

# aids treatment update

## boning up on osteoporosis

It now appears that some men and women with HIV experience the kind of bone problems that are often associated with older women, notably osteoporosis, or 'thinning of the bones'. At the moment we don't exactly know the causes and extent of the problem - and what the ideal preventative solution might be. The science of how HIV and its treatments affects bones is at a similar stage to where we were with lipodystrophy at the start of the millennium. However, the article that begins on page two provides an excellent overview of what we do know and what we could do today to prevent broken bones and hip replacements in the future.

NAM travelled to Rio de Janeiro in July to cover the Third International AIDS Society conference. The conference itself wasn't a major blockbuster, as scientific conferences go, but there were still plenty of data on new drugs in development, new information on treatment side-effects and other HIV treatment news for NAM's editors to get excited about. You can read our report on page six.

Finally, next month, exciting changes are planned for the look and feel of *AIDS Treatment Update*. On page eight you can read more about how and why NAM decided to redesign this newsletter. I'm very much hoping that you will welcome and appreciate the changes.

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# hiv and bone problems

## 2 what can we do today to prevent broken bones and hip replacements tomorrow? ask gus cairns & edwin j bernard

One of the most unexpected side-effects of living with HIV is the relatively recent discovery that some people with HIV are at increased risk of bone problems. Although osteonecrosis (literally, 'bone death') has been in the news recently due to media coverage of HIV-positive Erasure vocalist, Andy Bell - who had to have both hips replaced due to the condition - it is fortunately still a relatively rare HIV-related disease.

However, osteoporosis ('thinning of the bones') and its less severe cousin, osteopenia, appear to be much more common - even among traditionally lower-risk men and women under the age of 50.

### Osteopenia and osteoporosis

Bone is a living tissue which consists of fibres of the protein *collagen*, which gives bones flexibility and shock resistance, surrounded by crystals of the mineral *apatite* (calcium phosphate), which gives them rigidity. Cells called *osteoblasts* continually secrete new calcium, while others called *osteoclasts* dissolve the minerals and recycle them back into the bloodstream. If this circulation did not occur, bone would continually grow and thicken resulting in blocked blood vessels.

Bone mineral density, which measures how much calcium phosphate is in the bones, is measured by dual-energy X-ray absorptiometry (DEXA or DXA scans) that uses very low doses of X-rays. DEXA scans are usually carried out on the lower back (lumbar spine), spine and in the hip (femoral neck). The results are called t-scores.

The World Health Organisation (WHO) has defined osteopenia and osteoporosis by t-scores.

Osteopenia occurs when bone mineral density is between minus one (-1) and minus two-and-a-half (-2.5). At this stage there are usually no apparent effects, but the disease could progress to osteoporosis. A t-score below minus two-and-a-half (-2.5) means a diagnosis of osteoporosis. At this point the condition is usually severe enough to cause problems like compression fractures, where the thinning bone crumbles under its own weight during normal activity.

Osteoporosis is a silent disease. For most people, the first sign that something is wrong can be when they develop a fracture in the spine (or the wrist) after a minor incident. These compression fractures are not only painful, but when they occur in the spine they also often cause height reduction and curvature of the spine.

An estimated three million people in the UK suffer from osteoporosis. In the general population it is most commonly seen in women over 50, where it is associated with low levels of the hormone oestrogen.

### Bone problems and HIV

Recently, several studies have found that a surprisingly high percentage of relatively young, HIV-positive people have a reduction in bone mineral density and are, therefore, at a higher risk of bone fractures than HIV-negative people of the same age and gender. For example, a study presented at the recent IAS Conference in Rio de Janeiro<sup>1</sup>, involving DEXA scans from

## Tenofovir and osteopenia?

When the anti-HIV drug tenofovir (*Viread*) was first tested on animals, concerns were raised that loss of bone mineral density might be a long-term side effect of the drug. The probable mechanism for this is a mild version of *Fanconi's syndrome*, the name given to damage caused to the small tubes in the kidneys that filter urine out of the blood. When this happens, calcium and phosphate leak out of the bloodstream into the urine and it is thought that this mineral loss could lead to osteopenia. The latest US package insert for tenofovir includes 144-week data from the trial that compared tenofovir with d4T, plus 3TC and efavirenz, in treatment-naïve people. Some of the bone mineral density measurements suggest that tenofovir has more effects on the bones than d4T, although four people taking tenofovir and eight taking d4T had "clinically relevant fractures." However, initial decreases in hip and spine bone mineral density caused by tenofovir did not progress beyond the first year of treatment, according to 192-week data recently presented at the IAS Conference in Rio de Janeiro. The *Viread* package insert reminds doctors and patients that, "bone monitoring should be considered for HIV-infected patients who have a history of pathologic bone fracture or are at risk for osteopenia."

400 HIV-positive individuals (73% of whom were men; the median age was 43 for men, 42 for women) seen at the HIV clinic at Bordeaux University Hospital, suggests that 55% had WHO-defined osteopenia, and another 25% had WHO-defined osteoporosis.

Changes in bone mineral content in HIV-positive individuals were first reported as early as 1995. However, it wasn't until the turn of the millennium that scientific journals and conferences began seeing more reports of younger HIV-positive people being affected by bone problems. These problems were often found unexpectedly in people who underwent DEXA scans during lipodystrophy studies.

At the Royal Free Hospital in London, Professor John Studd, a gynaecologist who pioneered hormone replacement therapy in post-menopausal women, and HIV consultant Professor Margaret Johnson, current chair of the British HIV Association, began seeing compression fractures in younger, HIV-positive African women in the late 1990s. "Osteoporosis is, in fact, usually less common in African women," notes Professor Studd. "They generally have very strong bones." Professors Studd, Johnson and their colleagues<sup>2</sup> then conducted a survey where they found that some degree of bone mineral loss was extremely common in their patients with HIV: 58% had WHO-defined osteopenia and 13% had WHO-defined osteoporosis.

## How many people are at risk?

That Royal Free study and the recent Bordeaux study have found that bone mineral density is below average in 70-80% of the HIV-positive individuals studied - suggesting that bone problems could be very common. But other studies have found a lower rate of individuals with low bone mineral density where only about 20-40% of people with HIV appear to have some degree of bone problems.

These studies give different results due to the use of different measurements and definitions. For example, the condition may be defined by bone mineral content or by bone mass, and there are different statistical methods of comparing mineral scores (like t-scores) to the average population; not everyone uses the WHO definitions.

A diagnosis of osteoporosis suffers from the same problems of definition, with different studies reporting differing rates in HIV-positive people that vary between one percent and 25%. Professor Bill Powderly of University College Dublin is one of the few HIV clinicians to have closely investigated HIV-related bone conditions. He estimates the actual rate for HIV-related osteoporosis to be between "two and four per cent", which appears to be about 2.5 times higher than age- and gender-matched members of the general population.

## Is anti-HIV therapy the cause?

Professor Studd and his colleagues initially suspected that protease inhibitors (PIs) were a

possible cause of these bone problems, as there was a theory that the side-effects of these drugs (which includes an increase in blood fats) could cause a blockage of blood vessels in the bone. But only one other study<sup>3</sup> found a significant association with PIs, and this didn't take into consideration how long the participants had been on PIs, or how long they had been infected with HIV.

Since then, other studies<sup>4,5</sup> have failed to find a significant association with any specific anti-HIV treatment. In addition, they have found similar rates of osteopenia in HIV-positive people who have never taken any anti-HIV therapy. Confusingly, test tube studies have suggested that some PIs, including ritonavir (*Norvir*) and nelfinavir (*Viracept*), may actually strengthen bones<sup>6,7</sup>.

### Weight of evidence

Today, there is reasonable agreement about the association between osteopenia, osteoporosis and HIV infection. However, doctors and scientists are still debating the underlying mechanism that is triggering bone problems in HIV-positive individuals. The latest research suggests that it may have something to do with high bone turnover possibly linked to dysregulation of a system of several recently-discovered chemical messengers produced by the immune system - cytokines called osteoprotegerin (OPG), RANKL and RANK that are part of the tumour necrosis factor (TNF) family<sup>8</sup>.

Professor Powderly believes that people who are, or who have ever been, underweight are most at risk for bone problems. "A number of studies<sup>6,9</sup> suggest that prior weight loss from opportunistic infections or HIV itself is the most important risk factor," he says. "You see more osteoporosis in those who've had more HIV disease simply because they've been through a period of being very thin. It's purely physical," he explains, "As there is less weight putting stress on the bones, so they adapt and become thinner. This also happens to astronauts in zero gravity."

Not all HIV doctors agree with Professor Powderly's assessment, however. Dr Fiona Boag, an HIV consultant at London's Chelsea & Westminster Hospital, points out that there is also evidence from studies into

osteopenia, osteoporosis and *anorexia nervosa*, which suggest that as well as the weight loss associated with both *anorexia nervosa* and advanced HIV disease, low levels of sex hormones like testosterone and oestrogen may play an equally important role in the loss of bone mineral density.

A new Italian study<sup>10</sup> presented at the recent IAS Conference confirms that anti-HIV therapy is not associated with bone mineral density loss, and found five factors that correlated with an increased risk of osteopenia/osteoporosis: being female; aging; having more advanced HIV disease; being underweight; and having a high viral load.

### Prevention and treatment

Although gender and genetics play a major role in determining bone strength, various factors under your control can make a difference. Since smoking tobacco and drinking more than the recommended daily amounts of alcohol (3-4 units of alcohol/day for men; 2-3 units for women) are associated with an increased risk of osteopenia, it makes sense to stop or limit these activities if you are concerned about bone health. In addition, eating a diet rich in calcium (found in dairy products, green leafy vegetables and bony fish) and doing regular, weight-bearing exercise (like weight training) have been found to improve bone density. Men and women who have lived with HIV for some time can also have low levels of the sex hormones, testosterone and/or oestrogen, which is also associated with osteopenia: replacement therapy is an option.

Dr Boag points out that recent studies published in the *British Medical Journal* and *The Lancet* have found that that supplementation with calcium and vitamin D do not appear to make much of a difference to people already at risk of osteopenia and/or who suffer from osteoporosis. Nevertheless, Professor Powderly and many others working in field still currently recommend supplementation for those at risk: 1500mg of calcium and between 400 to 1000 IU (10-25 mcg) of vitamin D daily.

"Osteopenia needs to be managed through exercise, diet, stopping smoking and reducing alcohol consumption as an absolute minimum," says Dr Boag, "but we ourselves are already

recommending using the drug alendronate (*Phosphomax*) in those with significant osteopenia."

Alendronate is the only approved drug for osteoporosis, and works by inhibiting the reabsorption of bone minerals. As such, it is not a cure for osteopenia or osteoporosis, "but it helps", notes Dr Boag. The drug has been tested in HIV-positive people with some promising results. Two recent studies of alendronate<sup>11</sup> found that bone mineral density improved by 5%, compared with an improvement of 1% in people taking vitamin D and calcium alone. Nevertheless, no current treatment - including alendronate - significantly reverses bone problems once they have started "and," says Dr Boag, "it is much better to try and prevent bone loss, since recovery is an incredibly difficult process."

## Osteonecrosis

This relatively rare bone condition happens when the blood supply to the extremities of the bones fails. For this reason it is often called *avascular* ('lack of blood vessels') *aseptic* ('not caused by a bacterial infection') *necrosis* ('death of tissue'). Osteonecrosis usually affects the *femur*, the bone that connects the leg to the hip.

Studies that have specifically looked for osteonecrosis suggest that one in 500 people with HIV can be affected - up to 50 times the rate found in the general population. However, the largest osteonecrosis study to date<sup>12</sup> found 122 cases of osteonecrosis in 56,300 patients on the French hospital database between 1996 and 2002. This translates into one in 5000 - a lower rate than other studies, but still five times higher than the general population.

The French study was large enough to divide people into groups according to the length of time they had been on anti-HIV drugs, and a worrying pattern was seen; osteonecrosis incidence was seen to increase with the length of time on anti-HIV therapy. Those on anti-HIV therapy for up to three years were three times more likely to be diagnosed with osteonecrosis than those who had never taken anti-HIV therapy, and the incidence rose to seven times that of untreated patients in those who'd been on anti-HIV therapy for over six years.

"The pattern reminds me of the D:A:D study," comments Professor Powderly, referring to the ongoing study of cardiovascular disease (e.g. heart attack or stroke) among HIV-positive individuals which has found an increase in risk that relates to length of time on anti-HIV therapy. And, just as with cardiovascular disease, even HIV-positive individuals who had never been on anti-HIV therapy were at higher risk than the general population. This suggests that HIV must have a role to play in osteonecrosis, and that anti-HIV therapy appears to make this worse.

Initially protease inhibitors were suspected, for similar reasons to osteoporosis. However a review of cases<sup>13</sup> from the Johns Hopkins HIV Cohort between 1995 and 2000 found that the only significant predictor of osteonecrosis was duration of HIV infection and not protease inhibitor use.

"There's a lot we don't know," concedes Professor Powderly. "Most evidence has been anecdotal. It's a good job it's still relatively rare, as anyone who develops this condition will ultimately need surgery."

## Should we be concerned?

Professor Powderly thinks that people with HIV shouldn't worry unduly about the possibility of bone problems. "I think osteoporosis is a problem, but not a huge problem," he says. "Even in prospective studies, we haven't seen the risk of fractures increase, and bone mineral density stayed steady<sup>14</sup>."

Nevertheless, Dr Boag thinks that if we are aware early on of the possibility of bone problems, then prevention now is better than no cure later. "When one looks at the group who suffer from osteoporosis, mainly older post-menopausal women, the degree of pain and disability is enormous and it's the last thing we want for our HIV-positive patients," she says.

You can reduce the risk of future bone problems if you stop smoking, reduce your alcohol intake and increase weight-bearing exercise. Also if you are underweight or very overweight, talk to your HIV dietician about ways to normalise your weight, which can also help prevent future bone problems.

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## further information

Further information on osteoporosis and associated bone disease can be found online at the National Osteoporosis Society website: <http://www.nos.org.uk>



# rio report

## 6 highlights from the recent international AIDS conference in rio de janeiro, by edwin j bernard

The idea behind the Third International AIDS Society (IAS) Conference on HIV Pathogenesis and Treatment held in Rio de Janeiro in July is to bridge the gap between last year's International AIDS Conference in Bangkok and next year's International AIDS Conference, to be held in Toronto. The IAS Conference is a smaller meeting than these major biennial gatherings, allowing for a more intimate affair, resulting in better networking opportunities for scientists, researchers, doctors and policymakers. Although the city of Rio is a stunning location for a conference, and Brazil a fitting host country, having begun universal anti-HIV treatment in 1996 that has become a model for other middle-income countries, the conference itself provided less useful new information with UK relevance than its predecessor in Paris two years ago.

### Prevention

The biggest story by far came from South Africa where results from the first ever randomised controlled trial of male circumcision as an HIV prevention measure created much excitement. The trial found that men who volunteered to be circumcised as adults were 65% less likely to be infected with HIV over 18 months of follow-up<sup>1</sup> which has resulted in international discussions on the use of circumcision as a public health measure. On one hand UNAIDS has reacted with considerable interest to the trial's results and is awaiting confirmation from further circumcision studies in Uganda and Kenya before deciding whether to recommend circumcision as part of a bigger prevention package. On the other hand, anti-circumcision crusaders, calling themselves 'intactivists' have called on the United Nations to label the act a human-rights crime, as they already have with female circumcision.

In the UK, sex between men remains the most common mode of HIV transmission and a fascinating French study<sup>2</sup> shed some light on unexpected reasons why some gay HIV-positive men continue to have unprotected sex. Using a combination of quality of life questionnaires and one-on-one interviews, they found that the men in their study were more likely to take sexual risks if they were distressed by treatment side-effects, and in particular if they had experienced sexual dysfunction since starting anti-HIV treatment. The researchers also found that men reporting discrimination from their parents also appeared to take more sexual risks. This information may help develop interventions in the HIV clinic that take these factors into account.

### Side-effects

Lipodystrophy continues to be a major concern for individuals with HIV on treatment, and several presentations in Rio provided more sobering news. Researchers from the Data Collection on Adverse Events of Anti-HIV Drugs (D:A:D) study - which had previously found that anti-HIV therapy increases the risk of heart attack by 17% for each year on treatment - report that anti-HIV therapy is associated with a 5% increase in the risk of being diagnosed with diabetes for each year on therapy<sup>3</sup>. According to the researchers, most of the risk appears to be due to the increased triglycerides seen when protease inhibitor (PI)-based anti-HIV therapy is taken, suggesting that those who already have other risk-factors for diabetes - which include a family history of diabetes; being overweight; being aged over 45; and/or being of African ethnicity - should consider switching to NNRTI-based therapy or add

triglyceride-lowering fibrate drugs to their current PI-based combination.

Another recently discovered side-effect of anti-HIV therapy is its effect on the thyroid, a gland which produces a hormone that helps regulate growth and metabolism. Researchers at the Chelsea and Westminster Hospital in London linked PIs to an overactive thyroid (hyperthyroidism; symptoms include nervousness, irritability and unexplained weight loss) and NNRTIs to an underactive thyroid (hypothyroidism; symptoms include sluggishness and weight gain). However, although diagnoses of thyroid disorders have increased at the Chelsea and Westminster since the introduction of combination therapy, it is still relatively rare. A review of more than 2000 patient records found that 1.15% had hypothyroidism and 1.07% had hyperthyroidism<sup>4</sup>. At the moment, little is known regarding exactly how anti-HIV therapy interferes with thyroid function, but the researchers recommend routine thyroid-function testing for all people taking anti-HIV therapy, since thyroid disorders can be treated.

Although Professor Brian Gazzard suggested during a panel discussion that it was unfair to ask his patients to exercise in order to combat lipodystrophy when he preferred to sit in his chair and watch TV, a small study with five participants from Chicago suggests that a combination of aerobic exercise and weight training can help improve both the physical and metabolic symptoms of lipodystrophy<sup>5</sup>. The researchers designed a 16-week training programme that involved running on a treadmill three times a week for 20 minutes at 70% - 80% of their maximum aerobic capacity (which both improves cardiovascular fitness and burns fat) and using weights to train all the major muscle groups, using seven sets of exercises, twice a week. After 16 weeks, average total cholesterol levels dropped by 59mg/dl, there was an average 2% reduction in abdominal fat, and a 16% improvement in insulin sensitivity.

## New drugs

A new tablet formulation of ritonavir-boosted lopinavir *Kaletra* using *Meltrex* technology was announced at the conference<sup>6</sup>. This space-age-sounding process allows the drug to

be dispersed evenly throughout the tablet, rather than existing as large crystals in the current soft gel capsules, improving the ability of the drug to enter the bloodstream, as well as allowing storage at room temperature. When made available, at a date yet to be confirmed, it will mean a reduced pill burden of two tablets twice a day and easier storage, since the new pill will not require refrigeration. Studies so far have also found it easier to tolerate, with less diarrhoea.

A needle-free way of delivering T-20 (enfuvirtide, *Fuzeon*) may arrive in the UK as early as next year. The conference heard that use of the *Biojector 2000* system - which pushes the drug through the skin at high pressure - reduces, but does not eliminate, injection site reactions, which are the most common side-effects of T-20<sup>7</sup>.

In more news for individuals with very few treatment options, tipranavir, which should be approved in Europe by the end of the year under the name *Aptivus*, appears to work best as 'salvage therapy' when boosted with ritonavir and combined with T-20, according to a subanalysis of the RESIST studies presented here. Many of those who combined ritonavir-boosted tipranavir with T-20 in these studies have been able to achieve undetectable viral loads, despite their drastically reduced treatment options<sup>8</sup>.

Finally, small teasers of new data on drugs in development were presented in Rio: the NRTI D-d4FC (*Reverset*) is active in individuals with substantial treatment experience and NRTI resistance, but should not be used with ddI (didanosine, *Videx/VidexEC*), due to an increased risk of side-effects<sup>9</sup>; the NNRTI GW695634 significantly reduces viral load in those with NNRTI-resistant virus<sup>10</sup>; and the PI TMC114, when boosted with ritonavir, is significantly more effective in reducing viral load in PI-experienced individuals than any currently-approved anti-HIV combination, as long as it has an 'optimised background regimen' to back it up<sup>11</sup>. The best news about TMC114 was the comparatively few side-effects seen in the 24 week study compared with any of the other treatment regimens<sup>12</sup>.

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All references are abstracts from the Third International AIDS Society Conference on HIV Pathogenesis and Treatment, Rio de Janeiro, 2005.

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## further details

Full details of these and other studies presented at IAS can be found on NAM's website, [aidsmap.com](http://aidsmap.com).



# atu evolves

## 8 why next month's newsletter will look and feel different, by edwin j bernard

Next month will see the publication of the 150th issue of *AIDS Treatment Update*. Such a milestone seems the perfect opportunity to update the look and feel of the newsletter. NAM wants to make *ATU* a more appealing read, so that the important information it contains will reach everyone who might need it. Rest assured, however, that the content, style and tone of *ATU* will remain the same: this is evolution, not revolution!

### Supporting expertise

NAM has published *AIDS Treatment Update* since 1992. This monthly newsletter has developed to become *the* publication in the UK for "expert patients" living with HIV.

Although some people are happy to allow their doctor to make all the decisions regarding their healthcare, many others are interested in working together with their doctor. These so-called expert patients want to be actively involved in all aspects of their treatment decisions and also tend to be more interested in their general health and well-being.

NAM believes that supporting expert patients, and those who want to become more expert, is very important. Research has shown that HIV-positive individuals with access to treatment information outside of that provided by their doctor live longer, healthier lives.

However, for some time we have been concerned that subscriptions to *ATU* were not keeping pace with the growing and diversifying epidemic in the UK.

### In-depth research

Each year NAM carries out a survey with *ATU* readers who receive the newsletter in a personal

capacity. Each year the answers have been very similar in terms of who our readers are, and what they think about the newsletter. Although NAM is grateful for the high response rate and high rate of satisfaction with the newsletter, we realise that this standard survey may only be generating responses from people who are satisfied with *ATU*.

Last year we decided to undertake a more in-depth investigation of various views on, and experiences of, *ATU*. Over several weeks, we interviewed 21 people from London, Manchester, Edinburgh and Norwich. Six interviews were with people working within the HIV sector, and 15 were with people living with HIV, both readers and non-readers of *ATU*.

The results of the research were very informative. It was recognised across the board that *ATU* is a very valuable resource, and is serving certain groups of people, especially the expert patients, very well.

But it was also discovered that there is a large group of people who could benefit equally from the important information it contains, and who would find the information equally valuable, but who at the moment find *ATU* too daunting and difficult to get into.

### A new remit?

Interestingly, *ATU* has never officially had a remit; its content evolved through the need to update both people with HIV and those involved in HIV-related healthcare with important treatment information in the days before the Internet. Since 1999, NAM has developed its website, [www.aidsmap.com](http://www.aidsmap.com), to become a primary source of daily-updated HIV

information not just in the UK, but worldwide, particularly in resource-limited nations.

Amongst its many other resources, NAM also publishes award-winning patient information booklets on a wide variety of treatment issues that are updated yearly.

Our research allowed NAM to give its monthly newsletter a clear remit for the first time. After evaluating the results, NAM decided it wanted to focus the attention of the newsletter on developing the expertise of people living with HIV and on providing information for HIV-positive health.

This means that the publication will offer the information that people living with HIV need in order to develop a high-level dialogue with members of their healthcare team around all medical aspects of living with HIV, and not just antiretroviral therapy. In addition, it will allow readers to make informed decisions about other aspects of their health, including lifestyle choices.

NAM also wants to increase the appeal of patient expertise to a wider audience and to make the publication more widely-read. It is vital to broaden the newsletter's readership to include the men and women of all sexualities and ethnicities living with HIV in the UK today.

## Evolving content

Inspired by the feedback we received from both our in-depth research and the readers' survey, over the past year *ATU* has covered much more than just treatment-related issues, encompassing a wide variety of subjects that relate to different aspects of HIV-positive health.

Since many people rely on the newsletter to understand the latest news in the world of anti-HIV therapy, many articles have been, and continue to be, related to HIV treatments and their side-effects.

As most people with HIV continue to have active sex lives, the newsletter has also included articles about HIV as it relates to sexual health.

*ATU* has also explored how living with HIV fits within the larger picture of general health issues, covering subjects like alcohol use, mental health, cancer, aging and dementia, steroid use, and pregnancy.

And because people with HIV don't use just western medicines, the newsletter has included articles on complementary approaches like vitamin supplementation and herbal medicine.

Although the look of this newsletter will change next month, be reassured that we will continue to write in the same way about similarly wide-ranging and important topics, providing authoritative, educational and trustworthy information about all aspects of HIV-positive health.

## Changing the design

Our research found that the look of *ATU* was preventing many current and potential new readers from getting the most out of the publication. As one interviewee succinctly put it: "You don't need a medical degree to understand it, but it looks like you might."

We set about redesigning the newsletter to rectify areas that were identified as problematic. This is what we are planning to do:

- The general appearance of the newsletter will be less heavy and dense, using more white space over more pages, and it will be printed in full-colour.
- The front cover will be more inviting, making the newsletter more appealing to pick up in a waiting room, for example, and making the contents more obvious to even the most casual reader.
- There will be a descriptive contents section and a summary of the main articles to make it easier for the reader to decide what to read.
- There will be more pages of news, in two sections: one highlighting the most important treatment news, and the other a round-up of UK-focused HIV-related news.
- The features will be easier to read, since there be more visuals, graphs and charts to support the information.

## It's your newsletter

We hope you welcome next month's newsletter and look forward to hearing from you with your opinions about the redesign. If you have any comments, please email me, *ATU*'s editor, at the following address: [edwin@nam.org.uk](mailto:edwin@nam.org.uk)

## **UK sexual health worsens: HIV, LGV and other STIs increasing**

New figures for 2004 from the UK's Health Protection Agency (HPA) suggest that there is still much cause for concern over the country's sexual health. Overall, there were more than 750,000 new diagnoses of non-HIV sexually transmitted infections (STIs), a 2% increase from the previous year. However, although there was an increase in the number of cases of syphilis, chlamydia, and genital warts, a decrease was seen in cases of gonorrhoea and genital herpes. "A further rise in new diagnoses of STIs during 2004 is disappointing," noted the HPA's Dr Helen Ward, "but some encouragement can be taken from the slower growth seen in recent years." However, Dr Ward adds that, "we cannot be complacent about the continuing spread of infection."

There have now been 140 confirmed UK cases of LGV, the STI found exclusively in gay men, 80% of whom are also HIV-positive, according to another HPA report. The total for June was already more than twice of that seen in previous months, with the majority of cases being diagnosed in London (69%), followed by Brighton (14%), other cities across England (12%), and Scotland (4%). The first case in Wales was diagnosed in July. Being the

receptive partner in unprotected anal intercourse is the most likely way to acquire LGV, which has similar symptoms to Crohn's Disease (pain, loose and/or bloody stools), and is often misdiagnosed before antibiotic treatment is given.

The HPA have also released near-complete new HIV diagnosis figures for 2004. Of the 6973 diagnoses reported so far 58% (4034/6973) were acquired through sex between men and women, with almost two-thirds (2548/4034) of those being female. Sex between men, while making up 28% (1956/6973) of the total, remains the most common route of HIV transmission in the UK. It is almost certain that more than 2000 new HIV diagnoses in gay men will have occurred in 2004, the largest number of new diagnoses since the mid-1980s, when the HIV antibody test was first available.

## **Criminalisation of HIV transmission in UK and Europe on the rise**

A young Welsh woman, aged 20, was sentenced to two years' youth custody in July, after pleading guilty under Section 20 of the Offences Against the Person Act 1861 for 'recklessly inflicting grievous bodily harm' by transmitting HIV to her former boyfriend, a

young man also aged 20. It is the first time that a conviction for reckless HIV transmission has been secured in Wales by the Crown Prosecution Service, and the woman - who was aged 18 when the HIV transmission is alleged to have occurred - is both the youngest person, and the first female in the United Kingdom to be successfully prosecuted under English and Welsh law for "reckless transmission" of HIV. She is now the sixth person in the UK to be sentenced for transmitting HIV since 2001. The other five were men; one Scottish, one Portuguese and three African nationals.

Meanwhile, a groundbreaking new report prepared by The Global Network of People Living with HIV/AIDS Europe (GNP+ Europe) and the Terrence Higgins Trust (THT), suggests that what has been occurring in the UK over the past few years is not unique, but reflects a more sinister Europe-wide development, with substantial evidence suggesting that prosecutions for HIV transmission are on the increase throughout Europe. Out of the 45 European countries surveyed, in at least 36, the actual or potential transmission of HIV can constitute a criminal offence. At least one person has been prosecuted in 21 of these countries, and there have been at least 130 convictions Europe-wide. Notably, Austria, Sweden and Switzerland are responsible for more than 60% of the total convictions and have each prosecuted more than 30 people. At the other end of the scale, neither HIV exposure nor transmission appear to be criminalised in Albania, Bulgaria, Luxembourg, Slovenia, and the Republic of Macedonia. The full *Criminalisation of HIV transmission* in Europe report can be downloaded from [www.gnpplus.net/criminalisation/intro.shtml](http://www.gnpplus.net/criminalisation/intro.shtml) or [www.tht.org.uk/policy/policy.htm](http://www.tht.org.uk/policy/policy.htm).

## Body Positive North West funding furore

Body Positive North West (BPNW), an HIV self-help charity established for 20 years, is likely to close this month due to the withdrawal of its funding by North Manchester

Primary Care Trust (PCT), the leading commissioning body for HIV services in Greater Manchester. BPNW provides over 1200 HIV-positive individuals in and around Greater Manchester with drug adherence counselling, advice and advocacy, complementary therapies, a drop-in centre with cafe, self-management courses and a telephone helpline. In a statement, North Manchester PCT explained that that they had decided to withdraw BPNW's funding "due to concerns over...performance and lack of monitoring information against the agreed contract." BPNW claims there had been no agreed contract and that "... no dialogue could be achieved with North Manchester PCT". BPNW's Chief Executive, Felicity Greenham, says that her main concern now is making sure that BPNW's clients - who were not consulted - continue to receive services that were uniquely supplied by BPNW. HIV doctors and BPNW service users are now campaigning for the funding to be restored. HIV consultant, Dr Ed Wilkins and his colleagues at North Manchester General Hospital "condemn this decision and give their support to the efforts of BPNW to publicise this gross injustice."

## Tenofovir may linger longer than previously thought

French and Spanish researchers have found that some patients have levels of tenofovir (*Viread*) inside cells high enough to cause drug resistance, but not high enough to kill HIV, up to three weeks after discontinuing therapy with the drug. These findings question previous assumptions about the safety of stopping anti-HIV therapy that includes tenofovir, say the researchers, and until further research is carried out, they recommend using the same kind of discontinuation strategy as stopping NNRTIs like efavirenz (*Sustiva*) which may also linger for several weeks at suboptimal levels.

*Pruvost A et al. Measurement of intracellular didanosine and tenofovir phosphorylated metabolites and possible interaction of the two drugs in human immunodeficiency virus-infected patients. Antimicrobial Agents Chemother 49: 1907-1914, 2005.*

### news from



#### nam forum *illness and hiv in 2005*

Effective anti-HIV therapy can mean a longer, healthier life with HIV, but despite anti-HIV treatment, some people with HIV still have to deal with illness. These illnesses include treatment side-effects, co-infections like tuberculosis (TB) and hepatitis, and community-acquired infections like pneumonia. Two speakers will provide a doctor's and an expert patient's perspective on how an individual living with HIV can cope with illness and feel more in control of their health. The forum will take place on Monday 26th September, between 7-9pm, at the University of London Union, Palms Room, 3rd Floor (rooms 3C and D), Malet Street, London, WC1. Everyone is welcome and refreshments are provided.

Visit [www.aidsmap.com/en/events/forum.asp](http://www.aidsmap.com/en/events/forum.asp) for more details.

#### living with hiv

Work is currently underway on an updated edition of NAM's *Living with HIV*. The book includes short pieces written by people with first hand experience of life with HIV.

We need your experiences to be included in the next edition. If you would like to contribute, please go to <http://www.aidsmap.com/livingwithhiv> for more information.

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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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**information forums in London**

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

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0845 1221 200  
Mon-Fri 10am-10pm Sat-Sun 12-6pm

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