>. The recommendations were based on a study of the risks of AIDS-related opportunistic infections or death in 2,070 patients enrolled in the CDC's Adult and Adolescent HIV Spectrum of Disease Project, a medical record review surveillance project conducted in 11 US cities. Patients were included if antiretroviral-naïve and starting HAART with no history of opportunistic infections.

During a median follow-up of 18 months, 175 patients progressed to AIDS or death. The hazard ratios (HR) for AIDS

or death were 5.4, 2.5, and 1.7 for patients with baseline CD4 counts of 0-49, 50-199, and 200-349 cells/mm<sup>3</sup>, respectively, as compared with patients with CD4 counts >500 cells/mm<sup>3</sup>. HIV RNA >30,000 copies/ml was independently predictive of clinical progression (HR = 1.8). In patients with CD4 counts between 200 and 349 cells/mm<sup>3</sup>, the risk of disease progression was significantly elevated in those with HIV RNA >30,000 copies/ml but not in those with lower HIV RNA.

Patients with CD4 counts <350 cells/mm<sup>3</sup> at the start of HAART experience significantly less durable virologic responses during treatment than those who start HAART with higher CD4 cell counts, reported John Brooks and colleagues of the CDC. The relationship between CD4 cell count at initiation of HAART and virologic response was determined in 470 patients who were followed for a median of 176 days. A total of 31 patients (7 percent) experienced virologic failure, defined as  $\geq 0.5$  log increase in the HIV RNA nadir after HAART initiation followed by a second equally or more highly elevated HIV RNA level or a switch in antiretroviral regimen. The estimated probability of virologic failure at six months was 10.7 percent, 5.1 percent, and 0.3 percent in patients who initiated HAART with CD4 counts of 0-199, 200-349, and  $\geq 350$  cells/mm<sup>3</sup>, respectively. In multivariate analysis, virologic failure occurred at least 50 percent earlier in patients with CD4 counts of 0-199 and 200-349 cells/mm<sup>3</sup> at initiation of HAART as compared with those with CD4 counts  $\geq 350$  cells/mm<sup>3</sup> when starting HAART. The effect of the CD4 count at initiation of HAART on the time to virologic failure was independent of the effect of the maximal decline in HIV RNA during treatment.

Treatment adherence was shown to mitigate at least some of the effects of the CD4 cell count at HAART initiation on the risk of HIV disease progression in a study reported by Karen Peterson and colleagues from the Denver Public Health Service in Colorado. The CD4 cell count at HAART initiation as well as treatment adherence were determined in 1,211 patients with HIV infection who were followed for 3,583 patient-years. The rate of HIV disease progression events was significantly lower in patients with adherence greater than or equal to 90 percent than in those with lower levels of adherence (7.1

percent versus 9.0 percent;  $p = 0.04$ ). The event rate was similar in patients with CD4 counts of 200-350 cells/mm<sup>3</sup> at HAART initiation and greater than 90 percent adherence, and in those with CD4 counts of 50-199 cells/mm<sup>3</sup> at HAART initiation and greater than or equal to 90 percent adherence (6.6 percent versus 6.3 percent). The CD4 cell count at HAART initiation did not influence the HIV disease progression event rate in patients with adherence greater than or equal to 90 percent and CD4 counts  $\geq 200$  cells/mm<sup>3</sup> at HAART initiation. The findings suggest that the probability of patient adherence may be an important factor to consider when deciding when to initiate HAART.



### **Under construction: When to interrupt?**

Structured treatment interruption (STI) has emerged as a potential means of preserving drug sensitivity and enhancing the quality of life in patients with chronic HIV infection. Dozens of papers presented at the XIV International AIDS Conference examined various aspects of STI, including CD4 cell dynamics during STI, the benefits of STI in patients with multiple therapeutic failures, and the physical and psychological impacts of STI. While optimism for any possible immunomodulatory benefits of STI appears to be waning, enthusiasm remains for the role of STI in mitigating the toxicities of long-term HAART and reducing anti-retroviral treatment costs. The long-term consequences of STI are still unknown, and questions remain regarding the optimal timing and duration of STI and the identification of suitable candidates.

STI for six months was associated with significant improvements in blood lipid profiles without sustained adverse immunologic or virologic consequences in a study reported by Canio Martinelli and colleagues of the Careggi Hospital in Florence, Italy. In this study, 14 patients on HAART who had undetectable HIV RNA discontinued antiretroviral treatment and received periodic evaluation of immunologic, virologic, and metabolic variables. The mean CD4 count at the time of STI was 890 cells/mm<sup>3</sup>, and the mean serum triglyceride value was 471 mg/dl. After two months, the mean HIV RNA and CD4 count was 106,000 copies/ml and 528 cells/mm<sup>3</sup>, respectively. At six months, 10 patients with immunologic and virologic deterioration (mean HIV

RNA and CD4 count, 168,000 copies/ml and 360 cells/mm<sup>3</sup>, respectively) restarted HAART and experienced rapid immunologic and virologic improvement after two months (mean HIV RNA and CD4 count, 435 copies/ml and 634 cells/mm<sup>3</sup>, respectively). At six months the mean serum triglyceride value was 208 mg/dl, and lipodystrophy syndrome was reportedly improved in eight of 10 patients.

The mean duration of STI was extended to 69 weeks in a study reported by Joel Gallant and colleagues from the Johns Hopkins University School of Medicine in Baltimore. In this study, 75 patients with relatively higher CD4 counts and lower HIV RNA levels at initiation of HAART (mean: 426 cells/mm<sup>3</sup> and 27,000 copies/ml, respectively) underwent STI with the intention to restart treatment based on immunologic and virologic changes during STI. The mean CD4 count and HIV RNA at the start of STI was 677 cells/mm<sup>3</sup> and 263 copies/ml, respectively. Overall, 23 patients (31 percent) resumed HAART after a mean of 30 weeks. The mean CD4 count and HIV RNA at the time of restarting HAART was 258 cells/mm<sup>3</sup> and 160,500 copies/ml, respectively. The remaining 52 patients (69 percent) remained on STI for a mean of 69 weeks. The mean CD4 count and HIV RNA in patients who remained on STI was 508 cells/mm<sup>3</sup> and 22,151 copies/ml, respectively. By multivariate analysis, restarting HAART was predicted by a lower CD4 cell count at initiation of HAART. An increased probability of maintaining STI was predicted by a lower HIV RNA level and higher CD4 cell count during STI. The researchers noted that only 33 percent of those patients who maintained STI were eligible for initiation of HAART based on the current US Department of Health and Human Services "Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents" (February 4, 2002). This suggests that the best candidates for STI may be those who are least likely to be treated.

Christine Katlama and colleagues at the Hôpital Pitie-Salpetriere in Paris described the effects of STI on the efficacy of salvage therapy in HIV-infected patients with multiple therapeutic failures and advanced immunosuppression. In this study, 70 patients with a history of failure with at least two nucleoside reverse transcriptase inhibitors (NRTIs), one non-nucleoside reverse transcriptase inhibitor

(NNRTI), and two protease inhibitors (PIs) were randomized to receive salvage therapy immediately or after eight weeks of STI. The median HIV RNA and CD4 count at the time of randomization was 5.3 log<sub>10</sub> copies/ml and 27 cells/mm<sup>3</sup>, respectively. The salvage regimen consisted of three or four NRTIs and one NNRTI with or without hydroxyurea, RTV, amprenavir (APV), LPV, IDV, SQV, and/or NFV. During STI, the median increase in HIV RNA was +0.16 log<sub>10</sub> copies/ml and the median decrease in CD4 count was -10 cells/mm<sup>3</sup>. At 20 weeks after randomization (week 12 and 20 of salvage therapy in the STI and immediate treatment groups, respectively), the median decrease in HIV RNA from baseline was -1.91 and -0.37 log<sub>10</sub> copies/ml in the STI and immediate treatment groups, respectively. At week 20, an HIV RNA decrease  $>1$  log<sub>10</sub> copies/ml from baseline was observed in 62 percent of those patients in the STI group and 26 percent of those in the immediate treatment group ( $p = 0.007$ ). The proportion of patients with HIV RNA  $<400$  copies/ml at week 20 was 38 percent and 15 percent in the STI and immediate treatment groups, respectively ( $p = 0.053$ ). The researchers concluded that eight weeks of STI might enhance the efficacy of multi-drug salvage treatment in patients with extensive viral resistance and limited therapeutic options.

STI in patients receiving successful PI-based HAART results in a biphasic decline in CD4 cell counts which is inverse to the increase achieved during HAART, reported Goran Bratt and colleagues at the Karolinska Institute in Stockholm. The finding emerged in a study of 25 patients receiving successful PI-based HAART for a mean of 37 months who underwent STI. The mean monthly increase in CD4 count during PI-based HAART was +10 cells/mm<sup>3</sup>. The mean HIV RNA and CD4 count at the time of STI was  $<50$  copies/ml and 407 cells/mm<sup>3</sup>, respectively. The mean duration of STI was 11 months. During the first month of STI, the mean monthly decrease in CD4 count was -212 cells/mm<sup>3</sup>. During the remainder of STI, the mean monthly decrease in CD4 count was -16 cells/mm<sup>3</sup>. The mean decrease in CD4 cell count during STI positively correlated with the mean increase in CD4 cell count observed during PI-based HAART and the mean CD4 cell count at the start of STI. Blood

lipid levels normalized during STI, the researchers noted, and the amount of visceral adipose tissue tended to decrease.

Michelle LeBraz and colleagues from the Hôpital Cantonal in Geneva described the physical and psychological impacts of STI. A group of 89 patients received STI for two weeks and were retreated for eight weeks during four cycles, after which STI was continued uninterrupted for at least 12 weeks. All patients completed questionnaires regarding toxicities, compliance, and difficulties with taking medications at the initiation of antiretroviral treatment and when treatment was restarted after interruption. Gastrointestinal complaints, the most commonly reported side effects, were rated significantly less severe at antiretroviral treatment restart than at treatment initiation. Most patients (83 percent) reported that antiretroviral treatment was easier or as easy to take after restart than after treatment initiation. During the first STI, 80 percent of the patients reported no apprehension over not receiving antiretroviral treatment. General psychological and physical distress was reported by 23 percent and 19 percent of the patients, respectively, at study entry, and by 8 percent and 6 percent, respectively, during STI. Most patients (72 percent) reported a willingness to participate in additional trials of STI and viewed their overall experience as positive.



### **Under construction: Tuberculosis and HIV**

Infection with *Mycobacterium tuberculosis* (TB) is the leading cause of death among HIV-positive persons worldwide. The WHO estimates that about one-third of the world's population is currently infected with TB, and that nearly 1 billion people will be newly infected by 2020. The combination of HIV and TB is particularly lethal. HIV increases the risk of active TB in patients with latent infection, and TB-associated immune activation has been linked with increased risk of HIV disease progression. In sub-Saharan Africa, TB is the first manifestation of AIDS in about 50 percent of people living with HIV infection. Until recently, TB and HIV programs throughout the world have largely pursued separate courses. Growing recognition of the inextricable links between the AIDS pandemic and TB epidemics has led to calls for increased collaboration between TB and HIV programs as part of

a global strategy for reducing transmission, morbidity, and mortality of TB and HIV in high prevalence populations.

In Barcelona, Dermot Maher of the WHO's TB Programme explained that an effective global response to the epidemic of HIV/TB coinfection would require exploitation of the synergies between TB and HIV programs worldwide, as well as the delivery of collaborative HIV/TB interventions. Challenges to the integration of such programs include poor health-seeking behaviors in TB- and HIV-infected persons and the absence of adequate referral systems between TB and HIV programs. Strategies for addressing these challenges include the coordination of efforts for the provision of home-based HIV/AIDS treatment and directly observed treatment-short course (DOTS) for TB and the strengthening of national and international programs designed to provide general medical care in high HIV prevalence regions.

Recent collaborative HIV/TB efforts in Chiang Rai, the northernmost province of Thailand, have led to dramatic improvements in the delivery of TB treatment and prevention services in this region and may serve as a model for the development of integrated HIV/TB programs in similar settings. According to Somsak Supawitkul and colleagues from the Chiang Rai Provincial Health Office, the regional prevalence of TB increased 3.5-fold during the 1990s, and the rate of TB coinfection in persons with HIV infection increased from 5.3 percent in 1990 to 43 percent in 1999.

In response to the explosive rate of growth of both TB and HIV, regional health officials implemented a program of integrated HIV/TB services incorporating combined HIV/TB counseling services, peer support activities to increase anti-tuberculosis and antiretroviral treatment adherence, DOT for TB cases and antiretroviral-treated persons, home-based continual care programs, active case finding and household contact screening for HIV/TB, and isoniazid preventive therapy for HIV-infected patients. In the five years since the program's start, the treatment default rate for patients with TB decreased from 24 percent to 5 percent, the noncompliance rate for isoniazid preventive therapy decreased from 57 percent to 17 percent, and the rate of multidrug-resistant TB decreased from 6.5 percent to 2.8 percent.

Judith Glynn and colleagues at the

London School of Hygiene and Tropical Medicine in the United Kingdom reported that the risk of TB increases two-fold within the first year of HIV infection. The unexpected finding emerged in a study of 23,875 South African gold miners who were screened for TB and HIV between 1991 and 1997. The incidence of TB in HIV-positive and HIV-negative participants was 2.90 and 0.80 cases per 100 person-years. Increased risk of TB was associated with HIV infection and older age. Study participants who were initially HIV-negative and seroconverted during follow-up showed a doubling in the incidence of TB during the first year of HIV infection with only a slight further increase in those with HIV infection for up to seven years. The findings suggest that the TB disease burden in HIV-positive persons may be less than that predicted by current mathematical models.

According to Enrico Girrardi and colleagues at the University of Perugia in Italy, the treatment of patients with HIV-associated TB in the era of HAART is frequently incomplete and unsuccessful. The conclusion was based on a study of 195 HIV-infected patients with active TB in whom TB treatment outcomes were available. The median CD4 count at the time of TB diagnosis was 122 cells/mm<sup>3</sup>. Of the 195 patients who received TB treatment, 34 (17 percent) completed a full course of treatment, 50 (26 percent) were cured, 20 (10 percent) discontinued treatment, and 28 (14 percent) died. The mortality rate was 17 percent in patients with CD4 counts <200 cells/mm<sup>3</sup>, 13 percent in those with CD4 counts between 200 and 500 cells/mm<sup>3</sup>, and 0 percent in those with CD4 counts >500 cells/mm<sup>3</sup>. The probability of a favorable outcome, defined as cure or completion of treatment, was lowest in IDUs and those who were unemployed. In multivariate analysis, the CD4 count was the only significant predictor of mortality. The observations support the establishment of targeted interventions for TB in IDUs and other socially disadvantaged groups. ■

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Stay tuned for next month's issue of the IAPAC Monthly, featuring Part II of our XIV International AIDS Conference clinical coverage and analysis!



## ABSTRACTS

### *Journal of the International Association of Physicians in AIDS Care*

#### **Therapeutic drug monitoring**

David Back et al.

Highly active antiretroviral therapy (HAART) can suppress viral replication and substantially prolong patient life. It can also fail for a number of reasons, including poor adherence, insufficient drug potency, emergence of resistance, cellular factors, and pharmacokinetic factors. Although many antiretroviral drugs are now available, a limited number of combinations have been proven effective for individual patients. With sequential treatment failures, the durability of virologic response tends to decrease with subsequent treatment regimens until the patient is left with few or no therapeutic options. There is evidence that many treatment-naïve patients will switch from their initial regimen within one year. It is imperative that we adopt strategies that will optimize the use of available therapies, so as to achieve long-term viral suppression. Certain patient groups are clearly at increased risk for unpredictable and potentially damaging pharmacokinetic profiles, and could benefit from therapeutic drug monitoring. This includes patients with liver or renal damage, pediatric and pregnant patients, and patients with complex drug interactions. Much remains to be learned, and there are a number of challenges facing the introduction of therapeutic drug monitoring into clinical practice. The authors recommend that if clinicians can benefit some patients by ensuring efficacy or limiting toxicity simply by taking a couple of extra blood samples, the therapeutic drug monitoring approach should be vigorously standardized and validated.

*JAIPAC 2002;1:84-85*

### **AIDS**

#### **Durability and predictors of success of highly active antiretroviral therapy for ambulatory HIV-infected patients**

Frank Palella Jr. et al.

Researchers endeavored to evaluate the durability and correlates of the effectiveness of highly active antiretroviral therapy (HAART) in terms of AIDS-related mortality and morbidity, HIV viremia, and CD4 cell count. The setting for this research was the HIV Outpatient Study (HOPS), a prospective observational cohort from eight clinics in the United States that has been running since 1994. Mortality and opportunistic infection (OI) rates were calculated for 1,769 HOPS patients with CD4 cell count ever  $<100 \times 10^6/l$ . Data from 1,022 HAART recipients with CD4 cell count ever  $<500 \times 10^6/l$  were analyzed. The main outcome measures were mortality and AIDS-related OI rates. Treatment success was defined as a reduction in plasma HIV RNA copies/ml of  $1.0 \log_{10}$  or more, or to an undetectable level,

with a stable or rising CD4 cell count. Durable success was a successful response lasting at least 12 consecutive months. The study outcome was that HAART use remained high and mortality and OIs low. Patients received a mean of 1.8 HAART regimens. Median time on first HAART ( $n=1,022$ ) was 11.8 months; second HAART ( $n=424$ ) was 7.4 months; and third HAART ( $n=213$ ) was 7.2 months. Treatment success was most likely for pre-HAART treatment-naïve patients; durably successful first HAART most often contained one protease inhibitor, particularly indinavir or nelfinavir ( $p=0.006$ , adjusted for prior antiretroviral therapy). Durable success was most likely with first (49 percent) than with second (29.6 percent,  $p=0.013$ ) or third or more HAART regimens (14.9 percent,  $p<0.0001$ ). Time to success with first HAART was shorter for durable than non-durable responders (3.6 versus 5.3 months, respectively; unadjusted  $p=0.002$ ). The researcher's conclusion was the durable response to HAART was associated with being pre-HAART therapy-naïve, prompt response to HAART, and single protease inhibitor-based initial HAART (indinavir or nelfinavir). Sequential HAART regimens were progressively shorter duration, demonstrated less viral suppression and CD4 cell count benefit, yet low morbidity and mortality rates were sustained.

*AIDS 2002;16:1617-1626*

#### **Pharmacotherapy**

#### **Itraconazole and fluconazole and certain rare, serious adverse events**

Brian Bradbury and Susan Jick

Researchers conducted a population-based follow-up study in the United Kingdom to determine rates of drug-induced, rare, serious adverse events affecting the liver, kidneys, skin, or blood, occurring within 45 days of completing a prescription or refill for itraconazole or fluconazole. A total of 54,803 users of either fluconazole or itraconazole participated in the study. Four patients were identified with illnesses for which a drug-induced etiology could not be ruled out; one with an elevated liver function test while taking itraconazole, one with thrombocytopenia, one with neutropenia, and one with an abnormal liver function test just after receiving fluconazole. For itraconazole the rate was 3.2/100,000 prescriptions (95 percent confidence interval [CI] 0.6-17.9) for serious, adverse liver events; for fluconazole 2.8/100,000 prescriptions (95 percent CI 0.8-10.3) for serious, adverse blood events and 1.4/100,000 prescriptions (95 percent CI 0.25-8.2) for serious, adverse liver events. The researchers concluded that neither itraconazole nor fluconazole commonly cause rare, serious adverse events affecting the liver, kidneys, skin, or blood.

*Pharmacotherapy 2002;22:697-700*

### **Clinical Infectious Diseases**

#### **Does patient sex affect human immunodeficiency virus levels?**

M Gandhi M et al.

The researchers undertook a critical epidemiological review of the available evidence concerning whether women have lower levels of human immunodeficiency virus (HIV) RNA than do men at similar stages of HIV infection. The 13 studies included in this analysis reported viral load measurements in HIV-infected men and women at a single point in time (cross-sectional studies) or over time (longitudinal studies). Seven of the nine cross-sectional studies demonstrated that women had 0.13-0.35  $\log_{10}$  (approximately 2-fold) lower levels of HIV RNA than do men, this despite controlling for CD4 cell count. Four longitudinal studies revealed that women had 0.33-0.78  $\log_{10}$  (2- to 6-fold) lower levels of HIV RNA than do men, even when controlling for time since seroconversion.

*Clin Infect Dis 2002;35(3):313-22*

### **Journal of Acquired Immune Deficiency Syndromes**

#### **Do protease inhibitors increase the risk for coronary heart disease in patients with HIV-1 infection?**

Daniel Klein et al.

There is continued concern about protease inhibitors (PIs) causing increased risk of coronary heart disease (CHD) in HIV-infected patients. This ongoing observational study examines CHD and myocardial infarction (MI) hospitalization rates among HIV-positive members of the Kaiser Permanente Medical Care Program of Northern California, before and after PI use, and before and after any antiretroviral therapy (ART). Also, CHD and MI hospitalization rates among HIV-infected members are compared with members not known to be HIV-positive. With 4.1 years' median total follow-up, age-adjusted CHD and MI hospitalization rates were not significantly different before versus after PIs (6.2 versus 6.7 events per 1,000 person-years); or before versus after ART (5.7 versus 6.8). However, comparing HIV-positive and -negative members, the CHD hospitalization rate was significantly higher (6.5 versus 3.8,  $p=.003$ ), and the difference in the MI rate also was higher (4.3 versus 2.9,  $p=.07$ ). Differences between HIV-positive and -negative members in the CHD risk factors measured were mixed, and the overall clinical significance of these differences is uncertain. The researchers' data suggest that PIs and other antiretroviral therapies do not yet increase CHD or MI hospitalizations among HIV-infected individuals; however, longer follow-up is needed.

*JAIDS 2002;30:471-477*

## IAPAC-SARO advances DPP training component



Mulamba Diese, Executive Director of the International Association of Physicians in AIDS Care's Southern Africa Regional Office (IAPAC-SARO), conducts a training of physicians and nurses in Tanzania.

**T**he southern Africa region accounts for more people living with HIV/AIDS than any other region in the world. In addition to devastating families and communities, the AIDS pandemic is placing great demands on already overburdened public healthcare systems. Within this context, Pfizer in 2000 established its Diflucan Partnership Program (DPP), a philanthropic program through which Pfizer agreed to donate its antifungal drug fluconazole (Diflucan) to South African patients with HIV-related candidiasis and cryptococcal meningitis in government hospitals and public health centers.

The International Association of Physicians in AIDS Care's Southern Africa Regional Office (IAPAC-SARO) in Johannesburg, South Africa, was contracted to coordinate all DPP training programs. These programs are intended to strengthen

the capacity of health professionals to manage opportunistic infections and, when necessary, to administer fluconazole as treatment for esophageal candidiasis and cryptococcal meningitis.

In the past two years, physicians and allied health professionals have been trained through training symposia held and medical educational materials distributed throughout South Africa. And, in the past six months, following Pfizer moves to expand the DPP's geographical reach, IAPAC-SARO staff have trained health professionals in Botswana, Lesotho, Namibia, Malawi, Rwanda, Swaziland, Tanzania, Uganda, and Zambia.

In October 2002, IAPAC-SARO will begin hosting expanded DPP training symposia utilizing IAPAC's Global AIDS Learning & Evaluation Network (GALEN) training modules—specifically,

GALEN Module No. 8—Introduction to Antiretroviral Therapy and GALEN Module No. 9—Antiretroviral Therapy in Resource-Limited Settings.

“Health professionals in Africa are hungry for knowledge with which to improve the quality of care they are providing to their patients,” explained Mulamba Diese, IAPAC-SARO's Executive Director. “IAPAC is very aggressively conducting outreach to health professionals throughout the African continent with a goal toward building capacity for improved HIV/AIDS care and support.”

To learn more about IAPAC-SARO's DPP training activities, visit the DPP section of the IAPAC Web site—[www.iapac.org](http://www.iapac.org). Among the items posted in this section are educational materials, including candidiasis and cryptococcal meningitis posters and patient information booklets. ■



## I N T H E L I F E



### Luis Maldonado

*Vanity Fair* readers have every month since 1993 enjoyed *The Proust Questionnaire*, a series of questions posed to celebrities and other famous subjects. The *Vanity Fair* questionnaire—modeled after a questionnaire Marcel Proust was asked to fill out in the late 1800s—reveals much about the respondents' lives, thoughts, values, and experiences. In May 2002, *IAPAC Monthly* introduced "In the Life," through which IAPAC members are asked to bare their souls by answering 10 questions.

This month, *IAPAC Monthly* is proud to feature Luis Maldonado, who is an Internal Medicine Specialist at the Ecuadorian Air Force Health Service Command in Quito, Ecuador.

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**What proverb, colloquial expression, or quote best describes how you view the world and yourself in it?**

"The man is the wolf of the man. The human kingdom will be destroyed for the people who are working for evil."

**What activities, avocations, or hobbies interest you? Do you have a hidden talent?**

To write poems and tales; to play tennis; and to relax, swim, and play romantic songs on the guitar.

**If you could live anywhere in the world, where would it be?**

In a third world country, because I am sure there are a lot of poor people living there who need our help to survive.

**Who are your mentors or real life heroes?**

Jesus Christ and Mahatma Gandhi, because they fought for human rights without violence; and my parents, because they taught me how to be a winner in life.

**With what historical figure do you most identify?**

Mahatma Gandhi, because he always thought that poor people's happiness is real peace.

**Who are your favorite authors, painters, and/or composers?**

Authors: Camilo José Cela, Ernest Hemingway, and Gabriel Garcia Marquez; Painters: Oswaldo Guayasamin, Goya, and Michelangelo; and Composers: Beethoven, Strauss, and Tchaikovsky

**If you could have chosen to live during any time period in human history, which would it be?**

I would have liked to live in the 1940s, because those years were the most important in deciding the future of humanity. Perhaps I could have joined the Resistance and fought against engaging in World War II.

**If you did not have the option of becoming a physician, what would you have likely become given the opportunity?**

I am very happy as a physician, because I am able to help poor people who are living with disease.

**In your opinion, what are the greatest achievements and failures of humanity?**

Achievements: aviation, computerization, genetics, and cloning; Failures: World War I and World War II, atomic weapons, and the contamination and deterioration of the ozone layer.

**What is your prediction as to the future of our planet one full decade from present day?**

Our planet will be destroyed by a third world war if humanity stops atomic disarmament in developed countries. I try to envision a world full of peace, without AIDS and cancer, without thirst and hunger. It is a world with the same human rights for all people; one with a unique democracy, without corruption in politics, and with love rather than hate. ■



## [Strength in Numbers]

### [IAPAC Welcomes New and Renewing Members]

In August 2002, the International Association of Physicians in AIDS Care (IAPAC) welcomed 65 new and renewing dues-paying members from nine countries. IAPAC thanks the following physicians and allied health workers for their support of the association's mission to improve the quality of care provided to men, women, and children who are living with HIV/AIDS.

Vuyokazi N. Bandezi, *South Africa*  
Bruce Blacker, *USA*  
Leocadio Juan Blanco, *South Africa*  
James Carroll, *USA*  
Al Cennerazzo, *USA*  
Augustine Richard Chaumba, *South Africa*  
Karen Cohen, *South Africa*  
Charles Craig, *USA*  
Lucretia Vuyiswa Dlwati, *South Africa*  
Wayne T. Dodge, *USA*  
Steven Donohue, *South Africa*  
Milton Estes, *USA*  
Maria Elena Fuentes Carbonell, *South Africa*  
Hendrik Christiaan Fourie, *South Africa*  
Jcqueline Emilie Gawases, *Namibia*  
Dion Grace, *Cameroon*

Colette Gunst Smith, *South Africa*  
Donavon Charles Hiss, *South Africa*  
Simon Kimathi Ikandi, *Namibia*  
L. JamJam, *South Africa*  
Annalette Jooste, *South Africa*  
Harold Katner, *USA*  
Christopher Richard Kenyon, *South Africa*  
Phyllis A. Kephart, *USA*  
Ann Khalsa, *USA*  
Bryan Lipman, *USA*  
Gregory M. Loomer, *USA*  
Mercy T. Lukoto, *South Africa*  
Limpheo Lucy Maille, *Lesotho*  
Scott Mattix, *USA*  
Maria Masetona Makgoane, *South Africa*  
Kgomotso Masebelanga, *South Africa*  
Christopher Mathews, *USA*  
Samson Repones Awuma Mijoro, *Namibia*  
Annette Van der Merwe, *South Africa*  
Sai Kyaw Min, *Thailand*  
Lars Moberg, *Sweden*  
Matthew Mojekwu, *Namibia*  
Molotsi Monyamane, *Lesotho*  
Nkhangweni Mukheli, *South Africa*  
E.F. Nasir, *Lesotho*  
Likeleli Nkhopetla, *Lesotho*  
Joseph O'Neil, *USA*

Melissa Noble, *USA*  
Sahila Peerbhai, *Lesotho*  
Grace Phiri, *Lesotho*  
Abram Tefo Phahla, *South Africa*  
Gerald Pierone, *USA*  
Paul Quinn, *USA*  
Jorge Galindo Sainz, *Mexico*  
Veronica Sanders, *USA*  
Peter Selwyn, *USA*  
Farook Shaikhmag, *South Africa*  
Eyeusawit Shewangizaw, *Ethiopia*  
George Sinyangwe, *Botswana*  
Maria Emma Shiponeni, *Namibia*  
Dewald Steyn, *South Africa*  
Belina Thokoane, *Lesotho*  
Janet Thubuka, *Botswana*  
Francois W. D. Venter, *South Africa*  
Azeem, Hassan Walele, *South Africa*  
DeCarlo Wilkins, *USA*  
Ronald Wing, *USA*  
Elzabe Wolhuter, *South Africa*  
John N. B. Wright, *South Africa*

To learn more about IAPAC individual physician and/or allied health professional membership, please contact Joey Atwell, Director of Membership, at (312) 795-4941 or [jatwell@iapac.org](mailto:jatwell@iapac.org).

### [Recruit and Win]

Do you wish to strengthen the profession, enhance your colleagues' work, and win a prize? Your recruitment effort will not go unrecognized. Each time you recruit a new member, your name will be entered into a drawing to win one of the following prizes:

- One roundtrip, upgradeable, tourist class ticket anywhere United Airlines flies in the United States.
- One roundtrip, upgradeable, tourist class ticket anywhere United Airlines flies in Europe.

From March 1, 2002, to December 15, 2002, the more new members you recruit, the greater your chances of winning! Plus, you will receive recognition in the *IAPAC Monthly*.

Whether you sponsor one or 100 new members, you will receive a gift as recognition of your contribution to the success of this IAPAC membership campaign. There are four sponsorship levels; at the end of the campaign, you will receive a prize for the recruitment level you have met.

- Level 1 – Recruit one to four new members between March 1, 2002, and December 15, 2002, and receive an IAPAC lapel pin.
- Level 2 – Recruit five or more new members between March 1, 2002, and December 15, 2002, and receive an IAPAC lapel pin and a custom-designed plaque recognizing your commitment to IAPAC.

- Level 3 – Recruit 20 or more new members between March 1, 2002, and December 15, 2002, and receive Level 1 and 2 gifts and a 12-month complimentary extension of your IAPAC membership.
- Level 4 – Recruit 75 or more new members between March 1, 2002, and December 15, 2002, you may show off your accomplishment with a 10k yellow gold IAPAC lapel pin (and receive Level 2 and 3 gifts).

There is *Strength in Numbers*—encourage others to become IAPAC members. It is easy. To learn how easy, contact IAPAC's Membership Department at (312) 795-4941 or e-mail [membership@iapac.org](mailto:membership@iapac.org).



## SAY ANYTHING

... while it is important to teach children in an age-appropriate manner about compassion for those who contract certain diseases, we would like to inquire as to whether there is other PBS programming, aimed at an older age group, which may be more suitable for such sensitive messages.

*Excerpt from a letter sent by five US lawmakers to the President of the US government-funded Public Broadcasting System (PBS), following an announcement regarding the introduction of an HIV-positive Muppet to the South African version of "Sesame Street." The new female Muppet is scheduled for a September 30, 2002, bow in South Africa, where the show is called "Takalani Sesame." The letter from the five members of the US House of Representatives' Committee on Energy and Commerce essentially communicated that the new Muppet would be unwelcome in the United States. Within a week, the show's producers assured lawmakers that an HIV-positive Muppet was not in the works for the US children's show.*

**What will history say about us if we do not make every effort to address it? If we fail to get these treatments to those who need them most because they lack the money to pay for them, history's verdict will be harsh indeed.**

*An excerpt from an August 10, 2002, Houston Chronicle editorial entitled, "AIDS Plague Is the Defining Crisis of Our Time." The editorial's author, CBS News anchor Dan Rather, further wrote that until the AIDS pandemic is brought under control, "all other efforts toward peace, democracy, and development will be compromised." He added that the US\$10 billion a year the United Nations estimates is needed to adequately combat HIV/AIDS "will prove a bargain" if millions of lives are saved.*

The reality is severe but it's not impossible to manage. You can't dabble around any more. [HIV/AIDS] is big—you have to get on with it. *Brian Brink, Senior Vice President-Medical of Anglo American, as quoted in an August 8, 2002, Financial Times article about the mining group's decision to make anti-retroviral drugs available to HIV-infected miners within its 130,000-strong workforce. The announcement is considered a landmark not just for South African business but also for the African continent.*

**I can say without a shadow of doubt ... we'll take them to court on this. And we'll do it with the best scientific authorities in the world.**

*Mark Heywood of the AIDS Law Project at the University of Witwatersrand in an August 7, 2002, Associated Press report about his country's Medicines Control Council's reconsideration of its approval of nevirapine for the prevention of mother-to-child transmission (MTCT) of HIV. The Medicines Control Council is the South African equivalent of the US Food and Drug Administration (FDA). According to the Medicines Control Council, the move was in reaction to FDA comments about irregularities with a Ugandan MTCT study, results of which had supported the South African approval application. Although the FDA's comments prompted the drug's manufacturer, Boehringer Ingelheim, to retract its application for an MTCT indication in the United States, the company was quick to point out the irregularities revolved around paperwork and did not reflect on the study's integrity. Heywood contends that rescinding the drug's approval would in effect nullify a recent constitutional court decision forcing South Africa's government to make nevirapine available to all HIV-infected pregnant women.*

Saying everyone needs to be tested before starting drug therapy would add an enormous amount of expense at a time when funds are becoming short. *Margaret Fischl, Director of the University of Miami's AIDS Clinical Research Unit, in an August 8, 2002, Boston Globe article summarizing a New England Journal of Medicine paper in which researchers from US universities and government agencies revealed that the ranks of newly infected patients with drug-resistant HIV grew more than threefold from 1995 to 2000. Fischl was reacting to a recommendation from the paper's authors that before physicians prescribe antiretroviral therapy, patients should be tested for drug-resistant HIV. Although such tests cost between US\$300 and US\$1,000, the paper's authors argued that the tests are ultimately cost-effective because they prevent physicians from prescribing expensive drugs that may prove to be ineffective because of resistance mutations.*

**Perhaps some... are people for whom the medical regimen isn't working. And so they are going for some other way.**

*Mark Vosvick, speaking at the annual meeting of the American Psychological Association (APA), August 22-25, 2002, in Chicago. According to research findings he presented at the APA conference, a greater number of HIV-infected patients are using herbals, botanicals, or other alternative remedies. Vosvick and fellow researchers from the University of North Texas-Denton surveyed 158 San Francisco-area patients—almost half of whom were HIV-infected—on their use of alternative therapies. Most of those surveyed were on antiretroviral therapy. Two-thirds (67 percent) of patients on HIV-related medication also were taking an alternative supplement.*