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*Report from The Sixth International  
Congress on Drug Therapy in HIV*

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## I. INTRODUCTION

### A. What's a conference about?

The large international AIDS conferences tend to organize presentations into several themes or "tracks," such as:

- laboratory research (focus is inside the test-tube)
- studies of drugs in people
- studies about behaviour — usually about preventing the transmission of HIV and other sexually transmitted diseases (STDs)
- ethical and legal issues

Because HIV/AIDS affects so many people, attendance at these conferences has grown considerably, exceeding 10,000 people. As a result, more themes have been added, lecture halls are filled to capacity and often there is not enough time in question periods. With so many tracks, presentations, posters and piggybacking mini conferences, it is sometimes challenging to capture all the important information in such overwhelming circumstances. Therefore, not surprisingly, AIDS conferences may not always provide the ideal learning opportunity that they once did, particularly for people interested in the care and treatment of HIV/AIDS.

Over the past decade, smaller and more focused conferences and workshops have appeared to better deal with issues relating to HIV/AIDS care and treatment. One of these smaller conferences is the International Congress on Drug Therapy in HIV Infection, which is held in Glasgow, Scotland.

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Despite its remote location, the Sixth International Congress on Drug Therapy in HIV Infection attracted leading doctors and scientists from Australia, North and South America, Africa and the European Union. Conference organizers sought and accepted input from people with HIV/AIDS (PHAs). For instance, there was a session at the conference devoted to treatment strategies that was co-chaired by a knowledgeable community member from Paris. Presentations during this session were made by researchers from London, Paris and Vancouver. Eloquent talks by community members from New Mexico and Belgium helped to put a human face to important issues such as:

- if and when to start therapy
- dealing with co-infections
- fears and anxieties about therapy
- hopes for the future

There was also a session devoted to issues about anti-HIV therapy in low-income countries. For the first time at a major AIDS conference, a leading manufacturer of generic drugs in India, Cipla Ltd., presented data on a novel combination product. Their presentation revolved around the development of a pill containing the following three medicines made by three different drug companies (this pill is not available in high-income countries):

- 3TC (lamivudine, Epivir)
- d4T (stavudine, Zerit)
- nevirapine (Viramune)

In addition to lectures by leading researchers, panels on different topics and speeches by keynote speakers, there were about 300 posters on display. Posters are usually about one metre by one metre in size and filled with detailed descriptions of research, clinical trials or reports of a particular illness and its treatment. All in all, at conferences of this nature, it is easy to become overwhelmed with the density of information.

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## II. SIDE EFFECTS

### B. Who gets treatment and...side effects

For many years, particularly in the 1980s when people first heard about AIDS, it was seen as a gay male disease. As a result, some HIV positive women may not have been aware of their infection until serious symptoms appeared and their disease had progressed. Moreover, this stereotype of who-gets-AIDS may have influenced decision-making

by some doctors who treat women, who may have been reluctant to test their female patients for HIV. This, along with many other factors — including the lack of social networks for HIV positive women in the early years of the epidemic, women's role as caregivers, their lower socioeconomic status and partner violence — may have contributed to reduced survival for HIV positive women compared to their male counterparts.

Researchers in Italy and the U.K. have been monitoring the health of a large number of HIV positive men and women for several years. They analysed information in their database to compare differences between men and women in the following areas:

- their ability to access anti-HIV therapy
- the quality of that therapy
- rates of stopping therapy
- the development of AIDS-related illnesses

### Study details

Between 1996 and February 2001, researchers recruited 3,658 HIV positive subjects (37% women, 63% men) who had the following profile at the start of the study:

#### Men:

- average age – 36 years
- proportion with AIDS – 12%
- proportion with hepatitis C virus – 70%
- average CD4+ count – 402 cells
- average viral load – 25,000 copies

#### Women:

- average age – 34 years
- proportion with AIDS – 9%
- proportion with hepatitis C virus – 45%
- average CD4+ count – 451 cells
- average viral load – 16,000 copies

### Results

Researchers found that the following proportion of subjects began therapy once they entered the study:

- men – 64%
- women – 61%

The researchers grouped together men and women who entered the study at roughly the same time. In general, they found that despite entering the study at the same time, men began therapy about three months earlier than women did.

However, when researchers analysed the data, they noticed that even though, on average, men began therapy earlier than women, both sexes began therapy at the appropriate time for their health

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care needs — when taking into account CD4 counts and viral loads. This suggests that doctors were applying treatment guidelines equally to both sexes, at least when it came to the timing of therapy.

### Type of therapy

The researchers also looked at the complexity of combination therapy which PHAs used initially. They found the following:

- men – 71% began treatment with a combination of three drugs
- women – 66% began therapy with a combination of three drugs

Why some women were offered less complex regimens was not clear.

### Interrupting therapy

The researchers looked at the data about stopping therapy. Specifically, they were interested in PHAs who stopped taking their medications for three or more months. In this analysis, they found that:

- More women (19%) than men (15%) interrupted their therapy.
- Women were twice as likely as men to stop taking “at least one drug” in their combination.

### AIDS-related illnesses

A total of 147 subjects developed infections and/or cancers while in the study. There were a total of 43 deaths, nine of which were not related to HIV (for example, accidents). There were no major differences between men and women in the development of AIDS-related complications or deaths.

### Future research

The findings from this study raise some questions:

- Why were more women than men using less-than-optimal anti-HIV therapy?
- Did more women interrupt their therapy because of side effects?
- If so, are women more likely to experience side effects than men?

We hope the research team seizes the opportunity to answer these and other important questions relating to the care and treatment of both men and women with HIV.

### REFERENCE

Murri R, Cozzi-Lepri A, Phillips AP, et al. Access to antiretroviral treatment, incidence of sustained therapy interruptions and risk of clinical events according to gender: evidence from the ICONA study. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Plenary

lecture 6.4.

## C. Protection from nuke side effects

Nucleoside analogues (nukes or NRTIs) such as AZT, d4T and ddI may be associated with a number of side effects, including the following:

- wasting of muscle tissue, including the heart
- malfunctioning kidneys
- swollen pancreas gland (pancreatitis)
- type 2 diabetes (non-insulin dependent)
- thyroid hormone abnormalities
- swollen livers due to excess fat deposits
- nerve damage (peripheral neuropathy)
- loss of fat just under the skin (subcutaneous fat)

Some researchers think that these problems occur because nukes damage the energy-producing parts of cells called “mitochondria” (Mt). Large numbers of damaged or malfunctioning Mt produce lactic acid (lactate). When high levels of lactic acid in the blood occur, this is known as “lactic acidosis.” Generally, this condition is uncommon in PHAs. People with hepatitis B or C are at increased risk for developing lactic acidosis. Symptoms of lactic acidosis include:

- unexpected tiredness
- abdominal pain
- shortness of breath
- nausea and/or vomiting

The following blood tests help identify lactic acidosis:

- lactate levels of 5 mmol/L or greater
- bicarbonate levels of 20 mmol/L or lower

If left untreated, lactic acidosis can be deadly.

Doctors in Barcelona, Spain, have been studying remedies for lactic acidosis in PHAs.

### Study details

The doctors enrolled 9 subjects (2 female, 7 males) for their study of this rare complication between March 2001 and July 2002. All subjects had symptoms of lactic acidosis as well as the following profile:

- average CD4+ count – 108 cells
- average viral load – 250,000 copies
- nukes used – AZT, ddI, d4T and 3TC
- 2 had cancers (lymphoma of the brain and kidney respectively)

Upon entry to the hospital, all subjects stopped using nukes and reduced their sugar intake. Water was given to them intravenously. They also received the following supplements:

- vitamin C – 1 gram every 12 hours
- L-carnitine – 1 gram every 12 hours
- vitamin B<sub>12</sub> – 500 micrograms every 8 hours
- vitamin B<sub>1</sub> – 250 mg every 8 hours
- vitamin B<sub>6</sub> – 250 mg every 8 hours

Given this treatment, 8 of the 9 PHAs had their symptoms of lactic acidosis clear within a week. The ninth PHA's lymphoma in the kidney eventually resulted in death. Levels of lactate in the blood took more than a week to fall.

If this mix of B-vitamins and antioxidants is useful in the treatment of lactic acidosis, we wonder if smaller doses may also be helpful in preventing this complication. Researchers in Vancouver, British Columbia, are testing a combination of two B-vitamins in nuke users to find out if this strategy is effective.

#### REFERENCE

Bachs MR, Soler A, Villa C, et al. Focus on lactic acidosis therapy in HIV patients under nucleoside analogue reverse transcriptase inhibitors (NRTIs). *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Poster 125.

## D. Breaking free from nukes

The strange changes in body shape with the loss of fat under the skin (subcutaneous fat) and increased fat in the belly and breasts combined with increased risk of cardiovascular disease and diabetes is collectively called the "HIV lipodystrophy syndrome." Exactly why these changes occur is not clear. Some changes in body shape, such as the loss of subcutaneous fat in the face, arms and legs are most obvious. This side effect has been blamed on the use of a class of drugs called nukes (nucleoside analogues). Examples of nukes include:

- AZT (zidovudine, Retrovir)
- ddI (didanosine, Videx)
- d4T (stavudine, Zerit)
- 3TC (lamivudine, Epivir)
- abacavir (Ziagen, ABC)

An important question not explained in this theory of nuke-related fat loss is why and how can nukes cause fat to disappear from one part of the body

(under the skin) and then get deposited in the belly and breasts? Why don't nukes cause the disappearance of fat deeper inside the body?

Nonetheless, some PHAs and their doctors would like to test nuke-free regimens in the hope of either avoiding or reversing the changes in body shape seen in the lipodystrophy syndrome. So doctors in Canada and the European Union are testing nuke-free regimens. None of the studies have been completed, but here are preliminary results from one study in Germany.

### Study details

Doctors in Heidelberg and elsewhere in Germany recruited 18 HIV positive subjects who had used anti-HIV drugs and were experiencing mitochondrial toxicity or had signs of fat wasting. Subjects were switched from whatever regimen they were currently using to the following combination:

- saquinavir (Fortovase, Invirase) – 1,000 mg twice daily
- ritonavir (Norvir) – 100 mg twice daily
- efavirenz (Sustiva) – 800 mg once daily
- nevirapine (Viramune) – 200 mg twice daily

### Results

After six months on this regimen, subjects' CD4+ counts and viral loads remained stable. Blood levels of lactate — one measure of the damage caused by nukes — fell. Six subjects discontinued the study because of rash. As a result, researchers suggest that instead of starting with 800 mg/day of efavirenz, the dose should be started at 600 mg and gradually increased. Another drawback to this regimen is the number of pills that needed to be taken — 20 per day.

Although this short-term study shows that a nuke-free regimen is safe, whether or not it can stop or reverse changes in body shape cannot be assessed until more time has passed.

#### REFERENCE

Gey D, Boit R, Lorenz T, et al. Safety, tolerability and efficacy of an NRTI-free regimen in HIV patients with evidence of mitochondrial toxicity: a pilot study. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Poster 122.

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### III. ADHERENCE

#### E. What helps adherence to therapy?

Historically, the ability of people with chronic health conditions to take their medication as prescribed and directed, on time, every day — otherwise known as “adherence” or “compliance” — is not good. Skipping a few pills for a few days in a row may not have serious consequences for some people with mildly elevated blood pressure. However, the stakes are much greater in HIV because of the virus’ ability to mutate and escape the effects of anti-HIV medication. This can occur when doses are skipped and drug levels fall below the level that keeps HIV suppressed. It is estimated that adherence rates of about 95% are needed by PHAs who are taking highly active antiretroviral therapy (HAART).

The medications available for controlling HIV must usually be taken several times daily and some of them have food and water restrictions. All of them have varying degrees of side effects. Combined, these factors can affect a person’s adherence. Other factors can include unstable lifestyles, depression and a lack of psychosocial support.

What do PHAs and their doctors think about the factors that affect adherence? How do doctors measure adherence? To find the answers to these and related questions, researchers in Bonn, Germany, conducted a study.

#### Study details

Researchers conducted standardized interviews about adherence with 98 German doctors. The research team also surveyed 284 PHAs about their views on adherence.

#### Results — Doctors assess adherence

According to the researchers, doctors overestimated adherence levels in their patients. Indeed “only 64% of the doctors always discussed adherence with their patients.” The way that the doctors measured adherence was indirect: monitoring the results of blood tests, specifically CD4+ counts and viral load. Few doctors used a standardized questionnaire to assess adherence. When doctors noticed a decrease in CD4+ counts and/or an increase in viral load, then they raised the possibility of adherence difficulties with their patients. If during the discussion adherence was found to be a problem, the solution offered by 83% of the docs was to emphasize the importance of being adherent to HIV medications. According to the researchers, few doctors tried to determine the reasons for difficulties with adherence and offer “additional supportive measures.”

The doctors believed that there was a significant connection between being adherent and a patient’s “social status and educational level.” However, researchers found that this connection to adherence was, in fact, not significant.

#### Results — PHAs assess adherence

In surveying PHAs, the most important factors associated with non-adherence included the following:

- fear of both short- and long-term side effects
- interactions with other drugs
- low level of knowledge about HIV and treatment issues

Factors associated with being adherent included the following:

- knowledge about the importance of adherence
- integration of treatment into the routine of everyday life
- social support for adherence
- acceptance of treatment
- discipline

Since adherence is an important issue, these findings will be of interest to many people involved in the care and treatment of HIV/AIDS. Given how challenging it is for physicians to keep up-to-date on treatment information *and* look after many patients with a complex medical condition, it may be unreasonable to expect them to access a valid standardized adherence questionnaire and to constantly administer it to their patients. It is also not fair to expect physicians to carry the burden of adherence support and education. Unmeasured in this research project was the role played by other key members of a PHA’s health team in maintaining or enhancing adherence, including:

- pharmacists
- nurses
- social workers
- friends
- family

#### Many pills to swallow

The pharmaceutical industry also has a role to play in helping to improve adherence. When treatments first became available, they had to be taken three or more times daily. With combination therapy now the standard of care, this can mean multiple pills many times a day. Fortunately, several drugs are now being combined into a single pill, examples being:

- Combivir – AZT + 3TC
  - Trizivir – AZT + 3TC + abacavir
-

Results of satisfaction surveys presented at the conference found that users of simple treatment regimens such as Trizivir (taken twice daily) reported relatively higher rates of satisfaction than those who are on regimens that consist of more pills.

To help reduce “pill burden,” new formulations of existing drugs, such as ddI, are being made into once-daily pills — Videx EC. A similar change is underway for d4T (Zerit), and efavirenz (Sustiva) is now available in a single tablet.

Two protease inhibitors should be available in once-daily formulations in 2003 — atazanavir and fos-amprenavir (the new version of amprenavir [Agenerase]).

All of these innovations are important and help to reduce barriers to adherence. But future work still needs to be done on developing combination therapy with fewer side effects.

#### REFERENCES

Weilandt C and Rockstroh J. Adherence: providers versus patients views of associated factors and intervention approaches. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Poster 90.

Gatti A, Arpinelli F, Visona G, et al. Impact of less complex HIV-therapy on adherence and quality of life-ADEQUA survey. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Poster 96.

Jordan J, Delea T, Sherrill B, et al. Impact of fixed-dose combination zidovudine/lamivudine on adherence to anti-retroviral therapy: a retrospective claims-based cohort study. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Poster 97.

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## IV. VACCINES

### F. Rub-on vaccine study planned

Treatment for HIV/AIDS is readily available for most citizens and legal residents of high-income countries. However, the highest proportion of PHAs live in tropical, low-income countries where people can barely access these life-prolonging medications. In addition to anti-HIV drugs, many PHAs in low-income countries also need the following:

- treatment for common co-infections such as malaria, leishmaniasis and tuberculosis
- regular medical care
- access to nutrient-rich food and clean water

It may be many years before all of these basic needs are met. During this time, particularly in sub-Saharan Africa, against a backdrop of civil

wars and famine, HIV/AIDS will continue to spread, leaving a trail of death, reduced economic output, misery, millions of orphans and grieving, perhaps even disintegrating communities. It should come as no surprise that in the absence of a well-funded worldwide “Marshall Plan,” policy planners’ best hope for slowing down or stopping the spread of AIDS lies in an effective vaccine.

It has been difficult for researchers to create an effective HIV vaccine because the virus changes or mutates so quickly. Unlike previous attempts at vaccination against other diseases, HIV also infects cells of the immune system that are important in fighting the virus. Many attempts at vaccine design in the 1990s failed — both in monkeys and in people — because HIV is such a difficult target. Nonetheless, immunologists need more funding to test fresh approaches in vaccine design against HIV.

We now report on one different approach to an HIV vaccine that has potential to be used as a form of therapy in PHAs. Such products are called “therapeutic vaccines” and an example of this is a vaccine called DermaVir.

### DermaVir

Another aspect of DermaVir that makes it stand out from the crowd of potential HIV vaccines is that instead of being injected, it is applied to the skin. What’s in DermaVir? This vaccine is a mix of genetic material from HIV. Once applied to a small patch of skin, DermaVir stimulates immune cells (including CD8+ and langerhans cells) located in the skin. This vaccine may help activate these cells to recognize and fight HIV. The vaccine may therefore be useful in helping to control HIV in PHAs.

### Monkey business

A virus called SIV, simian immunodeficiency virus, causes an AIDS-like disease in some monkeys. Before testing vaccines in people, researchers commonly test them in monkeys. So researchers made up a batch of DermaVir using bits of SIV. Initial tests in a few animals showed that exposure to DermaVir was safe but unable to help the immune systems of the monkeys to control SIV.

### Back to the drawing board

Putting on their thinking caps, researchers realized that infection with SIV had clearly weakened the immune systems of the monkeys so much so that they were unable to benefit from the vaccine. Some way of bringing down the high levels of virus in the animals was needed so that their immune systems could respond to DermaVir.

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## Therapy with a twist

The researchers came up with a new idea. They thought that by giving the monkeys HAART to suppress SIV levels, this would give the immune system time to begin repairing itself. But they also came up with a different approach to treatment. HAART would be given to the monkeys in an on/off fashion. This is commonly called a “drug holiday,” or STI — structured treatment interruption. The monkeys would receive HAART for three weeks, followed by an STI for three weeks, and then resume therapy. These cycles on and off therapy would continue for several months.

The reasoning behind doing an STI is that during HAART, because SIV is suppressed, the immune system isn't exposed to enough SIV to learn how to fight the virus. By taking an STI, this re-exposes the immune system to SIV and hopefully it relearns to fight SIV.

During the time the monkeys would be on HAART, some would also receive DermaVir. Having worked out all these details, the researchers planned and conducted a study in which SIV positive monkeys would receive the following:

- 6 monkeys – no treatment
- 6 monkeys – DermaVir alone
- 7 monkeys – HAART + STI
- 7 monkeys – DermaVir + HAART + STI

## Results

The researchers found that, in general, monkeys receiving a combination of DermaVir, HAART and STIs, unlike the other regimens, had decreasing levels of SIV and increasing levels of CD4+ cells.

These promising results have prompted the researchers to design a study of DermaVir using HIV's genetic material for testing in people in the U.S. This initial study — called ACTG 5176 — will be small and is designed to examine the safety of DermaVir in 24 HIV positive volunteers who are on HAART. People in the study must also have a viral load below the 50 copy mark and CD4+ counts of at least 350 cells. Results from this clinical trial may not be available until 2004. The Research Institute for Genetic and Human Therapy (RIGHT), in Georgetown University in Washington, DC, is developing DermaVir.

## REFERENCE

Liszewicz J, Xu J, Lewis M, et al. DermaVir: a new topical DNA vaccine for the treatment of HIV/AIDS. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Plenary lecture 7.2.

## V. CANCER

### G. Cancer risk falls in some HAART users

In high-income countries, the availability of HAART has led to dramatic decreases in deaths from many AIDS-related complications, particularly infections. However, decreases in the risk for certain cancers, such as those of the lymphatic system — NHL or non-Hodgkin's lymphoma — have not been as dramatic in the first few years after HAART was released.

### CASCADE

In 2002, researchers in Canada, Australia and the European Union worked together on a giant database called CASCADE, collecting thousands of medical records on HIV positive people. One of the results of this work is a re-evaluation of the impact of HAART on the risk of developing NHL. Researchers analysed data on 7,103 subjects over three periods of time as follows:

- 1996
- 1997-1998
- 1999-2002

In reviewing the data, researchers specifically looked at the following factors:

- the CD4+ count at the time NHL was diagnosed
- the lowest CD4+ count a person ever had

### Results

- During the study period, 93 cases of NHL in 7,103 subjects occurred.
- PHAs whose CD4+ counts were below the 100 cell mark were at greatest risk of developing NHL.
- The risk of developing NHL fell significantly in the time 1999-2002 compared to in previous years.
- A person's history of CD4+ cell count changes (eg. lowest-ever CD4+ count) did not significantly affect their risk of developing NHL in this study. What mattered the most was the current CD4+ count.

These findings may be of some comfort to HAART users. However, the recovery of the immune system seen with HAART is incomplete and so some risk from NHL remains.

## REFERENCE

Bhaskaran K, et al. Incidence and predictors of non-Hodgkin lymphoma in European cohorts of HIV seroconverters. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Plenary Lecture 7.4.

## VI. INFECTIONS

### H. Syphilis — the great masquerader

According to doctors in Glasgow, Scotland, syphilis may be more aggressive in HIV positive than HIV negative people. The difficulty in diagnosing syphilis is that it can mimic symptoms of many other diseases.

Doctors at the Gartnavel General Hospital in Glasgow recently reported an unusual case of syphilis in an HIV positive male. He was 53 years old and sought medical help after experiencing the following symptoms over a five-week period:

- coughing
- shortness of breath
- rash on his palms, back, soles of the feet and penis
- pain in his joints
- diarrhea

Because of these symptoms he had stopped taking his HAART and Septra (Bactrim) two weeks before visiting the hospital. His CD4+ count was 882 cells and his viral load was 8,500 copies. Results of chest X-rays suggested a lung infection. Blood samples were taken for analysis.

Because of the duration of his symptoms and the result of the chest X-ray, doctors prescribed an intravenous antibiotic, cefotaxime. His condition did not improve. So another antibiotic, Septra, was also given intravenously, but this too didn't have much impact. Five days after entering the hospital, the man's blood tests were available and they were suggestive of syphilis. Treatment was switched to intravenous penicillin G (benzylpenicillin), and as he improved, this was changed to intramuscular injections of Procaine penicillin G (Jenacillin). His doctors warn that in PHAs who have pneumonia as well as rash suggestive of syphilis doctors should suspect syphilis as the cause of the pneumonia.

#### REFERENCE

Currie A, Bodasing N, Winter A, et al. Secondary syphilis with possible respiratory involvement in an HIV-positive patient. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Poster 257.

### I. Is hepatitis C virus going to become a major STD?

Rates of unsafe sex and, not surprisingly, sexually transmitted diseases (STDs) are increasing in Western Europe and North America. British researchers have done a preliminary study that suggests hepatitis C virus (HCV) infection may be increasingly transmitted sexually in HIV positive people.

#### Changes in hep C

Doctors in London (UK) analysed their database and found that between 1996 and 1997 less than 1% of their 1,930 clients who visited a clinic for treatment of STDs or HIV were positive for HCV. In the period 2001 to 2002, the proportion of people testing positive for HCV tripled. Researchers were able to identify and contact 23 of these previously HCV negative people for interviews. All but two of the people were also HIV positive. The reason that HCV testing was done was because many of the people had higher-than-normal levels of the liver enzyme ALT, so doctors suspected liver damage due to hepatitis.

#### Risk factors for hep C

In interviews, the doctors found that four people had a history of injection drug use while none had received blood transfusions. The doctors noted that 15 patients had recent unsafe sex, and in the past year, eight of them were diagnosed with syphilis. In four people there were no obvious risk factors for HCV transmission.

#### Suspicious

The doctors acknowledge that the numbers of HCV positive people in their sample are small. The low rate of injection drug use, combined with a background of unsafe sex and transmission of STDs including syphilis, lead the doctors to suspect that many of the people in their study had acquired HCV via sex. However, before leaping to the conclusion that an epidemic of sexually transmitted hep C is about to occur, they recommend that a larger study is needed to confirm these findings.

#### REFERENCE

Brown R, Asboe D, Gillece Y, et al. Increased incidence of HIV positive individuals with acute hepatitis C due to sexual transmission: a new epidemic. *Sixth International Congress on Drug Therapy in HIV Infection, 17-21 November 2002, Glasgow*. Poster 283.

### Disclaimer

**Decisions about particular medical treatments should *always* be made in consultation with a qualified medical practitioner knowledgeable about HIV-related illness and the treatments in question.**

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© CATIE, Vol. 14, No. 9  
December 2002



Funding has been provided by Health Canada, under the Canadian Strategy on HIV/AIDS.

### What CATIE Does

The Canadian AIDS Treatment Information Exchange (CATIE) enables people living with HIV/AIDS (PHAs) to make informed choices about their health care, to optimize their quality of life, to prevent the progression of disease and opportunistic infections and to reduce the impact of side effects. CATIE provides such information through a comprehensive Web site, a bilingual toll-free phone service, electronic and print publications, a national reference library and workshops and exhibits at conferences across Canada.

### Other CATIE Publications

#### A Practical Guide to HAART

The latest on what is known about the various aspects of treatment, including a description of the virus and the immune system, the stages of HIV disease, the tests used to assess health status, and anti-HIV medications.

#### A Practical Guide to HIV Drug Side Effects

The latest on what is known about various side effects related to treatment, from appetite loss to sexual difficulties, and tips for countering or preventing them.

*The Practical Guide series also includes:*

- **A Practical Guide to Nutrition**
- **A Practical Guide to Complementary Therapies**
- **A Practical Guide to Herbal Therapies**

#### Fact Sheets & Supplement Sheets

Concise overviews of conditions, symptoms, medications, side effects, complementary therapies, vitamins, herbs and other treatment issues.

#### Plain & Simple Fact Sheets

The basics of HIV/AIDS treatment.

#### Managing Your Health, 1999 edition

A must-read guide for PHAs which addresses social, legal, health-related and practical issues comprehensively and from a national perspective.

#### The Positive Side magazine

Holistic health, information and views for PHAs.

#### pre\*fix

A harm reduction booklet for HIV+ drug users.

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