

aids treatment update

the sex issue

why dare bare?

why do people decide to have condomless sex? *page 4*

filling years with life

reproductive options for couples with hiv *page 8*

sexually transmitted hepatitis c

how do you get it, and how do you know you've got it? *page 12*

positive guidance

how to have a happy and healthy sex life *page 18*

upfront

how should the nhs manage electronic patient records? *page 3*

news in brief

prezista appears superior to *kaletra* for
the treatment experienced *page 16*
does long-term hiv boost cancer risk? *page 17*



in this issue

If we believed everything we read and saw in the popular media, we'd have a rather skewed vision of the consequences of unprotected sex. In particular, television drama and Hollywood films often place dramatic impact over veracity, despite the best of intentions.

In fact, a 2005 analysis of the 200 most popular Hollywood movies released in the era of HIV, found that out of 53 sex scenes, there was only one suggestion of condom use, and no depictions of the real and important consequences of unprotected sex including HIV, sexually transmitted infections or unwanted pregnancies.¹

We should all know the consequences of unprotected sex, and yet many of us continue to have condomless sex – for recreation or for procreation.

This month's double issue attempts to uncover some of the realities facing HIV-positive people when it comes to sex: the risks and the benefits; our rights and our responsibilities; the pleasures and the pitfalls. Whatever you decide, make sure it's based on up-to-date knowledge.

ATU is taking its annual summer break in order to attend the 4th International AIDS Conference in Sydney, Australia. We'll be back in October with analysis from one of the most important scientific conferences of the year.

Have a great summer!

page 3 *Upfront* focuses on the important issue of confidentiality of patient records in the era of electronic record sharing, examining a new set of guidelines that help provide a balance between medical necessity and patient privacy.

page 4 In an ideal world everyone would use condoms every time they had penetrative sex. In *Why dare bare?* Gus Cairns examines the risks HIV-positive people are taking when we have condomless sex, and why so many of us are willing to take these risks.

page 8 Today, living with HIV should not, in itself, be an obstacle to new parenthood. In *Filling years with life* Derek Thaczuk examines reproductive options for individuals or couples with HIV, and what options are left when assisted reproduction is out of reach.

page 12 ATU talks with Drs Mark Nelson and Sanjay Bhagani about *Sexually transmitted hepatitis C*. What are the risks, and how can it be diagnosed and treated?

page 16 In *News in Brief*, we find that *Prezista* appears to be superior to *Kaletra* for treatment-experienced individuals; the experimental NNRTI, etravirine, is also showing a lot of promise; and the first integrase inhibitor is likely to be approved in the US next month.

page 18 Finally, some new guidelines provide us with some *Positive guidance* on how to have a happy and healthy sex life.



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editor Edwin J Bernard
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AIDS Treatment Update
 was founded by Peter Scott

contact details

Lincoln House, 1 Brixton Road,
 London, SW9 6DE, UK
 tel: 020 7840 0050
 fax: 020 7735 5351
 email: info@nam.org.uk
 web: www.aidsmap.com

medical advisory panel

Dr Fiona Boag
 Dr Ray Brettle
 Professor Janet Darbyshire OBE
 Heather Leake Date MRPharmS
 Dr Martin Fisher
 Professor Brian Gazzard
 Professor Frances Gotch
 Professor Margaret Johnson
 Dr Graeme Moyle
 Dr Adrian Palfreeman
 Kholoud Porter PhD
 Dr Steve Taylor
 Professor Jonathan Weber
 Dr Ian Williams
 Dr Mike Youle

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keeping it confidential

how the nhs should manage electronic patient records, by Edwin J Bernard

Confidentiality has always been an important issue for people with HIV. It's one of the main reasons why HIV testing – and many HIV clinics – remained sequestered for so long within the 'extra-confidential' boundaries of sexual health (GUM) clinics in the UK. In addition, concerns over breaches in confidentiality have been one of the most cited reasons for HIV-positive people not having – or trusting – their GPs. Now, in the era of the electronic patient record (EPR), the British Association of Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA) have produced guidelines on protecting patient confidentiality.

Consent, content and confidentiality

The National Health Service (NHS) – from hospital-running NHS Trusts to individual GP surgeries – is planning changes in the way it stores and distributes sensitive patient information.

For people living with HIV there are three main areas of concern – consent, content and confidentiality. The guidelines begin by stressing that there is a tension between providing wider access to an HIV-positive individual's treatment and other health-related information and ensuring that this information remains confidential and is accessed purely on a need to know basis.

It also notes that "robust processes for information governance are lagging behind" the move to electronic patient records by individual NHS Trusts and describes in detail some of the problems

that have already been experienced, such as inappropriate disclosure of HIV status.

What do they recommend?

The guidelines recommend that HIV identifying information should be available on NHS Trusts' electronic patient records systems as long as each Trust takes responsibility for ensuring that information is held securely and confidentially. They also recommend that procedures should be put in place for disciplinary action against anyone who accesses records inappropriately.

The guidelines' other main recommendations include:

- Every employee dealing with patient information should be specifically trained about confidentiality of health information.
- Patients should be made aware of how HIV identifying information (or any other sensitive health information) is held.
- There must be a process in place for recording HIV status and HIV identifying information in case a patient objects to the normal recording procedures e.g. use of GUM number.
- Ideally access should be role-based, so that, for example, all doctors (and perhaps nurses or allied health professionals) can access HIV related information, but administration staff cannot.
- If results of tests not ordered by GPs are sent directly to GPs this should not include HIV identifying information.

- When sending letters about patients with sensitive health information, permission to disclose this information to GPs and permission to send copies to the patient should be sought and recorded.
- At present GUM records should not be part of EPR unless they are recorded under different GUM numbers, with the number and date of birth only as identifiers. There should be no links to the patient's name and address in this system, which needs to be recorded separately.

Summary Care Records

In England, a new electronic document known as a Summary Care Record is also being created. This will contain information about an individual, including current medications, allergies and adverse reactions and will be uploaded onto a 'national data spine' from the Detailed Care Record held by an individual's GP. The guidelines make a further recommendation about both Summary and Detailed Care Records: "There MUST be a discussion with patients with regard to HIV identifying information and the Detailed Care Record and the Summary Care Record before the system goes live in each area. Patients should be able to choose (opt-in) whether HIV related information is included in this or is hidden from view." ■

A four-page briefing paper from Terrence Higgins Trust with more details about the Summary Care Record is available from: www.tht.org.uk/informationresources/publications/policybriefingpapers/summary_care_records.pdf.



why dare bare



Gus Cairns examines why people decide to have condomless sex

If we were all completely rational beings, able to make the best choices to support our health, everyone - HIV-positive, negative or untested - would use a condom every time we had penetrative sex.

However, many people either don't use condoms at all - or don't use them consistently - as evidenced by ongoing HIV transmission and increasing rates of other sexually transmitted infections (STIs).

In fact, the most recent Gay Men's Sex Survey suggests that 100% condom use is now a minority behaviour for gay men. Of the 87% who practised anal sex, only 44% said

they always used condoms, whereas 45% said they sometimes used condoms and 11% said they never used condoms.¹

The 2005/6 national survey of sexual risk-taking behaviours (focusing on heterosexuals of all ethnicities) found that 55% of men and 53% of women had not changed their behaviour based on their knowledge of HIV and STIs. Amongst people with two or more sexual partners in the previous year, men were more likely than women to report that they always used a condom (47% men versus 37% women) and were less likely to report that they never used one (18% men versus 28% women).²

Why use condoms?

For penetrative sex, condoms are the most effective way to protect you and your partners from HIV and other STIs. With consistent and correct use of male latex condoms, there is a near zero risk of HIV transmission. Although a female condom exists - giving women more control - it is hard to find, often difficult to use correctly, and still requires a partner's compliance and consent for it to be used.

The best systematic review on the effectiveness of male condoms in preventing HIV transmission concluded that, in the real world - where condoms might not be have used consistently or may have occasionally slipped off or

broken - had an efficacy rate 86.6%.³ In other words, condoms prevent at least 17 out of 20 potential HIV infections; and that's why condom use is known as 'safer sex' and not 'safe sex'.

However, consistent use is key; in a study on HIV transmission in couples where one was HIV-positive and one was HIV-negative at the start, the HIV transmission rate amongst *inconsistent* condom users was virtually the same as amongst couples who never used condoms.⁴

Condoms don't just protect against HIV, either. A 2004 World Health Organization review concluded that studies looking at the effectiveness of condoms "demonstrated the statistically significant effectiveness of condoms in protecting against HIV and most of the other sexually transmitted infections examined."⁵

Risks of not using condoms: superinfection

Superinfection - also known as reinfection - is when one HIV-positive individual infects another HIV-positive individual with another strain of HIV, which, in some cases could be drug resistant and/or more virulent than their first strain.

Despite a lot of investigation, it's still difficult to give definitive answers about superinfection. The current state of knowledge is probably summarised best as this:

- Superinfection definitely happens, as proved by the existence of recombinant HIV (which can only happen when two different strains of HIV swap genes inside a cell).
- However, some apparent superinfections could be dual infections (where two strains of HIV are caught at the same time) and where one strain has been 'hidden' behind the other.

- Some evidence suggests that the risk of superinfection is highest during early infection and tails off rapidly after that, with superinfection in people living with HIV for more than three or four years relatively rare.⁶ Before this, it can be quite common: one US study estimated the incidence of superinfection in recently-infected gay men to be as high as 5% a year.⁷ However after a few years, most HIV-positive individuals will probably have developed an immune response that should protect against reinfection. In addition, long-term partners may also develop a specific immunity to other partner's virus.

- Nonetheless, there are an increasing number of documented cases of people experiencing either treatment failure or accelerated progression to AIDS because they were apparently superinfected by either a drug-resistant virus, or one was more virulent than the original strain.⁸

Risks of not using condoms: STIs

Between 2000 and 2005, STI diagnoses amongst the general population went up 250%. Syphilis went up eightfold amongst men in general and 12-fold amongst gay men. In addition, previously rare STIs have made a comeback; *Lymphogranuloma venereum* (LGV), virtually unknown in the UK since the 1970s, appeared in 2002 and up to this time last year 400 cases, mainly amongst gay men with HIV, had been diagnosed.

One explanation for the recent increases in STIs, at least amongst gay

men and especially those with HIV, is that more of them are 'serosorting'; allowing themselves to have more condomless sex, but restricting it to men with their own HIV status. This may reduce the risk of passing on HIV (at least to HIV-negative partners) but still does not protect from STIs.

The thinking behind 'serosorting' is, "I have caught the 'worst' STI and others are either curable (like gonorrhoea) or at worst a nuisance (like herpes)".

Syphilis, however, can be harder to cure in people with HIV, and a recent study found that even the early stages of syphilis are associated with increases in HIV viral load and decreases in CD4 cell counts. Even after 'successful' treatment, however, the study found that viral loads remained elevated in some, due to persistent immune activation.⁹

Even more of a concern for HIV-positive gay men is sexually transmitted hepatitis C. A presentation at the 13th BHIVA conference in April found a 20% year-on-year increase in sexually acquired hepatitis C amongst HIV-positive gay men between 2002 and 2006.¹⁰ (For more on the sexual transmission of hepatitis C, see pages 12-15)

The rewards of condomless sex

Given all these health risks, why do some people have unprotected sex? Clearly it must be because, for the people who do it, the psychological rewards must be greater than the physical risks.

Firstly and clearly, so much of the risk depends on context. An HIV-positive gay man having regular weekly casual condomless sex in a group sex environment risks, quite substantially, all the possibilities detailed above, and if some of that sex is with HIV-negative or untested men into the mix, you add the risk of onwards transmission. On the other hand, a monogamous HIV-positive heterosexual

“It all comes down to intimacy and wanting to achieve intimacy. But it’s also hard to use condoms every time and be reminded of the risk of HIV every time.”

Gillian Elam, HPA

couple both of whom are on treatment with an ‘undetectable’ viral load, and who want to conceive, would probably risk very little other than a (probably) near-negligible risk of superinfection in their bid to have a baby.

However most people don’t decide whether or not to have unprotected sex based on a sober risk assessment, and certainly don’t necessarily experience their own decision-making process as rational.

One of the most in-depth studies conducted into the reasons why people have unprotected sex was the INSIGHT study conducted by the UK’s Health Protection Agency (HPA).¹¹

The HPA’s Gillian Elam took a group of 75 gay men who had tested positive within two years of a previous negative test and compared them with 159 men whose most recent test was negative. She found the following were reasons why the men who became HIV-positive did not use condoms:

- Their desire for love, trust and intimacy was greater than the fear of acquiring HIV.
- They believed that HIV only happens to other people.
- They thought that HIV was not the worst thing that can happen to them, due to improved treatments

for HIV and/or because of ambivalent feelings about ageing.

- Repeated negative HIV antibody tests had led to a sense of their being immune to HIV infection.
- Depression, low self-esteem, and/or lack of control often led to them having unplanned condomless sex.
- A common theme was that acquiring HIV often involved a conscious decision to trade safety for the possibility of love, approval and fun.

“The most striking finding for me was people’s dislike of using condoms, at least amongst those who seroconverted,” Gillian Elam tells *ATU*. “I had hoped that after years of campaigning we might get to a point where condom use was an absolutely accepted norm amongst gay men, but the findings make it clear that each new generation finds it difficult.”

“On the other hand,” she continues, “some of the men who had not seroconverted found condom use easy, and having safer sex had psychological rewards, too. Men who had maintained condom use felt more in control and more assertive. They made it clear, however, that this was a hard won skill, and some mentioned finding workshops, such as the ones run by GMFA, helpful in this respect.

“The other thing that stood out,” adds Elam, “was that relationships were a risk factor, particularly in situations where the partners did not share the same ‘ideals’ about the relationship; where they decided to stop condom use too soon; or when one partner seroconverted in the relationship and HIV suddenly became a barrier to intimacy.

In the end, she concludes, “it all comes down to intimacy and wanting to achieve intimacy. But it’s also hard to use condoms every time and be reminded of the risk of HIV every time. For some people, the anxiety about HIV transmission doesn’t diminish with condom use.”

Positive dilemmas

Recently, Damien Ridge of City University in London and colleagues undertook a series of qualitative interviews and focus groups with people with HIV on the topic of safer sex and risk management.¹² They interviewed 44 people with HIV: 19 white and five non-white gay men, 19 heterosexual Africans of whom ten were women, and one white heterosexual man. All participants had been interviewed for the UK patient video-education website www.dipex.org.

One notable aspect of the study was that, mindful of ethical and legal dilemmas around the criminalisation of HIV transmission and resulting concerns over legal liability, the researchers specifically avoided asking respondents about occasions when they’d decided to have unprotected sex after being diagnosed HIV-positive, concentrating instead on pre-diagnosis sex and current challenges in negotiating safer sex. Criminalisation, the researchers comment, is making it difficult to conduct honest interviews: “There is an understandable reluctance on the part of the researcher and the participant to discuss an activity that is potentially illegal,” they write.

This may have exacerbated a tendency for participants to emphasise that they, personally, were sexually responsible and that ‘other’ positive people out there were behaving recklessly or were in denial. As one participant said, “[Criminalisation] really feeds into the good gay/bad gay thing. I have to make a special effort to be a ‘good’ gay.”

Given this caveat, the main impression given in the interviews is the overwhelming sense of additional responsibility HIV-positive people feel for maintaining safer sex. The researchers comment that, “Many participants felt that they could be positioned in negotiations as the sentinels of safer sex, and yet the skill-set required by HIV-positive people to undertake that role in sexual relations is as yet little recognised in the literature.”

Gay men tended to describe this in terms of encounters with 'bugchasers' (i.e. individuals who claim to want to become infected with HIV) and partners who didn't care about their sexual health, with one commenting about how he'd had to persuade an HIV-negative partner "who was in total self destruct" to use condoms.

For African women it was more often a case of encountering men who were completely ignorant of, or in denial about, HIV, some even coming equipped with conspiracy theories about HIV being a 'white-inspired lie' or condoms 'poisoning' black men and making them impotent.

The researchers discovered a polarised split between interviewees (most of the women and some of the gay men) for whom condom use was easy, and the other half (the rest of the gay men and many, though not all, of the African men) for whom condom use was difficult.

Several themes stood out for those who had difficulties:

- For men, both HIV disclosure and using condoms (as in some men in the INSIGHT Study) was a constant reminder of HIV. Sex itself became tainted by the virus. An African man said that "sex is no longer enjoyable. She cannot just tell you that she does not trust you, but you can see from her reaction she is fearing for her own safety." Another said that HIV "in the African culture context, makes you feel that you are no longer a man. It is something you have to deal with mentally, it's nothing to do with HIV as such." The researchers speak explicitly about men, gay and straight, 'grieving' for a sense of lost masculinity and potency - a grief that was sharpened, for some, by condom use.
- Some respondents, especially gay men, acknowledged the role of depression and low self-esteem in decision-making, but it was often a depression denied at the time and

only acknowledged in hindsight. One gay man said, "I thought I was a balanced gay guy, but there I was getting fucked without a condom in a sauna. There was something going wrong with my life in general - not looking after myself, working too hard, having become a bit of an automaton."

- There was an acknowledgement amongst some interviewees that they'd had fantasies about having unsafe sex and even deliberately infecting others. A gay man said, "For a while you flirt with the idea 'Well, I got positive - what's the point in having protected sex?' Then I thought, 'What kind of road is that going to take me on?'" An African woman said she'd had explicit revenge fantasies she'd found hard to conquer. "Since you don't know who gave it to you," she said, "you want to spread it. It took a lot of courage and discipline to say it was my carelessness, why should I want to put someone else through what I'm going through?"

The researchers make an extremely valid point when they comment that, "issues of unprotected sex and intentionality could alternatively be understood as unmet mental health needs rather than

an issue that is effectively to be pursued through legal avenues."

If there's a difference between the recently-diagnosed people interviewed for the INSIGHT Study and the more experienced HIV-positive people interviewed for the DIPEX Study, the newly-diagnosed individuals were more in touch with what might be called the 'positive' reasons for unsafe sex: the longings, needs and urges that had led them to ditch condom use in the first place.

The DIPEX interviewees, on the other hand, saw condomless sex more as an issue of loss of control; they were more likely to see safer sex as a social duty to their partners which could on occasion be knocked sideways by depression, anger or - very credibly - by the persuasiveness of others.

The sense of social responsibility is summed up by an African woman whose partner walked out when she disclosed her HIV status to him: "A lot of my friends tell me, 'You kept this man alive, now he took another woman and left you. If you had kept quiet to yourself about HIV, he would be positive like you, you would be together.' I say 'It doesn't matter. I saved somebody's life, I have saved many'."



filling years

reproductive options for couples with hiv,
by Derek Thaczuk

Treatment and care have brought new hopes and possibilities to people with HIV. With long and healthy lives now a realistic expectation, many HIV-positive people are confronting the question of what else might be possible - and what would bring them the most fulfillment and joy. Now that so many more years of life are possible, in the words of Dr Augusto Semprini (a leading specialist in reproductive medicine), "do we fill that life with years, or those years with life?"¹

Today, being HIV-positive need not present an unsurpassable obstacle to biological parenthood. An increasing number of HIV-positive women are choosing to quite literally "fill their years with life" by having children.² Sperm washing and other 'assisted reproduction' technologies have also made biological fatherhood feasible for HIV-positive men.

Parenthood is certainly no casual undertaking (as anyone with a child can attest). When either one or both parents have HIV, prevention of transmission is obviously a crucial consideration - but far from the only one. The small but greater-than-zero chance that the child will be born with HIV, readiness to take on child-rearing responsibilities while looking after one's own health, the question of when and how to disclose HIV status to your child, the stigma and discrimination the family may

encounter - all are weighty issues that need to be carefully considered.

Newly published sexual and reproductive health (SRH) guidelines³ (see pages 18-19) help address such issues. According to the guidelines, "an increasing number of couples [are requesting] fertility investigations and assisted conception. ..More attention is thus being given to the wider health needs of people living with HIV/AIDS, including a renewed focus on sexual and reproductive health (SRH) needs."

Positive women, healthy babies

One of the most basic SRH concerns is the prevention of 'vertical' (i.e., mother-to-child) transmission of the virus. If no measures at all are taken to prevent vertical transmission, there is roughly a one-in-four chance that a mother with HIV will pass the infection along to her child. (The actual risk varies according to viral load levels and other factors.) During the gestation period, the risk is actually quite small: transmission is most likely during the birth process - or later, due to breastfeeding. The transmission risk can now be lowered to less than 2% by using antiretroviral treatment during pregnancy and delivery, formula feeding rather than breastfeeding, and (in some cases) choosing Caesarian over natural delivery.⁴

Antiretroviral therapy has been subject to long-term scrutiny for safety in

pregnant women and their children. Several drugs and combinations must be avoided by pregnant women or those trying to become pregnant - notably efavirenz (*Sustiva*), which has caused birth defects in animals and is presumably likely to do the same in humans. The nucleoside combination of stavudine (d4T) and didanosine (ddI) must also be avoided, due to the risk of lactic acidosis (which has resulted in the deaths of several pregnant women taking these drugs).

Apart from these specific exceptions, antiretroviral therapy has generally proven to be as safe and effective in pregnant women as in women who are not, and similar treatment guidelines apply. For women whose own medical status does not warrant immediate therapy (due to high CD4 counts), a short-term course of treatment is used to lower transmission risk to the child. The standard of care involves such a course of therapy, begun late in pregnancy and continued until delivery. AZT and nevirapine (*Viramune*) are preferred components since studies have proven them effective at lowering transmission risk. AZT is also given intravenously during delivery, and to the baby (in syrup form) for the first four weeks after birth. If the mother's viral load is not undetectable at the time of birth, a planned Caesarian delivery may be recommended to further reduce the risk of transmission.⁴

with life



Assisted reproduction

Once it was established that HIV-positive mothers could safely have children, the next step was to develop ways to help them do so - and offer similar assistance to women with HIV-positive male partners. Dr Augusto Semprini, the "founding father" of assisted reproduction for couples with HIV, established a clinic for this purpose in Milan in 1992. Since then, similar programmes have helped couples in Europe, the UK and elsewhere give birth to hundreds of healthy children.

Mixed-status couples, in particular, face a variety of challenges. These are couples where one partner is HIV-positive and the other, HIV-negative. (In medical terms, such couples are *serodiscordant*.) There is an obvious need to protect the negative partner from infection when mixed-status couples choose to conceive.

When the woman has HIV

The simpler case occurs when the woman is the HIV-positive partner. In this case, the couple can resort to artificial insemination (intrauterine insemination, or IUI). This straightforward, time-honoured technique consists of collecting fresh semen from the male and introducing it into the woman by a means other than intercourse - thereby avoiding risk to the male from sexual exposure. In its simplest form, a 'DIY' version of artificial insemination can be performed using a sterile syringe or other similar tool. A somewhat more

sophisticated version of IUI can be performed in a clinic using a fine catheter to pass sperm directly into the womb. The procedure is timed to correspond with ovulation for the best chance of conception.

Barring any fertility problems on the part of either partner, IUI may be all that is required to achieve pregnancy. The mother-to-be can then bring her child to term under careful medical supervision, including appropriate MTCT prevention protocols.

When the man has HIV

The case in which the would-be father is HIV-positive presents a greater challenge. How can a man safely impregnate his partner, when genital contact with infected semen poses one of the highest risks for HIV? The answer lies in the fact that HIV is carried in the seminal fluid, not in sperm themselves. This makes it possible to extract non-infectious sperm from the man's semen via a technique called 'sperm washing'. Artificial insemination can then take place with minimal risk to the woman.

Sperm washing can be accomplished through a variety of techniques, some more effective than others. A version called the 'swim-up' technique - pioneered at Semprini's clinic in Milan - has proven safest in terms of reducing HIV transmission. (The process involves centrifuging diluted seminal fluid to separate out the sperm, bathing the isolated cells in a culture medium,

isolating the healthy sperm which swim away from the accumulated mass, then washing them a final time.)

In its current incarnation, swim-up sperm washing cannot reduce infection risk to zero. It can, however, reduce the amount of virus in viable sperm more than 100,000-fold, resulting in undetectable levels. Since 1992, this process has been used in more than 4500 inseminations at clinics throughout Europe, without a single woman becoming infected.⁵ However, women have been infected through other, less effective sperm washing techniques. It is crucial that women be informed of and carefully consider the degree of risk involved.

(According to one recent report, a newly developed improvement to the swim-up technique is producing sperm completely free of infectious HIV, resulting in the potential for truly risk-free insemination.⁶ However, this refinement is not yet in clinical use.)

Making it happen - clinic sites

An increasing number of fertility clinics are beginning to offer services for couples with HIV. CREATHe (for Centres for Reproductive Assistance Techniques in HIV-infected Individuals in Europe) is a non-profit association, founded in 2003, involving 17 centres in nine countries including the United Kingdom. The sole centre available within the UK is the Viral Illness Fertility Programme at Chelsea & Westminster Hospital, London. ATU

spoke with the programme's Dr Carole Gilling Smith (one of the co-authors of the guidelines on sexual & reproductive health for people with HIV).

The Chelsea & Westminster programme was founded in 1999 to provide sperm washing and intrauterine insemination for HIV-positive men with negative partners, explains Gilling Smith. Since 2002, they have been providing services for HIV-positive women as well as couples who are both HIV-positive. Over 500 'cycles' (separate attempts at conception) have led to the births of 65 children, and none of the HIV-negative women who have used washed sperm have become HIV-positive.

"We carry out a full fertility screen on all couples who come into clinic to decide which treatments are most appropriate," says Gilling Smith. "If the woman is making enough eggs and there are no other fertility issues, we can proceed with a straightforward IUI [intrauterine insemination]. If necessary, the techniques can be adapted - we can perform a technique called ICSI if needed." (See glossary.)

What sort of success rates are they seeing compared to HIV-negative clients? "Interestingly, the success rates do not seem to be affected by HIV. Per-cycle success rates may range between 10% and 30%. It generally takes two or three cycles to result in a successful birth, but there are couples who do conceive on the first attempt."

Gilling Smith is candid on the subject of costs and other pragmatic obstacles. "There is usually a two- to three-month waiting list, due to our being the only clinic providing this service. The methods themselves are actually quite simple, but we do need to exercise extensive safety and quality control measures to guarantee the greatest possible safety for our participants. There are also procedural issues; for instance, we need to use a separate lab due to handling infectious materials. So the facilities and costing restrict the availability, as well as the large population and growing demand." The financial costs are significant; approximately £1200 per cycle for sperm washing and IUI and £3500, plus drug costs, for

in-vitro fertilisation. (An additional £650 covers costs of handling infectious materials.)

HCV and other viruses

As the Viral Illness Fertility Programme's name implies, HIV is not its only concern. Other viral infections, particularly hepatitis C (HCV) and hepatitis B (HBV), are also widespread and have significant impact on pregnancy. "We do see a lot of HIV/HCV co-infected people," says Gilling Smith. "The vertical transmission rate is around 12% with hepatitis C, and there is no vaccine." However, sperm washing techniques do appear to be effective against HCV as well as HIV: "HCV has never been found in sperm after washing. We have to be careful, as well, not to discriminate based on illness: for example, you would not deny the right to have a child to a woman with a congenital abnormality such as a cardiac condition, so we cannot treat HCV infection differently. There are no ethical guidelines that state a woman should not proceed with pregnancy if

hiv and reproduction: issues and options

status of a couple	issues to consider	options
HIV-positive woman HIV-negative man	<ul style="list-style-type: none"> transmission to male partner fertility transmission to child 	<ul style="list-style-type: none"> IUI MTCT prevention
HIV-positive woman HIV-positive man	<ul style="list-style-type: none"> superinfection fertility transmission to child 	<ul style="list-style-type: none"> sperm washing IUI MTCT prevention
HIV-negative woman HIV-positive man	<ul style="list-style-type: none"> transmission to female partner fertility 	<ul style="list-style-type: none"> sperm washing IUI

she has achieved a sustained virologic response to HCV treatment."

Natural conception

Another contentious issue is that of natural conception: the choice of some mixed-status couples - as well as couples who are both HIV-positive; in medical parlance, *seroconcordant* - to achieve pregnancy "the old-fashioned way", through unprotected intercourse. Obviously, in mixed-status couples, unprotected intercourse exposes the HIV-negative partner to the risk of infection. Even when both partners are HIV-positive, there is still the possibility of superinfection - exchanging different, possibly drug-resistant or more immune-damaging strains of the virus. Unprotected intercourse therefore carries some risk of one partner re-infecting the other with a drug-resistant or otherwise more harmful strain of HIV. While "real-world" cases of superinfection have been documented, the very limited number of such cases would seem to imply that re-infection is a rare occurrence. As the actual likelihood is

unknown, however, "seroconcordant partners wishing to conceive are often faced with the dilemma of whether to consider unprotected intercourse", according to the SRH guidelines. Indeed, "the overall extent to which superinfection occurs has not been quantified and there is concern by some community activists that the risks are often overstated. It is clear however that people living with HIV or AIDS have to balance [concerns regarding superinfection] with other life choices."

The choice of natural conception is certainly a reality, and in many cases may stem from frustration with safer techniques: a recent survey of 500 mixed-status couples found that "almost half of the couples who did not conceive with artificial insemination attempted spontaneous conception through unprotected intercourse, and at least one infection occurred."³

Nevertheless, there is also evidence to suggest that natural conception may be surprisingly safe, as long as the HIV-positive partner's viral load is undetectable. An undetectable viral

load in the blood plasma does not equal lack of infectiousness: viral loads can vary between blood, semen, and vaginal fluids. However, a recent Spanish study⁷ investigated 62 couples in which one partner (22 of the women and 40 of the men) was HIV-positive and on antiretroviral treatment, with undetectable viral load in the blood. Among 76 natural pregnancies in these couples over a seven-year span, none of the uninfected partners became infected.

This finding has not reversed the long-standing prevention message that an undetectable viral load test is not an 'all-clear' for unprotected sex. Yet Gilling Smith and others feel it is crucial to acknowledge the reality that there are couples who choose to go this route. "Over the next several years it's going to be important to look at natural conception risks and how they compare to current standards," she says. "It is certainly difficult ground ethically, but given that people are choosing natural conception, we should study it without actively encouraging it until we have more evidence of its safety."

glossary

IUI Intrauterine insemination or 'artificial insemination'. Sperm is injected into the uterus without intercourse; conception then proceeds naturally.

IVF In-vitro fertilisation. 'Test-tube' fertilisation in which a woman's ovum (egg) is removed, fertilised outside the body, then re-implanted in the uterus (womb).

ICSI Intracytoplasmic sperm injection. A 'micromanipulation' technique in which a single sperm is injected directly into the ovum.

MTCT Mother-to-child transmission of HIV, also called *perinatal* or *vertical transmission*.





In September 2002, *AIDS Treatment Update* (ATU 117) interviewed two HIV clinicians from London about their concerns over a new phenomenon being observed in a small but increasing number of their HIV-positive gay male patients.

Dr Mark Nelson, from London's Chelsea & Westminster Hospital, and Dr Sanjay Bhagani, from London's Royal Free Hospital, were seeing patients with hepatitis C virus (HCV) that could only have been acquired sexually.

Five years on, despite their warnings - and reports at conferences and in scientific journals - there is now a fully-fledged epidemic of sexually transmitted HCV, primarily affecting HIV-positive gay men. At the recent British HIV Association (BHIVA) conference in Edinburgh, Dr Murad Ruf

of the UK's Health Protection Agency said that by June 2006 there had been 389 cases of recently-acquired hepatitis C in HIV-positive gay men attending 15 HIV clinics in London and Brighton, and that increasingly more men were being diagnosed each year.¹

It is now thought that men who have already been diagnosed as HIV-positive and have frequent, unprotected and/or 'hard' sex with other HIV-positive men (often in groups, and often under the influence of recreational drugs such as ketamine or GHB) are most at risk, but some HIV-positive men diagnosed with HCV infection have only had condomless anal sex with another HIV-positive man.²

However, HIV-negative gay men are being diagnosed with HCV as well (although according to a recent

report from Brighton, most also become HIV-positive within a short time, as well).³

Although the epidemic is centred predominantly in the south of England (in London and Brighton), it is also being seen in other major northern European cities (including Amsterdam⁴, Paris⁵ and several major German cities⁶). Earlier this year, Brighton's Dr Martin Fisher told *aidsmap.com* that it was only a matter of time before it was seen in North American cities, too.

ATU spoke again with Dr Nelson and Dr Bhagani prior to their presentations at a NAM forum on the broader subject of HIV/HCV coinfection in London in June.

sexually transmitted hepatitis c

how do you get it, and how do you know you've got it?
by Edwin J Bernard

ATU: So far, the epidemic has focused on London and Brighton. Are we seeing sexually transmitted HCV in other major UK cities with a large population of HIV-positive gay men, such as Manchester, Edinburgh or Birmingham?

Sanjay Baghani (SB): We have heard of isolated reports, but not on the scale of London or Brighton. Now this may be because of testing strategies, or it may be because, so far, the epidemic has not reached these cities. As more data emerges we will get an idea whether this epidemic is going northwards or not. I can't see why not, if it's already crossing Europe.

Mark Nelson (MN): It really depends on testing strategies. We were guilty of missing diagnoses at first - if someone had raised liver function tests [a warning sign for further investigation], we'd blame it on something else. Of course, we now find HCV in HIV-positive gay men because they all get their liver function tests done on a regular basis during their routine HIV clinic bloodwork. But we still don't really know what's going in the non-HIV populations. However, a recent report from Brighton, where they have been looking at HCV risk in all gay men, has found sexually transmitted HCV in HIV-negative men, too. So I think it's often missed; but it could also be that where it is seen, especially in HIV-positive men, it is just not reported at conferences or in medical journals because it's no longer news - at least for HIV clinicians with a lot of gay patients.

ATU: In Brighton, HIV-positive men were about thirteen times more likely to have a new HCV diagnosis compared with HIV-negative men; and eight of the nine HIV-negative men became HIV-positive shortly after their HCV diagnosis. What does that tell us?

MN: It shows anyone who doesn't believe it, that hepatitis C can clearly be sexually transmitted. Clearly, if they've then gone on and caught HIV it's likely they've caught the HIV sexually. It's likely that they've been practising a lot of unsafe sex.

SB: The other interesting point is that it suggests that men who have both HIV and hepatitis C are more likely to transmit the hepatitis C sexually than men who don't have hepatitis C at all.

MN: For me, it underlines the importance of safer sex messages for HIV-positive men. Some men are having condomless sex because they perceive that they won't pass on HIV to someone who already has HIV, or if they have an 'undetectable' viral load for HIV, they can't pass on HIV to anyone. But it does seem they're passing on - and getting - hepatitis C. Then there's syphilis and LGV, both of which are on the increase amongst HIV-positive gay men, and which make HIV and HCV transmission even more likely.

ATU: Why do you think this is happening now?

MN: I wonder if there's a link between the Government's withdrawing of funding from HIV prevention. It's quite interesting that we've seen the hepatitis

C epidemic take off since 'ring-fenced' money for HIV prevention was taken away and spent on HIV treatment and care. If you aren't told all the time that you can pass on HIV, you soon forget about it.

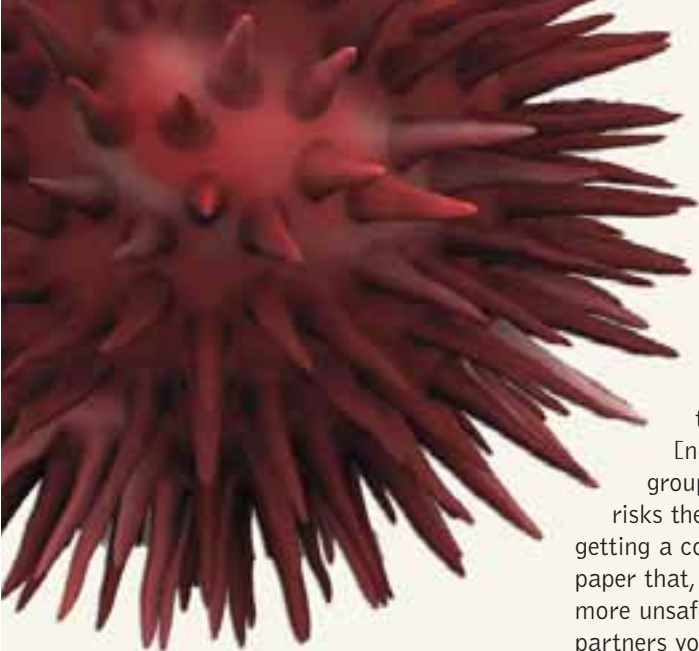
SB: It may also be that the rise of 'barebacking' (anal sex without condoms) and 'serosorting' (choosing to have condomless anal sex with other partners of the same perceived HIV status) created the perfect environment for the sexual transmission of HCV once it entered the pool of HIV-positive men who are practising condomless sex with each other.

MN: Many of the people who come in and see me who have caught hepatitis C are distraught. It's the new HIV, if you like, as far as stigma is concerned. At least amongst certain groups of urban gay men, HIV isn't stigmatised. But having hepatitis C as well is a massive stigma. In fact, I've had several patients who have chosen to take early HCV treatment primarily because they were afraid that no one was going to have anything to do with them again, either socially or sexually.

SB: Which brings us to a very important issue: is hepatitis C being transmitted by people who don't know that they have it, as it often the case with HIV? Where the people that are most likely to transmit are people that have just got the infection themselves, and are undiagnosed? This really emphasises our need to get our testing strategies right; we need to diagnose and treat people early.

recognising hepatitis c

- The incubation period, from the time of exposure to the virus until the onset of the disease, is one to six months.
- Early symptoms include poor appetite, lack of interest in food, nausea, aching muscles and joints, and light fever.
- Later symptoms include yellowing of skin, mucous membranes, and white portions of the eyes (known as jaundice); light-coloured stools; and dark urine.
- Only one in ten individuals with acute hepatitis will experience symptoms.
- HCV is usually diagnosed when routine liver function tests are abnormal.
- Tests for HCV antibodies and/or HCV viral load can confirm acute HCV infection.



MN: It's likely that one of the risk factors, or a couple of them, are highly significant and that the others are markers for the risks - such as [non-injecting] drug use or group sex - but not transmission risks themselves. But I think you're getting a constant message from that paper that, the more drugs you use, the more unsafe sex you have, the more partners you have, the higher the risk of acquiring, or passing on, hepatitis C.

MN: And that's only something you can do in the GUM (sexual health) clinic. The only way forward is to try to make sure that hepatitis C is re-classified as a sexually transmitted infection in order to get GUM clinics to test for it. Of course, they'll need money from the Government to do something like they already do for HIV [such as anonymous seroprevalence testing] to work out exactly what's going on in the sexually active population - both heterosexual and homosexual. Right now, you can't do a hepatitis C test every time someone comes in for a sexual health check-up, there just isn't the money there to do it.

ATU: One of the difficulties with the prevention of sexually acquired HCV is that we're not really sure exactly what 'unsafe sex' actually is. A recent paper that you both co-authored² suggests that there is no single unsafe act that puts someone at the highest risk, and that it's not just about having unprotected anal sex. Drug use, fisting, using and sharing sex toys, and group sex were also implicated - but not everyone in your study who had acquired HCV sexually did all of these.

SB: I think that paper highlighted a number of risks linked to hepatitis C transmission. It is very difficult to focus on individual risk factors because everybody we spoke to practised a multitude of risk factors. Some have sworn that they have never practised fisting but have had unprotected anal sex, and that's the only risk they've had. And so we think that all of these factors may play a role.

ATU: We know from three decades of safer sex campaigns that telling people not to do something that is natural or pleasurable doesn't usually work. However, the concept of harm reduction does appear to have an impact. So, if you are going to do some of the things that have been identified as being at a high risk of HCV transmission, what should you try and do to minimise the risk to yourself and others?

MN: So there are some things that make sense: if you are going to snort drugs, don't share straws, use your own. If you are going to be fisting or using sex toys, wear gloves and don't share toys or lubricant. And since fisting or using sex toys may be traumatic, use a condom afterwards. If you don't use a condom there is a risk that the little cuts or tears caused by fisting or sex toys may facilitate HCV transmission, as well as many other sexually transmitted infections. [Editor's note: if you have used oil or grease-based lubricant, rather than water-based, then use oil-resistant polyurethane - not latex - condoms for anal sex following fisting or sex toy use.]

ATU: The key to successful treatment - and to getting on top of this epidemic - is to diagnose HCV early, during its acute phase (within three months after infection). But how do you diagnose acute hepatitis C when there are often no symptoms? The BHIVA guidelines recommended testing all HIV-positive people for hepatitis C antibodies once a year. But even if hepatitis C antibody tests are reliable enough to pick up HCV during its acute phase (and up to 10% of HIV-positive people never

produce HCV antibodies), annual tests could miss the window of opportunity to treat acute HCV. In fact, most cases of acute HCV have been picked up during routine liver function tests as part of three-monthly HIV clinic blood tests. But now's there's a move from some clinics to reduce the number of clinic visits to two or three times a year; and stable patients, many of whom will be gay men at risk of HCV or other STIs, may well be keen not to visit their clinic so often. How, then, can acute HCV be diagnosed if the people at risk aren't being tested regularly?

SB: We're going to have to move this out from just HIV clinics. Everybody needs to be aware of acute hepatitis C, including GUM clinics and GPs. Every time you have blood tests done you should have your liver enzymes done and if they're abnormal you should get a hepatitis C antibody test.

MN: When you see your doctor, don't just let him say, 'Your liver's fine'. Say, 'What are my ALT numbers? Are they normal or abnormal?' and get him to test you for HCV if they're abnormal. Having an abnormal liver function test should ring alarm bells and result in further investigation. If you've got an abnormal liver function test, do an HCV antibody test. If it's negative, and there's no other explanation for your abnormal liver, then I'd do the PCR [HCV viral load test].

ATU: If you are diagnosed with HCV during the acute stage, the possibility of eradication is much greater than later on, when it has become a chronic infection. But a recent report from the Mortimer Market Centre at University College Hospital, London suggests that most of their HIV-positive patients diagnosed with acute HCV were declining treatment because they were worried about the side-effects of treatment and hoped that better, more tolerable therapy would become available in the future. Has that been your experience?

MN: I think a lot of people are scared about the drugs; interferon and ribavirin have got a very bad press. However, I haven't had a single patient who's turned the treatment down due

sexually transmitted hcv - the risks

- Insertive and receptive anal sex, without condoms, with or without ejaculation.
- Insertive and receptive fisting.
- Use of, and sharing of, sex toys.
- Group sex that includes fisting and/or condomless anal sex.
- Use of 'club' drugs that are sniffed, snorted or administered anally (crystal meth, ketamine, GHB, poppers, LSD).
- Active and passive rimming (anal-oral sex).



to concerns about toxicity. We spend a lot of time explaining the pros and cons of early treatment, and in fact, a lot of people don't get any serious side-effects. Yes, a lot of people do get some side-effects, but they can be tolerable if they are given the right kind of support.

SB: I have to say our experience is exactly the same. It's all about explaining the pros and cons of early treatment to the patient.

MN: That's where HIV nurses who are also trained in hepatitis have a very important role.

ATU: When we talked five years ago, you cautioned that sexually transmitted HCV was possible, and appeared to be happening amongst

HIV-positive gay men in your clinics. You provided an early warning for what lay ahead. Some community-based organisations, like NAM and UKC, have done our best to inform HIV-positive gay men of the risks, but the Health Protection Agency and the Department of Health have been very late to respond, particularly compared with the recent epidemics of syphilis and LGV amongst HIV-positive men. In fact, some 'experts' are still arguing that HCV can't be sexually transmitted, despite all the evidence that you and others have provided.

SB: It's amazing, isn't it, that we still haven't had a public health response. I feel very disappointed, quite frankly.

MN: I think people need to move on from saying there is no transmission of hepatitis C in HIV-positive people, to saying, 'How can we stop the transmission of hepatitis C in HIV-positive people?' There's not much else that we, as physicians, can do: we can test people, and treat people, but it doesn't stop it from happening in the first place.

further information

For more on HIV and HCV, see *ATU* 164, March 2007.

Visit www.aidsmap.com for the latest news on diagnosis and treatments.

news in brief

new drugs

Prezista appears superior to Kaletra for treatment-experienced individuals



The newest protease inhibitor, darunavir (*Prezista*), boosted by ritonavir, is more likely to suppress viral load below detectable levels in treatment-experienced patients than *Kaletra* (lopinavir/ritonavir), according to the results of the international TITAN study.

TITAN compared twice daily darunavir/ritonavir (600/100mg) with twice daily lopinavir/ritonavir capsules (the old formulation) (400/100mg), plus a background regimen selected by resistance testing. After 48 weeks of treatment, 77% of study participants randomised to receive darunavir had viral load below 400 copies/ml, compared with 68% of those randomised to lopinavir. A similar difference emerged when the proportion of patients with viral load below 50 copies/ml at week 48 was compared. These differences showed that

darunavir/ritonavir was statistically significantly superior to lopinavir/ritonavir in terms of viral load suppression.

Although diarrhoea was seen more frequently in the lopinavir/ritonavir group this might have been different if the new *Kaletra* tablet had been used. On the other hand, people taking darunavir more likely to experience a rash. Both drugs affected blood fats in similar way, although more people had high triglycerides on lopinavir.

For individuals who already had at least one protease inhibitor-related resistance mutation, TITAN showed that darunavir was significantly more likely than lopinavir to control viral load. This suggests that in future individuals with any signs of protease inhibitor resistance may be more likely to be offered darunavir than lopinavir.

hiv & law

Criminal HIV transmission laws 'irrational'



Laws criminalising behaviour that may transmit HIV are "the product, not of rational public health choices, but of irrational fears, which provide an inveterately poor basis for rational law-making," according to South Africa's Justice Edwin Cameron who spoke at Birkbeck College in central London in June, at an event co-hosted by NAM and the National

AIDS Trust. Mr Justice Cameron argued that the law's current place in the AIDS epidemic is primarily to create "legislation specially protecting the rights of those with HIV."

The full text of Mr Justice Cameron's talk entitled, *Using the law in the AIDS epidemic: sword or shield?* can be downloaded from: www.nat.org.uk

hiv & illness

HIV-related hospital admissions plummet

Further evidence of the dramatic effect potent anti-HIV therapy is having on the health of people with HIV was recently published. A US study showed that hospital admissions involving people with HIV fell by 40% between 2000 and 2004. The study also found that the people with HIV who needed admission to hospital were getting older and sicker. The study's author suggests that this could be because people with HIV were living long enough to develop age-related illness, such as heart problems.

new drugs

Experimental NNRTI etravirine showing promise

Two studies have found that a combination of the new non-nucleoside reverse transcriptase inhibitor etravirine (TMC125) together with darunavir (*Prezista*) boosted with ritonavir is significantly more effective than darunavir/ritonavir alone in highly treatment-experienced patients with resistance to both NNRTIs and protease inhibitors.

However the studies also found that in highly treatment-experienced individuals new to enfuvirtide (T-20), etravirine did not provide any extra benefit if the patients also started T-20, which is from a completely new drug class, when they entered the trial. On the other hand, of those who took TMC-125 without enfuvirtide, 55-58% achieved viral load below 50 copies by week 24, compared with one-third in the placebo group.

Only in patients with some degree of resistance to darunavir did etravirine shine when enfuvirtide was introduced as a new drug in the background regimen: among those with moderate darunavir resistance, etravirine recipients who also took enfuvirtide for the first time were twice as likely to achieve viral load below 50 copies/ml.

Like other NNRTIs, etravirine's signature side-effect appears to be rash, which typically emerged after about ten days on treatment and lasted for a median of twelve days. It does not appear to adversely affect blood fats or the liver, however.

These findings suggest that etravirine may prove a useful alternative to T-20 in protease inhibitor-experienced individuals still sensitive to darunavir, and that it will also provide useful back-up to an agent from a new class in circumstances where resistance to darunavir is growing, but there is still some sensitivity to NNRTIs.

new drugs

Ups and downs for more new anti-HIV drugs

US approval for Merck's integrase inhibitor, raltegravir (*Isentress*) is now expected in October. The drug is equally likely to be an important new option for people with extensive treatment experience as well as people who have never taken anti-HIV treatment before. The US approval of Pfizer's CCR5 inhibitor, maraviroc (*Celsentri*), has been delayed, however, because the US drug regulatory authority have some outstanding questions about the drug.

Studies for bevirimat, an experimental anti-HIV drug that belongs to a class of antiretrovirals called maturation inhibitors, are moving forward, following problems with the tablet formulation last year. Results of a small study of the liquid formulation are showing promise, and it is hoped that an improved tablet formulation will be created soon.

hiv & illness

Does long-term immune suppression boost cancer risk?

An analysis of previous studies examining cancer incidence in people with HIV suggests that cancer is likely to become an increasingly common complication as people with HIV live longer.

The study found that many of the cancers that are disproportionately affecting HIV-positive individuals have infectious causes. These include: human papilloma virus (HPV), which can lead to cancer of the cervix, vulva, vagina, penis,

anus, mouth and throat; Epstein-Barr virus, which can lead to Hodgkin's lymphoma and non-Hodgkin's lymphoma; HHV-8, associated with Kaposi's sarcoma; hepatitis C, which can cause liver cancer; and helicobacter pylori, a cause of stomach cancer.

However, the authors of this analysis admit that HIV-related immune deficiency is not linked with a higher risk of cancer in all studies in people with HIV.

positive guidance

It's hard to believe, but until the Joint BHIVA-BASHH-FFP guidelines specifically addressing the sexual and reproductive health needs of people living with HIV were published this summer, there had been virtually no guidance for HIV-positive individuals - and the clinicians who care for us - on the positive aspects of HIV-positive sex.

Certainly, in the past we have had plenty of expert guidance on how to avoid and treat infections and illnesses caused by sex; and there was also expert guidance on how to avoid or manage pregnancy.

But it always seemed as if the underlying assumption was that sex - and even pregnancy - was something that HIV-positive people did *despite* having HIV.

A right to enjoy sex and parenthood

The freedom to enjoy sex - for pleasure, for reproduction - is an inalienable right, something to be celebrated and enjoyed. There are times when it feels like the world doesn't want HIV-positive people to have those rights. This is particularly noticeable in the language used by judges, lawyers and the media around the issue of the criminalisation of 'reckless' HIV transmission. In this arena, we are often vilified purely as vectors of HIV transmission that would serve society better by abstaining from sex altogether.

Thankfully, these new guidelines explicitly acknowledge that life with HIV should include a happy and healthy sex life. They stress that HIV-positive individuals "have the right...to enjoy meaningful sexual relationships, and reproductive health." That's why there is detailed guidance and recommendations on reproductive options for HIV-positive individuals who want to become parents. Also included is guidance and recommendations to help us overcome some of the physical and psychological barriers that can get in the way of pleasurable sex.

A right to protect our own health

The guidelines also note that HIV-positive people have a right "to protect their own health". One of the concerns for HIV-positive people who desire to have unprotected sex with another HIV-positive person is the uncertainty over the risk of being re-infected with another strain of HIV that may negatively affect their health. For the first time, these guidelines provide an honest and pragmatic review of the risks of superinfection - which are real and impossible to predict - with several recommendations (see below).

Cervical and anal cancer - which can often be detected and successfully treated - are caused by certain strains of the sexually transmitted human papilloma virus (HPV). Accordingly, there is a great deal of discussion regarding screening for, and treating, cervical pre-cancer and

how to have a happy and healthy sex life, by Edwin J Bernard

cancer in HIV-positive women, and anal pre-cancer and cancer in HIV-positive men.

Although the guidelines do not currently recommend screening for anal cancer - something that may be a disappointment for some - they do review the evidence for and against such screening, asking some pointed questions, and recommending that each clinic decides for themselves how best to approach this issue.

Our responsibilities

Like it or not, rights also come with responsibilities. We do need to remember that although each individual is responsible for their own sexual health, the knowledge that we may be infectious to others means that we need to ensure that we play our part in avoiding passing on HIV to anyone else. Unfortunately, the criminal law now implicitly suggests that we are 100% responsible should HIV transmission occur without our partner explicitly knowing of and consenting to the risk.

One of the ways we can reduce the risk of HIV transmission occurring following sex when a condom has failed to provide adequate protection is to make sure we know where our partners can access Post Exposure Prophylaxis (PEP). The guidelines specifically recommend that all HIV clinics should make sure that all

of their patients know how and where PEP can be obtained locally.

Recommendation highlights

The guidelines cover many issues relating to the sexual and reproductive health of HIV-positive individuals. These are some of the highlights.

All HIV-positive individuals should have:

- A sexual health assessment by appropriately trained staff every six months.
- Access to ongoing high quality counselling and support to ensure good sexual health and to help maintain 'safer sex.'
- Syphilis blood tests every three months as part of routine HIV blood-work.
- The hepatitis B vaccine.
- Annual screening for hepatitis C, for those who are at risk (i.e. all sexually active gay men, and all individuals with sexual partners who have hepatitis C).
- Information regarding their HIV clinic's procedure to access PEP.

- Counselling regarding the risk of superinfection, particularly people who choose to serosort (i.e. have unprotected intercourse with partners who are also HIV-positive), as well as HIV-positive couples that wish to conceive, and where there is limited access to specialised conception services.

HIV-positive individuals who wish to have children should undergo:

- Counselling before they conceive regarding HIV transmission risks, the impact on their long-term health, and the possible effects of antiretroviral medication on the unborn baby.

Cervical and anal cancer:

- Annual cervical smears are recommended for all HIV-positive women.
- All major HIV clinics should develop clinical guidelines for the management of suspected anal cancer and pre-cancer and develop either local clinical expertise or clear referral pathways for people

identified as having suspected anal cancer and pre-cancer.

Criminalisation issues:

- Healthcare staff should be aware about the important legal issues regarding HIV transmission and their responsibilities to the duty of care of patients, confidentiality and public health concern.
- There may be legal implications in having unprotected sex, particularly when an individual has not disclosed their HIV status and transmission occurs. This should be raised in the context of safer sex discussions. ■

The 2007 UK guidelines for the management of sexual and reproductive health (SRH) of people living with HIV infection were produced jointly by the British HIV Association (BHIVA), the British Association for Sexual Health & HIV (BASHH) and the Faculty of Family Planning & Reproductive Health Care (FFP). They can be downloaded in full from: www.bhiva.org/cms1191550.asp

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news in brief [page sixteen]

Prezista appears superior to Kaletra in treatment-experienced individuals

1. Madruga JV et al. *Efficacy and safety of darunavir-ritonavir compared with that of lopinavir-ritonavir at 48 weeks in treatment-experienced, HIV-infected patients in TITAN: a randomised controlled phase III trial*. *The Lancet* 370: 49-58, 2007.

HIV-related hospital admissions plummet

1. Hellinger FJ. *The changing pattern of hospital care for persons living with HIV: 2000 through 2004*. *JAIDS* 45: 239 - 246, 2007.

Experimental NNRTI etravirine showing promise

1. Madruga JV et al. *Efficacy and safety of TMC125 (etravirine) in treatment-experienced HIV-1 infected patients in DUET-1: 24-week results from a randomised, double-blind, placebo-controlled trial*. *The Lancet* 370: 29-38, 2007.

Does long-term immune suppression boost cancer risk?

1. Grulich AE et al. *Incidence of cancers in people with HIV/AIDS compared with immunosuppressed transplant recipients: a meta-analysis*. *The Lancet* 370: 59-67, 2007.

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where to find out more about hiv

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On the last Monday of every month, an expert speaker discusses an HIV treatment related topic. Entry is free. The next forum is on 24th September 2007. The topic is Feedback from the International AIDS Society Conference. For more details, go to www.aidsmap.com/forums.
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feedback from the international aids society conference 2007, sydney

You don't have to go all the way to Sydney to hear about the latest HIV reasearch and developments

NAM's September forum will be a feedback session, looking at the latest global HIV research in a UK context.

when

Monday 24th
September 2007
7-9pm

where

Rooms 3 C & D
Third floor
University of
London Union
Malet Street
London WC1

speaker

to be confirmed

For more information
telephone NAM on
020 7840 0050 or email
info@nam.org.uk

