

aids treatment update

special issue: mental health and HIV

In the June 1st edition of the *British Medical Journal* the Director of the PHLS Communicable Disease Surveillance Centre, argued that rising trends in HIV, gonorrhoea and syphilis in western Europe are symptomatic of complacency about HIV among individuals, populations and some governments.

In the UK, a recent report published by the British HIV Association (BHIVA) and the Terrence Higgins Trust suggests we are facing a looming public health crisis because the government is not doing enough to prioritise HIV services. Government plans to devolve the management of people with HIV to primary care trusts, BHIVA clinicians argue, will do nothing to resolve the impending crisis.

The government's healthcare priorities are cancer, heart disease and mental health. People with HIV are disproportionately affected by each of these illnesses. Therefore this month's ATU looks at mental health, one of the government's health targets, within the specific context of HIV in the HAART era.

This month the 14th International Aids conference takes place in Barcelona. NAM will be providing same day news summaries on our website aidsmap.com and August's ATU will be a special conference-focused edition. NAM will be providing conference feedback sessions across the UK during the summer. Details will be published in August's ATU.

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depression and HIV

2 people with HIV are more prone to mental health problems than the general population. What strategies can be deployed to combat depression? by robert fieldhouse

Whilst the encouraging progress made in treating HIV infection since the introduction of HAART has led to people with HIV living longer, healthier and ultimately more fulfilling lives, living with a chronic long-term infection requires individuals to adjust to a range of new issues precipitated by this extended life expectancy. HAART may have led to declines in HIV-related dementia and damage to memory, but people living with HIV remain disproportionately affected by depression and a host of other psychiatric disorders.

Psychiatric disorders among people with HIV may impair quality of life, adversely affect both the need for and uptake of health services, have a negative effect on health outcomes, and act as a barrier to adherence to HAART.

Depression among HIV clinic populations ranges from 22% to 32%¹. This is two to three times higher than the prevalence of depression identified in general community populations.

Other studies that have included HIV-negative comparisons from the same populations as those who are HIV-positive have failed to show large differences in the prevalence of psychiatric disorders between the HIV-positive and HIV-negative sub-populations. Rates of depression are similarly high among HIV-negative and HIV-positive gay men. In the general population, depression occurs twice as often in women compared to men. In community and clinic samples, the highest rates of clinical depression have been reported among HIV-positive women, where rates as high as 30% to 60% have been described².

Depression

The most common psychiatric disease seen in HIV clinics is mild to moderate depression. Depression is different from ordinary sadness, which may only last a few days and allow you to continue with your normal life. Depression consists of a range of symptoms which compromise your ability to function normally. Activities that were once pleasurable may no longer be enjoyable and you are unlikely to be able to 'pull yourself together'.

Symptoms of depression include: a persistent sad or anxious mood, feelings of hopelessness, helplessness, worthlessness, pessimism or guilt; lack of interest in activities that were once enjoyable (including sex), fatigue, difficulty concentrating, remembering or decision making; insomnia or oversleeping, appetite and/ or weight loss, or overeating and weight gain, thoughts of death or suicidal ideation or attempt. It is also possible to have physical symptoms such as headaches, pains or digestive disorders.

Dysthymia is a less severe form of depression. It usually consists of long-term chronic symptoms that prevent one from functioning well or feeling good. Many people with dysthymia may also experience major depressive episodes at some point. Less prevalent than other forms of depression is bipolar disorder, also known as manic depression. It is characterised by alternating mood cycles, ranging from severe highs (mania) to lows (depression). When depressed, an individual with bipolar disorder may have any of the symptoms of depression, while when manic, the individual may be overactive.

Mania can affect thinking, judgment and social behaviour, and cause serious problems.

Researchers have shown that physical changes in the body can be accompanied by mental changes. Illnesses such as stroke, heart attack and cancer can cause depression, making a person apathetic and prolonging recovery time. Serious loss, financial or relationship difficulties or stress can all trigger depression. Often the cause of a depressive episode is a combination of genetic, psychological and environmental factors.

People with HIV can experience extreme reactions when they first learn that they are HIV-positive, and again on learning that HIV is progressing or that their CD4 count is falling. Some people feel simply overwhelmed. Cognitive behavioural therapy (as described below) may be beneficial, since it encourages people to adopt certain behaviours or thoughts to increase function in the face of adversity.

Treating depression

If practical difficulties are the cause of depression, then dealing with these may be helpful. For more severe depression, help is available from trained counsellors, psychologists and psychiatrists through your HIV clinic, or sometimes in the case of counselling, through your local HIV organisation.

Doctors or psychiatrists may prescribe antidepressants which can relieve the symptoms of depression by acting on the brain's neurotransmitter system, which influences mood and behaviour. A range of antidepressants have been available since the 1950s. The newest and most widely-prescribed class today is the SSRIs (selective serotonin re-uptake inhibitors), of which the best known example is fluoxetine (*Prozac*). A significant proportion of people experience early side-effects such as headaches, diarrhoea, insomnia, giddiness and nausea. These side-effects usually pass after a few weeks of treatment.

Antidepressants do not take immediate effect.

It may be some weeks before you notice improvements and it is important to keep taking the medication until you begin to feel better. Patients are often tempted to stop the medication too soon, thinking either the medication is not working or that they no longer need it.

SSRIs don't usually cause weight gain, although they can affect sexual function. Impotence or delayed ejaculation are side-effects which may affect 10-20% of people taking *Prozac*. Withdrawal symptoms are not usually seen when the drug is stopped.

It is unclear how long antidepressants should be taken for in order to 'cure' depression. The standard duration of antidepressant treatment is six months, followed by review. At this point the decision will be made to continue, reduce the dose or completely discontinue the medication. There is some evidence that psychological interventions (talking therapies) alongside antidepressant treatment improves the outcome of treatment.

Drug interactions

Antiretroviral therapy, particularly protease inhibitors, may interact with medications used to treat mood and anxiety disorders. SSRI doses may need to be cut by one half to two thirds initially, and increased as appropriate for therapeutic response. SSRIs may also increase blood levels of protease inhibitors, but the clinical significance of this interaction is not known. As always, the best advice is for your doctor to be aware of all the medication you are taking, in order that harmful interactions may be minimised.

See **Table 1**, overleaf, for further information.

St John's wort and kava kava

Interest in the use of herbs to treat both anxiety and depression has increased over the past few years. St John's wort (*Hypericum perforatum*) is a commonly used herbal treatment for depression, with proven effectiveness against mild depression. Today in Germany, St John's wort is more widely-prescribed to treat depression than any of the SSRIs. A three year trial is

editor's note

This edition of ATU was edited by Robert Fieldhouse. With thanks to Michael Carter and Thomas Paterson.

thanks

The editor would like to thank Dr Pepe Catalan and Dr Angela Byrne for comments on this article.

glossary

A booklet of medical terms, *Glossary*, used to discuss HIV & AIDS is available from NAM. Copies are free to people with HIV. Telephone 020 7627 3200 or email info@nam.org.uk.

references

- 1 Bing E et al. Archives of General Psychiatry 58; 721-728, 2001.
- 2 Suarez S et al. AIDS 15; 195-200, 2001.
- 3 Cohen R et al. AIDS 15; 341-345, 2001.
- 4 Rabkin J et al. Archives of General Psychiatry 57; 141-147, 2000.



depression and HIV continued

Table 1: Dose ranges and interactions with HIV medications and commonly used antidepressants

| Antidepressants | Usual Dosage Range | Interaction with HIV medications |
|-------------------|---|--|
| <i>Prozac</i> | 20 mg in the morning (reduced dose in hepatic impairment and the elderly) | <i>Prozac</i> increases APV, DLV, EFV, IDV, L-RTV, RTV, NFV, and SQV levels; NVP decreases <i>Prozac</i> levels. L-RTV and RTV increase <i>Prozac</i> levels |
| <i>Lustral</i> | 50-150 mg in the morning | L-RTV and RTV increase <i>Lustral</i> levels |
| <i>Seroxat</i> | 10-50mg at bedtime | L-RTV and RTV increase <i>Seroxat</i> levels |
| <i>Cipramil</i> | 20-60 mg in the morning | L-RTV and RTV increase <i>Cipramil</i> levels |
| <i>Dutonin</i> | 200-300 mg bd | <i>Dutonin</i> increases EFV and IDV levels. RTV, SQV, IDV, NFV, APV, DLV and EFV all increase <i>Dutonin</i> levels. EFV and NVP decrease <i>Dutonin</i> levels |
| <i>Efexor</i> | 75-300 mg in the morning | L-RTV and RTV increase <i>Efexor</i> levels |
| <i>Zispin</i> | 30-45 mg at bedtime | No known interactions |
| <i>Wellbutrin</i> | 100-400mg/d in divided doses | RTV increases <i>Wellbutrin</i> levels (contra-indicated) |

key

PIs

| | |
|-------|-------------------------|
| APV | amprenavir |
| IDV | indinavir |
| L-RTV | lopinavir/ ritonavir |
| NFV | nelfinavir |
| RTV | ritonavir |
| SQV | saquinavir |

NNRTIs

| | |
|-----|-------------|
| DLV | delavirdine |
| EFV | efavirenz |
| NVP | nevirapine |

underway at the National Institutes of Health (NIH) in the USA, comparing St John's wort with an SSRI and a placebo. In total, 336 people will be enrolled. The results are soon-to-be published.

Research published in February 2000 revealed that St John's wort should not be taken at the same time as protease inhibitors or NNRTIs, since it reduces levels of these drugs, promoting the emergence of resistance and possibly contributing to treatment failure. Earlier this year, warnings were issued

regarding the herbal preparation kava kava and potential liver toxicity; these 'natural products' should not be used without the knowledge of your doctor.

Psychological interventions

Over 450 different forms of psychotherapy have been identified, though these can be reduced to a much smaller range of therapy types. The most common are described below. The term cognitive behavioural therapy (CBT) pertains to a range of therapies that include behaviour therapy, behaviour modification,

and cognitive therapy in various combinations. They are all theroretically distinct.

Behavioural approaches typically involve a formal behavioural analysis of a patient's problem. This is followed by an individually tailored application of techniques to change behaviour. Behaviour change is of paramount importance.

Cognitive approaches emphasise the role that cognitions play in mediating feelings and behaviour. The aim is to modify thought processes directly. Therapy involves trying to identify automatic thought processes (such as hopelessness during depression), and tuition in how to recognise and challenge such thought processes. It helps people to connect life events to mood episodes, and encourage people to find new goals.

Long-term **psychodynamic psychotherapy** may last several years. It is based on psychoanalytic theory, and its distinctive feature is the resolution of unconscious conflicts. It makes direct use of the patient's experience of both the therapist and the therapeutic relationship. It aims to improve the patient's conscious understanding of difficulties and enable the assimilation of previously avoided, potentially painful experience. Brief psychotherapy may last for six months with weekly or bi-weekly sessions. It is focused on specific issues in the hope that the improved understanding it brings about will facilitate patients to effect a more lasting symptomatic change. This is achieved through processes which extend beyond the end of treatment. Patients who opt for this approach will need adequate capacity to tolerate frustration and psychic pain.

Counselling is usually conducted on a short-term basis (4 to 12 sessions), by individuals who have formal qualifications in counselling. Counselling may be used to help people to cope better with distress caused by immediate crises, to help people better understand their reactions to events, and to develop better coping strategies. It is particularly useful for the treatment of sub-clinical depression and interpersonal problems. It can be used to facilitate patients

in determining a realistic assessment of their adherence to treatments, and in adjusting to the daily routine of taking HAART.

Clinical psychologists may draw upon several different therapeutic methods during the course of treatment. Particular psychiatric problems do not preclude or require intervention with a particular therapy. At best, patients should be evaluated in a co-ordinated psychological treatments service which has expertise in a range of specific therapies.

The role of HAART

Since the introduction of HAART in 1996 the incidence and severity of opportunistic infections has declined dramatically among HIV-positive people and survival times have improved. Conflicting data have been published on the ability of protease inhibitors to cross the blood-brain barrier, while the data on the effect of protease inhibitors on neuropsychological impairment is limited.

In the pre-HAART era, dementia occurred in around 7% of people with advanced HIV disease. This has declined dramatically. In our interview, Dr Catalan reveals that both manic episodes and suicide have become much less frequent events in recent years.

HAART has been shown to help maintain intact cognitive functioning. In addition, some studies have shown that HAART can curb central nervous system (CNS) disease, since it directly improves neuropsychological functions through the reduction of viral load both in plasma and cerebrospinal fluid (CSF)². HAART has also been shown to reduce brain lesions linked to cognitive impairments.

People treated with HAART have been shown to improve in verbal fluency, information processing, and psychomotor speed, whereas HIV-positive people not on HAART worsened over time. One study in HIV-positive women found that neurocognitive improvements were greater for women who had been taking HAART for more than 18 months than for women who received HAART for 12 months or less, suggesting that sustained therapy may be

Glossary

bd Abbreviation of a Latin term meaning twice daily.

cognitions Thought processes.

hypogonadism A condition characterised by deficient production of the hormones secreted by the gonads; that is the ovaries and the testes.

motor Movement.

neuropsychological impairment Diminished brain function.

psychomotor speed The ability to co-ordinate body movement.

suicidal ideation To think about, or consider suicide.

depression and HIV continued

necessary to obtain optimal cognitive benefit³. Benefits were not dependent on age or educational background of the participants. Due to the necessity of high levels of adherence, protease inhibitors and other antiretroviral therapies will have no benefit for people who are too disturbed to take them.

Though dementia only now occurs in a small subset of HIV-positive people, milder HIV-associated cognitive and motor impairments are still common, and often affect quality of life. Limited data are available on the long-term effectiveness of HAART in reducing the central nervous system manifestations of HIV.

Anti-HIV drugs themselves have been blamed for causing psychological distress and disturbance to sleep and concentration. The NNRTI efavirenz is contra-indicated in someone with a history of depression or anxiety. Studies have suggested that central nervous system (CNS) side-effects occur in between the 14%-50% of people taking efavirenz in the first few months of using the drug. However, these are only severe enough to require discontinuation in a small percentage of patients.

A role for testosterone?

Testosterone has been evaluated for its efficacy to alleviate hypogonadal symptoms (diminished libido, depressed mood, low energy, depleted muscle mass) in men with symptomatic HIV infection. One small, double-blind, placebo-controlled trial which enrolled only men, found that short-term twice-weekly injections of testosterone cypionate were effective in alleviating depressed mood⁴.

The six week trial enrolled 74 men, of which

70 completed the treatment course. Of the 26 completers with current mood disorder, 11 (58%) of the 19 randomised to testosterone and 1 (14%) of 7 randomised to placebo were regarded as mood responders. Of the 11 patients taking antidepressants, 7 were randomised to testosterone and 4 to placebo; response rates to either testosterone or placebo did not differ significantly from those not taking antidepressants, and quality of life improved more among those taking testosterone.

Limitations of the study include, the small sample size, short duration of double-blind phase, and the exclusion of women (for whom testosterone is not approved). Advantages include testosterone's low cost and relatively good side-effect profile. The most worrying side-effect of medically supervised testosterone therapy is exacerbation of prostate cancer (the mood swings associated with steroid megadoses used by body builders have not been reported with the doses medically prescribed).

key conclusions

- HIV-positive people are more prone to depression than the general population.
- A range of psychological interventions exist to treat depression.
- Antidepressants have been studied in and are effective for people with HIV.
- HIV-associated dementia has declined during the HAART era.
- HAART is effective at enhancing neurocognitive performance.
- Testosterone therapy requires further study.

dr pepe catalan

dr pepe catalan, consultant psychiatrist in the psychological medicine department at the chelsea and westminster hospital, london, speaks to atu by michael carter

Dr Pepe Catalan's (PC) department of Psychological Medicine has psychiatrists, psychologists and psychiatric nurses who handle a combination of emergency and non-urgent referrals from the Chelsea and Westminster Hospital, which provides mental health services to the Kobler Centre, the largest HIV clinic in the UK. Of the 6,000 people a year referred to the department, half are HIV-positive.

Michael Carter (MC): Are people with HIV more likely than the general population to have mental health problems?

(PC): There was a lot of research into this, especially before the mid 1990s, which compared rates of psychological morbidity, especially depression, between people with symptomatic HIV and control groups - that's to say HIV-positive gay men were compared with HIV-negative gay men, and so on. While the overall conclusion was that people with HIV had more psychological problems, especially as the disease progressed, became

symptomatic and developed into AIDS, there was no greater level of psychological distress. The reason for this could be because the levels of psychological distress in the negative groups (for example gay men) may have already been elevated in comparison with the general population, so when compared with the positive gay men, there was little room for difference.

There has been very little information about resource-limited countries and the psychological impact of HIV, but I think you could safely say that there must be raised psychological distress.

It's very difficult to be precise about the extent of psychological distress in the HIV population as a whole. It's been suggested that something like 4% of people with HIV will develop a major depressive episode. That doesn't sound very much, but that's employing a very strict definition of depression as a severe illness. Also, if you compare this with the general population of the same sex and

dr pepe catalan continued

age (and remember that HIV has predominately affected younger people), the rate would be approximately half - so although this severe illness is not common, it's more common than in the general population.

The majority of people who have HIV infection cope well; it's only a minority who end up being referred to specialist mental health services. This applies to cancer or other potentially serious illnesses as well. That's not to say that it doesn't cause distress, but by and large people make adjustments. The service here at the Chelsea and Westminster is well-developed and has been in existence since 1989. Individuals will be referred to either a psychiatrist, psychologist or liaison psychiatric nurse. Now every patient has contact with their regular clinic doctor, and it might be that they have some sort of mental health need which is dealt with there, or by a social worker or health adviser.

(MC): Since the widespread use of HAART, has there been any change in the kind of mental health issues in the people you see?

(PC): There has been a change in the demand on our services. We're seeing more people than ever, and that reflects the fact that people are living longer with HIV. But there has been a dramatic change since the early 90s. We're seeing positive changes in the mental health field, but we're also seeing problems we didn't see before.

First of all, on the plus side we see far fewer people who are very distressed and out of control after being told that they are HIV-positive. I think this reflects the fact that the great sense of stigma and fear has gone. It may be this still happens, but it might be managed more effectively by doctors or health advisors in the sexual health clinic.

What's also good is that two of the most dramatic and worrying illnesses seen in advanced HIV disease, dementia and acute manic episodes, are now very rarely seen. Dementia was always less common than the early studies suggested it might be – one in three people with AIDS were expected to become demented, when in reality it was never more than 7%. Since combination therapy came along, it's gone down to between 0% and 1%. In 2001 we saw three patients with dementia here, and in all three cases they had not received antiretroviral treatment. So the message is that antiretrovirals are pretty effective at preventing dementia, and we only see it in people who have not been treated at all, where the treatment has failed, or they have abandoned treatment. There are some people who developed brain impairment before antiretrovirals and have subsequently stabilised. The infrastructure for their care doesn't exist any more – there's now only the Mildmay [which houses the only specialist unit for people with HIV associated brain impairment].

The other problem we used to see a lot was manic episodes, such as people becoming hyperactive, spending money with abandon, or fighting. Manic depressive illness is very common in psychiatry, but here it was different; it was seen in people with advanced HIV disease. In a study we did here, the average CD4 count was about 70, and the majority of people had no prior history of mania, or had not used recreational drugs like speed and ecstasy, or steroids – all of which can precipitate the condition. It can present quite dramatically and often requires hospitalisation. Although people did respond to treatment within a month, we found a high proportion had brain impairment, an early sign of dementia. We used to see a case a

week in the early 1990s, but now we see it very rarely and only in failure-to-treat patients [those who are diagnosed at a late stage of HIV disease, or those who have failed to maintain regular contact with their clinic]. This is a reflection of the brain-protective effects of antiretrovirals even if they don't cross the blood-brain barrier; the immune system is strong enough to prevent HIV doing enough damage to lead to the conditions.

Another interesting issue is suicidal behaviour. There were a number of papers in the 1980s and 1990s which suggested that the rate of completed suicide in people with HIV was much greater than expected. One paper from New York suggested it was 36 times greater. There were problems with this, because the rate should have been compared with control populations (for example, the rate of suicides in HIV-positive gay men should have been compared to suicide in HIV-negative gay men, who already have an increased risk factor). Suicide has become a much rarer event, there have been no recent reports here.

On the down side, the referrals continue unabated, and they tend to be issues which are less easily dealt with by a single course of treatment or a course of five sessions of therapy. On the one hand we're dealing with problems of normalising life – sexual dysfunction is very common, either as a consequence of antiretroviral treatments or as a result of life issues. Treatment for men usually consists of *Viagra*, but there may well be other psychological or physical treatments. We have had some women referred to us too. Treating people with *Viagra* raises issues about facilitating sexual contacts for HIV-positive people, and whether they will have unprotected sex. The published work suggests that people who have been prescribed *Viagra* do not seem to have more unprotected sex. However, the population who buy it on the black market do seem to have more unsafe sex.

We also see people with issues around adjusting to having an extended life expectancy. Some people may well have made difficult decisions; preparing to die because of

HIV and giving up their job for example, and five years later they find themselves alive and fairly well, and are asked to start thinking about work again or find their benefits are at risk. Or there's the whole question of 'what do I do with my life?', and this may be more marked and profound in people with HIV, who may have unresolved issues about self-esteem, sexuality, career, and family, which HIV effectively distracted them from tackling.

And of course having HIV can still cause concerns. There are side effects; lipodystrophy can cause particular concerns over appearance, and other issues like diarrhoea and fatigue don't make life easy. In practice, this means that we are dealing with more people with long-term difficulties in the context of HIV: self-esteem, intimacy, making sense of themselves, relationships, which means that they may well cope for a while but may need help intermittently on a chronic basis. I find myself seeing people for many years, not necessarily very frequently, but every six months or so, as a crisis develops or if they stop being able to manage an existing condition.

We've had to move away from brief, acute intensive treatments, and now we deal with much longer term issues which involve psychological input, possibly medication like antidepressants. We've had to change our way of working and develop different skills and approaches.

(MC): Is mental health a factor in people's likelihood to adhere to their antiretroviral regimens?

(PC): In the mid 1990s there were a number of studies looking into the psychological aspects of adherence, the assumption being that psychological interventions could be important and useful. Interest has now settled down, partly because treatment regimens have become easier and also because there's good evidence that a well structured start to therapy, with input from doctors and pharmacists who can provide specialist information, can be very useful. For some people there can be psychological issues; high

nam forum

July's NAM Information Forum takes place on Monday 29th July, from 7-9pm, at the University of London Union, Malet Street, London, WC1. We will be providing feedback from the 14th International AIDS Conference to be held in Barcelona 7-12 July 2002.

The nearest tube station is Goodge Street. Refreshments, and a sign language interpreter, are available. These events are free and are aimed at people with HIV, and those who work in the field.

forum evaluation

NAM would like to evaluate the usefulness of our patient information events, held every month at the university of london union.

We would like to hold a focus group in August with people who currently do not attend the forums, to find out why.

If you would like to attend, please contact us on 0207 627 3200 or email forums@nam.org.uk



alcohol consumption seems to be a predictor of bad adherence, but so does full-time work. So it's not an easy straight forward issue where you can say people who are depressed or take drugs are less likely to adhere. Clearly for some very chaotic people it may be an issue, but I'm less convinced that it's a primary component, and it's more likely to be related to personality issues. It's like the debate on safer sex. There's evidence to suggest that people who are depressed are less likely to have protected sex, but there's just as much evidence which says that people who are well and optimistic are just as unsafe. You can't be simplistic about it.

(MC): Are there any concerns about mental health side-effects of antiretrovirals?

(PC): Clearly some antiretrovirals have obvious and very marked side effects, obviously efavirenz which causes sleeplessness and nightmares. There have been some suggestions that antiretrovirals cause mania. I have not been convinced, but clearly medications cause side-effects. It's quite a complex issue; how to cope with a medication which you know is keeping you alive, but which has side-effects which may affect the quality of your life.

(MC): Do the different communities affected by HIV in the UK present with different mental health issues?

(PC): At the Chelsea and Westminster we mainly see gay men. We did a study looking at the black African population we see, and we discovered that black Africans were three-times less likely than gay men to be referred to mental health services. The reasons are unclear. It might be that we are not practised at recognising signs of psychological distress in the black African population. I also suspect that the patients themselves are very reluctant to request treatment because there could be fears about what will happen. So there are issues on both sides. When we look at the black Africans we have seen here and compare them with other patients of comparable age and sex, we see a difference in the mental health problems. Referred black Africans are much more ill, both physically and psychologically. They are much more likely to be referred at an advanced stage of HIV infection and with a major depression or brain problem. So what we don't tend to see in the black African

population are the milder, complex, making sense of life issues. The black African population also tends to be harder to engage. We've also treated a fair number of drug users over the years where there have also been problems with engagement.

(MC): Are there any interactions between the medication you use as a psychiatrist and antiretrovirals?

(PC): This is a major question of concern. It has become clear over the past few years that many of the psychotropic drugs (drugs used in psychiatry) have interactions with anti-HIV drugs. Some psychotropic drugs may be removed more quickly by the body, or by contrast blood levels of a drug may be increased to toxic levels. Similarly, taking a psychotropic drug may affect the way an antiretroviral is metabolised. As we've become more aware of this, we've been working with the pharmacists to see if it is safe to use a drug, and what might happen. Often we work on a theoretical basis, looking at how drugs are metabolised and what might happen. Often there is no evidence for the interaction other than the theory, as nobody has conducted a trial or the evidence is concerned with a single drug, not the three or four drugs which make up most anti-HIV combinations. So the actual empirical evidence is limited, and we work largely on theoretical assumptions.

We're clear about some of the safe antidepressants which can be used with any combination, because of the way the body breaks them down. In practice we look much more closely at what we prescribe and the resulting interactions. The classic case is the interaction between *Viagra* and the protease inhibitors, which means that people who take both protease inhibitors and *Viagra* have higher blood levels of *Viagra*. This means that a small dose goes a long way, and a standard dose can be toxic. It's not so clear with many other drugs and requires long-term monitoring. The question of interactions is going to become more important and complex.

news in brief

Heart abnormalities in babies born to positive women

Babies of HIV-positive mothers are at greater risk of developing heart abnormalities than the infants of HIV-negative mothers, irrespective of whether they are born infected with HIV.

In a five year study, investigators compared 600 infants born to HIV-positive mothers to 195 babies of HIV-negative mothers. Of the babies with HIV-positive mothers, 93 tested HIV-positive, and 463 were HIV-negative.

The infants' cardiac function was monitored every four-to-six months for five years using echocardiography. The babies of HIV-positive mothers, regardless of whether they were infected with the virus or not, had faster heart rates. In addition, the babies of HIV-positive mothers were unable to efficiently pump oxygenated blood around their bodies. In HIV-positive babies, such cardiac abnormalities have been associated with an increased risk of heart failure and death in infancy.

Maternal nutrition and the inflammatory process triggered by HIV are thought to be responsible for the heart abnormalities. More research is needed to determine the longer-term cardiovascular health of the offspring of HIV-positive mothers.

Reference Lipshultz S E et al. The Lancet online June 15, 2002

Over 50s do as well on HAART

In the pre-HAART era, older patients had higher rates of disease progression and progressed more rapidly to AIDS and death. New research suggests that older age does not appear to impact upon the effectiveness of HAART

Researchers conducted a retrospective analysis of the medical records of 52 patients aged 50 or over, and 52 patients aged under 50, who received care for HIV between 1986 and 1998. Data compared included first and last CD4 counts, viral load, risk factors for infection, length of time care for HIV was received, incidence of opportunistic infections, number of hospitalisations, side-effects, death, and whether treatment with HAART had been recommended or received.

The under 50s and over 50s were similar in most respects. There was no significant difference with regard to the development of opportunistic infections or drug related side-effects. The number of hospitalisations was also similar. In the HAART era, both groups experienced comparable increases in CD4 count and fall in viral load. The mortality rate was higher in the over 50s (nine deaths against two for the under 50s), but when data was analysed it was found that the majority of these were caused by factors unrelated to HIV, and that there was no significant difference in AIDS deaths.

Reference: Grimes M et al. Clin Inf Dis 34: 1530-1533, 2002

further news

Daily news updates are available on NAM's website, aidsmap.com.

nam factsheets

NAM's Factsheet's provide easy-to-understand overviews of the key medical aspects of HIV and AIDS.

Every month a new Factsheet is distributed with ATU and earlier Factsheets are available on aidsmap.com and these are updated regularly. The most recently updated Factsheets are the ones on adherence; anti-HIV therapy; dementia; diarrhoea; preventing infections; primary HIV infection; unprotected sex. Forthcoming updates include CD4 T-cell counts; drug checklist; mental health; and treatment failure.

Factsheets can be down-loaded from aidsmap.com, or are available free by telephoning NAM on 020 7627 3200.



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any questions

For an introduction to HIV treatment issues

The booklets in NAM's Information Series for Positive People are free to people with HIV. This easy-to-read series includes: Anti-HIV Drugs, Anti-HIV Therapy, Clinical Trials, Glossary, Lipodystrophy, Nutrition, Resistance, and Viral Load & CD4.

The HIV & AIDS Treatments Directory

This 600 page book, published twice a year, is a comprehensive guide to the medical aspects of HIV. Available at only £12.95 to people with HIV, £64.95 to professionals.

<http://www.aidsmap.com>

NAM's resources are also available online at [aidsmap.com](http://www.aidsmap.com). These include our extensive and searchable treatments database, the latest news on treatment developments, our online directory of AIDS service organisations, hundreds of links to recommended HIV-related sites, and free downloadable resources.

Monthly NAM information forums in London

Each month an expert speaker discusses a treatment-related topic. Entry is free. Future forums are advertised inside this newsletter.

THT Living Well Phonenumber 0845 9470047 Mon-Thu 6-9pm
i-Base Treatment Phonenumber 0808 8006013 Mon-Wed 12-4pm

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



subscriptions

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AIDS Treatment Update is available on audio tape, and can be emailed to you as a pdf file for viewing with Acrobat Reader. Telephone NAM on 020 7627 3200 for details.

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