

aids treatment update

Crime and punishment

This might come as a shock, but since Mohammed Dica was found guilty of transmitting HIV last month, those of us who are HIV-positive now appear to have a legal duty to disclose our HIV status to our partners before engaging in high-risk sexual activities in England & Wales.

That is the conclusion drawn by the learned author of the main article in this month's *ATU*, and it means that many of us are going to have to rethink our 'don't ask, don't tell' policy when it comes to having sex, if we also want to avoid the risk of being prosecuted.

The last thing we need is the added stigma of being a potential criminal every time we have sex, which is, after all, our inalienable right. However, we also surely have a moral responsibility to protect others from our own infection, as well as a duty to protect ourselves as best as possible from other sexually transmitted infections.

Sometimes the law of the land can change attitudes and behaviour, and sometimes it can just feel oppressive. Perhaps if this ruling had not come through the 'back door' but if instead the legal issues surrounding HIV transmission had been part of a considered approach to the sexual well-being of all people, this might have been an easier pill to swallow.

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2 what the first ever criminal conviction for transmitting HIV in England & Wales means to people living with HIV by james chalmers

On October 14th 2003, Mohammed Dica was convicted of two counts of “unlawfully and maliciously inflicting grievous bodily harm” on two women for infecting them with HIV. This represents the first conviction for the sexual transmission of disease in England & Wales for well over a century – and the first ever for the transmission of HIV. It is not, however, the first such conviction in the United Kingdom – that took place in Scotland (where a different system of criminal law applies) in February 2001, when Stephen Kelly was convicted of having “recklessly injured” his former partner by infecting her with HIV.

Why did this happen?

For some time, it was thought that there could be no criminal offence under English law in circumstances such as those in the Dica case. This view goes back to a court decision known as *R v Clarence*, decided in 1888.¹

In that case, Clarence knew that he was infected with gonorrhoea. He did not inform his wife of this fact, and she became infected as a result of sexual intercourse with him. Initially, he was convicted of the offence of “unlawfully and maliciously inflicting grievous bodily harm” – an offence under section 20 of the *Offences Against the Person Act 1861* – the same offence of which Mohammed Dica was convicted. His conviction was, however, quashed on appeal. The appeal court took the view that a person could not be said to “inflict” grievous bodily harm unless they had attacked the victim in some way, for example by striking a blow or using a knife.

For some time, it was thought that the decision in *Clarence* would make it impossible to convict anyone of a criminal offence for passing on a sexually transmitted infection (STI) by consensual sexual intercourse. However,

subsequent decisions of the courts suggested that the interpretation given to the word “inflict” in *Clarence* was too narrow. In particular, the House of Lords held in 1998 that a man who had caused psychological illness to a woman by “stalking” her over a period of time could be guilty of this offence, despite never actually having attacked her.²

It was recognised that this called the decision in *Clarence* into doubt,³ but the Dica case appears to represent the first successful attempt to bring a prosecution in such circumstances.

The sentence imposed

On November 3rd 2003, Dica was sentenced to a total of eight years’ imprisonment (three and a half years in respect of one of the convictions, and four and a half in respect of the other). The maximum penalty which can be imposed for this offence is five years (there is no minimum penalty).

The sentence is broadly consistent with the approach which has been adopted in other jurisdictions – Stephen Kelly was sentenced to five years’ imprisonment, while the Canadian courts have imposed a sentence of as high as eleven years in a case where two women were infected with HIV as a result of conduct similar to Dica’s.⁴

Dica will become eligible to apply for parole after he has served four years’ imprisonment (half of the sentence imposed). He will also be eligible to apply for early release on compassionate grounds if his health deteriorates seriously while he is still in prison.

What happens next?

According to media reports, Dica’s lawyers have indicated that they intend to appeal against his conviction and sentence. Given that the courts

have never expressly overruled the decision in *Clarence*, it is important for the law to be clarified by the Court of Appeal, and the case could well end up in the House of Lords. If the case goes that far, it could take some time – perhaps a couple of years – before a final decision is reached. Given earlier court decisions on the meaning of “inflicting grievous bodily harm”, it is unlikely – although not impossible – that the courts will hold that the transmission of HIV in this way cannot be a criminal offence. A decision of an appeal court should, however, help to clarify the law. At present, the legal position is far from clear. The Court of Appeal may, however, consider a reduction in the sentence imposed, particularly as the sentence on one charge is very close to the maximum permitted by law.

What follows is an attempt to provide guidance on the consequences of the case, although it is impossible to be precise until a higher court clarifies the issues.

Is the decision retrospective?

Yes. Unlike an Act of Parliament, which normally only applies to conduct taking place in the future, a court decision applies to conduct which has taken place before that decision as well. It is, therefore, theoretically possible that prosecutions could be brought for cases of transmission prior to this decision. However, it is unlikely that any prosecutions will be brought for cases that occurred a considerable time ago, and any attempt to bring such a case might well fall foul of the right to “trial within a reasonable time” under the European Convention on Human Rights.

Is the government likely to intervene?

Successive governments, both Conservative and Labour, have shown no inclination to legislate to make the transmission of HIV a criminal offence. In 1992, there was public controversy after a man was accused of deliberately infecting four women with HIV. The matter was repeatedly raised in Parliament, and the government repeatedly indicated that it had no intention of acting, citing “difficulties both of principle and of practice in bringing this type of behaviour within the scope of the criminal law.”⁵

In 1998, the Home Office did publish a consultation paper, suggesting that legislation might be brought forward criminalising the deliberate transmission of serious disease. However, no such legislation has been introduced.⁶

Ironically, the government’s failure to act in this area may have resulted in the courts “creating” an offence that is potentially far wider than anything for which the government might have been prepared to legislate. The government is likely, however, to leave these issues in the hands of the courts. There would be little political mileage in any other course of action.

The current government is, however, considering longer-term proposals for wide-ranging reform of the criminal law – in particular, bringing major criminal offences together in a single “criminal code”. The criminalisation of HIV transmission might be addressed as part of this process, but any such reform is likely to be years away yet.

Will there be a flood of prosecutions?

It is very unlikely indeed that the *Dica* case will result in a significant number of prosecutions for transmitting HIV. In Scotland, there do not appear to have been any further prosecutions since Stephen Kelly’s conviction in February 2001. The experience of other jurisdictions that have criminalised the transmission of HIV in certain circumstances suggests that prosecutions are likely only to be brought in exceptional cases.

In that respect, it is significant that both Kelly and *Dica* were accused of having actively discouraged their sexual partners from using condoms. Additionally, the charge against Kelly expressly alleged that he had claimed to his partner that he was not HIV-positive. It is unlikely that the Crown Prosecution Service will be as keen to bring a prosecution where the allegation is simply one of a failure to disclose one’s HIV status, without the HIV-positive partner having actively encouraged the other party to engage in unprotected and unsafe intercourse.

Furthermore, prosecutions are unlikely to be brought unless there is more than one complainant – otherwise, the evidence of one alleged victim is unlikely to be sufficient for proof beyond reasonable doubt.

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Is the offence limited to HIV?

The offence recognised by the court in the *Dica* case is not limited to cases involving HIV, but could extend to any STI that might be regarded as "grievous bodily harm".

There are, in fact, UN guidelines on the criminalisation of HIV transmission that explicitly recommend that such criminal offences should not be limited to HIV, because it would be wrong to "single out" the virus in this fashion.⁷

Indeed, there was an attempt early in 2002 to prosecute a man for transmitting viral herpes to his partner, although there were no newspaper reports of the case after an early procedural hearing and it is not clear what happened to the case thereafter.⁸

The "state of mind" required for the offence

To be guilty of any serious criminal offence, a person must have acted with a culpable state of mind – which lawyers refer to as *mens rea*. The *mens rea* required for the offence of inflicting grievous bodily harm is intention or recklessness. In other words, for a conviction, it would be necessary to show that the defendant intended to infect the other party with HIV, or that they were reckless as to this possibility – that is, that the defendant was aware of the risk of infection.

It is theoretically possible, therefore, that a person could be guilty of this offence even if they had not received a positive result from an HIV test. It would, however, be necessary to show that they were aware of a significant risk that they might be HIV-positive. For example, if they had previously been regularly engaged in unprotected intercourse with a person or persons whom they knew to be HIV-positive. While a prosecution in such a case would be unlikely, it should be made clear that avoiding

taking an HIV test does not provide immunity from criminal prosecution. This is the case in both Scotland and England & Wales and suggestions to the contrary⁹ are simply wrong¹⁰.

What is the effect of consent?

What if a person consents to unprotected sexual intercourse knowing that the other party is HIV-positive? Can an offence be committed in these circumstances, or does the consent of that person operate as a defence? Unless and until such a case comes before the courts, it is impossible to give a firm answer to this question. Some *ATU* readers may be familiar with *R v Brown*¹¹ – the so-called "Spanner" case – where a group of men who engaged in consensual sadomasochistic activities were charged with assault. The House of Lords – by a majority of 3 to 2 – held that the fact that the activities were consensual was no defence, because of their "harmful" nature. The case later went to the European Court of Human Rights (ECHR), which held unanimously that the convictions had not been a breach of the ECHR.¹²

It is sometimes assumed that, because of *Brown*, the English courts would be obliged to hold that consent could not be a defence to a charge of inflicting grievous bodily harm by transmitting HIV.¹³ However, the Canadian courts have rejected this argument, pointing out that, first, consent to a risk of injury is not the same as consent to injury and secondly, consensual sexual intercourse is seen as serving a "positive social purpose", unlike sadomasochistic acts.¹⁴

It is likely that this approach would be followed in the English courts, although at least one US court has reached a different conclusion.¹⁵

Again, however, a prosecution in such a case is probably highly unlikely. The issue only arose in the Canadian courts because of an unsuccessful attempt to argue that, where a person unknowingly consented to a risk of HIV



“Effectively, the decision in the Dica case suggests that there is a legal duty for HIV-positive people to disclose their HIV status before engaging in high-risk sexual activities.”

infection – because of their partner’s failure to disclose their HIV status – their consent to sexual intercourse was thereby rendered invalid.

Tacit consent

What about cases where a person knows themselves to be HIV-positive, but their sexual partner consents to unprotected sexual intercourse without the issue of HIV (or other STIs) ever being raised? My view is that, under the law as it stands, there would be criminal liability in such a case if HIV were to be transmitted as a result. This is because it is difficult to argue that the HIV-negative party genuinely “consented” to the risk of transmission, given that they were not specifically aware of the risk.

However, it might be argued that there is a genuine consent to a risk of HIV transmission in some circumstance, perhaps between gay men who engage in unprotected anal intercourse without specifically discussing HIV infection – in backrooms, saunas or sex clubs, for example – because of the higher risk involved in such cases and the – arguably – greater awareness of such risks.

As indicated earlier, I doubt that a prosecution would be brought unless it could be shown that

the accused person had lied to their sexual partner about their HIV status – as in the Kelly case – or had actively sought to dissuade their partner from using condoms, as was alleged in the Dica case. That does not, however, mean that a prosecution is ruled out as a matter of law.

Is the offence limited to cases where the transmission of HIV or an STI has actually resulted in infection?

If an HIV-positive person has unprotected sexual intercourse without disclosing their serostatus, but the other party does not become infected, then a prosecution would be unlikely. It is possible that there could be a prosecution for an attempt to inflict grievous bodily harm in such a case, but the prosecutor would have to show that the defendant actually intended to transmit the disease. It would not be enough to show that the positive person was simply reckless as to the possibility of the disease being transmitted.

What if condoms are used?

What if a person who is HIV-positive does not disclose this fact to their sexual partner(s), but uses condoms? Would a criminal offence still be committed if HIV were transmitted despite the use of condoms? The answer is probably that no offence has been committed, because that person

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could not be said to be acting “recklessly”. In this context, the Canadian Supreme Court has suggested that the “careful use of condoms might be found to so reduce the risk of harm” that criminal liability would not result.¹⁶

Similar considerations would apply where the parties have engaged in sexual conduct but have refrained from “high-risk” sexual activities such as unprotected anal or vaginal intercourse. The courts might have more difficulty with unprotected oral sex, which cannot be considered “high-risk”, but does present a more than negligible risk. One Canadian court has taken the view that unprotected oral sex is insufficiently risky to be caught by the criminal law.¹⁷

Again, my view is that any future prosecutions will be confined to what might be considered “extreme” cases. It is, therefore, unlikely that any prosecution would be brought in such a case. The prosecution in the Canadian case mentioned above took place on the basis of an allegation of unprotected anal intercourse, and the question regarding oral sex only arose because the defendant denied that allegation but accepted that unprotected oral sex had taken place.

Non-sexual transmission

The discussion above has focused on the sexual transmission of disease. Transmission by other routes is possible, however – most obviously by the sharing of drug-injecting equipment – and the criminal law would apply equally to such a case. I suspect, however – although this may be an overly cynical view – that the prosecution authorities are likely to be less interested in such cases. A person who has become infected with HIV through intravenous drug use is unlikely to arouse sympathy to the same degree as the complainants in the Dica case.

Medical confidentiality

As a final point, it should be noted that although doctor-patient communications are generally

regarded as confidential, a doctor is not entitled to refuse to give evidence of such matters in court. This is a long-established rule of law in both Scotland and England & Wales, and the court in the Stephen Kelly case rejected an objection to the leading of evidence along these lines.

Conclusion

It is impossible to state the current law with precision. From an academic perspective, this illustrates the difficulty of criminal law reform being undertaken by the courts rather than by Parliament.

From a practical point of view, however, the difficulties are more serious. If Dica’s appeal against conviction is not pursued – and at the time of writing, this remains a possibility – the law may be left unclear for some considerable time. Even if it is pursued, the decision of the higher court – or courts – is unlikely to result in absolute certainty on the questions that have been highlighted above.

The most important point is, I think, that prosecutions for this offence are likely to be very rare indeed. The public prosecution authorities are likely, at least at present, only to be interested in cases where a person is accused of having actively deceived multiple victims. Private prosecution is, however, still an option in England & Wales, although unusual. Nevertheless, criminal liability remains a possibility in cases falling short of this.

The best legal advice that can be given at the current time is that HIV-positive individuals who are concerned about the risk of criminal liability should either disclose their serostatus to their sexual partners prior to sex, or insist on the use of condoms, or preferably do both. Effectively, the decision in the Dica case suggests that there is a legal duty on persons who are HIV-positive to disclose their HIV status before engaging in high-risk sexual activities.

editor’s note

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lipid-lowering drugs

When lifestyle and drug switching strategies aren't enough, how do you deal with high cholesterol and triglycerides? by edwin j bernard

Last month's *ATU* looked at how supporting and encouraging lifestyle interventions – like stopping smoking, exercising and eating a more heart- and pancreas-friendly diet – and switching to a less atherogenic HAART combination are two of the main ways that clinicians are attempting to manage lipodystrophy's metabolic syndrome, which appears to increase our risks of cardiovascular disease.

But what happens when lifestyle changes and/or drug switching aren't enough to move levels of cholesterol and triglycerides to a range that would reduce the risk?

And what about those people who are unable to switch to a more heart-friendly HAART? When resistance and/or tolerability issues reduce the choice of available drugs, keeping control of viral load is likely to preclude drug-switching strategies, unless there are already high coronary heart disease (CHD) risks due to non modifiable factors, like age or a history of smoking or a family history of cardiovascular disease.

According to the latest US¹ and UK² guidelines, under either of these circumstances, lipid-lowering drugs should be used.

However, the use of these therapies is not straightforward, since the class of lipid-lowering drugs known as statins can interact with both antiretrovirals and other medications used by people with HIV. The good news is that if

interactions can be avoided, these drugs appear to have a similar effect in people with HIV as those without. The bad news, however, is that even in the general population, only a minority of patients treated with lipid-lowering drugs achieve National Cholesterol Education Programme (NCEP) lipid goals³.

The British HIV Association (BHIVA) guidelines for the treatment of HIV-infected adults with antiretroviral therapy include very little guidance on using lipid-lowering therapies, other than warnings about drug interactions (see below). Fortunately, recently published US guidelines provide a detailed analysis of what to use and when to use it.

What to use when high LDL cholesterol is the main problem

Normal levels of LDL cholesterol are considered to be 3.5-6.5 mmol/L. The US guidelines make HMG-CoA reductase inhibitors – otherwise known as statins – the first choice for attempting to lower LDL cholesterol that is above this range. Statins lower cholesterol by slowing down the body's production of cholesterol and by increasing the liver's ability to remove the LDL cholesterol already in the blood. They have been used extensively in HIV-negative people to both reduce the risk of CHD in people who have not yet had a cardiovascular event, and also to reduce the progression of CHD in people who have already had a heart attack.

glossary

atherogenic Producing the most degenerative changes in the walls of arteries.

cardiovascular disease Cardiovascular disease includes coronary heart disease (about 50%), stroke (about 25%), and all other diseases of the circulatory system.

cholesterol A waxy substance, mostly made by the body and used to produce steroid hormones.

coronary heart disease (CHD) The two main forms of CHD are heart attack (also known as myocardial infarction) and angina.

diabetes Raised concentration of sugar in the blood, due to problems with the production or action of insulin (insulin resistance, or reduced insulin sensitivity, are also known as pre-diabetes).

HAART Highly Active Antiretroviral Therapy, a term used to describe anti-HIV combination therapy with three or more drugs.

hypertriglyceridaemia High level of triglycerides.

insulin Hormone produced by the pancreas that tends to lower blood sugar levels.

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Statins have also been studied in HIV-positive people and although significant toxicities were not reported in these trials, few people actually had clinically significant reductions in their LDL cholesterol levels.

Nevertheless, the US guidelines suggest that when LDL cholesterol or non-HDL cholesterol is elevated, but triglyceride levels are no higher than 5.65 mmol/L (twice the upper level of normal) the two recommended statins to use are either:

- pravastatin
(20-40 mg daily as a starting dose)

or

- atorvastatin
(10 mg daily as a starting dose).

At the recent Ninth European AIDS Conference in Warsaw, a team from London's Chelsea & Westminster Hospital presented a paper comparing these two cholesterol-lowering drugs in people on both PI- and NNRTI-based HAART.⁴ Out of 179 people (102 on atorvastatin and 77 on pravastatin) 82% had a modest decrease in LDL cholesterol: a mean of 1.26 mmol/L on atorvastatin and 1.30 mmol/L on pravastatin. However, 56% of those on atorvastatin managed to decrease their LDL cholesterol levels to below 6.6 mmol/L compared with 32% of those on pravastatin, suggesting that atorvastatin is somewhat more effective.

In this study, the two drugs did not appear to affect people on PIs or NNRTIs differently, but a second paper presented in Warsaw *did* see a short-term time-dependent difference between those on PI- and NNRTI-based HAART. In this Spanish study⁵ 86 individuals, 60% of whom were on NNRTI-based HAART, were prescribed pravastatin (20 mg/day) for a year. After four months, the people on NNRTI-based HAART appeared to do better than the people in the PI

arm with LDL reductions of 21% and 11%, respectively ($p=0.05$). But after eight months this difference had disappeared, in fact the PI-treated group showed a trend towards greater LDL cholesterol reduction (-36 vs -25% $p=0.008$). After eight months, 40% of those in the study achieved NCEP goals. One in five were stepped up to a higher dose of pravastatin (40 mg/day) after the fourth month, however, and pravastatin therapy was stopped in 6% due to what the study's authors euphemistically term "unremarkable side effects", which means no serious muscle or liver toxicity occurred.

The US guidelines also suggest other options to the two recommended statins, noting that fluvastatin (20-40 mg/daily) is a "reasonable alternative." They add that if statins cannot be used – e.g. due to drug-drug interactions – then another class of drugs, fibrates, might be considered (see below).

Since it has been estimated that it will take five or six years to accumulate a clinical benefit from the use of statins in people with a risk of CHD due to high LDL cholesterol, it is probably never too early to start if you are at risk.

What to use when high triglycerides are the main problem

People with HAART-related metabolic disorders tend not to have high triglycerides without also having elevated LDL cholesterol. Sometimes, however, LDL can just be on the wrong side of the upper limit of normal and under these circumstances – when triglyceride levels are above 5.65 mmol/L – then fibrate therapy should be used. Fibrates work in several ways, the main effect being to reduce VLDL (very low density lipoproteins) in the blood which are largely made up of triglycerides. The two recommended drugs are gemfibrozil (600 mg/twice daily, 30 mins. before meals) or micronised fenofibrate (54-160 mg/daily).

“Niacin – aka vitamin B3 – ought be a really useful supplement for treating high lipid levels. Not only does it raise HDL cholesterol, but it lowers LDL cholesterol and triglycerides. The problem, however, is that as well as causing flushing, it can induce insulin resistance.”

An Italian study published in the journal *AIDS* earlier this year⁶ compared fibrates with statins for the treatment of hypertriglyceridaemia. One of three different fibrates (bezafibrate, gemfibrozil or fenofibrate) or one of two statins (pravastatin or fluvastatin) were given to 113 PI-based HAART recipients with high triglycerides for a year. Since the numbers on each were small – between 18 and 25 on any one drug – the conclusions reached were no surprise: the fibrates were more effective at reducing triglyceride levels.

Several studies published last year⁷ found that both gemfibrozil and fenofibrate not only reduced triglyceride levels but also raised HDL (“good”) cholesterol levels. However, only a minority of those enrolled in these trials actually achieved normal levels of these beneficial lipids.

When statins or fibrates alone aren’t enough

The US guidelines suggest that if statin therapy has not reduced elevated LDL cholesterol, adding either a fibrate or niacin (see below) is a possible approach, but due to the risk of myopathy, statin-fibrate therapy should be used with great caution.

If statins and fibrates *are* to be used together, the US guidelines recommend pravastatin or fluvastatin in combination with either gemfibrozil or micronised fenofibrate. Additionally, since niacin treatment is associated with an increased risk of insulin resistance, regular fasting glucose levels should be taken.

If fibrate therapy has not reduced elevated triglycerides, the guidelines suggest adding a fish oil supplement (see below) or niacin. Adding statin therapy is not recommended.

Is there a role for more *natural* therapies?

Niacin – also known as vitamin B3 or nicotinic acid – ought to be a really useful supplement for treating high lipid levels. Not only does it raise HDL cholesterol but it also lowers LDL cholesterol and triglycerides. The problem, however, is that as well as causing flushing – a sort of intense, itchy tingling in the skin – it can induce insulin resistance. Since insulin resistance is already commonly seen in many people with metabolic syndrome, that would be counterproductive. However, a study published three years ago⁸ concluded that niacin was safe to use in people with diabetes, although glucose levels were still increased by niacin by an

glossary continued

lipodystrophy Disruption to the way the body produces, uses and distributes fat.

lipid General term for fats.

lipoatrophy Another term for fat loss.

myopathy Muscle wastage or disease.

National Cholesterol Education Programme

A US programme aimed at reducing high blood cholesterol.

NRTI Nucleoside analogue reverse transcriptase inhibitor, the family of antiretrovirals which includes AZT, ddI, ddC, 3TC, d4T and abacavir.

omega-3 fatty acids A form of polyunsaturated fats, one of four basic types of fat that the body derives from food.

Cholesterol, saturated fat, and monounsaturated fat are the others.

PI Protease inhibitor, the family of antiretrovirals which target the protease enzyme.

triglycerides Basic 'building blocks' from which fats are formed.

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average of 0.4 mmol/L in those with, and 0.3 mmol/L in those without, diabetes. The US guidelines, therefore, sensibly suggest that niacin should be avoided as first-line therapy for treatment of high lipids if on PI-based HAART or suffering from lipoatrophy, but reason that it might be useful in some cases.

The amino acid L-carnitine may also reduce triglyceride levels but so far only one small study has been published.⁹ This open-label, single arm study found that 3 grammes daily (that's six 500 mg tablets) of L-carnitine resulted in a 35% reduction in mean triglyceride levels after an average of nine months, with 40% achieving normal levels (<2.3 mmol/L) and 69% near-normal (<3 mmol/L) levels.

As discussed in last month's article on diet and lipodystrophy, omega-3 fatty acids – found mainly in oily fish – appear to be quite effective in reducing triglyceride levels. If you can't bring yourself to add fish to your diet on a regular basis, you can also buy or be prescribed fish oil capsules. Be aware, however, that you have to take around six a day to get enough omega-3 fatty acid to have an effect.

Drug-drug interactions

The latest BHIVA guidelines place their focus squarely on the possible interactions between statins and PIs. They agree with the US guidelines that the use of simvastatin and lovastatin in people on PI- or delavirdine-containing HAART is not recommended.

- Atorvastatin levels could be doubled in people on PIs, but both suggest that this drug can be used with caution.
- Pravastatin appears to be safe with PIs, but whereas the UK guidelines say it appears to have a low likelihood of PI interactions, the US guidelines caution that pravastatin doses may need to be increased when taken along with ritonavir-containing regimens.
- Fluvastatin does not appear to have any PI-related drug-drug interactions.
- Any of the statins are probably safe in efavirenz or nevirapine-containing regimens.
- The US guidelines also suggest that levels of fibrates may be reduced in ritonavir-containing regimens, but otherwise no interactions are known at this time.

key conclusions

- Lipid-lowering medications can be used instead of, or in addition to, lifestyle changes and/or drug-switching.
- Statins – particularly pravastatin and atorvastatin – are relatively safe and somewhat effective in reducing high LDL cholesterol levels, but interactions can occur with some PIs.
- Fibrates – usually fenofibrate or gemfibrozil – are used to reduce high triglyceride levels when high LDL cholesterol is not the main concern. They appear to have no significant interactions with PIs.
- NNRTIs can be used with any fibrate or statin therapy.
- Statins and fibrates should only be used together with great caution. UK guidelines suggest a specialist lipidologist oversee this type of treatment.
- Niacin, fish oil and possibly L-carnitine can also be used to lower lipids, but niacin can increase the risk of insulin resistance, and should be used with great caution.
- Few people on HAART actually achieve clinically important changes in their lipid profile on these drugs over the short term, and this lipid-lowering therapy should therefore be considered to be a long-term risk-reduction strategy.

Bareback hep C risk

Data presented from Professor Brian Gazzard of London's Chelsea & Westminster Hospital at the 9th European AIDS Conference in Warsaw in October suggests that being the passive partner during unprotected anal intercourse is the main sexual practice associated with gay HIV-positive men becoming coinfecting with hepatitis C.

Receptive unprotected anal intercourse was the common risk factor amongst the 44 HIV-positive men for whom sex was identified as the only transmission risk out of the 50 men seen at London's largest HIV clinic since January 1997, 44 of which have been in the past 21 months. "They all had passive anal sex," Prof. Gazzard told the conference, "but many of them were also fisting. We did ask about [snorting drugs] and we didn't find any association, so I don't think that was a risk factor." Around 40% had also been diagnosed with syphilis in the year prior to HCV coinfection. Four of the men injected drugs, and transmission risk has not been identified in four additional cases.

ATU first reported on this new sexually transmitted epidemic in September 2002.

Nelson M. et al. 9th EACS, Warsaw, abs F12/3, 2003.

Anal wart cancer risk high in positive men

A study from London's Chelsea & Westminster Hospital suggests that HIV-positive men who are infected with anal human papilloma virus (HPV), and have abnormal cells in the anus, are usually infected with multiple HPV strains, which are often potentially cancer-causing. This finding, reported in the November 7th edition of *AIDS*, stands in contrast to research into HPV infection and cervical cancer which found that infection with multiple strains of HPV was rare in women.

This news will add strength to Peter Tatchell's ongoing campaign for anal pap smears to be offered every three years to gay men who practice receptive anal intercourse, similar to the vaginal pap smear tests currently used successfully to detect cervical cancer. The National Screening Committee is taking Mr Tatchell's recommendations seriously, and has agreed to assess existing research and fund further studies.

In the meantime, ask your HIV clinician or GUM clinic for an anal pap smear if you are concerned about your HCV risk.

Stebbing J et al. AIDS 17: 2401, 2003.

FTC approved

Last month, the European Commission approved a new NRTI, FTC (emtricitabine), after its US approval in July. It is available as a 200 mg hard capsule dose for adults and a 10 mg/mL oral solution for use in infants and children. FTC will be marketed by Gilead as Emtriva™.

FTC is a once daily nucleoside analogue, with a similar structure and resistance profile to 3TC (lamivudine).

The drug is also active against hepatitis B, but has not yet been approved for hepatitis treatment.

Paul McCrory

Sadly, Gilbert Vieri informs us of the death of his partner, Paul McCrory, a very early member of Body Positive who also established the Network of Self-Help Groups for HIV/AIDS. Those wishing to pay tribute to Paul's life and work are asked to make donations to: The Patrick Manson Unit, Cecil Flemming House, University College Hospital, Grafton Way, London WC1E 3BG.

news from nam

new *atu* editor

This newsletter has a new editor, Edwin J Bernard. Edwin has lived with HIV for 20 years, and was formerly an entertainment journalist. A regular *ATU* contributor, Edwin also edited the 2003 edition of NAM's *HIV Treatments Training Manual*. NAM's director, Caspar Thomson writes: "I am delighted Edwin will be joining the team. We are extremely lucky to recruit someone with Edwin's experience, knowledge and calibre to this important role."

december *atu*

The next *ATU* will be a double issue, featuring the latest on *New Fill* for facial wasting.

nam information forums

NAM's last forum of 2003 on will be on hepatitis coinfection and takes place at the University of London, Palms Room, 4th Floor, Malet St, WC1 on Monday December 1st.

news in brief

credits

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about NAM

NAM is a charity that exists to support the fight against HIV and AIDS with independent, accurate, up-to-date and accessible information for affected communities, and those working to support them.

For more information, and details of our other publications and services, please contact us, or visit our website, www.aidsmap.com.

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any questions

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This is a comprehensive guide to the medical aspects of HIV. Available at only £12.95 to people with HIV and £64.95 to professionals. Please contact us to order your copy.

www.aidsmap.com

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information forums in London

Each month an expert speaker discusses an HIV treatment-related topic. Entry is free. Future forums are advertised inside this newsletter and on our website.

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0808 8006013

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NAM recommends that you discuss all your treatment decisions with your doctor.