

aids treatment update

Expecting the unexpected

It is a frustrating fact that we are still learning when it comes to identifying all the side-effects of anti-HIV medicines. Rare side-effects, or those that develop after months or years, may not have been recognised during clinical trials. Instead, they often only come to light when individual reports have been published in medical journals, or when doctors and pharmacists report them to a government agency, like the UK's Medicines and Healthcare Products Regulatory Agency (MHRA).

Until recently, the MHRA relied solely on doctors and pharmacists to report side-effects, as well as unusual interactions between prescription drugs and over-the-counter medicines, herbs and/or recreational drugs. However, there is now a pilot scheme (see page 8) that allows patients to report their side-effects and interactions directly to the MHRA.

Last month we reported how Bristol-Myers Squibb (BMS), the drug company that makes efavirenz (*Sustiva*), responded to four reports of serious birth defects in infants born to women who took efavirenz during the first three months of pregnancy. They now advise women who are taking efavirenz, and who are capable of becoming pregnant, to double-up on their contraception methods: to combine condoms with hormonal contraception to make sure they don't fall unexpectedly pregnant.

In the light of the efavirenz warning, and given the complex interactions between most anti-HIV drugs and hormonal contraceptives, Bridget Haire provides a comprehensive guide for HIV-positive women - and their partners - on how to prevent unwanted pregnancies, starting on page 2.

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a woman's guide

Summary

- Some contraception methods are more reliable than others.
- Most anti-HIV medicines interact with some hormonal contraceptives, reducing the effectiveness of the contraceptives.
- Contraceptive method is an important issue to consider when choosing the right anti-HIV combination for you.
- Doubling up - using both barrier and hormonal contraception - is one way of being more certain that you will not become pregnant.
- Hormonal contraception cannot replace condoms in order to prevent transmission of HIV or other sexually transmitted infections.
- Talk to your doctor or nurse at your HIV clinic if you have concerns about combining your anti-HIV medicines with hormonal contraceptives.

Contraceptives prevent pregnancy in a variety of different ways, and these can be divided into four broad groups: barrier methods, devices that are inserted into the womb, hormonal contraceptives and surgical interventions. This article will focus on the two most common methods - barrier and hormonal contraceptives - in detail.

How effective is contraception?

When the prevention of HIV transmission is the priority, the male condom is the obvious contraceptive choice for women with HIV. However, condoms don't always provide the ideal solution for every woman in every situation. First and foremost, women don't control the use of male condoms. Also, some people tend to prefer

sex without condoms (see *When both partners are positive*). Finally, even if condoms are used, they are not 100% effective, due to a variety of issues, including improper use, breakage and loss of erection. (See table 1: *Effectiveness of Contraception Methods*).

The problem for women on highly active antiretroviral therapy (HAART) is that many anti-HIV medications interact with hormonal contraception. This interaction could reduce the effectiveness of contraceptives (although there is no evidence that contraceptives reduce the effectiveness of HAART) and result in an unplanned pregnancy. For a woman determined not to fall pregnant, an additional contraception method to the male condom may be needed in order to both practise safer sex and be confident that an unwanted pregnancy does not occur. Adding hormonal contraceptives to condoms appears to be the safest approach. However, as you will see, there are several available options, and there should be at least one method of contraception that suits you.

Barriers: condoms and diaphragms

Barrier contraceptives prevent the male sperm meeting the female egg by literally creating a barrier between them. This group of contraceptive choices comprises male condoms that fit onto the penis, female condoms that fit into the vagina, and diaphragms and cervical caps that are inserted through the vagina and fitted over the opening of the cervix.

The main disadvantage of relying solely on barrier contraception is that in order for it to be effective it needs to be used - and used correctly - each time sexual intercourse occurs. Many people find this difficult. In instances where barrier contraception fails, or when it is not used, emergency hormonal contraception (commonly referred to as the 'morning-after Pill', although it is effective up to 72 hours after sex) can be used as a back-up.

Female condoms (*Femidom*) can be a good option for women with HIV and they offer some advantages over the male version: they can be put in place well before sexual intercourse and the woman controls the insertion. There are also disadvantages: care needs to be taken that the penis goes into the inner ring of the condom, not up the side between the vagina and the condom; they are detectable by partners; and they can make a 'scrunching' noise during sex.

Both female and male condoms provide varying degrees of protection from a wide range of sexually transmitted infections. They are also an obvious choice for couples where one partner has HIV and the other does not. Condoms are usually available for free at most family planning, HIV and GUM clinics. Unlike male and female condoms, diaphragms and caps need to be expertly fitted by a doctor initially, and from then on are self-inserted.

Hormonal contraception: an overview

Hormonal contraceptives can be taken as tablets ('the Pill'), as patches, as implants under the skin, or as periodic injections. A hormone-releasing contraceptive device can also be inserted inside or within the womb by a doctor or a nurse.

Hormonal contraceptives work by altering your body chemistry to prevent ovulation (the release of eggs that can be fertilised by sperm) and/or to thin the lining of the uterus to prevent the implanting of a fertilised egg and thicken the cervical mucus to provide a barrier to sperm (some progesterone-only preparations do not prevent ovulation).

The major advantages of hormonal contraception for women are that they are in control of its use, and it requires no action at the time of sexual intercourse. This means that it doesn't interrupt the flow, and that a partner need not be aware that contraception is being used.

The main problem with most hormonal contraceptives is that many drugs used as part of a HAART combination interact with them, possibly reducing their effectiveness (see table 2). This includes the non-nucleoside reverse transcriptase inhibitors (NNRTIs), nevirapine (*Viramune*) and efavirenz (*Sustiva*), and the entire class of protease inhibitor (PI) drugs, with the exception of indinavir (*Crixivan*) and

Table 1: Effectiveness of Contraception Methods

Contraceptive method	Contraceptive effectiveness
Vasectomy	More than 99%
Female sterilisation	More than 99%
Combined pill	More than 99%*
Contraceptive injection	More than 99%*
IUS (<i>Mirena</i>)	More than 99%
Implant (<i>Implanon</i>)	More than 99%*
Mini-pill	96-99%*
Male condom	90-98%
Female condom	85-98%
Diaphragm or cap with spermicide	85-96%

*excluding drug interaction issues

hormonal contraception and haart continued

When both partners are positive

If you are both HIV-positive, and ideally if both of you are sure that the other is not having sex outside of your relationship, then you may prefer not to use condoms at all for contraception, relying instead on other contraceptive methods. Couples making this choice need to be aware that there are still some risks involved.

Condoms reduce the chance of acquiring or passing on sexually transmitted infections (STIs), although they do not eliminate the risk entirely. Wart viruses that can cause pre-cancerous and cancerous cells in the cervix are an STI. Women with HIV are more susceptible to pre-cancerous changes, so this is an important consideration especially if a male partner is sexually active with others.

A recent study from Kenya¹ found that the use of hormonal contraception leads to a small increase in the shedding of HIV-infected cells in the cervix. This means that a woman on hormonal contraception may be more likely to pass on HIV. There have been some documented cases of 'superinfection', where a person already HIV-positive gets infected again with a new strain of HIV by his or her sexual partner. It is thought that if this happens, it might hasten disease progression. There are only a handful of cases in the scientific literature where superinfection is proven to have occurred. However, since the detection of superinfection is very complex, some experts believe it happens more frequently despite the lack of data to support this. Superinfection has not been documented when couples are taking anti-HIV therapy: one large Californian study of HIV-positive couples on antiretroviral therapy showed no evidence of superinfection.

atazanavir (*Reyataz*), which boost hormonal contraceptive levels, and which may result in increased side-effects. However, since both indinavir and atazanavir are usually boosted with an additional dose of ritonavir - which reduces oestrogen levels - the interaction is complex, and requires specialist advice.

The only hormonal device that states in its package insert that it is not affected by medicines taken at the same time is the hormone-release device that is inserted into the womb, known as the intrauterine system (IUS) or *Mirena*.

However, knowledge about drug interactions is constantly being updated, so if you have any concerns about your anti-HIV combination interacting with your choice of contraception method, it is best to discuss it with your HIV physician.

'The Pill'

The Pill is the most common form of hormonal contraception. It comprises two active synthetic hormones, oestrogen and progestogen, so it is sometimes called the 'combined Pill'. It is sold under many different brand names, although the dosage of hormones differs in different brands and formulations - some of which have lower levels of the active ingredients at certain parts of the cycle. The Pill is estimated to be over 99% effective in preventing pregnancy, although this will be less when combined with most PIs and NNRTIs, drugs used to treat tuberculosis (TB) such as rifampicin and rifabutin, common antibiotics, as well as with the herbal antidepressant, St. John's wort.

The 'mini-Pill'

The mini-Pill (also know as 'POP', for progestogen-only pill) contains only progestogen and, under normal circumstances, is 96-99% effective. It can be used by women for whom the Pill is unsuitable, such as women

Table 2: Anti-HIV drugs that reduce levels of hormonal contraceptives

Drug	Effect on hormonal contraception	Notes
non-nucleoside reverse transcriptase inhibitors		
efavirenz (<i>Sustiva</i>)	Not fully studied	May reduce contraceptive effectiveness - since efavirenz is associated with birth defects, double-up with barriers
nevirapine (<i>Viramune</i>)	Significant decrease in blood levels of both oestrogens and progestogens	Reduces contraceptive effectiveness - double-up with barriers
protease inhibitors		
fosamprenavir (<i>Telzir</i>)	Can interact with progestogens and oestrogens	May reduce contraceptive effectiveness - double-up with barriers
lopinavir/ritonavir (<i>Kaletra</i>)	Lopinavir reduces both oestrogens and progestogens; ritonavir reduces oestrogens	Hormonal contraception not usually recommended
nelfinavir (<i>Viracept</i>)	Reduces oestrogens and progestogens	Reduces contraceptive effectiveness - significant association with contraceptive failure
ritonavir (<i>Norvir</i>)	Reduces oestrogens	Increase contraceptive dosage or use progestogen-only contraception
saquinavir (<i>Invirase, Fortovase</i>)	Reduces oestrogens	Not recommended with oestrogen-based contraceptives (combined Pill or patch)

who are over 35, those who smoke, and those who have high blood pressure, diabetes, migraine or those who are prone to blood clots. However it is more likely to cause menstrual side-effects such as infrequent or very heavy periods, and it is less effective in women who are overweight. The mini-Pill is perhaps not the best option for a woman taking anti-HIV drugs that interact with hormones, since it is less effective than the Pill, and as a result any further dilution of potency is more likely to result in unwanted pregnancy unless barrier methods are also used.

The Patch

This is a small beige patch that is stuck onto smooth, hair-free skin and delivers into the

bloodstream the same combination of synthetic hormones found in the Pill. If used correctly, it is 99 % effective. However, the hormones delivered by the patch have the same interaction problems with anti-HIV drugs as the Pill.

Injections

There are two available forms of injected hormonal contraception that provide longer-lasting protection. Injections are usually given every twelve weeks for medroxyprogesterone acetate (*Depo-Provera*) and every eight weeks for norethisterone enantate (*Noristerat*). Each product uses progestogen only and side-effects are the same as for the 'mini-Pill'. Women with a history of severe depression are cautioned against these

hormonal contraception and haart continued

products, so this may be a matter of consideration for women dealing with the range of difficulties that HIV can bring. Becoming pregnant after having an injectable contraceptive may take longer (up to several months after *Depo-Provera*, although fertility may also return immediately), so it is not a good option for women who wish to conceive in the relatively near future.

Injected contraceptives are usually more than 99% effective. However, this is only the case when there are no interaction issues. A woman taking anti-HIV drugs that can cause an interaction may need to have more frequent injections: one London clinic gives *Depo-Provera* every ten weeks, and no increased side-effects have been observed. This is not a proven strategy, however, and there is a risk of increased side-effects, as well as the risk of contraceptive failure.

Implants

The contraceptive implant *Implanon* (etonogestrel) is another progestogen-only product that is usually more than 99% effective. This is a small rod, about the size of a matchstick, that is inserted under the skin of the upper arm where it slowly releases the hormone. This device provides protection for three years, but is readily reversible if pregnancy is desired or if the side-effects - most commonly irregular bleeding - are not tolerated. It may be less effective for women taking drugs that can cause an interaction, including most anti-HIV medicines, St John's wort, and TB drugs.

Intra-uterine system

The IUS (*Mirena*) is a small T-shaped device that is inserted into the womb by a doctor or

trained nurse. It slowly releases the hormone progestogen. Correctly placed, it is more than 99% effective. This form of hormonal contraception is unlikely to be affected by other medicines, so it should be effective regardless of your anti-HIV drug regimen.

Unlike other intrauterine devices (IUD - formerly called coils) that can cause heavy bleeding and particularly painful periods, the IUS can actually improve difficult menstrual symptoms, often making periods lighter and less painful. Fertility quickly returns upon removal.

Side-effects include some irregular bleeding, spotty skin and headaches for the first few months. Harmless cysts may also form on the ovaries. There is a very small possibility of perforation of the uterus if the device is improperly inserted, and in this case it needs to be surgically removed. The likelihood of this is reduced if inserted by an experienced and skilled doctor or nurse. During the first twenty days of insertion there is a risk of acute pelvic inflammation, similar to infection with chlamydia, so a sexual health check-up prior to insertion is a good idea.

The 'morning-after Pill'

The 'morning-after Pill' can be used after a barrier contraceptive either fails or has not been used. It consists of two tablets, containing a single hormone, progestogen. The 'morning-after Pill' can prevent around 95% of possible pregnancies if taken in the first 24 hours - although it can still be used up to 72 hours - after unprotected sexual intercourse. It is available from the pharmacy at most chemists, as well as from your GP or family

planning clinics. Late at night or at weekends, it is available at some NHS walk-in clinics and Accident and Emergency (A&E or Casualty) departments.

The 'morning-after Pill' is affected by anti-HIV drugs in the same way that other oral contraceptives are, so for women taking combinations that lower the blood levels of contraceptives it is likely to be less effective.

For women who need emergency contraception and are taking one or more anti-HIV drugs that may interact with it, getting some individual medical advice is recommended. However, taking the pills as soon as possible is also advisable, so taking the standard dose immediately while waiting for further advice would be better than waiting.

Abortion pill

If a woman has an unplanned pregnancy, the abortion pill, mifepristone (*Mifeprex*, RU-486) can terminate a pregnancy up to 49 days after conception. Its usage is governed by the Abortion Act, so it can only be prescribed by doctors working in a termination-of-pregnancy service. Since the product information advises caution with protease inhibitors, this suggests that its effectiveness may be reduced by all the drugs listed in table 2. Use of the abortion pill in HIV-positive women taking HAART requires a discussion with a doctor or nurse at your HIV clinic, along with advice from a specialist in family planning.

Change your HAART or your contraception method?

Balancing your current and future health with your contraception preferences is not an easy task. Decisions taken now regarding anti-HIV treatment can affect your treatment options later on. It is always best to discuss your contraception needs and choices with your doctor or nurses at your HIV clinic, since they will be in the best position to advise you. You could also ask to be referred to a family planning clinic for further advice.

Based on current knowledge, the PIs saquinavir and ritonavir only appear to interact with oestrogens, but not with progestogens. Although this removes combined hormonal preparations

from the contraceptive list, implants, the mini-Pill and injections are more likely to be effective.

If you stay on HAART that does interact with contraceptive hormones, one option is to double-up: combine one of the most potent forms of hormonal contraception with barrier protection (e.g. condoms) whenever possible.

It is difficult to say how great the risk of unplanned pregnancy is when taking an anti-HIV drug that interacts with hormonal contraception. One study² that looked back at medical records of women in one HIV clinic found that eleven women out of 88 on anti-HIV therapy fell pregnant while taking hormonal contraception. Ten of these were taking the Pill, and one had *Depo-Provera* injections. Of the failures on the Pill, eight women were taking nelfinavir, two were taking efavirenz and one took saquinavir. Nelfinavir was found to significantly increase the risk of contraceptive failure, so this drug should definitely be avoided if taking oral contraception.

Choose carefully

On paper, the IUS (*Mirena*) appears to be the best hormonal contraceptive option, since it is effective, long-lasting and does not interact with any anti-HIV regimen. However, no one option is going to suit every woman with HIV, and the IUS, like other hormonal contraceptives, has its side-effects.

Progestogen-only contraceptives interact with a smaller number of anti-HIV drugs than combined products, and the longer-lasting options like implants and injectables mean one less pill to take on a daily basis.

The combined hormonal contraceptive options involve some degree of compromise - either of contraceptive effectiveness, or accepting significant limitations on anti-HIV options. Since tailoring a regimen around possible contraceptive interactions is not advisable - especially for women who need maximum antiviral potency - one option would be to stick with the anti-HIV regimen that suits you best and combine a potent hormonal contraceptive with a second form of contraception, like the male or female condom.

references

1. Wang CC et al. *AIDS* 18: 205-209, 2004.
2. Clark et al. *JAIDS* 37, 1219-1220, 2004.



reporting side-effects

8 how a new pilot scheme is putting patient power into practice, by edwin j bernard

The Medicines and Healthcare Products Regulatory Agency (MHRA) co-ordinates two schemes for the reporting of suspected side-effects to medicines that are marketed in the UK. The Yellow Card Scheme was set up in 1964, in the wake of the thalidomide tragedy, and records unwanted effects associated with any prescribed medicine, herbal remedy or over-the-counter medicine (including vitamins).

The more recent Blue Card Scheme was established specifically to record suspected reactions in people with HIV.

Until the start of this year, Yellow Card reports on suspected side-effects could only be completed by health care professionals, but the MHRA have now launched a pilot scheme allowing patients to complete Yellow Card reports themselves. The MHRA are testing a number of different ways for patients to report their side-effects, and permanent systems will be introduced next year, based on the success of the initiative.

We asked the newest member of *ATU's* medical advisory panel, Heather Leake Date, Principal Pharmacist in HIV/Sexual Health at Brighton and Sussex University Hospitals, to explain more about the scheme, and why it may be beneficial for people living with HIV.

ATU: What exactly is the MHRA testing?

HLD: They want to see if patient reporting of suspected side-effects increases knowledge and awareness of medicine side-effects and ultimately makes medicine use safer. They want feedback on the pilot scheme so they can decide how user-friendly the reporting forms are, so if you submit a Yellow Card report they will send you a questionnaire to complete.

ATU: How do you fill in a Yellow Card?

HLD: You can go to www.yellowcard.gov.uk and fill in the form electronically. There is also a paper-based Yellow Card reporting form, which the MHRA will send to you if you email them at patientreporting@mhra.gsi.gov.uk or telephone 020 7084 2000. These forms have also been distributed to over 4000 GP surgeries across the UK, although since people with HIV tend not to use GPs, the internet scheme is probably the most useful. Later in the year, the MHRA will pilot other methods of reporting, as well as make the paper reporting forms available in a greater number of locations.

ATU: If someone has noticed unwanted symptoms that may be due to a new combination therapy or an interaction between their anti-HIV meds and something else - like herbs or recreational drugs - what should they do?

HLD: You can talk to your clinic doctor, pharmacist or nurse, who will be able to advise you on what you should do. If necessary, they can report the suspected side-effects through either the Blue or Yellow Card reporting schemes, or you can complete a patient Yellow Card report yourself. If you think a suspected side-effect requires urgent attention, or if you have any concerns, you should contact your clinic or your GP as soon as possible ('out of hours' if necessary) so that you receive appropriate medical care. Remember that if you have a suspected reaction to your anti-HIV medicines (especially those containing abacavir - *Ziagen*, *Trizivir* and *Kivexa*), then it is vital to seek advice from an HIV expert (e.g. your clinic doctor) as soon as possible. Do not stop taking any of your anti-HIV medicines without taking advice from your treatment centre.

ATU: How can you tell what is causing the side-effect?

HLD: When deciding if your new medicine may have caused your unwelcome symptoms, a number of factors should be taken into account. If symptoms begin after you start a new medicine, they may be related to this medicine, but this will not always be the case. Your symptoms may be related to a medical condition that you have, or may simply be coincidental, particularly if you experience commonplace symptoms like a headache. If your symptoms go away after the medicine is stopped, this may suggest that they are more likely to have been caused by the medicine.

Your doctor is in the best position to advise what might have caused your symptoms and to give you advice on how to deal with them, since they should be aware of your full medical history, any other medicines you are taking and any other information that might be relevant.

ATU: Is the Yellow Card scheme only for reporting unusual side-effects?

HLD: In an ideal world every single instance of an adverse effect would be reported, but in reality this is impractical. It is particularly important to report suspected adverse effects of newer medicines, because side-effects which are rare or that develop after months or years may not have been recognised during clinical trials (when they may have been taken by a smaller number of people and for a shorter time than in the 'real world' after they are licensed). Serious unwanted effects (e.g. those which result in hospitalisation or an increased length of stay in hospital) should always be reported, as well as suspected side-effects that are not mentioned in the Patient Information Leaflet for the medicine.

ATU: A real benefit of self-reporting may be the discovery of unknown interactions between herbal medicines and/or recreational drugs and anti-HIV medicines. But if someone mentions that they are taking illegal recreational drugs, will they be reported to the police?

HLD: All Yellow Card reports received at the MHRA are treated with complete confidentiality, and the personal details of any report will not be shared with anyone unless we

have the patient's consent. If you still have concerns about providing your details to the MHRA, you can ask your pharmacist to send a healthcare professional report. The pharmacist's code of ethics states that if they discover someone has used, or is in possession of, an illegal substance then confidentiality should be maintained, unless the person is found to be in possession of such a large quantity of drugs that they couldn't be purely for personal use.

ATU: How exactly does the MHRA respect a patient's privacy?

HLD: If you complete a patient Yellow Card report yourself, then you will be asked for your contact details and other personal information in case more information about the suspected adverse drug reaction is required.

It would also be helpful to include details of your CD4 count and viral load (even though there isn't a box for these on the Yellow Card forms), as some reactions may be more common in particular groups of people with HIV. For example, when this information was included on the Blue Card, it became clear that the risk of rashes and liver problems associated with nevirapine was at least partly related to CD4 count.

The Yellow Cards which your doctor, pharmacist or nurse use to report suspected adverse reactions to medicines do not request information such as your name or date of birth, which could identify you. If you have concerns about providing your name and contact details to the MHRA, you can ask your doctor, nurse or pharmacist to send a healthcare professional report to the MHRA, for which your personal details would not be required.

ATU: Does submitting a Yellow Card report really make a difference?

HLD: Yes. Information collected from the Yellow Card Scheme is vital in helping the MHRA to protect the public, by ensuring that medicines are used safely. The information provided helps to continue identifying new side-effects and ways in which the risks of recognised side-effects can be minimised. Every report submitted contains potentially useful information; without the reports, the MHRA would not be able to continue this important work.

further information

For 24-hour information on suspected side-effects of any non-HIV-related medicines you are taking, you can call NHS Direct on 08 45 46 47 or visit www.nhsdirect.nhs.uk

If you are concerned about any HIV-related medicines, it is probably best to speak to your specialist HIV pharmacist, clinic nurse or doctor.



Draft 2005 BHIVA treatment guidelines now available

A draft version of the first British HIV Association (BHIVA) HIV treatment guidelines to be published since 2003 is now available to download from the BHIVA website at www.bhiva.org.

The BHIVA guidelines are the blueprint for all HIV treatment decisions in the UK, and their influence reaches far beyond the clinic. This year they appear to be entering new territory by including a list of drug prices in order to allow cost comparisons to be made between different regimens. Although it is clearly important in the current climate to address the issue of cost within the treatment guidelines, it is also important that the guidelines contain a clear statement that costs should only be a consideration in the choice of regimen once the needs of the patient have been taken into account. Hopefully, the finalised guidelines will reflect that balance.

There is little change from 2003's guidelines in terms of recommendations for when to start or change therapy. The guidelines now appear to favour efavirenz (*Sustiva*) over nevirapine (*Viramune*) as the NNRTI of choice for people taking anti-HIV treatment for the first time, although this may change in finalised guidelines. Also, as evidence associating AZT (zidovudine, *Retrovir*) alongside d4T (stavudine, *Zerit*) with fat loss (lipoatrophy) continues to grow, the guidelines move away from firmly recommending an AZT-containing regimen as part of HAART's nucleoside 'backbone'. The guidelines will be finalised and published by September 2005.

Wait three months before treating acute hepatitis C in HIV-positive patients

Treatment for hepatitis C virus that has been recently acquired (i.e. within the past six months) is significantly less likely to be effective in HIV-positive individuals, compared to people who are HIV-negative, according to a study from the Chelsea and Westminster Hospital. They found that only about 60% of people with both HIV and recently-acquired hepatitis C responded to anti-hepatitis C treatment, compared with over 90% of HIV-negative people newly infected with hepatitis C.

However, the investigators found that a significant number of HIV-positive patients spontaneously cleared hepatitis C virus within the early weeks of infection. Of the 50 men included in the study, twelve (24%) spontaneously cleared hepatitis C virus infection by week twelve. Spontaneous clearance of hepatitis C virus was significantly associated with a CD4 cell count above 500 cells/mm³ and a lower hepatitis C viral load.

Consequently, the investigators recommend that if treatment for hepatitis C is started during acute infection, it should be delayed for twelve weeks to avoid unnecessary, unpleasant side-effects from anti-hepatitis C drugs.

Gilleece YC et al. Is the treatment of acute hepatitis C in HIV-positive individuals effective? 11th Annual BHIVA/BASHH Conference, abstract 026, Dublin, 2005.

share the knowledge

If this issue of *AIDS Treatment Update* includes information which you think might be useful for a friend, family member or colleague, please do share it with them. Better still, why not encourage them to subscribe themselves? *ATU* is available free to individuals in the UK affected by HIV and AIDS by filling in the form on the back page, calling 020 7840 0050, or emailing info@nam.org.uk.

Stopping smoking only factor associated with improvement in heart attack risk

Giving up smoking was the only factor associated with a reduction in the risk of cardiovascular disease, according to the results of a recent French study. Investigators from the Aquitaine Cohort study examined the impact of various strategies to reduce hardening of the arteries, an early indicator of cardiovascular disease risk. These included changing anti-HIV therapy to more heart-friendly drugs, the use of lipid-lowering drugs and stopping smoking. The investigators concluded that "the potential impact of smoking cessation... should encourage its active promotion by clinicians providing HIV care."

Thiebaut R et al. Change in atherosclerosis progress in HIV infected patients: ANRS Aquitaine Cohort, 1999 - 2005. AIDS: 19(7): 729 - 731, 2005.

Many HIV-positive children receiving too low doses of anti-HIV drugs

On average, HIV-positive children have been receiving inadequate doses of their anti-HIV drugs for almost half of their time on therapy, according to investigators from the Collaborative HIV Paediatric Study (CHIPS). After evaluating antiretroviral drug dosing in 73% of all HIV-positive children aged between two and twelve, in the UK and Ireland, the investigators concluded that "largely unwittingly, we have greatly underdosed HIV-infected children on antiretroviral therapy over the past seven years." This, they suggested, was due to a variety of factors, including complex dosing guidelines based on insufficient clinical evidence, practical difficulties surrounding the adjustment of children's doses as they grow, and limitations of current paediatric formulations.

Menson EN et al. Extent of underdosage of antiretroviral therapy in HIV-infected children. 11th Annual BHIVA/BASHH Conference, Dublin, abstract 036, 2005.

Planned vaginal delivery appears safe with an undetectable viral load

Planning to have your baby by vaginal delivery appears to be a safe option for HIV-positive pregnant women with an undetectable viral load at the time of delivery. A recent report from London's Chelsea and Westminster Hospital found that the women who delivered this way did not pass on HIV to their newborn baby. Until recently, it was recommended that all HIV-positive women deliver by caesarian. "With careful monitoring of women throughout pregnancy and during labour, the risk of HIV transmission with a planned vaginal delivery is very low," the researchers wrote. "We are of the opinion that women with a viral load below 50 copies/ml and no obstetric indications for an elective caesarean should be offered a vaginal delivery if this is their preference," they conclude.

Browne R et al. Outcomes of planned vaginal delivery of HIV-positive women managed in a multi-disciplinary setting. 11th Annual BHIVA/BASHH Conference, Dublin, abstract P45, 2005.

LGV spreading throughout UK; gay HIV-positive men most affected

Sixty-seven confirmed cases of the previously rare sexually transmitted infection, LGV (lymphogranuloma venereum), have now been confirmed in gay men in the UK, the vast majority of whom are chronically infected with HIV, according to the Health Protection Agency. Although the majority (47, or 75%) were diagnosed in London, and six were in Brighton, one or two confirmed cases of LGV have now been diagnosed in Birmingham, Chichester, Edinburgh, Glasgow, Gloucester, Liverpool, Manchester, Norwich and Oxford.

Ison CA et al. Enhanced surveillance for lymphogranuloma venereum (LGV) in England. 11th Annual BHIVA/BASHH Conference, Dublin, abstract 037, 2005.

news from



nam forum: hiv and the liver

NAM's June forum will focus on one of the most important organs in our body, the liver. HIV consultant, Dr Sanjay Bhagani, from London's Royal Free Hospital, will be looking at the various causes of liver problems for people with HIV. These include anti-HIV medicines, hepatitis B and C co-infection, other drugs, including over-the-counter medicines, herbs and recreational drugs, and alcohol. Dr Bhagani will explain how to avoid, identify and treat liver problems. The forum will take place on Monday 27th June, between 7-9pm, at the University of London Union, Palms Room, 4th Floor, Malet Street, London, WC1. Everyone is welcome and refreshments are provided. Visit <http://www.aidsmap.com/en/events/forums.asp> for more details.

criminalising hiv infection

The article planned for this month on the legal aspects of HIV transmission in the light of recent court rulings has been postponed until the British HIV Association finalise their own guidelines, which we hope will be the definitive consensus on what the law requires HIV-positive people, their partners, and their healthcare providers, to do to prevent breaking the law.

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AIDS Treatment Update

founded by Peter Scott

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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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i-Base Treatment Phoneline

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