

# aids treatment update

## Aging gracefully

It would have been unthinkable a decade ago, but there is now a substantial aging population of people living with HIV in the UK; some of whom have been positive for more than twenty years while others have been only recently diagnosed.

In fact, data from the latest readers survey – the results of which are detailed in this issue – suggest that 40% of all *ATU* readers are aged 45 or older.

Although this is something to celebrate, it also has a down side. As we live longer with HIV, we seem to be more prone to all kinds of other illnesses, including heart disease and cancer.

Should we add dementia to the list? HAART appeared to all but wipe out AIDS-related dementia, but new research suggests that HIV is likely to subtly alter the way our brains work as we age. However, as Gus Cairns discovered when he interviewed NAM's Specialist Adviser on the neurological aspects of HIV disease, Dr Pepe Catalan, it's not all bad news.

For those of us who hope to live long and well with HIV, this article provides much insight into whether we ought to be concerned about dementia, and what we can do in order to prevent this from happening to us.

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# losing our minds?

## 2 how much should we worry about dementia? by gus cairns

For many of us living with HIV, dementia is a frightening subject. We can imagine coping with many of the ills HIV might throw at us, but not if it robs us of the very thing that does the coping – our sense of self.

Those of us who have known elderly relatives affected by dementia know only too well what the so-called 'second childhood' looks like and how it robs people of their identity and independence.

So when an [aidsmap.com](#) headline in February declared: "Over-50s at increased risk of cognitive impairment, even with HAART"<sup>1</sup>, my guess is that many of us were concerned.

Michael Carter's report was based on a special supplement in the scientific journal *AIDS*, which documented recent research aimed at finding if there was an increase in dementia and/or mental illness (as we will see below, it's very important to distinguish between the two) among people over 50 with HIV. Most alarming was a study that found that more than one in five HIV-positive people over 50 had dementia, and that HIV-positive people in general were three times more likely to experience cognitive impairment than the general population.

This seemed particularly worrying to me, since, at 47, I (like a significant number of *ATU* readers) am approaching the age at which these deficits were observed. In fact, an estimated 11% of people with HIV in both the US and the UK are already over 50 years old.

### Whatever happened to AIDS Dementia Complex?

The first associations between AIDS and brain disease were made back in 1986, when two New York neurologists unveiled alarming

findings in the *Annals of Neurology*.<sup>2</sup> They concluded that up to a third of their patients with AIDS had a specific group of abnormalities in cognitive (thinking) and motor (movement) skills – disabilities they named AIDS Dementia Complex.

This was followed a year later by a report in the *Annals of Internal Medicine*<sup>3</sup>, which found neuropsychological abnormalities in many people with asymptomatic HIV disease. These abnormalities took characteristic forms, such as poor concentration, poor memory and loss of fine motor co-ordination.

However, the findings of these early studies were criticised at the time by others working in the field, including Dr Pepe Catalan, Consultant Psychiatrist at London's Chelsea & Westminster Hospital, whose own studies suggested that although HIV might have subtle mental effects, frank dementia was quite rare.

"The original *Annals of Neurology* paper was based on autopsies of people who had died, and weren't necessarily representative of all people with AIDS," explains Dr Catalan. "They were patients who had been specifically referred for neurological observation. In addition, what they called AIDS Dementia Complex was a loose diagnosis. I wrote the following in a 1993 paper: 'It is clear that the original description included more than dementia in the usual sense of the word, and that patients who had a variety of neurological and, possibly, psychiatric disorders were grouped together under a novel label.'<sup>4</sup>

"Using standard definitions, the figures came right down," Dr Catalan continues. "We found that the pre-1996 prevalence of classical dementia in people with AIDS was no more than 7% in the last year of their life.

"Instead, we started talking about 'MCI' – Minor Cognitive Impairment. This, which is not uncommon in people with HIV, essentially means being a bit slow, a slightly advanced aging. You behave as if you're ten years older than you are.

"When HAART came along, AIDS-related dementia became a rarity. I've seen two or three cases in the last three years, in people diagnosed very late or who don't seek HAART till very late, and it is difficult to get them back to normal. We also see cases of people who get physically better on HAART, but whose brain impairment doesn't improve and turns out to be caused by something else – in some cases, alcohol abuse.

"But we were wondering what was going to happen as the population aged. We did do a case notes study in 1998 of people over 50 referred to the psychological medicine service from the Chelsea & Westminster HIV clinic. We found some form of neurological impairment to be more common in people over 50 compared with younger people – the rates were 13% and 4%, respectively.

"But remember, these were people taken from the one-third of HIV patients who get referred because they have some sort of psychological complaint in the first place. We certainly haven't seen the amount of impairment that these US papers claim."

## The Becker study in AIDS

However, several studies in the *AIDS* supplement certainly suggest much higher rates of brain impairment in people over 50.

James Becker of Pittsburgh University and colleagues<sup>5</sup> recruited 289 HIV-positive and 124 HIV-negative people into a study that subjected them to a battery of psychological tests designed to see how well they performed at specific tasks.

The basic findings certainly sound alarming. The HIV-positive individuals were three times more likely to be impaired either by dementia or by a milder degree of impairment that Becker termed 'CIND' – Cognitively Impaired, No Dementia.

Amongst the HIV-positive group, only 69% fit the definition of having 'normal' functioning compared with 89% of the HIV-negative group. Across all ages, 22% of HIV-positive individuals were found to have CIND and 9% had dementia.

When the HIV-positive over-50s were looked at specifically, no fewer than 22% of them had dementia, compared with none of the HIV-negative over-50s.

However, when one looks into Becker's results more deeply, they are not quite what they seem.

When the same tests were performed again a year later, the results were actually better. Of the original 289 HIV-positive people, 169 (58%) returned and 83 of the 124 HIV-negative people (67%) returned for more testing – the rest were lost to follow-up. This time the rates of CIND and dementia in the HIV-positive people were 'only' 15% and 4.7% respectively.

Additionally, Becker defined both CIND and dementia very broadly. To have dementia, a person was only required to have quite low scores on two or more individual tests, which did not have to include memory-specific tests. To have CIND, a person needed only to have quite low scores in just one test area. For example, you could be fine at doing everything else but, say, be bad at naming animals starting with 's' – which is a standard verbal fluency test.

"Forty per cent of the people in Becker's study didn't even notice they were impaired, and I can tell you that when patients start developing dementia, they definitely notice and are frustrated by their impairments," concurs Dr Catalan. "Again, a very loose definition of 'dementia' is being used."

What is more, there are all kinds of conditions that can affect memory, thinking or movement, and HIV-positive people may be more prone to these conditions than other people. For example, depression, poor sleep or the effects of too much alcohol may profoundly affect concentration.

Another concern is that Becker's sub-category of people over 50 was really very small. Only 22 HIV-positive people were over 50 and a scant

three people were HIV-negative. With groups this small, it is highly likely that some of the results could be due to chance.

Most importantly, however, only 17% of Becker's HIV-positive participants were on HAART, so this study does not measure dementia in a population where the majority are on HAART, as is the case with people with HIV in the UK.

"This study does suggest that there may be increased incidence of cognitive impairment in the over-50s, possibly of a mild to moderate nature, but it's nothing to be overly concerned about," concludes Dr Catalan, "particularly for people on HAART."

### The other studies in *AIDS*

Igor Grant and colleagues<sup>6</sup> compared neuro-psychological abilities in 67 HIV-positive individuals aged at least 50 with those in 52 HIV-positive people aged 35 or less. He found that 64% of the over-50s had at least one deficit in one of seven cognitive or motor 'domains', compared with 54% of those under 35. Grant specifically excluded individuals who were current alcohol or substance abusers. However, the numbers in his study were so small that the differences between the over-50s and the under-35s did not achieve statistical significance.

Additionally, the study participants had quite advanced HIV infection: 69% of those under 35 had an AIDS diagnosis, as did 76% of the over-50s. Despite this, only 55% were on HAART, and, of these, 51% of the older group and 28% of the younger group had undetectable viral loads.

Amy Justice and colleagues<sup>7</sup> compared psychiatric and cognitive disorders among HIV-positive and HIV-negative patients in the care of the US army veterans' medical system.

They took results from an intensive study of a small group of patients and used them to calibrate results from quicker but less accurate questionnaires of the entire patient group. The group was large enough to include HIV-positive and -negative people in their 60s and 70s – not a feature of the previous two studies.

They found, as expected, that memory problems increased with age in both HIV-positive and HIV-negative individuals. However, people with HIV had a higher rate of memory problems than those who were HIV-negative, by between six and 14 percentage points according to age group. When people with depressive symptoms were excluded, the HIV-positive people had a higher rate of memory problems in their 60s than HIV-negative people did in their 70s.

But the 'big story' of this study was of the psychological factors that were not specifically to do with organic neurological impairment. Contrary to popular wisdom, it has been found that older people tend to have lower rates of depression than younger people. However, depression rates in the older HIV-positive people stayed quite high compared with similarly aged HIV-negative people. So did rates of drug abuse, with, for instance, 24% of HIV-positive people in their 60s reporting recreational drug use compared with 10% of HIV-negative people. This may, however, include phenomena such as 'medical marijuana' use for symptom control.

Pepe Catalan comments: "They didn't match the HIV-positive people with HIV-negative people who had other chronic medical conditions, like cancer or renal impairment. Essentially they were comparing healthy old people with less healthy ones. Nor were they controlling for risk factors like being gay, so we may just be seeing that older gay people are less happy than older heterosexuals."

Another study<sup>8</sup> that specifically looked at dementia and organic cognitive impairment was of a group called the 'Hawaii Aging with HIV Cohort'. This was a prospective study of a group of older people specifically followed to see what problems they developed with age. Hawaii is a good location for a study like this, since 20% of the HIV-positive people in this state are over 50.

It found that whereas 88% of HIV-positive people aged 20-40 had normal or near-normal neuro-cognitive functioning, only 58% of those over 50 did.

This looks like a conclusive result. However, Pepe Catalan stresses that this study did not use the very specific psychological tests used by

the other studies, but only a doctor-evaluated estimation of how well a patient is coping, called the *Memorial Sloan Kettering Scale*.

He says: "It's a very inaccurate measurement of functioning. It doesn't even require the doctor to ask the patient how they are, so it can be easily distorted by physician bias."

The final study<sup>9</sup> in *AIDS* which looked at organic brain impairment performed brain scans on people with HIV to see what changes were happening in the brain. It found that HIV infection was causing damage to cells in a part of the lower brain called the *basal ganglia*, and that this increased with length of infection. There was also less serious damage seen in higher cortical areas, which did not increase with length of infection.

Whereas the cortex controls higher functions like thinking, the basal ganglia control impulses towards movement. This is the same area that is damaged in Parkinson's disease, which may explain why a degree of mild motor impairment is the most common neurological symptom seen in people with AIDS.

However, this study specifically excluded people on HAART – so what it really measures is the damage resulting from untreated HIV infection.

## In conclusion

The *AIDS* studies do seem to show that as we get older we may expect to develop minor – and in a few cases major – motor, cognitive and memory problems sooner than HIV-negative people our age.

However, it is unclear whether these are the results of HIV infection or other factors to which people with HIV are prone. Co-factors such as depression, lower testosterone levels, and alcohol and drug use can all affect mental functioning at least as much as HIV itself and these factors can, at least, be dealt with by specific therapies or interventions.

Another unknown factor is the effect of HAART's increased cardiovascular risks. Having high cholesterol levels is another predictor of brain impairment. This is because cardiovascular problems may cause tiny strokes in small areas of the brain, which could build up into a picture of dementia in the long run.

Smoking is also a very significant factor here, and giving up cigarettes may be one of the best ways someone with HIV can protect themselves against the risks of dementia and cardiovascular problems as they age.

Lastly, all but end-stage dementia is at least partially preventable by pursuing a life with a high level of intellectual stimulation and social interaction. This is sometimes called 'use it, don't lose it'.

A recent study published in the *British Medical Journal*<sup>10</sup> followed 2058 people who were born in 1946. One of the findings was that people with good reading scores either in their youth or in their late 40s were much less likely to be showing signs of dementia in their late 50s.

The brain is a very adaptable mechanism and, given the right environment, can often compensate for the gradual loss of nerve cells that comes with age. Leading a healthier and stimulating life can do much to prevent us getting slower as we get older.

## Key Conclusions:

- AIDS-related dementia is very rare today, usually occurring only in people not on HAART.
- However, people over 50 on HAART do appear to have a three-fold higher chance of slowed-down movement or thought processes, or 'forgetfulness', than younger people on HAART.
- These 'impaired cognitive functions' may be very mild, and often do not affect everyday life.
- HAART may not be the only cause of these symptoms: depression, poor sleep patterns, smoking, binge drinking and/or drug/alcohol dependence are also important factors.
- The best protection from these problems is to take HAART, and to treat depression, sleep problems and any addictions (drug, alcohol, nicotine) to reduce long-term harm.
- Leading a stimulating life may also protect your brain from slowing down.

## glossary

**cognitive** pertaining to thoughts or thinking; cognitive disorders are disorders of thinking.

**dementia** changes in mental function, coordination and personality.

**neurological** relating to the brain or nervous system.

**psychiatry** a branch of medicine that treats people, using drugs and other physical methods, to change the way they act and feel.

**psychology** a branch of medicine that tries to explain why people act, think and feel the way they do.

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# funding nam's treatments information

6 caspar thomson, nam's director, answers questions about how the organisation's recently launched 'friends' scheme contributes to its treatments information work

**Q: What made NAM decide to launch the Friends scheme?**

A: There are more and more people living with HIV in the UK requiring our resources, and raising the funds to support this work poses increasing challenges. When we undertook a readers survey in 2002, we learned that nearly 40% of our subscribers weren't aware that NAM is a registered charity. Quite a number also expressed a willingness to contribute to our work. It was this that gave us the confidence to launch the Friends scheme.

I am delighted to be able to report that the scheme is working very well indeed. We have already succeeded in raising over £8,000. Thank you to everyone who has become a Friend. Support of this kind makes a huge difference and will enable us to reach even more people

with essential treatments information, such as *AIDS Treatment Update*.

**Q: So what do you need funds for?**

A: NAM was set up to provide relevant, accurate, independent and comprehensive HIV information. In the UK we're probably best known for our information on treatment issues. This comes in a variety of media, from hi-tech to no-tech, and is pitched in different ways to reach a broad range of audiences. With the exception of the *HIV & AIDS Treatments Directory*, all of the resources we produce are free of charge to people with HIV.

The resources include:

- AIDS Treatment Update and NAM Factsheets.

- Our award-winning website, [www.aidsmap.com](http://www.aidsmap.com).
- Our annually updated booklet series
- Monthly information forums
- A Directory of Complementary Therapies in HIV and AIDS
- The HIV & AIDS Treatments Directory, the world's most comprehensive resource on the medical aspects of HIV.

**Q: Where do the funds come from to support these resources?**

A: This year we need to raise £1.1 million to fund what we believe are vital information services. Roughly 18% will come from sales of our resources to professionals working in the HIV sector; 31% from NHS Primary Care Trusts and the Department of Health; 22% from pharmaceutical companies and 22% from charitable trusts. The remainder will have to come from our own fund-raising efforts, and this is where our Friends are playing such an important role.

**Q: Isn't there a danger that receiving money from drug companies compromises the independence of NAM's resources?**

A: The funds we receive from drug companies are an important contribution to our work and we are very grateful for this support. There is no question, however, of companies being able to interfere with our editorial stance or influence us in any other way that undermines our independence.

**Q: Do you need more Friends?**

A: Absolutely! Anyone who becomes a Friend will play a vital role in ensuring our resources continue to be available to people with HIV. Just £15, £10 or even £5 a month will help us to reach our target of £30,000 this year. If you want to help, simply complete and return the flier enclosed with this issue of *ATU*. We know our treatments information makes a vital contribution and, with more Friends, we'll be able to reach even more people with HIV.

**Do you have a story to tell about living with HIV?**

Later this year NAM will publish an updated and substantially expanded edition of its very popular book *Living with HIV and AIDS*, edited by Michael Carter, NAM's Patient Information Editor. The book has been out of print for a number of years – in fact, the last edition was published in 1996, just before HAART became available.

As with the 1996 edition, we plan to include short personal testimonies from people with HIV on the realities of living with the virus. These can be on any aspect of living with HIV. One or two personal testimonies will be published to accompany each chapter of the book – the chapters are likely to include the following: a basic introduction to HIV, anti-HIV treatments, illnesses and symptoms commonly experienced by people with HIV, prognosis, HIV and the law, HIV and travel, HIV and sexual health, mental health, HIV and hepatitis, nutrition, exercise and finding information.

This is where we need your help. Do you have a story to tell? We would like your testimonies in no more than 500 words, in English (preferably e-mailed or typed, but legible hand-written submissions are acceptable too).

Money is very limited, so we are unable to pay for contributions. However, we plan to send the book to all *ATU* subscribers free of charge. If we publish your contribution, we won't include your name unless you particularly want us to.

Please e-mail your contributions to [michael@nam.org.uk](mailto:michael@nam.org.uk). Alternatively, you can send them postage-free to:

NAM  
 FREEPOST  
 Lincoln House  
 1 Brixton Road  
 London  
 SW9 6BR

**Deadline for submissions is: July 1st 2004.**

# readers survey

## 8 reporting back from the annual *atu* readers survey by edwin j bernard

Late last year, NAM surveyed the more than 5000 people who have a free subscription to *AIDS Treatment Update*. This annual exercise is one of the most important methods by which we learn about who is using our resources, and how effectively they are meeting needs.

As well as being used internally, to generate ideas for the development of new and existing resources, these data are crucial in supporting funding applications. At close to 14%, the response rate to our survey was remarkably good. Thank you to all who responded.

### Who responded?

Just over 85% of survey respondents were male; 70% were gay men; and 87% were White. Around 42% were aged 35-44, with another 30% aged 45-55. English was the first language for 85%, and 54% were educated to degree level or higher. Just over 10% had dependent children, of whom one in five had an AIDS diagnosis.

Eighty-seven per cent of survey respondents knew they were HIV-positive. Of these, just over a third (36%) were asymptomatic, another third (34%) had symptoms of HIV disease, and just under a third (30%) had been diagnosed with AIDS.

More than 85% were currently on, or had ever taken, anti-HIV medication. Of those on HAART, the vast majority were highly treatment-experienced, with most people having taken three or more combinations in their lifetime. It makes sense, then, that half of

respondents were diagnosed prior to 1996 – the beginning of the HAART era.

### How is *ATU* read and rated?

Seventy per cent of respondents read all or almost all of each issue of *ATU*. Close to 92% found the language that we use – and 81% the length of the main articles – to be about right. More than 44% shared their copy of *ATU* with at least one other person.

Amongst HIV-positive readers, just over 94% described *ATU* as being helpful in making decisions about treatment. Eighty-one per cent discuss the information in *ATU* with others, with 58% talking to their doctor about articles they had read in *ATU*.

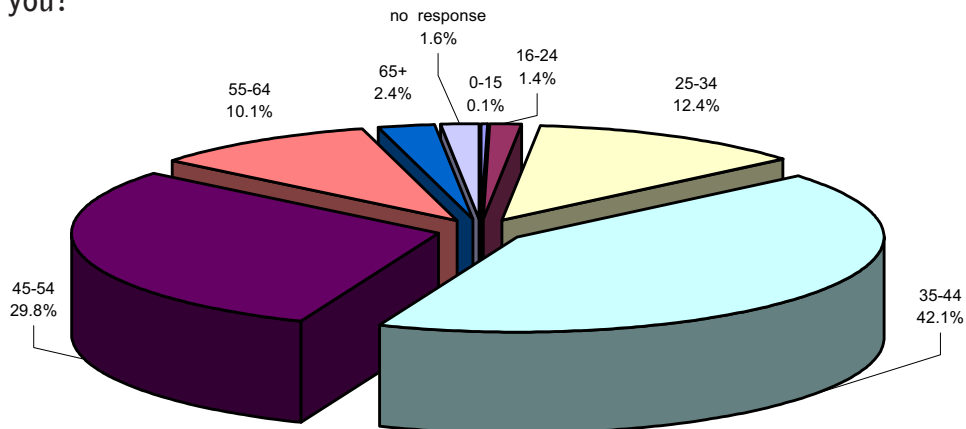
### Improving *ATU*

Two open questions invited respondents to suggest changes which would improve *ATU*. It was striking how many were very happy with, and protective of, the newsletter, and this is extremely heartening. However, there were also extremes of opinion ranging from people wanting *ATU* to cover a broader spectrum of issues – including legal, social, immigration and employment concerns – to others who felt *ATU* should only cover clinical treatments and HIV-related medical issues.

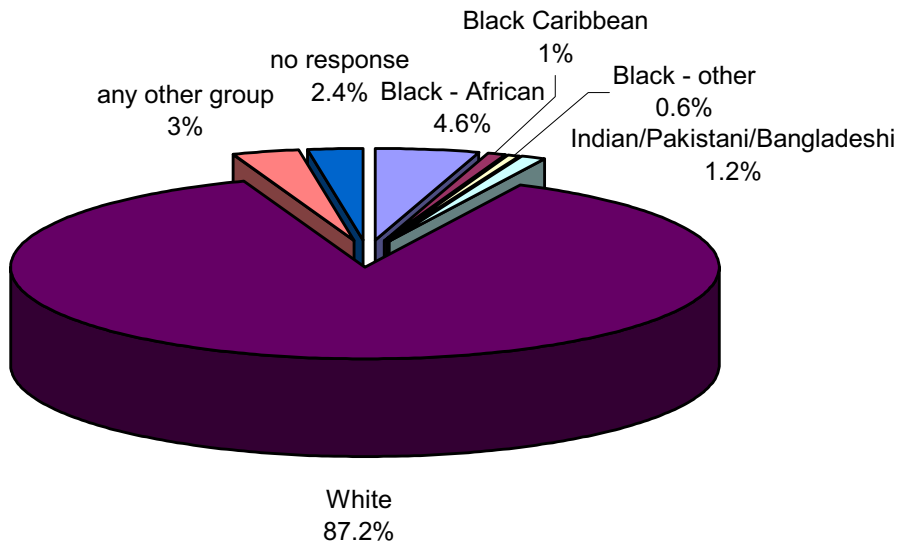
The areas most often named as needing improvement were the name, colour and design of *ATU*. Respondents often wanted more news, more on non-HAART-related treatment issues, more on complementary therapies and more first-person experiences.

**"I find *ATU* to be very comprehensive and, together with [aidsmap.com](http://aidsmap.com), everything is covered for my needs."** *ATU* reader

how old are you?



describe your ethnic background?



### The future

Although it appears that *ATU* is read by a large number of expert patients who are very involved in their HIV treatment, it is clear when you compare the demographics of the survey respondents to the UK HIV population currently registered at an HIV clinic (the SOPHID data) that there are many HIV-positive people in the UK who are neither reading nor receiving *ATU*.

NAM is committed to making sure that everyone who wants to become more expert in their knowledge of HIV treatment issues has access to *ATU*. With a new editor at the helm, NAM is undertaking a full review of *ATU* later

this year, to ensure that its direction is in line with current and future readers' wishes and needs. The review will be informed by the data from this survey, feedback received during the past few months, and a number of face-to-face, qualitative interviews. This will, we hope, benefit everyone living with HIV who is already – or wants to become – expertly involved in their HIV treatment decisions.

“Since your article on testosterone, a lot of people attending my clinic are now on treatment.” ATU reader

## 'Missed' TB causing HIV-positive deaths in UK

UK doctors are often failing to diagnose tuberculosis in HIV-positive patients, according to a presentation at a Royal Society of Medicine-sponsored conference on TB and HIV held in London in March.

Professor Sebastian Lucas of St Thomas's Hospital presented a case series involving the 200 HIV-positive patients on whom he had performed autopsies between 1994 and 2004. Ten of these individuals had died of TB without it first being recognised before death, indicating that TB was being missed even in patients with severely damaged immune systems.

Prof. Lucas suggested that his case study showed that there was a role for treating TB presumptively in individuals who had advanced immune damage and whose symptoms could be suggestive of TB, rather than use a wait-and-see approach.

## More UK salvage therapy options available

Tipranavir, an experimental protease inhibitor (PI) developed by Boehringer-Ingelheim, is now available to more people in the UK who need the drug to construct a viable treatment regimen.

Individuals with CD4 cell counts below 100 cells/mm<sup>3</sup> are now eligible to receive the drug. Previously the drug was rationed to people with CD4 cell counts below 50 cells/mm<sup>3</sup>, who were at immediate risk of disease progression despite treatment with HAART.

It is expected that tipranavir will be licensed for treatment-experienced individuals in 2005, provided that current clinical trials do not produce any unpleasant surprises.

People not eligible to receive tipranavir may be able to join a clinical trial of another PI, TMC-114. Like tipranavir, TMC-114 is designed to be active against HIV that is resistant to most other PIs. The study, called C213, is now recruiting patients who have experience of all three classes of antiretrovirals in Manchester, London and Edinburgh.

For more information on how to enter this study, visit [www.aidsmap.com](http://www.aidsmap.com) and click on **UK trials for protease inhibitor-experienced people** in the clinical trials section.

## Fosamprenavir recommended for EU approval as *Telzir*

GlaxoSmithKline's PI, fosamprenavir, has received a recommendation for marketing approval in the EU from the Committee for Proprietary Medicinal Products.

Fosamprenavir is a prodrug of amprenavir which can be delivered in fewer pills than the existing amprenavir formulation, *Agenerase*.

As with the recently approved PI atazanavir, the European drug regulatory body has approved a different dose from the one approved in the US, reflecting a more cautious attitude towards the use of PIs without ritonavir boosting. The recommended dose is 700mg of fosamprenavir twice daily with 100mg of ritonavir twice daily (in combination with at least two other antiretrovirals).

Fosamprenavir will also be known by a different name (*Telzir*) in Europe from the brand name used in the United States (*Lexiva*).

It is expected that *Telzir* will receive full European marketing approval by the end of June.

## TB now second most common AIDS-defining illness in UK

Adults with TB in the UK should have an HIV test offered and recommended, according to Dr Barry Evans of the Health Protection Agency, who presented data at a recent London conference showing that TB is now the second most common AIDS-defining illness in the UK after *Pneumocystis carinii* pneumonia (PCP).

In 2003 a total of 178 new cases of PCP were diagnosed in HIV-positive individuals, comprising 28% of all AIDS diagnoses, whereas 167 new cases of TB were diagnosed, contributing 27% of all AIDS diagnoses.

Problems with under-reporting and misdiagnosis mean that many cases of TB in HIV-positive patients are likely to go unrecorded, noted Dr Evans. He estimated that 30% of TB cases in HIV-positive patients were not recorded on the Health Protection Agency's TB database. He also estimated that of all HIV-positive individuals in the UK, 3.7% had TB, and that 2.7% of all TB cases in the UK involved patients infected with HIV.

As with HIV, last year there were approximately 7,000 new TB cases diagnosed in the UK, and, again like HIV, TB caused 400 deaths.

Data were also revealed that suggested TB had a distinct impact on different communities. According to Dr Evans, only six HIV-positive gay men were diagnosed with TB in 2003, with nearly all the remaining diagnoses in HIV-positive individuals made in people from Africa.

On the basis of these data, Dr Evans suggested that all adult patients aged between 15 and 64 who are diagnosed with TB should be offered and recommended an HIV test.

## Tenofovir/FTC combo pill due next year

A once daily tablet providing a combination of 300mg tenofovir (*Viread*) and 200mg FTC (*Emtriva*) is likely to be available for prescription in Europe and the US by 2005. Tenofovir is a nucleotide analogue and FTC is a nucleoside analogue. Both drugs inhibit HIV's reverse transcriptase enzyme.

Gilead Sciences applied for US and EU marketing approval last month for the fixed-dose tablet, which does not yet have a brand name. It usually takes drug regulators six to nine months to reach a decision.

If approved, the pill would compete with another fixed-dose combination tablet about to come to market, which combines 3TC and abacavir in a once daily tablet. This new fixed-dose tablet, manufactured by GlaxoSmithKline, is also awaiting a brand name.

Both are likely to provide an attractive alternative to *Combivir*, the fixed-dose combination of AZT and 3TC, which must be taken twice a day.

## US HIV visitors ban update

Senator John Kerry, the frontrunner for Democratic Presidential candidate in the November elections, has pledged to "work to end the HIV travel and immigration ban" if he is elected US President, according to his campaign website, [www.johnkerry.com](http://www.johnkerry.com).

### next issue

Next month's issue of *AIDS Treatment Update* will feature an article on HIV and drug-related peripheral neuropathy, postponed from this issue. We will also be examining the causes of – and treatments for – sexual dysfunction.

### nam forum

The May NAM forum will be on the subject of pain control. People with HIV may experience pain due to anti-HIV medications, HIV infection, or various non-HIV related causes. This can include short-term pain like headaches or stomach pain, or chronic pain due to skin conditions or peripheral neuropathy.

Come to the Palms Room on the 4th floor of the University of London Union, Malet Street, London WC1 at 7pm on May 24th to find out about avoiding, treating and managing pain; how to cope with chronic pain; and the role of complementary therapies.

For more information, please visit [www.aidsmap.com](http://www.aidsmap.com)

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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](http://www.aidsmap.com).

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## any questions

### for an introduction to HIV treatment issues

NAM's information booklets are free to people with HIV. Titles include: **adherence, anti-HIV drugs, clinical trials, glossary, HIV & hepatitis, HIV therapy, lipodystrophy, nutrition, resistance, and viral load & CD4**. Please contact NAM for your copies.

### HIV & AIDS Treatments Directory

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

Visit our website for the latest news and conference reports, a fully searchable treatments database, and The Wheel – your personal pill planer.

### 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.

### THT Direct Phoneline

0845 1221 200

Mon-Fri 10am-10pm Sat-Sun 12-6pm

### i-Base Treatment Phoneline

0808 8006013

Mon-Wed 12-4pm

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