PAN PACIFIC GATHERING FOR HIV+ PEOPLE 2008
Auckland, New Zealand September 2-5, 2008

:::::::::: Special Edition -September, 2008 ::::::::::
reporting on World AIDS conference - Mexico

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The official publication from *Body Positive Inc*. A peer support organisation for people living with HIV/AIDS

Former US President Bill Clinton *speaks in Mexico*

> **We know there is so much yet to be done: to expand prevention, treatment and care, to strengthen undeveloped health systems.**

Former President Clinton at a session during the XVII International AIDS Conference in Mexico City on Monday said that the fight against HIV/AIDS is far from over and called for improved health systems, prevention and treatment worldwide, the Wall Street Journal reports (Chase, Wall Street Journal, 8/5). "AIDS is a very big dragon," he said, adding, "The mythological dragon was slain by Saint George, the original knight in shining armor, but this dragon must be slain by millions and millions of foot soldiers."

According to Clinton, increasing food and oil prices, as well as the mortgage crisis, have further compounded the lives of HIV-positive people. Clinton also said that there is no "silver bullet" to eradicate HIV/AIDS worldwide. "We know there is so much yet to be done: to expand prevention, treatment and care, to strengthen undeveloped health systems," he said (Nicholson, AFP/Yahoo! News, 8/4).

Clinton said the U.S. and other nations should reform their health systems to reach the groups at highest risk for HIV/AIDS, which have been neglected over the past 25 years (Pettypiece, Bloomberg, 8/4). He called for a 50% increase in funding to reduce the price of antiretrovirals and keep pace with expanding antiretroviral programs (BBC News, 8/5). Clinton also said that health clinics should routinely test for HIV, particularly in developing countries, where 80% of people living with the virus are unaware of their status.

Clinton said that the U.S. has failed to prevent the spread of HIV among blacks. He added that 30% of infants born to HIV-positive women in Africa contract the virus, although drugs can reduce the risk of mother-to-child HIV transmission to less than 2%. He said that the Clinton Foundation will work to reduce such rates (Bloomberg, 8/4). Clinton also cited some of the successes of his foundation, including reducing the price of some pediatric antiretrovirals from $600 annually to $60 annually in the previous three years. He also discussed the possibility of using pre-exposure prophylaxis to prevent HIV transmission until a vaccine is developed, the Journal reports (Wall Street Journal, 8/5).

Clinton during the session praised the passage of legislation to reauthorize the President's Emergency Plan for AIDS Relief, which President Bush signed into law last week. "This is a stunning development for which we should all be grateful," he said. Clinton also lauded United Nations Secretary General Ban Ki-moon and Mexican President Felipe Calderon for speaking out against discrimination during the conference (AFP/Yahoo! News, 8/4).

He also commended Mexico for passing legislation to increase access to health care, adding that such legislation can help reduce new HIV cases (Bloomberg, 8/4). He also praised Mexico's policy of universal access to antiretroviral drugs for all people who need them and added that he hopes the Bush administration "will follow" and provide universal access to antiretrovirals in the U.S.

In addition, Clinton said that a recently released CDC study about annual new HIV infections in the U.S. highlights the need for increased attention to the virus in the country, particularly among blacks (Connolly, Washington Post, 8/5). The study "should be a wake-up call" for U.S. citizens "that even as we keep working globally we need to do much more to fight AIDS at home, and I intend to do so with my foundation" (Bloomberg, 8/4).

In a Washington Post interview after the speech, Phill Wilson, CEO of the Black AIDS Institute, , "I have been extremely disappointed with the Clinton Foundation, especially with it headquartered in Harlem of all places, that it has been silent" on the issue of blacks and HIV/AIDS. He said that HIV/AIDS is a "direct attack on black America." Wilson said, "I'm very grateful, and it is appropriate that President Clinton is committed to taking this on" (Washington Post, 8/5).

The recent CDC study found that 45% of new infections in the U.S. occur among non-Hispanic blacks (Kaiser Daily HIV/AIDS Report, 8/4).

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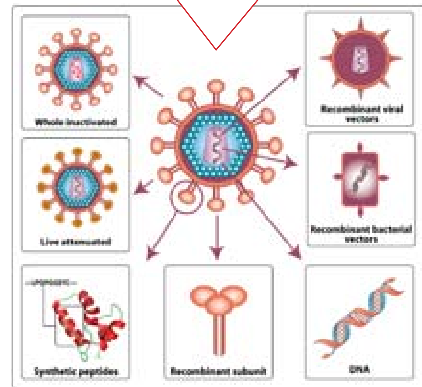
HIV Vaccine

'allow drug breaks'

Scientists are testing a vaccine designed to give HIV patients a prolonged break from their regular medication without side effects. The Aids 2008 conference in Mexico City was told 345 patients in 21 centres in the US and Europe will take part in the largest-ever trial of its kind.

Scientists are testing a vaccine designed to give HIV patients a prolonged break from their regular medication without side effects.



The vaccine has been developed by a biotechnology company based in Norway, Bionor Immuno. Results from the trial are due by the end of 2009. A break from standard HIV therapy would potentially alleviate the adverse side effects associated with the drugs, which can include problems with the heart and liver, diarrhoea, nausea and fat loss. It may also help delay the emergence of drug-resistant viruses, as well as providing substantial savings for health care services.

Dr Barry Peters, of Kings College London, is leading the research in the UK. He said: "A successful immunotherapeutic HIV vaccine would give patients and doctors enormous advantages over current treatments, both in developed and developing countries. "Even if this vaccine is not the final answer, it could help the march towards a successful immunotherapeutic HIV vaccine." However, he stressed the vaccine was still at a very early stage of development.

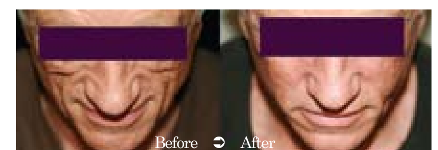
The vaccine works by stimulating an immune system response, in contrast to standard HIV drugs, which block replication of the virus. It has already been tested in two small trials on 11 and 38 HIV patients with promising results.

The majority of patients were able to refrain from taking their usual antiretroviral therapy (ART) for an average period of 31 months. During this time their level of key infection-fighting CD4+ cells remained high above the level they had before they started taking ART.

At a follow up 44 months after treatment interruption, 34% of the patients were still not back on ART. Some patients were still off ART five years after the trial was completed. ART cannot usually cannot be interrupted for more than three to four months without side effects. Lisa Power, head of policy at Terrence Higgins Trust said: "Any advance that gives people more treatment choices and delays the progress of the virus is a good thing. "We are not yet clear whether this vaccine will work, but we'll know more by the end of next year."

Christchurch Clinic

Opens For HIV+ Clients For "AQUAMID" Treatment



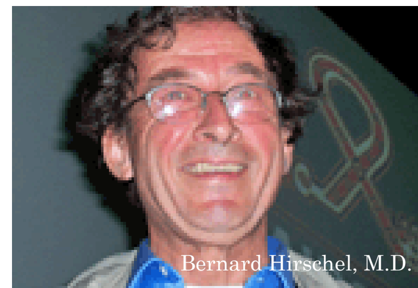
Body Positive Inc is pleased to confirm agreement has been reached for Dr Ken McDonald to treat Body Positive members concerns with facial wasting lipoatrophy. Previously clients were flown to Auckland making this an expensive exercise for people on limited incomes.

The treatment is an immediate cosmetic improvement for people with "hollowed out" facial features which has been caused by highly toxic HIV medication. Those drugs identified as responsible for this are D4T and AZT. Others to a limited extent.

The service is provided free to HIV+ people with this concern and they should contact Body Positive in the first instance to initiate treatment.

Call toll free on **0800 HIVLINE**

The Debate *Continues:* Does "Undetectable" Mean "Uninfectious"?


Bernard Hirschel, M.D.

> **...whether it's safe for an HIV-infected person in a monogamous relationship to have unprotected sex with an HIV-uninfected partner...**

One of the most provocative sessions of the XVII International AIDS Conference (AIDS 2008) likely took place before the conference even officially began. In a charged satellite event, a panel of researchers and a huge audience took part in a debate over whether it's safe for an HIV-infected person in a monogamous relationship to have unprotected sex with an HIV-uninfected partner, provided the HIV-infected partner has an undetectable viral load, is on stable antiretroviral therapy (ART) and has no sexually transmitted diseases (STDs).

In this summary at the end of the satellite event, Bernard Hirschel, M.D., of the University Hospital in Geneva, recaps the major points. Dr. Hirschel is one of the physicians who inadvertently ignited this controversy in February 2008 by helping author the now-infamous "Swiss statement," which you'll read about in a moment.

I'm not a member of the [Swiss] Federal Commission [for AIDS-related Issues]. I'm guilty by association. I have for a long time been a fan of Julio [Montaner]'s, particularly since his talk at the Toronto [International AIDS] Conference.What we need is new methods for prevention. Vaccines are pie in the sky. Microbicides have not worked so far. We have circumcision; that's partly effective.We do have treatment, and we need treatment for prevention.

Pietro Vernazza explained to you what the SWISS statement is.It's directed at physicians. It is of help in counseling. It evaluates the relative risks of sex on ART without condoms versus sex off ART with condoms. And it is very tightly qualified: on ART for at least six months, consistently undetectable viral load, no STDs, and perfect adherence. The Swiss statement does not advise against condoms and does not condone unsafe sex.

Behind the Swiss statement is the general idea that all risks are created equal, and that there is a problem in equal risks, unequally treated. Because how can one permit sex with condoms, untreated, while prescribing sex without condoms, treated, when the latter is equally or less risky than the former? I have not yet found an answer to this question.

Myron Cohen pointed out the great biological plausibility and that certainty is very difficult to come by. Events are rare and there are many confounding influences, such as the pharmacology of ARVs [antiretrovirals]. His pioneering study of discordant couples will give us some of the numbers we need, but will take a long time.

Nancy Padian looked at the Swiss statement from the woman's standpoint. She finds pros and cons, states that compliance with condoms is disappointing, and points out the issues related to power and gender.

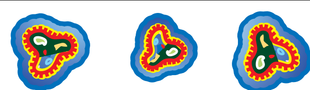
Nikos [Dedes], from the standpoint of the people living with HIV and AIDS, I quote him here: "The conscience of being infectious is a heavy burden to carry, and lifting it off is taking a load off of HIV-positive people. There are other issues: regaining the right to uninhibited intimacy, procreation, and the fact that I very strongly believe myself, that being less infectious will reduce stigma and discrimination."

Catherine Hankins points out that first-world views are called the truth, and that most HIV-infected patients have no access to viral load testing and to diagnose STDs. It is therefore doubly difficult to, quote-unquote, be sure about ends of risk in less developed countries. The Swiss statement will find its first application in pregnancy planning, perhaps complemented by pre-exposure prophylaxis, but has little applicability to other situations where condom promotion, in combination with treatment and circumcision, must remain the rule.

Let me now hazard into the difficult fields of politics and philosophy. What do we do when we, as a panel, make recommendations? Well, we have to cope with what I would call the asymmetry of risk. To say that something is dangerous while in reality it is not has no consequences for the politician or the panel member who says so. The opposite, however, to say that something is not dangerous and then something bad happens is, at times, career-ending. Therefore, there is a natural tendency of panels and commissions to, first and foremost, protect themselves.

One way of protecting themselves is to ask for more evidence. But the time it takes to obtain perfect evidence has a great cost. Remember that for circumcision, between good circumstantial evidence that it worked and the acceptance through a randomized controlled trial, 17 years elapsed. No offense meant to my attractive fellow panelists, but there is one sure thing at every World AIDS conference, and that is that the panelists are two years older. Of course, I'm part of them. And their sex lives are largely behind them. So I think we should take heed from that venerable institution, the Catholic Church, and make a second Swiss statement: Let us not be AIDS cardinals.

Inflammatory bowel disease
in HIV positive individuals



Chronic HIV infection and consequent immune system decline have been linked to many conditions in HIV positive people, but the association with inflammatory bowel disease (IBD) has not been extensively studied. IBD is a general name for chronic inflammatory conditions of the gastrointestinal tract, including Crohn's disease and ulcerative colitis. The cause of IBD is not well understood, but autoimmunity (when the immune system attacks the body's own tissues) appears to play a role. As reported at the Digestive Disease Week 2008 conference this week in San Diego, British researchers analyzed the prevalence of IBD and the relevance of CD4 count as a predictive factor in a large cohort of HIV positive patients treated at London's Chelsea and Westminster Hospital between 1999 and 2006.

Criminal HIV Transmission & Exposure Laws

Concern over the growing international trend towards the criminalisation of HIV transmission or exposure was documented in a Wednesday morning session at the XVII International AIDS Conference that highlighted "criminalisation creep" in Europe and Central Asia as well as the rapid spread of "highly inefficient laws" in West and Central Africa.

UNAIDS is so alarmed by these developments that this week they produced a new policy paper strongly suggesting that governments should repeal current laws that criminalise HIV transmission and exposure laws with the exception of intentional transmission.

With five major sessions over four days and least 20 different oral or poster presentations, the criminalisation of HIV transmission or exposure is one of the burning topics of the XVII International AIDS Conference agenda. And on Friday, South African Supreme Court Justice Edwin Cameron will deliver a plenary speech calling for an unambiguous rejection of the use of criminal law to regulate the sexual behaviour of those with and at risk of HIV.

Today, however, the conference heard evidence that laws enabling prosecutions for HIV exposure or transmission – whether via sex, needle-sharing or from a mother to an unborn child or infant – are high on the agenda of many nations around the globe, despite the fact that there is no evidence these laws change behaviour, and growing evidence that they may inadvertently exacerbate the HIV epidemic.

West African model law confusing and problematic

In a session entitled, 'To transmit or not to transmit: is that really the question? Criminalisation of HIV transmission', the conference heard that since 2005, Western and Central Africa has witnessed an explosion of national HIV-specific criminal exposure and transmission laws that threaten to make it one of the most legislated regions in the world for HIV.

So far, Benin, Guinea, Guinea-Bissau, Mali, Niger, Togo and Sierra Leone have passed laws in rapid succession and more Western, Central and Southern African countries are proposing similar laws, including Angola, the Democratic Republic of Congo, Malawi, Madagascar, Tanzania and Uganda.

Most of these laws are based on the African Model Law, created in September 2004 during a workshop by Action for West Africa Region– HIV/AIDS (AWARE–HIV/AIDS), in N'djamena, Chad.

Richard Pearshouse of the Canadian HIV/AIDS Legal Network noted that AWARE-HIV/AIDS receives USAID funding, and is implemented by Family Health International with additional funding from US-based organisations including Population Service International and the Constella Futures Group. He suggested to conference delegates that they politely let these organisations know how they feel about this at their stands in the exhibition hall.

The model law comes in the guise of human rights legislation in order "to protect those who are infected and exposed to HIV," and Mr Pearshouse pointed out that the model law does have some positive provisions, including a guarantee of pre- and post-test counselling; a right to healthcare services and medical confidentiality; and protection from discrimination when receiving healthcare and in the provision of goods and services.

However, Mr Pearshouse also pointed out that the model law contains a number of problematic provisions, such as the requirement that someone newly diagnosed with HIV must disclose their status to a "spouse or regular sexual partner" as soon as possible and at most within six weeks of the diagnosis; mandatory HIV testing during antenatal care, following a rape charge, and "to solve a matrimonial conflict"; and, most worryingly, the extremely vague offence of "willful transmission" defined as transmission of HIV "through any means by a person with full knowledge of his/her HIV/AIDS status to another person" including via sex, needle-sharing, and mother-to-child transmission. He argued that the phrase "through any means" was imprecise and may end up criminalising all HIV-positive individuals, even those who practise safer sex regardless of disclosure and regardless of the actual risk of transmission.

Criminalising mother-to-child transmission is especially problematic, he said. The UNAIDS policy brief on criminal HIV transmission released this week argues that this is inappropriate because:

- Everyone has the right to have children, including women living with HIV;
- When pregnant women are counselled about the benefits of antiretroviral therapy, almost all agree to being tested and receiving treatment;
- In the rare cases where pregnant women may be reluctant to undergo HIV testing or treatment, it is usually because they fear that their HIV-positive status will become known and they will face violence, discrimination or abandonment;
- Forcing women to undergo antiretroviral treatment in order to avoid criminal prosecution for mother-to-child transmission violates the ethical and legal requirements that medical procedures be performed only with informed consent;
- And often, HIV-positive mothers have no safer options than to breastfeed, because they lack breastmilk substitutes or clean water to prepare formula substitutes.

Concern over the grow towards the criminalis sion or exposure was

Do women really need these laws?

These new laws have arrived under the guise of protecting women – who have few legal or human rights in many African nations – noted Michaela Clayton of the AIDS & Rights Alliance for Southern Africa (ARASA), but, "is this what women really want?" she asked.

She said that 61% of HIV-positive individuals in sub-Saharan Africa are women and that women are the often the first person in a couple to know their HIV status due to antenatal screening.

Women, she said, are then often blamed for "bringing HIV home" and consequently often feel unable to disclose their HIV status to their male partners due to a very real fear of physical harm and eviction. In addition, due to power imbalances within relationships most women are unable to practise safer sex, since condoms are a male-controlled prevention method.

Under these laws, she said, it seemed likely that women as well as men will be arrested and prosecuted and suggested

Spreading Around The World '*LIKE A VIRUS*'

that these laws may deter women from accessing HIV testing and services aimed at preventing mother-to-child transmission of HIV.

"Criminalisation is bad public policy," she concluded. "Jurisdictions should not adopt criminalisation policies and those that have already done so should reverse course." **"Criminalisation creep" in Europe and Central Asia**

The same conclusion was asserted even more forcefully by HIV-positive advocate, Julian Hows, who presented results of an updated scan by the Global Network of People Living with HIV/AIDS (GNP+) and the Terrence Higgins Trust (THT) of criminal HIV exposure and transmission laws in 53 countries in Europe and Central Asia.

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documented.

A 2004 rapid scan, published in 2005, previously revealed that out of the 45 European countries surveyed, in at least 36, the actual or potential transmission of HIV can constitute a criminal offence.

During his presentation, Mr Hows revealed that Sweden, Switzerland and Austria remained at the top of the prosecutions league table, followed by Denmark, Finland, France, Italy, Netherlands, Norway, and the UK.

Only Albania, Bulgaria, Estonia, Luxembourg, and Slovenia had no existing or HIV-specific laws criminalising HIV exposure or transmission, although reliable data were lacking for Greece, Monaco, Portugal, Spain, and Uzbekistan. However, Mr Hows pointed out that data on prosecutions is difficult to obtain in many countries and that the data may "significantly underestimate prosecutions."

He noted that in the United Kingdom although there have 'only' been 16 prosecutions and twelve convictions to date, there have been more than 100 police investigations that did not reach the court, "but which also had devastating effects on individuals, their families and their communities" and suggested that this may also be the case in the other countries that currently prosecute HIV exposure or transmission.

He added that information on the enforced quarantine of HIV-positive individuals perceived to be a threat – such as is the case in Sweden – is also difficult to ascertain.

Since 2004, six countries have enacted or proposed laws that criminalise HIV exposure or transmission, including Albania, Moldova, Montenegro, Kyrgystan, Serbia and Turkey. In addition, Malta, Poland, Kyrgystan and Serbia can now be added to the list of countries that have prosecuted at least one individual for HIV exposure or transmission. One bright spot, noted Mr Hows, is advocacy that has – or may have – a positive impact in four countries.

In Switzerland, the Swiss Federal AIDS Commission's statement regarding the lack of infectiousness of individuals on effective treatment may reverse the trend that has seen ten prosecutions and eight convictions in the past four years. However, last month the highest Swiss court ruled that all people with HIV can be criminally liable for HIV transmission, even if untested.

In the Netherlands, no prosecutions or convictions have taken place since 2005 due to two Dutch Supreme Court rulings in 2005 and 2007 following intense discussion between legislators, lawyers and civil society organisations. However, there has been one prosecution for intentional transmission of HIV by a needle filled with HIV-infected blood.

In the United Kingdom, new guidelines by the Crown Prosecution Service have clarified some of the uncertainties that have surrounded prosecutions for reckless HIV transmission, and given the high threshold of evidence required it seems likely that prosecutions will become increasingly rare – in fact the last three attempts to prosecute reckless HIV transmission in England and Wales have failed.

And, although there has been no change in law, the Ukrainian Network of People Living with HIV/ AIDS has had success in highlighting the unreliablity of phylogenetic testing and have avoided several prosecutions being initiated.

Mr Hows concluded, however, that "there is a slow 'creep' of increasing criminalisation across the countries being studied," and that "laws are being introduced or being made more punitive without any regard or consideration for the evidence."

He noted that "advocacy efforts to decriminalise where possible, mitigate where it is not, and ensure that laws are not introduced where there are none – are mainly noticeable by their absence".

UNAIDS argues only intentional transmission should be prosecuted

In an attempt to counter the growing trend of criminalising HIV exposure and transmission, UNAIDS this week published a new policy brief that strongly argues against all prosecutions for HIV exposure or transmission with the exception of "cases of intentional transmission i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it."

The paper states that, "there are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights."

It argues that alternatives to criminal sanctions should be explored: "Instead of applying criminal law to HIV transmission, governments should expand programmes which have been proven to reduce HIV transmission while protecting the human rights both of people living with HIV and those who are HIV-negative"

Further, UNAIDS suggest that governments "strengthen and enforce laws against rape (inside and outside marriage), and other forms of violence against women and children; improve the efficacy of criminal justice systems in investigating and prosecuting sexual offences against women and children, and support women's equality and economic independence, including through concrete legislation, programmes and services. These are the most effective means by which to protect women and girls from HIV infection and should be given the highest priority."

AIDS may be curable

preventable by 2031, top scientist says

Patients infected with HIV might be able to live symptom free without medicines as aggressive treatment with newer drugs better control the disease.

Aug. 6 (Bloomberg) -- Patients infected with HIV might be able to live symptom free without medicines as aggressive treatment with newer drugs better control the disease, the head of U.S. infectious disease research said today.

While research on a vaccine continues, early treatment with the current AIDS drugs also could prevent some people from getting infected, Anthony Fauci, director of the National Institute of Allergy and Infectious Disease in Bethesda, Maryland, said at the International AIDS Conference in Mexico City. Scientists should conduct more studies to assess that theory, he said.

Current drugs reduce the amount of the virus in the body to undetectable levels, making HIV a treatable disease similar to diabetes or arthritis, Fauci said. Still, only one person is getting the drugs for every three people infected, he said. There were 2.7 million new infections in 2007, according to a July report by UNAIDS, and an estimated 33 people worldwide have HIV, the virus that causes AIDS. “A cure will likely require early diagnosis and treatment,” Fauci said. “Studies need to be done in next few years to determine if very aggressive therapy early on will allow us to get a functional cure.”

Treating patients soon after they are infected may protect the immune system and suppress the virus so patients can slowly stop taking the drugs, Fauci said. Merck & Co.’s Isentress and other new classes of drugs may help do this, he added.

Timing Essential

“I believe we will be able to, in some patients, not very many, eradicate HIV microbiologically and we will have a functional cure in others,” Fauci said. “But this will likely require aggressive drug regimens and rely on the timing of initiating therapy.”

A vaccine targeted at people with a specific genetic makeup may also be possible in the next two decades though two vaccine experiments failed, Fauci said. Merck ended development of its experimental AIDS vaccine last year after trials showed it was ineffective. The U.S. government in July said it had stopped a test of its vaccine, which was similar to Merck’s product.

Some medicines already can be taken immediately following exposure to prevent infection in infants. Boehringer Ingelheim GmbH’s nevirapine, in combination with other drugs, can reduce the risk of transmission from 30 percent to less than 2 percent between HIV-positive mothers and their infants.

AIDS treatments made by Gilead Sciences Inc. will be tested in healthy people to see if they can prevent the lethal disease, according to the AIDS Vaccine Advocacy Coalition, a New York- based group that promotes prevention. Pfizer Inc.’s Selzentry is being studied as a topical cream to prevent transmission.

Industry Support

Continued investment from the pharmaceutical industry, something that may be waning, is needed to develop the current drugs as preventative treatments, said Peter Piot, executive director of UNAIDS in a speech today in Mexico City. By 2031, most patents on existing drugs will have expired, cutting into company profits.

“We have to make sure the drug development remains in step with the evolution of the virus and that industry continues to invest,” Piot said. “There are worrying signs that that isn’t the case and that is something we have to put on the table.”

More effective prevention methods that target men who have sex with men, sex workers and drug users also are necessary to reduce infection rates, Piot said. Health officials must communicate prevention messages more effectively, he said.

“No company will try to sell soap if they haven’t done research for the community they are trying to sell to,” Piot said. “It would pay off if we could bring that experience from the business world to our amateur approaches.”

Raltegravir

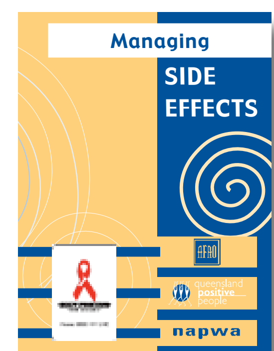
in first-line treatment

Raltegravir (Isentress) is as powerful as efavirenz (Sustiva) when used in first-line HIV treatment in combination with FTC and tenofovir (Truvada), results of a two-year study presented to the International AIDS conference show. One advantage of raltegravir over efavirenz was that it caused fewer side-effects.

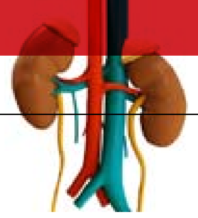
At the moment, the integrase inhibitor raltegravir is only approved for use by people who have taken HIV treatment before, in both Europe and the US. Researchers wanted to see how safe and effective the drug was in people starting HIV treatment for the first time.

The latest research shows that identical numbers of patients (83% vs 84%) taking raltegravir and efavirenz (the current leading first-line drug) had an undetectable viral load after 96 weeks. Increases in CD4 cell count were also very similar. But fewer patients taking raltegravir reported side-effects (51% vs 74%).

Managing Side Effects



A new publication licensed to Body Positive from the Australian Federation of AIDS organisations dealing with side effects and how to manage them is now available free of charge. For your copy, phone Body Positive 0800 HIV LINE



Tenofovir kidney toxicity
most likely with high blood pressure medications and PIs

Kidney toxicity is most likely to occur in patients taking tenofovir if they are controlling high blood pressure with potentially kidney-toxic drugs, and also taking protease inhibitors, delegates at the XVII International AIDS Conference heard on Wednesday.

Tenofovir (Viread) is a widely-used antiretroviral and a preferred component of first-line regimens whose safety has been generally well-established. However, it is known to cause relatively rare but potentially serious kidney toxicity, including acute renal failure and Fanconi's syndrome, in some patients. Previous studies have investigated some risks for developing toxicity, including high blood pressure, diabetes, and ritonavir use.

During an oral session on Wednesday morning, Chelsea Castellano of Duke University Medical Center presented findings from a carefully designed, NIH-funded case-control study which aimed to estimate the frequency of kidney toxicity in HIV-positive patients taking tenofovir, and to find factors which predicted its occurrence. There was no pharmaceutical sponsorship.

Nephrotoxicity (kidney toxicity) was defined as: a decrease in glomerular filtration rate (GFR) of more than 50% (as per "RIFLE" criteria, a standard accepted definition), or an absolute decrease in creatinine clearance (CrCl) of ≥ 25 ml/minute. This additional component of the definition was added, Castellano stated, to capture kidney function declines in people with good creatinine clearance at baseline. (Questioned about this later, she added that most of the identified cases of toxicity – 29 out of 35 – fit the standard definition. An additional six were identified purely due to the absolute CrCl decrease of ≥ 25 ml/minute.)

The study group in this investigation was drawn from 1574 patients seen at the HIV clinic of North Carolina's Duke University Medical Center between October 2001 (when tenofovir was approved by the US FDA) and August 2007.

From this group, records were selected for all patients who had received tenofovir for at least three months, and for whom serum creatinine levels had been recorded one year prior to starting the drug. This resulted in a study group of 744 patients. From the remaining 830 clinic patients, 191 (who had been on a non-tenofovir-containing regimen for ≥ one year) were randomly selected as controls for comparison.

Of these 744 patients, 56 cases of tenofovir-associated nephrotoxicity were identified. These were compared to 74 controls, randomly selected from tenofovir recipients who had had no significant change in serum creatinine levels. Demographically, the two groups were both similar to the overall clinic population, which was: 71% male, 55% African-American, 37% Caucasian, 37% on private insurance, and 35% on Medicaid or Medicare. Duration of HIV infection was not presented, but was "not different between the groups." Twenty percent of the control group had a history of opportunistic infections (OIs) (a slightly lower incidence than the overall clinic population).

Information was also available on a wide range of other clinical factors, co-morbidities including hypertension, hyperlipidemia, diabetes, smoking, hepatitis B or hepatitis C infection, and concomitant and potentially kidney-toxic medications including NSAIDs, foscarnet, amphotericin, ACE inhibitors and others.

What predicted kidney toxicity?

Overall, kidney toxicity occurred nearly twice as frequently in patients on tenofovir than in the control group: 35/744 (7.5%) versus 8/191 (4.2%), with a borderline statistical significance (p=.052).

Two new NNRTIs
look promising in early clinical trials

Two new non-nucleoside reverse transcriptase inhibitors (NNRTIs) have demonstrated good antiviral efficacy and favourable safety profiles in seven-day monotherapy trials, according to late-breaker presentations Thursday at the XVII International AIDS Conference in Mexico City.

RDEA806

In the first study, Graeme Moyle of Chelsea and Westminster Hospital and colleagues compared the novel NNRTI RDEA806 to placebo in treatment-naive HIV positive patients.

IDX899

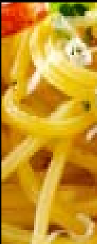
In the second study, Carlos Zala from Buenos Aires and colleagues compared the second generation NNRTI IDX899 to placebo in treatment-naive HIV-positive individuals.

Like RDEA806, IDX899 showed activity in preclinical testing against both wild-type HIV and strains with NNRTI-resistance mutations, and the drug demonstrated a high barrier to resistance. IDX899 also exhibited favourable safety and pharmacokinetic parameters in healthy HIV-negative volunteers.

Brief

Staying Alive Group

A group for those who want to maximise their health. Main pitfalls to watch out for, how to eat well, to prevent heart disease, diabetes, cancer, exercise–keeping fit, build up your immune system, understanding your blood results. What test should I get to stay healthy and fend off complications. This group is hands on and will look at your diet, your blood results and your fitness regimen. Phone for details.



Straight Arrows

Monthly Straight Arrows dinners for heterosexual members are being held at Body Positive House on the last Thursday of every month. The dinners are a good chance to mix and mingle and we would love to see you. Call us at BP on 0800 HIV LINE or Positive Women 09-309 1858 if you would like to come along.

Monthly Luncheon

Every 2nd Wednesday of the month – Dinner, 7pm

Every 4th Wednesday of the month – Lunch, 12pm

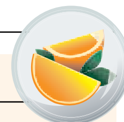
Here at Body Positive House

1/3 Poynton Terrace, Newton, Auckland.

TRAVEL INSURANCE

Buy your Travel insurance from ***Mike Henry*** Agent Body Positive, whether you are Positive or Negative, travelling to Sydney or the Seychelles just call 0800 HIV LINE for a travel insurance quote. (When you buy from us you help support our work + you get a good deal!)

VITAMINS



Body Positive has fantastic *Swisse brand vitamins* available to members for only $10.00! (Usually over $20) *Swisse Women's Ultivite Multi vitamins* & *Swisse Men's Ultivite Multi vitamins*. Both with the highest quality ingredients that will give you a kick! Drop by BP House or call **0800 HIV LINE**

RECYCLED MEDICATION

If you have unused medication or no longer need left over medication, please either return your unused medication to your prescribing physician or send it to us at:

Body Positive Inc
P.O. Box 68-766
Newton, Auckland

We will pass it on to physicians.

6 ON 6

The next *6 on 6 support Group* is due to start Monday, 19th Jan 2009 at Body Positive House. This facilitated peer support group is for anyone who has issues around their HIV status. It is particularly useful to the recently diagnosed and is open to men and women.

Phone **0800 HIV LINE** to join the group.

FOOT DOCTOR

Announcing a new service: ***A FOOT DOCTOR***

Yes, a real podiatrist will run a clinic here at Body Positive on a monthly basis. Next clinic date - 16th Sept 2008 (Tues) from 1pm-5pm

Phone now for an appointment 09-309 3989

Fee: $40.00 per consultation
WINZ Benefit by negotiation

MASSAGE

Both Swedish (Therapeudic) and Sports massage are available FREE at Body Positive on Wednesdays and Thursday. Phone 09-309 3989 and book an hour to pamper your body.

* *Koha appreciated*

QUIT SMOKING

Apart from adhering to your medication regime, quitting smoking is the next most significant improvement HIV+ people can take to improve their health and life expectancy. Smoking increases the risk of brain, heart and lung diseases, various cancers and opportunistic infections. If you would like to quit smoking, we can help. Phone 0800 HIV LINE.

HIV RAPID TEST for our whanau & friends

The 60-second HIV Rapid Test is now available at Body Positive House. A simple pin-prick is done, to test the blood with a 99.7% accuracy. It's always better to know your status early, so you can keep healthy, if you become HIV positive. Call **0800 HIV LINE** to book a *FREE no-hassle Rapid Test*.

This publication "Positively Positive" is sponsored by J.R. McKenzie Trust