BODY POSITIVE
NEW ZEALAND

positively POSITIVE

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LONDON EXPERT VISITS NEW ZEALAND

Dr Mark Nelson

On Tuesday 29 November, Body Positive was visited by Dr Mark Nelson.

Dr Nelson holds a significant number of impressive job titles at Chelsea and Westminster Hospital in London, the largest HIV-treatment centre in northern Europe. Most notably, since 1994 he has been the hospital's director of HIV Services, deputy director of research and director of HIV Clinical Trials Unit.

As those titles would suggest, Dr Nelson is heavily involved in clinical studies at Chelsea and Westminster. His HIV-related research has run the gamut, though his latest work tends to focus on antiretroviral therapies, treatment of HIV/hepatitis B co-infection and AIDS-related lymphoma. Dr Nelson has authored or co-authored more than 50 published articles over the past two years.

In addition to his clinical duties, Dr Nelson teaches undergraduates and graduates at Chelsea and Westminster Hospital and has lectured extensively throughout the world at conferences and as an invited speaker.

Body Positive was grateful to Janssen who sponsored his visit. We asked Dr Nelson about a range of issues.

We started off by asking Dr Nelson's recommendation when an HIV+ person should start taking medication. The United States generally starts a person on life-long medication when the positive persons CD4 cell count (a measure of the human immune system that HIV attacks) drops to around 500 cells per ml of blood. (A normal healthy person can have a count somewhere between 500 and 1500.) In the UK and Europe - the model New Zealand follows - the starting time is much lower, at about 300 CD4 cells per ml blood.

Dr Nelson tells us the European guidelines are starting to shift towards 500 but he reminded us that Europe is a very big place and there are still many people who can't access medication at all, particularly in Eastern Europe where access is not only difficult but will also often be guided by expense. In many other countries though, patients are coming in to see their physicians and asking about starting earlier, on higher CD4 cell counts. People are concerned about "transmission" and staying safe by starting on medication. Many patients are asymptomatic and a short while after they have started medication, they come back and say they are feeling better than before and wish they had gone on to medication earlier. What has stopped people going on to medication before is the toxicity of the drugs, which today is much less. He says he has had people come back to him and shout at him as to why he didn't start them on medication much earlier as they feel markedly better. In fact, starting earlier seems advantageous as we now see evidence of people living much longer on treatment. There is even a theory that living with HIV might mean living longer than the general population because the general population don't come in to hospital regularly to have blood tests and to have their heart, bones and liver regularly monitored and checked.

Dr Nelson says, "We shouldn't be too negative about the drugs we take today and we should be prepared to switch until we find what we are comfortable with. There are over 26 drugs available that present viable options for people to consider. We need to look at all sorts of things we haven't before. Sex – women versus men, age, race, and size are all considerations when we start to prescribe medication. It needs to be individualised. We are lucky to have the choice we have today. Dosage, metabolism of the drugs and different amount of fat in the person – these are all items to be taken in to account when prescribing."

We discussed the current European guidelines and in particular the UK guidelines for prescribing medication for HIV+ people.

"Until recently, Atripla was heavily prescribed because it consists of just one pill taken once a day. The one pill actually consists of three pills previously prescribed - positive people have loved getting the one pill per day. I mentioned until recently because now the UK physicians are told not to prescribe the drug and go back to separate medications. There is a financial reason for this. There is no data to tell us if this is a good or bad decision. Currently we are asked to prescribe Kivexa [A much less expensive drug)]."

Dr Nelson said it is easy for doctors to "bamboozle" their clients with the information and science available. He mentioned there is very little "activism" at the moment on behalf of clients. "There is a lack of information for clients particularly young clients, and the general trend is 'I'll do whatever you think, doctor'."

"There is a lack of knowledge amongst the patients. They are less interested in their care compared to ten years ago, today it is much more complex."

"Because there is a lack of interest coming from the

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patient, we are tending to leave their clients on the regimes they have always been on. Financial costs are a concern and it is a case of conversing with pharmaceutical companies and convincing them to make drugs available and to get them to lower the prices. In other countries the positive groups are consulted by the pharmaceutical companies."

We then asked Dr Nelson about the new reports that treating people with medication reduces their infectivity by 96%.

"There is growing data for prescribing medication on diagnosis to help with prevention. 'Seeking and treating' is the most successful model of prevention. There has never been a reported case of someone transmitting the virus when they have an undetectable viral load. It comes down to the fact that if you are going out there to diagnose a lot of people you have got to be able to provide treatment. You have got to have the resource to support them. The danger is if you do not support them, then you will have people spreading a resistant virus."

"The real issue around transmission is that people who are newly infected are highly infectious and it is these people who are spreading the virus. Once they know they have the virus then generally they adopt a whole new approach to their personal prevention."

"Generally for those who seek treatment it is often for protection of their partner that drives them to want to go on to the medication."

"People living with HIV need to be responsible for not infecting others. There was a recent case in the UK where someone was taken to court for infecting another with herpes. Of course there are always two people involved and there needs to be education. When Freddie Mercury was dying there was six hours of AIDS-related telecast on every television channel but today there seems to be nothing going on."

"The current lack of education is really worrying. The biggest new group of people with HIV in the UK is very young people. The attitude is a real concern. 'So I have to take some tablets,' they say."

"When we start treatment for people we start off using the guidelines but then we individualise them to the person taking in to account their personal health and lifestyle situation."

"There have been concerns about people failing to respond to their drugs, so we did some tests and found most of them had no resistance to the drugs, which tells us that their failing drugs was due to them not taking their drugs. We tried them on Kaletra by itself and found 50% of the study group became undetectable, confirming compliance was the failure, not the drugs. If people are worried about taking their drugs because of side effects then we tell them to come in to hospital for a few days where we can monitor them and ensure that help is available if they need it. This is about kindness – we don't say 'We don't believe you' about having side effects."

"If someone is adamant they are not going to take their drugs, I prefer to introduce them to someone who also had that attitude and finished up in a wheel chair with serious toxo. No one wants to be seriously ill and not taking medication will lead to being exactly that."

"We need to remember all drugs have side effects – alcohol, smoking, even crisps have side effects. Our HIV meds are the same and people need to monitor them."

By Bruce Kilmister

HIV/AIDS in New Zealand in 2011

The theme of this year's World AIDS Day, "Getting to Zero", echoes the UNAIDS vision of "Zero new HIV infections. Zero discrimination. Zero AIDS related deaths". One strategy to achieving no new infections or deaths from AIDS is through the early detection of HIV infection.

The earlier HIV is diagnosed the better it is for the individual and for control of HIV in the community. It means that the most effective treatment can be offered and that infected people can be advised to behave in safe ways. Hence early diagnosis and treatment can reduce the risk of new infections. In addition, people taking antiretroviral therapy are less infectious.

New Zealand information just published shows that, in the last six years, half of all people diagnosed with HIV infection presented late - that is, past the ideal stage for starting treatment. Very late presentation (Advanced HIV disease) was more common among heterosexuals, among Māori and Pacific men who had sex with men (MSM), and among people 40 years or older.

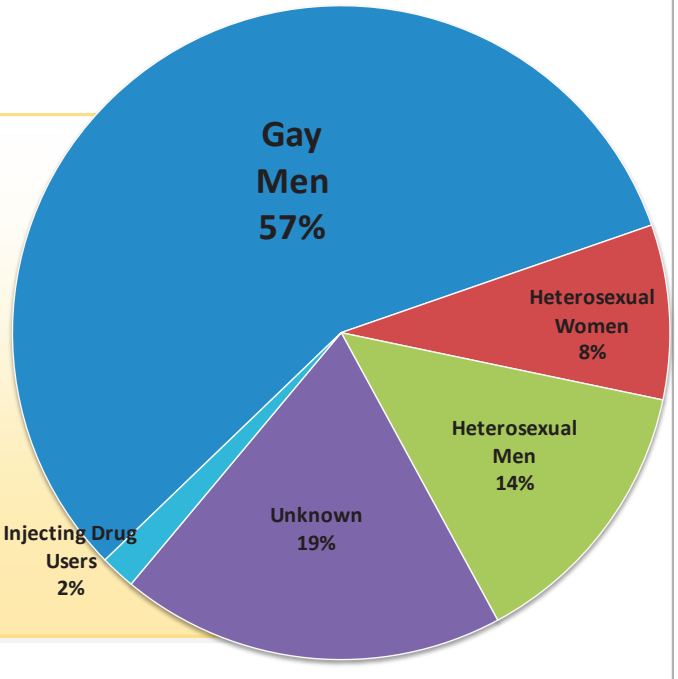
Source: AIDS - New Zealand

HIV INFECTIONS

Fifty-eight people (49 males and nine females) were diagnosed with HIV through antibody testing in New Zealand in the first half of 2011.

Thirty-three were men infected through sex with other men, 13 (eight men and five women) through heterosexual contact, one man through injecting drug use in New Zealand, and one child through mother-to-child transmission overseas. For the remaining 11 people the means of infection was unknown or information is still awaited.

Of the 33 men infected through sex with other men, 26 (78.8%) were infected in New Zealand, and seven (21.2%) overseas.



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Reforming HIV Criminalisation

There have been many criminal convictions in New Zealand against people living with HIV who fail to exercise their legal responsibility in taking care not to transmit the HIV virus when engaging in sexual activity, specifically penetration. Currently the Crimes Act has been interpreted as requiring people living with HIV to ensure a condom is used when having sex. An HIV positive person is NOT required to disclose their status but they are required to use a condom. Criminal charges usually consist of a charge under criminal nuisance if no infection is made and can result in a prison sentence if found guilty. Where an infection does happen the charges are escalated to grievous bodily harm and can result in a serious, longer term in prison.

Internationally the criminalisation is seen as a failure to prevent the transmission of HIV and some countries have made significant progress in recent times by reforming laws around HIV transmission and exposure offences, Edwin J Barnard from the UK told people during the last annual ASHM Australasian HIV/AIDS conference in Canberra.

While there are still many jurisdictions around the world (including New Zealand) that continue to charge people with HIV under specific HIV laws or under general criminal law, there have also been some countries who have realised that recent research into undetectable viral load and lowered infection must be taken into account in consideration of HIV transmission offences.

In 2005, the Netherlands government looked at the scientific evidence of transmission risk and decided to narrow the scope of their law so that only those who can be proven to have intentionally transmitted the virus may be charged.

In recent years, court judgments in Switzerland and Canada have taken into account the findings of the 2005 Swiss Statement on HIV infectiousness. A court in Geneva has found a person with HIV not guilty of transmission based on the statement and Canadian courts have decided that having an undetectable viral load means you cannot be convicted of causing a "significant risk of serious harm" due to HIV exposure.

There is also the possibility that the United States will review its position, with representative Barbara Lee about to introduce a bill to Congress to ascertain whether their current laws are consistent with science.

Denmark has suspended their laws on HIV pending further research into the issue and there is hope that the laws will soon be repealed there.

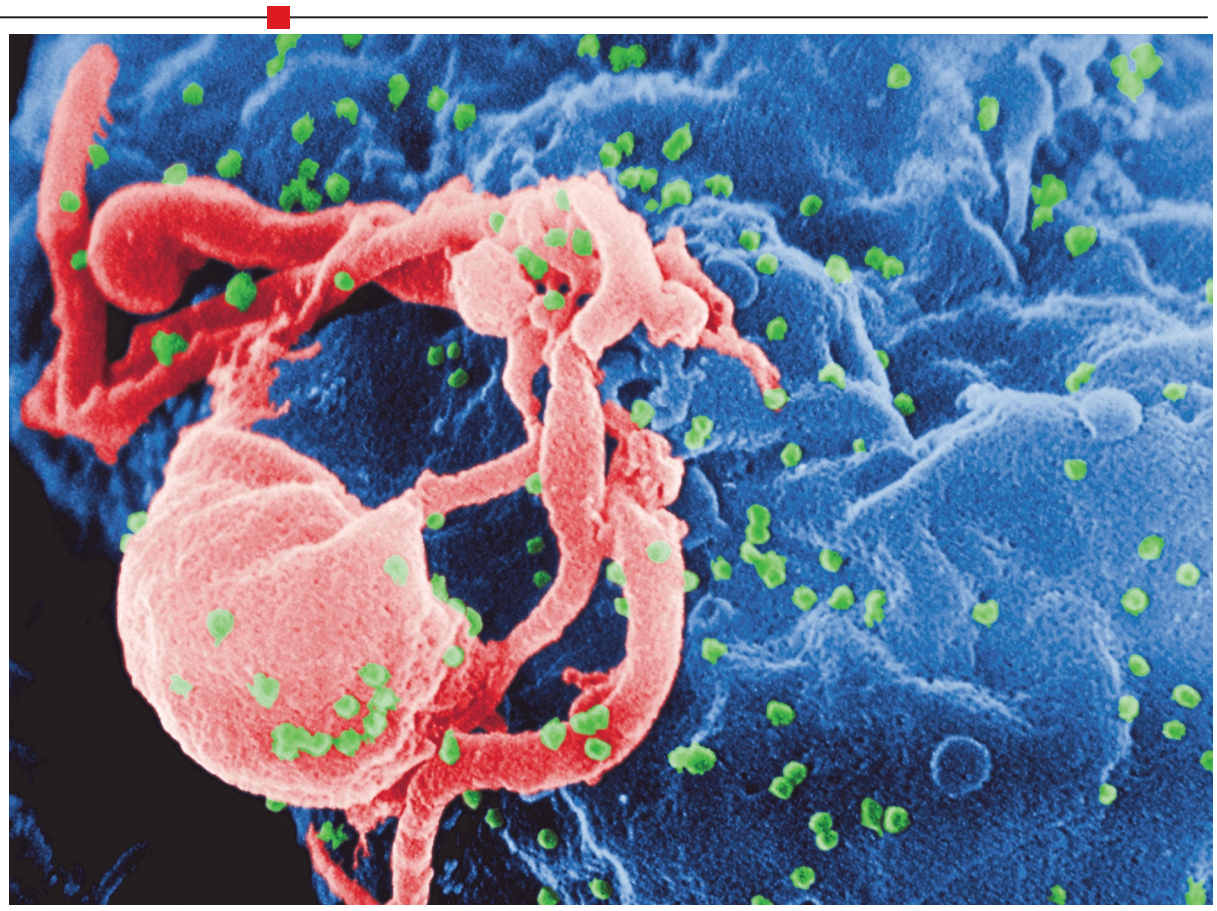
Source: Positive Living Magazine (NAPWA Australia)

The Beginning of AIDS?

In the early 1980s, epidemiologists were racing to understand a mysterious disease that was killing young men in California. As we now know, that disease was AIDS. And it soon grew into one of the biggest global pandemics in human history. But back in 1984, no one knew what it was or how it was spreading. So the CDC commissioned a study to look at whether it might be sexually transmitted.

And the results were startling - the data seemed to point to a figure at the centre of the outbreak from which all the other cases radiated. A few years later, Randy Shilts published a formative book on AIDS called *And the Band Played On*, which, along with documenting the early history of AIDS in the US, revealed the name of the man at the center of that CDC study: Gaetan Dugas. Dugas was soon dubbed Patient Zero and labelled by the media as the cause of the AIDS epidemic. But as Carl Zimmer and David Quammen explain, Dugas was absolutely not Patient Zero. Not by a long shot. Michael Worobey and Beatrice Hahn help us search for a much earlier Patient Zero, by taking us to Africa and turning back the clock on a series of virus mutations and pinpointing one fateful moment of cross-species spillover in a jungle in Cameroon. And virus hunter Nathan Wolfe takes us back even farther, to an intracellular instant that created a chimp Patient Zero hundreds of thousands of years ago.

Source: www.radiolab.org



SYPHILIS, SILENT BUT VERY DANGEROUS

Syphilis, the old enemy. In England it was known as the pox or the "the French disease". The French returned the honour calling it "la maladie Anglaise". Henry VIII of England is rumoured to have passed it on to his children Edward VI, Mary I (Bloody Mary) and Queen Elizabeth I, the Virgin Queen, none of whom bore living children. It spelt the end of the House of Tudor and led to the takeover of the English throne by their Scottish cousins, the Stewarts. Once common in Western Europe and North America, it was considered to be all but dead once Sir Alexander Fleming discovered penicillin in 1928. But it seems that it is returning and with a vengeance.

Syphilis once detected is quite easy to cure. However, it is dangerous because it appears, then disappears leaving victims to think it has gone. Also, its symptoms can often be mistaken for other diseases. However, if untreated, syphilis lurks ready to inflict brain damage and blindness in later years. It is not nice. One of the problems for us in New Zealand is that because the disease was considered all but eradicated, many health professionals may diagnose symptoms as something else. The only way to be sure is to undergo a painless blood test to check.

"Testing for all men at risk is critical"

A recent study in the United States by the Centre for Disease Control has suggested a link between HIV and syphilis. The CDC undertook an examination in major American cities and found in all new reported cases of syphilis, 56% of those diagnosed were also found to have HIV. John Su of the CDC said there is an "urgent need" to increase HIV and syphilis prevention campaigns. The startling statistic is that it seems to be affecting one community more than others. Black Americans/Afro Caribbean men who have sex with men (MSM) are particularly affected. Between 2006 and 2009 this group's diagnoses rose by 48%.

In response, the CDC has rolled out a campaign called "Testing Makes Us Stronger". Richard Wolitski of the CDC says that regular testing for all men at risk is "critical". Those who know they are infected can take steps to get cured and also to prevent passing on the disease.

In New Zealand, the statistics are also grim. In 1995 there were less than five new cases of syphilis recorded by the sexual health team in Auckland. This low rate remained fairly constant until 2001 when the number of new infections tripled. Since then there has been a steady increase. In 2009 there were 138 new cases. This dropped to 119 in 2010. But the figures for the first half of 2011 show 52 new cases. New cases seem to be divided into two groups. Those caught through heterosexual contact from overseas (particularly Fiji) and MSM contact contracted mainly in New Zealand.

Most gay men are familiar with the condom message in preventing HIV but syphilis in New Zealand does not seem to share a correlation in growing awareness. I asked Dr Sunita Azeriah of Auckland Sexual Health Service if other sexually transmitted infections such as gonorrhoea and chlamydia were also on a comparable growth climb. She said that they appear not to be so. Chlamydia is on the increase but not at the same rate as syphilis.

A person with a sexually transmitted infection is more receptive to HIV infection, especially because STIs damage the soft lining of the anus and mouth, making it easier for the HIV to enter a person's body. Dr Azeriah also informed me that having HIV and another STI will make the individual secrete more of both viruses in semen and pre-cum as the blood tries to compensate by upping the immune system. In other words a man living with HIV and an STI is more likely to be more infectious than one without an STI.

Syphilis is a problem for gay men. Unlike gonorrhoea which is immediately obvious to the victim through an infected penis or throat, syphilis appears as a rash then goes, leaving many men to think it has passed. However, it is still there, able to inflict brain damage and blindness later in life if untreated. It can also lie undetected in a man's anus where it does not cause pain or irritation and can go unnoticed. However, when detected it is very easily treated.

So what should we do? In England most gay men accept that as sexually active creatures they have go for a regular test whether they have symptoms or not. They refer to it as going for the MOT (the equivalent of the WOF). In a sexual health clinic they get tested for the whole gamut of STIs, including syphilis and HIV. One of the reasons syphilis appears to be rising is that is spread not only through anal intercourse but also through oral sex, fingering, rimming and toy play, activities where most gay men don't consider condom use as necessary. Dr Azeriah stresses that men just need to know the risks and take responsibility. Most men should get tested once a year; men who party, every six months. Tests should include:

- Blood test for Hepatitis A, B, and C and also for HIV
- Urine test for gonorrhoea and chlamydia

I asked Dr Azeriah, what of the future? She said, "New Zealand really needs a public health action plan" for both syphilis and chlamydia. Unlike HIV, syphilis is not a notifiable disease so statistics can be hard to collate and patterns hard to discern. For such a plan to be effective the MSM community needs to be involved in its creation along with health practitioners, many of whom are unfamiliar with the disease due to the rarity of syphilis in New Zealand until recently. The aim of such a campaign would be to diagnose as many as possible new cases to stop new infections and to create a targeted campaign aimed at the MSM community. For us, knowledge is power.

So men, diarise an annual WOF of your driving equipment. The sexual health clinic at Greenlane Hospital is always available and apparently is popular with men on Tuesday nights. I asked whether as in England, Auckland Health ran gay nights/ rainbow clinics where gay men can feel more comfortable discussing what they've been up to. I was told it is something they are discussing. Contact details for sexual health clinics are below.

By John Windle

Auckland

– Central (Greenlane)	09 630 9770
– North (Glenfield)	09 443 9580
– South (Mangere)	09 255 5172
– West (Henderson)	09 836 0838

Christchurch

– St. Asaph Street	03 364 0485

Wellington

– Cuba Street	04 385 9879

Dunedin

– Dunedin Public Hospital	03 470 9780

Body Positive also provides rapid testing for HIV, syphilis and hepatitis in Auckland CBD, Mon-Fri 9am-5pm
See www.bodypositive.org.nz for details or call 09 309 3989

HIV SERVICES AVAILABLE AT BODY POSITIVE

- Safe, comfortable Drop-in Centre
- HIV Rapid Testing Service
- Full Sexual Health Check Up
- Counselling for HIV+ People
- Budgeting Service
- Food & Vitamin Bank
- Treatments Information
- General Doctors visits
- Specialist HIV Physician
- Facial Lipoatrophy Treatment Clinic
- Work & Income [WINZ] monthly clinic
- Peer Support Counselling
- Social Support
- Weekly Massage
- Podiatrist Service
- Monthly Hairdressing
- Pot-luck Lunch every Friday
- Club Phoenix every Wednesday from 6pm
- Annual HIV Treatments Update Seminar
- Annual Retreat for HIV+ men from all over New Zealand
- Social Workers to assist your needs with Work & Income [WINZ], Housing, Employers, Medical, Dental

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To enquire about any of our services, Freephone -
0800 HIV LINE (448 5463)
Auckland - 09 309 3989