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ARV4IDUs

ANTIRETROVIRAL TREATMENT FOR INJECTING DRUG USERS: A QUARTERLY BULLETIN

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Antiretroviral Tretment for Injecting Drug Users: A quarterly bulletin

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ARVs4IDUs is a not-for-profit community publication that aims to provide a review of the most important medical advances related to clinical management of HIV and its related conditions for injecting drug users, as well as access to treatments. Comments to articles are compiled from consultant, author and editorial responses.

We thank those organisations for recognising the importance of providing widely distributed free access to information both to people living with HIV and to the healthcare professionals involved in their care.

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EDITORIAL

Welcome to the third issue of ARV4IDUs….

We'd also like to encourage new writers who would like to contribute to future issues. This can include research reports and overview articles. If you would like to contribute to future issues or have news to include, please email:

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CONFERENCE REPORTS

IDUs access to HIV/AIDS treatment and care in Central and Eastern Europe

On November 24-25 2007, the European AIDS Treatment Group (EATG) in partnership with the Eurasian Harm Reduction Network (EHRN - formerly CEEHRN) held a seminar in Vilnius, Lithuania, entitled Access to HIV treatment drugs for injecting drug users (IDUs) in Central and Eastern Europe. The seminar was organised within the framework of the ""AIDS Action & Integration", led by AIDES and funded by the European Commission (DG SANCO).

The Action and Integration project is designed to promote the development of local, community based actions on HIV/AIDS in Central and Eastern Europe.

The November seminar targeted primarily people directly involved in the provision of HIV treatment and care to injecting drug users (IDUs) such as NGOs, activists, representatives of the drug users'community, and people living with HIV/AIDS from the new Member States and accession countries of the European Union. The purpose was to share experience and learn more about delivering treatment to IDUs. Targeting IDUs in Central and Eastern Europe is based on evidence that injecting drug use represents one of the major transmission routes of HIV in the region.

Today, the question of HIV care for IDUs in the Region is less a matter of financial resources than one of delivery.

Scientific evidence demonstrates that treatment outcomes for IDUs can be as good as the outcomes for other patients if appropriate services are provided.

The seminar gave East and Central European participants the opportunity to exchange best practices in the region and neighbouring Europe in order to overcome barriers faced by IDUs with HIV.

Other relevant issues were pointed out to raise awareness on the importance of integrating adequate TB and Hepatitis care as well as the provision of substitution therapy services with antiretroviral therapy (ART) services.

Eastern Europe is the home of 1.6 million people living with HIV (PLWH) and up to 2.8 million injecting drug users (IDUs). The region suffers from a heterogeneous dynamic. In the Czech Republic, Hungary, Slovakia and Slovenia, the predominant mode of transmission is sexual (heterosexual) intercourse even though there have been increases in the number of new cases reported among men who have sex with men. In Romania, most HIV infections took place among children who are now adolescents and young adults and recently HIV cases are reported to be acquired through heterosexual intercourse.

In Eastern Europe and Central Asia, the predominant transmission route for HIV infection is the sharing of injecting equipment. However, there is evidence of increasing heterosexual transmission. 64-85% of cumulative registered HIV cases with known transmission routes in Azerbaijan, Belarus, Estonia, Latvia, Lithuania, Moldova, Russia and Ukraine occurred among IDUs.

These figures suffice to demonstrate that harm reduction measures targeting IDUs need to be scaled-up in the region. There is also a need to improve both access to and the quality of health and social services (based on a non-discriminatory approach).

A number of studies were carried out to monitor current access to services including antiretroviral therapy (ART). The European and Central Asian governments signed the Dublin Declaration and thus committed themselves to eliminate inequality in treatment provision and to ensure equal universal access to ART for all people in need by 2005. It is worrying to observe that the region is far behind schedule.

Central European countries, like Western European countries, report good access to ART (defined as 75% and higher treatment coverage of the estimated number of people in need of ART) in 2004.

Eastern Europe and Central Asia have the second lowest coverage of antiretroviral therapy in the world. However, the region has seen significant increases in funding available for access to ART and significant expansion of access to ART within the last few years.

Despite this progress, access to ART for IDUs remains disproportionately low in the region overall.

Russia and Ukraine, where most of HIV-positive IDUs live, show low coverage and are rolling out antiretroviral therapy programmes, with ambitious plans to provide therapy to 60% (inRussia) and 55% (in Ukraine) of people in need by 2008.

The Baltic countries with fast developing upper-middle income economies, relatively small populations and with injecting drug use-driven HIV epidemics continue to experience problems with delivery of ART to IDUs.

A number of social and physical barriers are still in place. The impact of stigma cannot be underestimated. IDUs living with HIV face dual stigma associated with both injecting drug use and positive HIV status.

Low levels of knowledge about ART and misconceptions about treatment for IDUs is also one of the key barriers to treatment. In particular, the knowledge of ART needs to be improved in low prevalence countries. Myths or incomplete information about side effects, interactions with illicit drugs and interactions with opioid substitution treatment (OST) often discourage treatment uptake.

Patient's education is thus recognized as a key facilitator of treatment adherence. Some interesting programmes for patient's education have been piloted such as "patient schools" but are often challenged to find sustainable funding. Adequate education of health care staff is essential in order to improve access to treatment and care for IDUs.

CONFERENCE REPORTS

15th Conference on Retroviruses and Opportunistic Infections

Boston, 2-6 February 2008

Introduction

This annual conference is one of the most important scientific meetings. Abstracts for the meeting are online as soon as the conference opens, and many of the most important oral abstract sessions and overview sessions are posted as webcasts within a day or so. We encourage readers to go directly to the source for many of these sessions.

www.retroconference.org

A non-technical summary of general news from the conference, covering 25 studies and presentations in 12 key areas, is available from the i-Base website.

www.i-Base.info

While there were few studies relating to ARV4IDUs several studies on coinfection were interesting:

- MELD score predictive of pre-transplant mortality in HIV/HCV coinfected patients
- Does abacavir decrease SVR rates with HCV treatment?
- No effect of interferon maintenance therapy on fibrosis progression in non-responders

MELD score predictive of pre-transplant mortality in HCV coinfected patients

Simon Collins, HIV i-Base

Aruna Subramanian form Johns Hopkins University looked at determining incidence, cause, and time to pre-transplant mortality in transplant candidates compared to HIV-negative patients in a prospective cohort study at 20 US sites, with particular reference to the MELD score.

The MELD score (Model for End Stage Lover Disease) incorporates creatinine, bilirubin and INR checked at the same visit and is validated as predictor of mortality in HIV-negative patients. It is used as a basis for organ allocation so that sick patients get earlier access to transplant.

Patient in this study needed to fulfill local criteria to be included on a transplant list, with CD4 count n >100 cells/mm3 within 16 weeks of transplant (>200 if a recent OI) and to have undetectable viral load (except for ARV-related hepatotoxicity and a resistance profile that indicated HIV suppression post transplant would be likely. Clinical follow-up was at least every three months from joining the list until transplant.

Each case was matched (by age, gender, race, time of listing and HCV coinfection) with up to five controls, and compared by time to death, transplant and reaching MELD >25.

During follow-up the cohort included 167 HIV-positive patients (51% were not transplant, 14% died and 35% received a transplant) and 792 controls (41% not transplanted, 11% died and 48% transplanted).

Median baseline CD4 was lower in patients who died compared to those who received a transplant (median 237 vs 315, p=0.01). There was no difference by percentage with undetectable viral load, use of PI-based treatment or percent with HCV coinfection.

Cause of death pre-transplant were broadly similar in the HIV-positive vs control group, including sepsis (25% vs 20%), multi-organ failure (17% vs 26%), GI haemorrhage (13% vs 6%), other causes (29% vs 27%) and unknown (17% vs 20%).

Comparative time to death was similar in cases and controls, as was time to transplantation and to elevated MELD >25.

However, in multivariate model MELD showed the strongest risk (HR=21.8 95% CI 6.3, 75.7, p<0.0001) and CD4 count <200 had only borderline significance (HR 2.6, 95%CI 0.98, 6.9, p=0.05). Viral load was not predictive.

The researchers concluded that low CD4 count at time of listing may be predictive of greater risk of death, but that after controlling for CD4 and viral load. MELD had excellent predictive value of pre-transplant mortality and should be used routinely for patients with cirrhosis to help guide decisions for early transplant referral.

The group plans to develop a scoring method that incorporates CD4 count and MELD to predict mortality that could be validated for all patients, not just at transplant listing, and to determine optimum CD4 count for transplantation, and to determine any relationship between MELD score and post-transplant outcomes (which limited data indicate may be poorer in coinfected patients).

An online MELD calculator is available at:

http://www.unos.org/resources/MeldPeldCalculator.asp?index=98

C O M M E N T

These results should not be a surprise as MELD is well validated for assessing liver failure. MELD is used by European and US transplant centers, There are clearly concerns that 'standard' criteria for listing urgency may not apply for HIV-positive patients due to faster risk of progression and re-thinking listing priorities in this group of patients may be important. It is re-assuring that 'standard' MELD criteria still apply.

Ref: Subramanian A et al MELD is the best predictor of pre-transplant mortality in HIV-infected liver transplant candidates. Oral abstract 64. http://www.retroconference.org/2008/Abstracts/31927.htm
This oral presentation is available to view online from the conference website (Monday 4 February).

Does abacavir decrease SVR rates with HCV treatment?

Simon Collins, HIV i-Base

Three studies from Spain reported on the relationship between nucleoside/tide analogues and response to HCV treatment. [1, 2, 3] Last year at CROI, a poster from French researchers reported that abacavir use was significantly associated with poorer outcome to HCV treatment, through a possible intracellular competition between abacavir and ribavirin. [4]

Jose Mira and colleagues from Hospital University de Valme, Seville presented a retrospective analysis comparing HIV/HCV-co-infected patients treated with peg-IFN plus ribavirin, who were taking a NRTI backbone consisting of either abacavir + 3TC or tenofovir + 3TC/FTC. [1]

In an intention-to-treat analysis, sustained virological response (SVR) was seen in 20/70 (29%) individuals receiving abacavir and 83/186 (45%) patients using tenofovir, (p=0.02). NRTI backbone containing TDF was an independent predictor of SVR in the multivariate analysis (adj odds ratio, 95%CI: 2.6; 1.05 to 6.9); p=0.03).

HCV genotype 2 or 3, baseline LDL cholesterol levels ≥100 mg/dL, lower baseline plasma HCV viral load and undetectable baseline HIV viral load also predicted SVR. The association between abacavir use and lower SVR rate was mainly seen in patients with plasma HCV viral load >600,000 IU/mL, HCV genotype 1 or 4 and in patients who received lower doses of ribavirin.

Of patients using a daily dose of ribavirin of less than 13.2 mg/kg, 3 (20%) of those under abacavir vs 22 (52%) under tenofovir achieved SVR (p = 0.03), whereas the rates were 31% and 38% (p = 0.4), respectively, in those receiving RBV dose higher than 13.2 mg/kg.

A second retrospective cohort analysis, from Juan J Gonzalez-Garcia and colleagues from the GESIDA 50/06 Study Group looked all HIV/HCV coinfected patients treated for HCV while on HAART between January 2003 and November 2005 from 35 sites. [2]

Patients were categorised in 2 groups: tenofovir, used with 3TC or FTC (n = 238); and non-tenofovir (n = 481) that included patients using AZT + 3TC (n =265), d4T + 3TC (n = 164), or abacavir + 3TC (n =52). They excluded patients receiving ddI or tenofovir with AZT/d4T or abacavir from the analysis.

The two groups were well matched in baseline characteristics except for a lower CD4 cell count mean (535 vs 601; p=0.003), exposure to more HAART regimens (7.2 vs 5.7; p <0.001), and a higher mean GOT/GPT quotient (0.84 vs 0.77; p=0.04). Safety analysis revealed no differences between the groups in relation to death, hepatic decompensation and interruption of HCV treatment due to side effects.

Ribavirin dose-reductions were more frequent in non-tenofovir treated patients (12.8 vs 19.5%; p=0.03), particularly in patients treated with AZT (23.2%; p = 0.003). No significant differences were found in the SVR among patients in the tenofovir and non-tenofovir groups, by ITT analysis (45% vs 39%; p= 0.12).

In a multivariate analysis, adjusting for HCV genotype, HCV viral load <500,000 IU/mL, baseline HIV viral load <50 copies/mL, GOT/GPT quotient, and alcohol intake >50 g/day, SVR was positively associated with use of tenofovir (OR 1.70 95%CI 1.05 to 2.77, p=0.03) and negatively associated with use of AZT (OR 0.60, 95%CI 0.37 to 0.99, p=0.05), detailed in the Table 1.

Table 1: Odds ratios of SVR by nucleoside backbone

NRTI use	OR of SVR	95%CI	p
TDF+3TC or FTC	1.70	(1.05 to 2.77)	0.03
AZT+3TC *	0.60	(0.37 to 0.99)	0.05
d4T+3TC	1.09	(0.65 to 1.82)	0.73
ABC+3TC	0.80	(0.32 to 2.08)	0.68

*including patients with AZT+3TC+ABC

The study concluded that the use of TDF + 3TC/FTC was associated with an improved response to peg-IFN plus ribavirin, and that, as shown in previous studies, AZT is associated with a worse tolerability and effectiveness.

In the third study, Ana Moreno and colleagues from Hospital Ramon y Cajal, Madrid looked at use of abacavir or tenofovir in 174 HIV/HCV coinfected patients starting their first cycle of peg-IFN plus weight-adjusted ribavirin. Approximately half the patients used Pegysys and half used PegIntron [3]

Most subjects were male (76%), prior intravenous drug users (87%), with a median age of 40 years (28 to 63). The median duration of HCV infection was 21 years, and 102 (59%) had HCV-genotype 1 or 4. 82% were on HAART (49% PI, 32% NNRTI, and 18% triple-nuke). Tenofovir was used in 69 (48%), abacavir in 56 (39%), with 25 (18%) patients using a triple-nucleoside regimen. The mean ribavirin dosage was 14.7±2.4 mg/kg/day.

Baseline CD4 count, and HCV viral load were 513 cells/mm3 and 5.8 log IU/mL respectively, and two-thirds patients entered the study with undetectable HIV viral load.

SVR was reported in 79/174 (45%) patients. After each adjusted regression analysis however, neither abacavir (p = 0.59), tenofovir (p = 0.92), nor triple NRTI use (p = 0.12) had any significant effect on SVR.

By multivariate analysis, HCV genotype 1 or 4 (OR 7.8, 95%CI 2.6 to 22.93, p = 0.0001), and higher baseline HCV RNA levels (OR 3.5, 95%CI 1.7 to 7.3, p = 0.001) or fibrosis scoring (OR 1.7, 95%CI 1.2 to 2.6, p=0.003) remained independently associated with failure to achieve SVR.

The researchers concluded that in their cohort, use of abacavir, tenofovir or triple nucleosides significantly influenced the rate of SVR in patients receiving peg-IFN + weight-adjusted-RBV.

C O M M E N T

The first study from Mira et al. is a merger of data from Madrid and Seville. The data from Madrid were already presented at IAS and AASLD 2007 with similar findings. The study from Moreno et al. is considerably smaller which may explain the negative finding for abacavir. The GESINA cohort took a different route by including abacavir in the group of AZT, ddI and d4T – all of which are known to have toxicities limiting treatment efficacy in coinfected patients.

In summary, these data are no surprise and do not tell us much about abacavir.

References:

1. Mira J, et al. Efficacy of pegylated interferon + ribavirin treatment in HIV/HCV-co-infected patients receiving abacavir + lamivudine or tenofovir + either lamivudine or emtricitabine as nucleoside analogue Backbone.15th CROI, Boston 2008. Abstract 1074.
http://www.retroconference.org/2008/Abstracts/30917.htm

2. Gonzalez-Garcia J, et al. The use of TDF+ 3TC/ FTC is associated with an improved response to pegylated interferon + ribavirin in HIV/HCV-co-infected patients receiving HAART: the Gesida 50/06 study. 15th CROI, Boston 2008. Abstract 1076.
http://www.retroconference.org/2008/Abstracts/32077.htm

3. Moreno A, et al. Does the choice of NRTI have a significant influence on the outcome of peg-IFN plus Ribavirin among HIV/HCV-co-infected Patients? 15th CROI, Boston 2008. Abstract 1075.
http://www.retroconference.org/2008/Abstracts/32710.htm

4. Bani-Sadr F et al. Factors associated with virological non-response to peg-interferon + ribavirin therapy in HIV/HCV co-infected patients: the role of abacavir. 14th CROI, Los Angeles, 2007. Abstract 897.
http://www.retroconference.org/2007/Abstracts/28572.htm

No effect of interferon maintenance therapy on fibrosis progression in non-responders

Simon Collins, HIV i-Base

One aspect of HCV management that is informed by little data, is whether continued treatment of virologic non-responders with maintenance peg-IFN therapy can reduce the rate of clinical HCV progression.

This question was addressed in a study presented by Kenneth Sherman and colleagues in a multicentred US study that treated a mixed group of 329 patients (68% naïve and 32% refractory to previous treatment) with peg-IFN-alpha-2a plus weight-based ribavirin for 12-18 weeks. Median age was 48 years; 83% male; 43% white, 37% black, non-Hispanic and 15% Hispanic; baseline median HCV viral load was 6.6 log IU; CD4 was 498 cells/mm3; 74% had HIV RNA <50 copies/mL.

Early virologic response (EVR) was defined as achieving undetectable HCV viral load (<600 IU) or 2-log drop at week 12. Patients without an EVR received biopsy and were randomised to peg-IFN 180ug alone or observation for 72 weeks.

Liver biopsy obtained at start and end of therapy were blinded and read by a single pathologist. The study design required 134 subjects to show whether maintenance treatment produced 0.18 unit/year reduction in the rate of Metavir fibrosis progression.

EVR was observed in 55.6% patients (95%CI 50 to 61%; ITT analysis) and was strongly associated with expected factors (gender, race, degree of fibrosis, AST, absolute neutrophil and heamoglobin levels.

86 patients without EVR were then randomised to peg-IFN vs observation. Median entry Metavir score was 2; 28% had advanced fibrosis (F3, F4).

However, lack of fibrosis progression in both groups, lead to DSMB-recommended early closure of the study, when 62 patients had completed 72 weeks of follow-up, only 45 of who had paired biopsy results for this analysis (24 in the IFN, 21 in observation arm).

Compared to the expected rate of 0.18 units/year, median fibrosis change was 0.0 (Q1,Q3: 0.0, 0.69) in the maintenance groups and 0.0 units/year (Q1,Q3: –0.69, 0.61) in the control group.

The authors concluded that in contrast to recent reports, this randomised controlled trial failed to identify significant change in hepatic fibrosis among untreated non-early virologic responses over 72 weeks. They also commented that weight-based ribavirin achieved higher levels of EVR (55.6% vs. 41%) than the ACTG 5071 study which used lower doses of ribavirin and that race (Causaian>Hispanic>Black) appears to be an important independent factor in early virologic response.

C O M M E N T

Right from the early registrations studies for interferon and ribavirin investigators had noted a slight reduction in hepatic fibrosis scores in patients who did not have a virological response to therapy. A question that had been asked was does this therapy have an anti-fibrotic effect over and above its anti-viral effect?

This phenomenon was recently explored in the HALT-C study (AASLD 2007, De Bisceglie et al), where HCV mono-infected patients with Child-Pugh A cirrhosis and previous non-response, were randomised to continue pegIFN-alpha 2a at half-dose (90mg) or placebo over 3.5 years. The end-points were death, de-compensation, HCC or an increase in fibrosis by two points. The results, presented by the authors at AASLD, suggested that for all individual end-points, there was no significant difference between the pegIFN arm and the placebo arm, thus suggesting that in clinical terms, pegIFN maintenance therapy did not prevent progression in cirrhotic patients.

This study, also called the SLAM-C study, included HIV/HCV co-infected patients, 15% of whom had cirrhosis. After a lead in period of treatment with pegIFN and weight-based ribavirin, patients with no EVR were randomised to maintenance therapy with pegIFN 180mcgs/ week or no therapy. Liver biopsies were evaluated after 72 weeks. There was no fibrosis progression in either arm. However, there was a greater reduction in inflammatory scores in patients on pegIFN arm. Clearly this begs the question of whether maintenance therapy will help reduce fibrosis progression in non-virological responders. From this study, evidently not, although these were small numbers, therapy and follow-up was only for 72 weeks and that these patients had good CD4 counts and well-controlled HIV disease, and were therefore likely to have slow progression of HCV related fibrosis.

Taking HALT-C and SLAM-C results into account, current evidence does not support pegIFN maintenance in patients with no virological response.

Ref: Sherman K, et al. Sustained Long-term Antiviral Maintenance with Pegylated Interferon in HCV/HIV-co-infected Patients: Early Viral Response and Effect on Fibrosis in Treated and Control Subjects.15th CROI, Boston 2008. Abstract 59.
http://www.retroconference.org/2008/Abstracts/31871.htm

ORIGINAL ARTICLES

HIV and HCV research and drug users

Tracy Swan, Treatment Action Group

HIV and hepatitis C are prevalent among current and former injection drug users (IDUs). For years, activists have been protesting the exclusion of people who use drugs from clinical trials of novel agents for HIV and hepatitis C. Excluding high prevalence populations from all research of new treatments is unacceptable, unless there is a compelling safety reason to do so.

Recently, exclusion criteria have become slightly less restrictive in some cases, leaving the investigator holding the bag, as it were. He or she is empowered to decide whether a person's drug and/or alcohol use, dependence or abuse will interfere with the ability to participate in a trial—or if it could endanger study volunteers.

In theory, this is progress, but in practice, the impact is limited. Concerns about adherence and drug-drug interactions need to be addressed. Regular attendance at clinic visits may be a good indicator for the ability to participate in a clinical trial, rather than whether or not a person is using drugs and/or alcohol. Drug and alcohol use, dependence and abuse are not the same, and should be assessed with validated, easy-to-use tools such as the AUDIT-C. It may be possible to identify drug-drug interactions by in vitro studies—and if not, a safe way to gather this information must be determined.

Some drug-and alcohol-related exclusion criteria have become gospel, although the information they are based on may be limited or outdated. These have rendered drug and alcohol users ineligible for approved treatments and interventions, as well as clinical trials. Here are two examples:

- Early HCV treatment trials, using interferon monotherapy, reported poorer outcomes among people who drank before or during HCV treatment versus non-drinkers. [1, 2, 3] Hence, many doctors are unwilling to treat drinkers for hepatitis C, despite newer information, and more effective HCV treatment. Two recent studies, which used interferon plus ribiavirin), reported that people who drank prior to, or during HCV treatment responded as well as non-drinkers. [4, 5]
- Although recent alcohol and/or drug use is considered a "relative" contraindication for liver transplantation in the United States, candidates with a history of substance abuse must be abstinent for six months before they are put on the waiting list. [6] This delay may be fatal for some people ,since the chronic shortage of donor organs may mean a long wait. However, a recent study did not find any difference in survival of liver transplant recipients who resumed substance use versus those who remained abstinent after transplantation. [7]

HIV and hepatitis C trials for people who use drugs

The following listing of studies that are currently recruiting-or soon to open is compiled from:
http://clinicaltrials.gov

Unless listed under "international", these trials are in the United States.
Listing these trials is not an endorsement or comment on either the research or trial design.

International

Adolescent Drug and HIV Prevention in South Africa
http://clinicaltrials.gov/ct2/show/NCT00336180

Methadone Maintenance & HIV Risk in Ukraine
http://clinicaltrials.gov/ct2/show/NCT00351026

Naltrexone and Adrenergic Agents to Reduce Heroin Use in Heroin Addicts
http://clinicaltrials.gov/ct2/show/NCT00142948

Project HERMITAGE: HIV Prevention in Hospitalized Russian Drinkers
http://clinicaltrials.gov/ct2/show/NCT00483483

Addiction Treatment in Russia: Oral vs. Naltrexone Implant
http://clinicaltrials.gov/ct2/show/NCT00218426

Hepatitis C Among Opioid addicts in Opioid maintenance Treatment in Zurich, Switzerland (HepCOP)
http://clinicaltrials.gov/ct2/show/NCT00473993

Prisoners

Prison Buprenorphine
http://clinicaltrials.gov/ct2/show/NCT00574067

Effectiveness of Opiate Replacement Therapy Administered Prior to Release From a Correctional Facility - 1
http://clinicaltrials.gov/ct2/show/NCT00142935

Buprenorphine Maintenance for Opioid-Addicted Persons in Jail and Post-Release (males only)
http://clinicaltrials.gov/ct2/show/NCT00367302

Hepatitis C (HIV status not specified unless noted)
Psychoeducation for Hepatitis and Alcohol Behaviors
http://clinicaltrials.gov/ct2/show/NCT00598416

A Video-Based HCV Curriculum for Drug Users
http://clinicaltrials.gov/ct2/show/NCT00241917

Improving Hepatitis C Treatment in Injection Drug Users
http://clinicaltrials.gov/ct2/show/NCT00148031

Study of the Effects of Motivational Enhancement Therapy on Alcohol Use in Chronic Hepatitis C Patients
http://clinicaltrials.gov/ct2/show/NCT00596960

Treatment of Acute Hepatitis C Virus Infection With Pegylated Interferon in Injection Drug Users (for HIV-negative people only)
http://clinicaltrials.gov/ct2/show/NCT00194480

Prevention/Drug Treatment (HIV status not specified unless noted)

Computer-Assisted HIV Prevention for Young Drug Users
http://clinicaltrials.gov/ct2/show/NCT00182585

Treatment of Heroin and Cocaine With Methadone Maintenance and Contingency Management Users
http://clinicaltrials.gov/ct2/show/NCT00292110

Drug Treatment Combined With Drug and Risk Reduction Counseling in the Prevention of HIV Infection Among Injection Drug Users (HIV negative)
http://clinicaltrials.gov/ct2/show/NCT00270257

HIV Positive Women

Brief Therapy Intervention for Heavy/Hazardous Drinking in HIV-Positive Women
http://clinicaltrials.gov/ct2/show/NCT00127231

HIV Positive or At-Risk Men	HIV-Positive: Women and Men
Mirtazapine to Reduce Methamphetamine Use Among MSM With High-Risk HIV Behaviors http://clinicaltrials.gov/ct2/show/NCT00497081	Comparison of HIV Clinic-Based Treatment With Buprenorphine Versus Referred Care in Heroin-Dependent Participants http://clinicaltrials.gov/ct2/show/NCT00130819
Aripiprazole Treatment for Methamphetamine Dependence Among High-Risk MSM http://clinicaltrials.gov/ct2/show/NCT00497055	Buprenorphine and Integrated HIV Care Evaluation http://clinicaltrials.gov/ct2/show/NCT00124358
Acceptability of Pharmacologic Treatment for Methamphetamine Dependence Among MSM http://clinicaltrials.gov/ct2/show/NCT00318409	Directly Administered HIV Therapy in Methadone Clinics http://clinicaltrials.gov/ct2/show/NCT00279110
Behavior Change and Maintenance Intervention for HIV+ MSM Methamphetamine Users http://clinicaltrials.gov/ct2/show/NCT00432926	Skills Based Counseling for Adherence and Depression in HIV+ Methadone Patients - 1 http://clinicaltrials.gov/ct2/show/NCT00218634
12 Week Group Therapy Intervention for HIV+ Methamphetamine Users and Deliver It Within an HIV/AIDS Primary Care Setting. http://clinicaltrials.gov/ct2/show/NCT00249678	The Effects of Nutritional Supplementation and Drug Abuse on HIV http://clinicaltrials.gov/ct2/show/NCT00149656
Behavioral Therapy Development for Methamphetamine Abuse http://clinicaltrials.gov/ct2/show/NCT00252434	Pharmacotherapy for HIV+ Stimulant Dependent Individuals http://clinicaltrials.gov/ct2/show/NCT00599573
Addressing Young Men's Substance Use and HIV Risk http://clinicaltrials.gov/ct2/show/NCT00325702	The CORE Buprenorphine Project - An HIV Primary Care Program Demonstration http://clinicaltrials.gov/ct2/show/NCT00227357
	Buprenorphine HIV Care Integration Project http://clinicaltrials.gov/ct2/show/NCT00348868

References

1. Mochida S, Ohnishi K, Matsuo S, Kakihara K, Fujiwara K. Effect of alcohol intake on the efficacy of interferon therapy in patients with chronic hepatitis C as evaluated by multivariate logistic regression analysis. Alcohol Clin Exp Res. 1996 Dec;20(9 Suppl):371A-377A.
2. Ohnishi K, Matsuo S, Matsutani K, et al. Interferon therapy for chronic hepatitis C in habitual drinkers: comparison with chronichepatitis C in infrequent drinkers. Am J Gastroenterol. 1996 Jul;91(7):1374-9.
3. Okazaki T, Yoshihara H, Suzuki K, et al. Efficacy of interferon therapy in patients with chronic hepatitis C. Comparison between non-drinkers and drinkers. Scand J Gastroenterol. 1994 Nov;29(11):1039-43.
4. Anand BS, Currie S, Dieperink E, et al; VA-HCV-001 Study Group. Alcohol use and treatment of hepatitis C virus: results of a national multicenter study. Gastroenterology. 2006 May;130(6):1607-16.
5. Schaefer M, Schmidt F, Folwaczny C, et al. Adherence and mental side effects during hepatitis C treatment with interferon alfa and ribavirin in psychiatric risk groups. Hepatology. 2003 Feb;37(2):443-51.
6. Lucey MR, Brown KA, Everson GT, et.al. Minimal Criteria for Placement of Adults on the Liver Transplant Waiting List: A Report of a National Conference Organized by the American Society of Transplant Physicians and the American Association for the Study of Liver Diseases. Liver Transpl Surg. 1997 Nov;3(6):628-37.
7. Nickels M, Jain A, Sharma R, et al. Polysubstance abuse in liver transplant patients and its impact on survival outcome. Exp Clin Transplant. 2007 Dec;5(2):680-5.

Russia: drug dependence treatment system impedes human right to health

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In the last few years, Russia has made some progress toward ensuring access to antiretroviral drugs for those in need. Even in a place like Kuznetsk, a remote and dilapidated town several hundred miles south-west of Moscow, an increasing number of people living with HIV is starting treatment. These people include injection drug users who, until recently, were routinely told that they were not deserving of ART or even specifically excluded from ARV programs. Yet, Russian injection drug users by no means have equitable access to ARV. As Larisa Badrieva and Konstantin Lyazhentsev point out in an article in the last edition of ARV4IDU, many barriers to access persist, with the lack of maintenance treatment chief among them.

Earlier this year, Human Rights Watch conducted research in three Russian regions to take a closer look at the drug dependence treatment system. We found that the vast majority of drug dependent people in Russia do not have access to evidence-based medical care to treat their dependence. As a result, many drug users who might otherwise have successfully entered into treatment programs are condemned to a life of continued drug use with its increased risk of HIV infection, other drug-related health conditions, and death by overdose. Undoubtedly, the lack of adequate drug dependence treatment will also result in some drug users dropping out of ARV treatment programs or having difficulty adhering to the treatment regimen.

Illicit drug use is a serious problem in Russia today, with estimates of the numbers of users ranging between 3 and 6 million people. Many of these people—though by no means all—have developed drug dependence, a serious chronic, and often relapsing, disease as a result of prolonged drug use. More than ten percent of injection drug users are living with HIV, and about seventy percent with hepatitis C. As is the case with people affected by other diseases, persons dependent on drugs have a right to medical care for their condition, both under Russian and international law.

Russia has an extensive system of state substance abuse clinics that offer services for alcohol and drug dependence and has, in the past few years, invested considerable funds into the development of rehabilitation centers for people dependent on drugs. Yet, our detailed field studies in Kazan (Republic of Tatarstan), Kaliningrad, and Penza, shows that the services offered at state clinics in Russia are generally of poor quality and not consistent with international best practices in the field of drug dependence treatment. This is due to policy decisions that Russia has made with regard to the provision of medical treatment that restrict the availability and accessibility of drug dependence treatment services, and affect their appropriateness and quality.

While detoxification treatment is widely available throughout Russia, rehabilitation treatment remains unavailable in many parts of the country. Private drug dependence clinics, some of which offer evidence-based rehabilitation treatment, are often unaffordable for drug users. Various obstacles keep drug users away from seeking treatment at state clinics, including the risk of restrictions on civil rights by being registered as a drug user, breaches of confidentiality associated with treatment, and a widespread distrust of drug treatment services that also undermines take-up rates. The treatment offered at detoxification clinics does not follow lessons learned from decades of research on effective drug dependence treatment modalities. On the contrary, policy decisions relating to what drug treatment programs can be offered deliberately ignore the best available medical evidence and recommendations, and as such arbitrarily restrict drug users' access to appropriate health care.

Despite these important failings of the drug dependence treatment system in Russia, healthcare institutions, policy makers, and the Russian public routinely blame drug users for the failure to overcome their drug dependence. In its research, Human Rights Watch was repeatedly told that drug users simply lack the motivation, character, or perseverance to stop using drugs. Various officials are currently advocating new laws and policies that would enable the state to force drug users to undergo treatment. Undoubtedly, some drug users do not want to end their drug habit. But various studies show that almost all drug users in Russia who have used drugs for more than one year have made multiple attempts to stop using, either at healthcare facilities or on their own. Every single one of the around 60 drug users Human Rights Watch interviewed for this report had made at least one attempt to stop, and many had made multiple attempts. A young woman in Kazan expressed exasperation at both the drug treatment system and her own dependence:

I'm not going back there. There's no point, they don't cure you. I would go to the detoxification clinic if they actually helped [me] there. I'm sick and tired of injecting. But I can't do it [withdraw] at home… I would like to live to 30 at least...

—Svetlana S. (a pseudonym), 25 years old

Studies repeatedly demonstrate, however, that, no matter how strong a drug-dependent person's motivation to address his or her drug use, the odds are that he or she will not succeed without access to an evidence-based drug dependence treatment program. Drug dependence is a chronic disease that often relapses, even for drug users who participate in proven treatment programs and are committed to their treatment. For many people affected by the disease, there are biological and psychological reasons why will power does not suffice to overcome the disease—just as people who suffer from depression cannot overcome their condition on will power alone but need medications, therapy, or a combination of the two.

A considerable part of the blame for the drug dependence treatment gap thus lies with the Russian government and Russia's healthcare system, which leave most drug users who wish to stop using drugs or to gain control over their addiction to their own devices in the face of a serious chronic disease. As a result, many drug users who might otherwise have successfully entered into treatment programs are condemned to a life of continued drug use with its increased risk of HIV infection, other drug-related health conditions, and death by overdose. But Russian society also pays a price for the state's failure to provide easily accessible and evidence-based drug dependence treatment services. In other countries, evidence-based treatment of drug users has been shown to lead to considerable savings on drug-use-related law enforcement efforts, incarcerations of drug users, and healthcare costs due to HIV, hepatitis C and other drug-related health conditions.

The right to health, which Russia has explicitly recognized in its constitution and by becoming party to various international human rights conventions, requires states to make healthcare services available for people affected by disease, including by drug dependence. These services must be accessible—without discrimination—for people who need them, and have to be culturally and ethically acceptable, scientifically and medically appropriate, and of good quality. Although the right to health, in recognition of the great variation in resource availability in different countries, is not prescriptive about a specific standard of care that has to be provided, states are obliged to work toward full realization of the right and to progressively improve the care offered. A rights-based health policy also requires states to ensure that policy decisions and choices are objective and evidence-based, directed towards maximizing the right to health of individuals, and not made on criteria that are discriminatory, arbitrary, or have an unjustifiably restrictive or negative impact on the enjoyment of the right to health, in comparison to other available policy options.

Availability of drug dependence treatment is mixed in Russia. While there are narcological clinics in all major towns of Russia, most of these clinics offer only detoxification, which, on its own, does little to help a drug user achieve a lasting remission. State-run rehabilitation or relapse prevention centers, which provide the crucial second phase of drug dependence treatment by helping drug users manage psychological craving for drugs, exist in only 26 of Russia's 86 regions. In some regions commercial or faith-based rehabilitation centers exist, but treatment at the former is often too expensive for drug users while many drug users do not feel comfortable using the latter.

One of the most effective and best-researched drug dependence treatment modalities for opiate dependence known today, methadone or buprenorphine maintenance treatment, is altogether unavailable in Russia. Although dozens of countries have successfully used these medications in the treatment of drug- dependent persons for several decades and the World Health Organization and the United Nations Office on Drugs and Crime have strongly endorsed them, their use is explicitly prohibited by law in Russia. Top

officials in Russia, including in the healthcare sector, oppose their use on the mostly ideological ground that it substitutes one drug for another. The policy decision not to make methadone and buprenorphine available for the treatment of drug-dependent persons, based on factors that ignore medical evidence, can only be described as arbitrary and unreasonable, and as such is a failure of Russia's obligation to fulfill the right to health.

Accessibility of treatment, the second requirement under the right to health, is highly problematic in Russia. Whereas research indicates that drug treatment services should be easily accessible so as to ensure that as many drug users make use of them as possible, in Russia numerous barriers exist that keep drug users away from these services. Most drug users distrust state narcological clinics; they do not believe that the treatment offered is effective, and see the clinic staff as corrupt and uninterested in their recovery. State narcological clinics in the regions we visited have done little to counter this distrust. A central, and easily remedied, obstacle to treatment seeking is the fact that clinics in all three regions tell drug-dependent persons who voluntarily seek help—behavior that states should clearly encourage—that unless they pay for their own treatment, their names will be entered into a database of people considered to be drug dependent—under Russian law, all drug users who seek free treatment at state narcological clinics are placed on this state drug user registry—and that consequently certain restrictions will be imposed on their rights. Other factors that keep drug users away from state narcological clinics are the cost of paid treatment, including out-of-pocket charges for medications patients are supposed to receive for free, the requirement to collect paperwork on various health conditions prior to admission, and poor conditions in the clinics. Most drug users therefore do not believe that the treatment offered is effective, and they see the clinic staff as corrupt and uninterested in their recovery. State narcological clinics in the regions we visited have done little to counter this distrust.

Russia also fails to meet the requirement that treatment services offered be "scientifically and medically appropriate, and of good quality." Decades of research into drug dependence treatment have created a vast body of evidence on the effectiveness of various treatment approaches. These findings have been summarized, among others, in the United Nations Office on Drugs and Crime's "Drug Dependence Treatment Toolkit." Yet, Russia has made little effort to incorporate lessons learned into its drug dependence treatment services.

Research findings, for example, underscore the fundamental importance of beginning psychosocial interventions with patients during the detoxification stage to motivate them to stay in treatment after detoxification is over. However, we found that this hardly happens in Russia's drug dependence clinics. First of all, patients are generally heavily medicated with tranquillizers and antipsychotic medications, even if research shows that this is not necessary for most patients. As a result, patients are often in a reduced state of consciousness, making counseling efforts difficult or even pointless. Secondly, we found that only very limited counseling took place. Most drug users said that a psychologist or peer counselor from a rehabilitation center had talked to them about the possibility of continuing treatment but that that was the extent of psychosocial interventions. Various drug users mentioned extreme boredom while in the detoxification clinic. Patients are also generally not counseled on HIV while in the detoxification clinics, although best practice standards for drug dependence treatment recommend that such counseling take place. Research also demonstrates the high effectiveness of methadone and buprenorphine maintenance programs, which, as mentioned above, are prohibited in Russia.

There is ample evidence that the state drug dependence treatment system in Russia is largely ineffective. In a 2006 survey of almost 1,000 injection drug users in 10 Russian regions conducted by the Penza Anti-AIDS Foundation, 59 percent of drug users who had made use of the state treatment system had gone back to using drugs within a month of finishing their treatment course; more than 90 percent had relapsed within a year. Various other studies also found that less than 10 percent of patients of state narcological clinics remain in remission a year after their treatment. Indeed, Human Rights Watch interviewed drug users in each of the regions visited for this report who told us that they had gone back to using drugs within days of their release from the detoxification clinic. Using other measures of treatment effectiveness, such as the treatment system's ability to recruit patients and retain them for a length of time adequate for appropriate treatment, the Russian system fares equally poorly.

Some narcological clinics in Russia also appear to routinely violate the privacy rights of those who try to access them. Governments and their agents are required to observe confidentiality of medical information. It appears, however, that some state narcological clinics in Russia share information on patients who are on the state drug user registry with law enforcement and other government agencies. The Penza Anti-AIDS Foundation survey found that respondents in many of the 10 regions surveyed believed that narcological clinics had shared information on them with others, mostly law enforcement agencies. The routine sharing of medical information of drug users violates the acceptability component of the right to health, and the right to privacy protected under the European Convention on Human Rights, to which Russia is a party.

Human Rights Watch also found that Russia imposes unnecessary restrictions on the rights of people on the drug user registry, such as the right to obtain a driver's license or hold certain jobs, and thereby violates the principle of non-discrimination. While the rationale behind these restrictions—public safety—may in principle appear to be legitimate, the restrictions are imposed selectively only on those drug users who have to avail of free treatment at state clinics because they cannot afford to pay for treatment services. Whether a patient can pay for services is not a legitimate criterion on which to determine that private information about them should be retained on a registry and be used to restrict certain civil rights. Furthermore, the restrictions are disproportionate as they are imposed for a five-year period without any assessment whether there is a need to impose them on the individual in question or any periodic review to determine whether that need continues to exist.

The close links between injection drug use and HIV infection add extra urgency to the need for effective drug dependence treatment. Injection drug users make up an estimated 65 to 80 percent of all persons living with HIV in Russia and around 10 percent of injection drug users in Russia are HIV-positive. Effective drug dependence treatment has been shown to help reduce HIV infections as patients

may either stop using drugs altogether or may adopt less risky injection behavior. Today, as Russia is rapidly expanding access to antiretroviral (ARV) treatment for people living with HIV, effective drug treatment programs, including methadone maintenance therapy and drug-free programs, could play an important role in aiding drug users in accessing and adhering to ARV treatment. If Russia does not take steps to address the problems of its drug dependence treatment system, it runs the risk of continued and increasing spread of HIV, and even drug resistant HIV strains, due to lack of access by drug users to ARV and their suboptimal adherence due to poor quality drug dependence treatment programs.

Russia needs to take urgent steps to address the various failings identified in this report, and reform its drug dependence treatment system in accordance with the findings of scientific evidence. Human Rights Watch makes the following key recommendations:

- Immediately lift the ban on the medical use of methadone and buprenorphine in the treatment of drug dependence and introduce maintenance therapy programs.
- Integrate evidence-based drug treatment policies into the drug treatment system.
- Adopt and fund a federal plan aimed at increasing the availability of rehabilitation treatment by opening new rehabilitation programs and centers in regions that do not currently have any. This plan should have a clear timeline and benchmarks for implementation, and should prioritize regions and towns on the basis of need.
- Take steps to ensure drug users can enter treatment without delay. This should include measures to remove arbitrary requirements to present certificates on various health conditions upon admission, and steps to minimize, to the extent possible, waiting lists for admission.
- Provide adequate funding to narcological clinics and cease out-of-pocket charges for medications that should be provided free of charge.
- Reform the detoxification treatment protocol to end overmedication of patients and introduce clear guidance on psychosocial interventions aimed at patient retention.
- Take steps to ensure all patients in detoxification receive proper counseling on HIV and other diseases that are prevalent among drug users.
- Take active steps to counter distrust toward state narcological clinics among drug users. These should include the adoption of a patient bill of rights, clear guidelines on treatment options and costs, and steps to root out corrupt practices by clinic doctors.
- Reform the drug user registry to remove blanket restrictions on rights of people on the registry.
- Take steps to ensure respect for confidentiality of medical information.

This article was based on an initial post to the HRW website:
http://hrw.org/english/docs/2007/11/08/russia17278.htm (English)

http://hrw.org/english/docs/2007/11/08/russia17278.htm (Russian)

GUIDELINES

US adult and adolecent HIV treatment guidelines updated

The US Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents were recently updated twice – on 1 December 2007 and 29 January 2008.

http://www.hivatis.org

http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf

Taken together, the updates included the following changes

- Resistance testing on diagnosis and before starting treatment
- Starting treatment when CD4 count is <350 cells/mm3
- Use of HLA B*5701 testing prior to using abacavir
- Starting HIV treatment for people coinfected with HBV who need to treat their hepatitis
- Preferred first line dual nukes: tenofovir/FTC or abacavir/3TC; this is the first time that the guidelines have even mentioned lipoatrophy, and although they recognise it occurred more frequently with AZT compared to tenofovir, AZT is no longer a preferred first line choice.
- Preferred NNRTI is efavirenz; aternative is nevirapine

- Preferred boosted PIs for first-line therapy are atazanavir/r, fosamprenavir/r, lopinaivr/r, Alternative PI-regimens are unboosted atazanavir (but not with tenofovir), saquinavir/r, fosamprenavir twice daily, boosted fosamprenavir once-daily and lopinavir/r once-daily. Lowest recommendations are for nelfinavir, and boosted saquinavir.
- Nelfinavir is now contraindicated in pregnancy because of the unknown risk of small amounts of a byproduct (ethyl methanesulfonate or EMS)
- Changes to management of treatment experienced patients stress for the need for at least two or preferably three active drugs and includes recently developed drugs (maraviroc, raltegravir, etravirine), but also recognises that there is no consensus on the optimal time to switch a failing regimen
- A new discussion on immunological failure that quantifies chances of reaching over 500 cells/mm3.

"The proportion of patients experiencing immunologic failure depends on how failure is defined, the observation period, and the CD4 T-cell count when treatment was started. In the longest study conducted to date, the percentage of patients with suppressed viremia who reached a CD4 T-cell count >500 cells/mm3 through 6 years of treatment was 42% (starting treatment with a CD4 <200 cells/mm3), 66% (starting with CD4 200–350 cells/mm3) and 85% (starting with CD4 >350 cells/mm3) increases in CD4 T-cell counts in treatment-naïve patients with initial antiretroviral regimens are approximately 150 cells/mm3 over the first year. A CD4 T-cell count plateau may occur after 4–6 years of treatment with suppressed viremia.

A persistently low CD4 T-cell count while on suppressive antiretroviral therapy is associated with a small, but appreciable, risk of AIDS- and non– AIDS-related morbidity and mortality. For example, in the FIRST study, a low CD4 T-cell count on therapy was associated with an increased risk for AIDS-related complications (adjusted hazard ratio of 0.57 for CD4 T-cell count 100 cells/mm3 higher). Similarly, a low CD4 T-cell count was associated with an increased risk for non-AIDS events, including cardiovascular, hepatic, renal and cancer events. Other studies support these associations."

Unlike French guidelines, use of IL-2 to boost CD4 counts to above 200 cells/mm3 in immunological non-responders is only recommended within a clinical trial setting.

The section on Injecting Drug Users is included below.

Challenges of treating IDUs infected with HIV

Injection drug use represents the second most common route of transmission of HIV in the United States. Although treatment of HIV disease in this population can be successful, injection drug users (IDUs) with HIV disease present special treatment challenges. These include the existence of an array of complicating comorbid conditions, limited access to HIV care, inadequate adherence to therapy, medication side effects and toxicities, need for substance abuse treatment, and the presence of treatment-complicating drug interactions [311-313].

Underlying health problems among this population result in increased morbidity and mortality, either independent of or accentuated by HIV disease. Many of these problems are the consequence of prior poverty-related infectious disease exposures and the added effects of non-sterile needle and syringe use.

These include tuberculosis, skin and soft tissue infections, recurrent bacterial pneumonia, endocarditis, hepatitis B and C, and neurologic and renal disease. Furthermore, the high prevalence of underlying mental illness in this population, antedating and/or exacerbated by substance use, results in both morbidity and difficulties in provision of clinical care and treatment [311-313]. Successful HIV therapy for injection drug users often rests upon acquiring familiarity with and providing care for these comorbid conditions**.**

IDUs often have decreased access to HIV care and are less likely to receive antiretroviral therapy than other populations [314, 315]. Factors associated with lack of use of antiretroviral therapy among drug users have included active drug use, younger age, female gender, suboptimal health care, not being in a drug treatment program, recent incarceration, and lack of health care provider expertise [314, 315]. The chaotic lifestyle ofmany drug users, the powerful pull of addictive substances and a series of beliefs about the dangers of antiretroviral therapy among this population impact on and blunt the benefit of antiretroviral therapy and contribute to decreased adherence to antiretroviral therapy [316]. The chronic and relapsing nature of substance abuse and lack of appreciation of substance abuse as a biologic and medical disease, compounded by the high rate of coexisting mental illness, further complicates the relationship between health care workers and IDUs.

Efficacy of HIV treatment in IDUs

Although underrepresented in clinical trials of HIV therapies, available data indicate that, when not actively using drugs, efficacy of antiretroviral therapies among IDUs is similar to other populations.

Further, therapeutic failure in this population is generally the degree to which drug use results in disruption of organized daily activities, rather than drug use per se. Whereas many drug users can control their drug use sufficiently and over sustained periods of time to engage in care successfully, treatment of substance abuse is often a prerequisite for successful antiretroviral therapy. Close collaboration with substance abuse treatment programs, and proper support and attention to the special needs of this population, is often a critical component of successful treatment for HIV disease. Essential to this end as well are flexible, community-based HIV care sites characterized by familiarity with, and non-judgmental expertise in, managing the wide array of needs of substance abusers, and the development and use of effective strategies for promoting medication adherence [312, 313].

Foremost among these is the provision of substance abuse treatment. In addition, other support mechanisms for adherence are of value, and the use of drug treatment and community-based outreach sites for modified directly observed therapy has shown promise in this population [317].

IDU/HIV drug toxicities and interactions

IDUs are more likely to experience an increased frequency of side effects and toxicities of antiretroviral therapies. Although not systematically studied, this is likely because of the high prevalence of underlying hepatic, renal, neurologic, psychiatric, gastrointestinal, and hematologic disease among IDUs. The selection of initial and continuing antiretroviral agents in this population should be made based upon the presence of these conditions and risks.

Methadone and antiretroviral therapy

Methadone, an orally administered long-acting opiate agonist, is the most common pharmacologic treatment for opiate addiction. Its use is associated with decreased heroin use, improved quality of life, and decreased needle sharing. Methadone exists in two racemic forms, R (active) and S (inactive). As a consequence of its opiate-induced effects on gastric emptying and metabolism by cytochrome P450 (CYP) isoenzymes 3A4 and 2D6, pharmacologic effects and interactions with antiretrovirals may commonly occur [318]. These may diminish the effectiveness of either or both therapies by causing opiate withdrawal, opiate overdose, or increased toxicity or decreased efficacy of antiretrovirals.

• **Methadone and NRTIs**. Most of the currently available antiretrovirals have been examined in terms of potential pharmacokinetic interactions of significance with methadone. (See Table 21.)

Among the NRTIs, none appear to have a clinically significant effect on methadone metabolism. Conversely, important effects of methadone on NRTIs have been well documented. Methadone is known to increase the area under the curve of zidovudine by 40% [318], with a possible increase in zidovudine-related side effects. Methadone decreases levels of stavudine and the buffered tablet didanosine formulation (no longer available) by 18% and 63%, respectively [319]. This marked reduction in didanosine levels is not observed with the EC formulation. Recent data indicate lack of significant interaction between abacavir and tenofovir and methadone.

• **Methadone and NNRTIs**. Pharmacokinetic interactions between NNRTIs and methadone are well known and clinically problematic [320]. Both efavirenz and nevirapine, potent inducers of CYP isoenzymes, have been associated with significant decreases in methadone levels. Methadone levels are decreased by 43% and 46% in those receiving efavirenz and nevirapine, respectively, with corresponding clinical opiate withdrawal. It is necessary to inform patients and substance abuse treatment facilities of the likelihood of occurrence of this interaction if either drug is prescribed to those receiving methadone. The clinical effect is usually seen after 7 days of coadministration and is treated with increase in methadone dosage, usually at 5-10mg daily until the patient is comfortable.

Delavirdine, an inhibitor of CYP isoenzymes, increases methadone levels moderately and without clinical significance.

• **Methadone and PIs**. Limited information indicates that PI levels are generally not affected by methadone, except for amprenavir, which appears to be reduced by 30%. However, many PIs have significant effects on methadone metabolism.

Saquinavir does not affect free, unbound methadone levels. However, amprenavir, nelfinavir, and lopinavir administration each results in a significant decrease in methadone levels [321, 322]. Whereas fosamprenavir may result in mild opiate withdrawal, decrease in methadone concentration from nelfinavir was not associated with opiate withdrawal. This is likely because of lack of effect on free, rather than total, methadone levels.

Lopinavir/ritonavir combination has been associated with significant reductions in methadone levels and opiate withdrawal symptoms. This is because of the lopinavir, not ritonavir, component [323]. Another study indicates a lack of pharmacokinetic interaction among atazanavir and methadone [324].

Buprenorphine

Buprenorphine, a partial μ-opiate agonist, is increasingly being used for opiate abuse treatment. Its decreased risk of respiratory depression and overdose enables use in physician's offices for the treatment of opioid dependence. This flexible treatment setting could be of significant value to drug-abusing opiateaddicted HIV-infected patients requiring antiretroviral therapy, as it would enable one physician or program to provide needed medical and substance abuse services.

Only limited information is currently available about interactions between buprenorphine and antiretroviral agents. In contrast to methadone, buprenorphine does not appear to raise zidovudine levels. Pilot data indicate that buprenorphine levels do not appear to be reduced and opiate withdrawal does not occur during coadministration with efavirenz.

Summary

Provision of successful antiretroviral therapy for injection drug users is possible. It is enhanced by supportive clinical care sites and provision of drug treatment, awareness of interactions with methadone, and the increased risk of side effects and toxicities and the need for simple regimens to enhance medication adherence. These are important considerations in selection of regimens and provision of appropriate patient monitoring in this population. Preference should be given to antiretroviral agents with lower risk for hepatic and neuropsychiatric side effects, simple dosing schedules, and lack of interaction with methadone.

Extract from US Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, January 2008.

References

311. Tindall B, Cooper DA. Primary HIV infection: host responses and intervention strategies. AIDS, 1991. 5(1):1-14.
312. Niu MT, Stein DS, Schnittman SM. Primary human immunodeficiency virus type 1 infection: review of pathogenesis and early treatment intervention in humans and animal retrovirus infections. J Infect Dis, 1993. 168(6):1490-501.
313. Kinloch-De Loes S et al. Symptomatic primary infection due to human immunodeficiency virus type 1: Review of 31 cases. Clin Infect Dis, 1993. 17(1):59-65.
314. Schacker T et al. Clinical and epidemiologic features of primary HIV infection. Ann Intern Med, 1996. 125(4):257-64.
315. Daar ES et al. Diagnosis of primary HIV-1 infection. Los Angeles County Primary HIV Infection Recruitment Network. Ann Intern Med, 2001. 134(1):25-9.
316. Hecht FM et al. Use of laboratory tests and clinical symptoms for identification of primary HIV infection. AIDS, 2002. 16(8):1119-29.
318. Hoen B et al. Highly active antiretroviral treatment initiated early in the course of symptomatic primary HIV-1 infection: Results of the ANRS 053 trial. J Infect Dis, 1999. 180(4):1342-6.
319. Lafeuillade A et al. Effects of a combination of zidovudine, didanosine, and lamivudine on primary human immunodeficiency virus type 1 infection. J Infect Dis, 1997, 175(5).1051-5.
320. Lillo FB et al. Viral load and burden modification following early antiretroviral therapy of primary HIV-1 infection. AIDS, 1999. 13(7):791-6.
321. Malhotra U et al. Effect of combination antiretroviral therapy on T-cell immunity in acute human immunodeficiency virus type 1 infection. J Infect Dis, 2000. 181(1):121-31.
322. Smith DE et al. Is antiretroviral treatment of primary HIV infection clinically justified on the basis of current evidence? AIDS, 2004. 18(5):709-18.
323. Mehandru S et al. Primary HIV-1 infection is associated with preferential depletion of CD4+ T lymphocytes from effector sites in the gastrointestinal tract. J Exp Med, 2004. 200(6):761-70.
324. Guadalupe M et al. Severe CD4+ T-cell depletion in gut lymphoid tissue during primary human immunodeficiency virus type 1 infection and substantial delay in restoration following highly active antiretroviral therapy. J Virol, 2003. 77(21):11708-17.

JOURNAL REVIEWS

Injection drug use, low baseline CD4 counts continue to predict poorer HAART response after six years

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Four to six years after starting anti-HIV treatment, higher rates of AIDS and mortality were seen in injection drug users and in those who had had AIDS-defining events or CD4 cell counts less than 25 cells/mm3 before starting therapy. The study, conducted by the Antiretroviral Therapy Cohort Collaboration, was published in the December 15th issue of the Journal of Acquired Immune Deficiency Syndromes. [1]

Previous studies have found that rates of AIDS-related illness and death are higher in people who begin antiretroviral therapy with lower CD4 cell counts. Poorer response has also been found in injection drug users (IDUs) compared to other patients. However, most studies to date have looked at response over relatively short time periods. In this study, the Antiretroviral Therapy Cohort Collaboration (an international alliance of investigators from sixteen cohort studies of people with HIV [2]) analysed data from 20,379 HIV-positive adults who had been on anti-HIV drugs for up to six years.

Participating cohorts were included if they had enrolled at least 100 treatment-naïve patients, 16 years of age or older, who had begun treatment with a combination of at least three antiretroviral agents. People with baseline viral loads less than 1000 copies/ml were excluded as possibly not treatment-naïve. This yielded a total of 20,379 patients from twelve European and North American cohorts. Baseline characteristics were as follows: median age, 36; median CD4 cell count 224 cells/mm3; median month of therapy initiation, February 1999. Before treatment initiation, 2737 patients (23%) had already had a diagnosis of AIDS; 3231 (16%) were presumed infected due to IDU. Of the initial regimens, 66% were NRTI/PI, 24% NRTI/NNRTI, 7% NRTI only, 2% triple-class; and 2% other (NRTI-sparing, or including T-20). The majority of participants (88%) began on a three-drug regimen.

Over a total of 61,798 person-years of follow-up, 1844 participants developed at least one AIDS-defining event, and 1005 died. AIDS-defining events and deaths were analysed by: baseline CD4 cell count (<25, 25 to 49, 50 to 99, 100 to 199, 200 to 349, and >350 cells/mm3), baseline viral load(<100,000 or ≥100,000 copies/mL), presumed mode of transmission (IDU or other), and AIDS diagnosis before baseline (yes or no). Consistent with previous studies, lower baseline CD4 cell counts were consistently the strongest predictor of poorer outcomes. The effect was strongest for the lowest baseline counts, and tended to decline with length of time on therapy for all strata of CD4 count. Beginning therapy at a baseline CD4 cell count between 200 and 349 continued to show a benefit until the four-year mark. Compared to those beginning at >350 cells/mm3 (the comparator group), the hazard ratio for progression to AIDS at one to two years on therapy was 1.5 (95% confidence interval [CI]: 1.0 to 2.3), 1.4 at two to three years (95% CI: 1.0 to 2.1), and 1.0 at four to six years (95% CI: 0.6 to 2.0). For each time period, hazard ratios were progressively higher for each lower CD4 stratum. For baseline CD4 counts <25 cells/ mm3, the hazard ratio for developing AIDS was 3.7 at one to two years (95% CI: 2.2 to 6.1), 2.4 at two to four years (95% CI: 1.5 to 3.8), and 2.3 at four to six years (95% CI: 1.0 to 2.3). At four to six years, the hazard ratio for mortality was 2.5 (95% CI: 1.2 to 5.5) for baseline CD4 counts <25 cells/ mm3.

For people presumed infected through IDU, at four to six years on HAART, the hazard ratio for AIDS was 1.6 (95% CI: 0.8 to 3.0)

and the hazard ratio for mortality was higher at 3.5 (95% CI: 2.2 to 5.5). Note that cause of death was not analysed and was not necessarily directly due to HIV; mortalities due to hepatitis-related liver disease, overdose, trauma and other causes were not excluded. Mortality rates were still lower than would be expected in the absence of anti-HIV therapy. Diagnosis of AIDS before the initiation of anti-HIV treatment also continued to predict AIDS-defining events at four to six years, with a hazard ratio of 2.3 (95% CI: 1.2 to 4.4); the predictive value for mortality ceased to be significant. HIV viral load (greater than, or less than, 100,000 copies/ml) was not a significant predictor of progression or death at any time point. The study was limited by declining numbers of patients in follow-up after longer periods on antiretroviral treatment. At the end of the fourth year of anti-HIV therapy, 6838 participants were still being followed (23% of the original cohort); only 791 (4%) were followed for more than six years. As most original patients were still being followed up at the time of analysis, the researchers "do not believe that informative censoring is likely to be an important source of bias."

However, results may have been confounded by socioeconomic and other factors which caused people to begin treatment late in the course of HIV progression. Larger hazard ratios for mortality than for development of AIDS were seen in several groups, which may be evidence of such confounding. Also, race and ethnicity were not included in the analysis due to lack of sufficient data. The researchers concluded that "rates of AIDS and death were persistently higher in patients infected [through injection drug use]", and that "although the prognostic value of baseline CD4 count and a prior AIDS diagnosis declined with time, patients who were severely immunodeficient when they started therapy experienced higher rates of AIDS and death up to 6 years later." They believe these results may "strengthen the case for screening for HIV, because delaying treatment… has long-term disadvantages."

Source: aidsmap.com

http://www.aidsmap.com/en/news/8ACEB690-26EB-4583-BF14-A4353CE335EC.asp

References:

1. Antiretroviral Therapy Cohort Collaboration. Importance of baseline prognostic factors with increasing time since initiation of highly active antiretroviral therapy: collaborative analysis of cohorts of HIV-1–infected patients. J Acquir Immune Defic Syndr 46 (5):607-615, 2007.

2. http://www.art-cohort-collaboration.org/

OTHER NEWS

Community concern over Thai government reinstating war on drugs

Within days of his appointment earlier this month, Thailand's Interior Minister, Chalerm Yubamrung, reinstated a war on drugs. Thai AIDS Treatment Action Group (TTAG) is concerned that those responsible for past human rights violations committed in the name of drug control have not been held accountable, nor have steps been taken to ensure oversight, professionalism, and accountability in drug suppression efforts. Human Rights Watch (HRW) recently provided unpublished data from the previous government's investigation into the 2003 war on drugs, which found that 2,819 people were killed in 2,559 murder cases between February and April in 2003. Of those killed, more than half had no relation to drug dealing or had no apparent reason for their deaths. No concrete action has been taken to redress these wrongs, or to prevent their occurrence in the future.

The government's rash drug war announcement has not been accompanied by appropriate mechanisms in place to guard against history repeating itself. Apart from prosecuting perpetrators of past drug war-related crimes, the Thai government must immediately hold public consultations to discuss the impact, including human, social, political, and health costs, of the Thai drug war approach, and develop policies and laws that uphold human rights, not undermine them. Wholesale repression of the type experienced in 2003 will again result in thousands of inappropriate arrests, deaths, and the disruption of HIV prevention and other services.

Prime Minister Samak Sundaravej must urgently renounce the drug war and all human rights violations that have taken place in its context. Drug suppression efforts need to take place with full respect for due process of law and human rights standards. In addition, Prime Minister Samak should encourage his government to work with civil society organisations including people who use drugs to develop a humane approach to the country's drug problem, for example through the promulgation of a national harm reduction policy supporting comprehensive harm reduction services integrated into existing health and social policies and programs and the immediate cessation of military-style compulsory drug "treatment."

Continued rates of HIV infection among drug users in Thailand, and reports of abuses by law enforcement, demonstrate how much is at stake. Rather than being subjected to indiscriminate suppression, people who use drugs must be supported to be actively and meaningfully involved in leading harm reduction work in Thailand.

Efforts to force tens of thousands into prison or drug treatment are ineffective and immoral.

Recommendations from two previous Human Rights Watch (and TTAG) reports still go unheeded. Please review these recommendations, and send letters to the Prime Minister and Interior Minister demanding that they SAY NO TO A THAI DRUG WAR and urgently hold past police officers guilty of abuse and criminal offenses accountable.

Demand that people who use drugs are treated as human beings by the government and receive appropriate, effective health and harm reduction services that meet them where they are at, and prevent government actors from committing human rights violations, in the name of drug demand and supply reduction and national security.

Harm Reduction Saves Lives! NO MORE THAI DRUG WAR!

Address your letters and faxes to:

His Excellency Samak Sundaravej, Prime Minister of the Kingdom of Thailand, Government House, Pitsanulok Road, Bangkok 10300 THAILAND. FAX: +66-2-282-5131

Chalerm Yubamrung, Minister of the Interior, Ministry of the Interior, Asdang Road, Bangkok, 10200 THAILAND. FAX: +66-2-222-8866

Source: Thai AIDS Treatment Action Group (TTAG) Press Release ˆ February 14, 2008

ON THE WEB

Web resources

The following organisations all include web resources about ARV4IDUs:

http://www.emcdda.org	http://who.org
http://www.drugusers.org	http://unodc.org
http://www.drugtext.org/library/legal/eu/default.htm	http://forward-thinking-on-drugs.org/review2.html
http://www.harmreduction.org	http://www.sorosny.org/harm-reduction
http://www.drugalliance.org	http://www.ceehrn.org
http://www.erowid.org	http://www.ihra.net
http://www.union.ic.ac.uk/advice/health/drugs/	http://www.hit.org.uk
http://www.dancesafe.org	http://www.opiateaddictionrx.info
http://unaids.org	

IHRA newsletter - December 2007

http://www.ihra.net

IHRA is a leading organisation in promoting evidence based harm reduction policies and practices on a global basis for all psychoactive substances (including illicit drugs, tobacco and alcohol).

- HRA Launch Death Penalty Report
- Report on Sweden's Human Rights Obligations - An Update
- IHRA Conference Update
- INPUD Demand Answers from the European Commission
- International Network of Drug Consumption Rooms Founded in Bilbao
- Cambodia to Open First Methadone Clinic

JAIDS supplement: focus on IDUs

http://www.jaids.com

The November Supplement to JAIDS included 12 articles from the INSPIRE research trial. Unfortunately regitration is required for access to text. Abstract are available free online.

- Microsocial Environmental Influences on Highly Active Antiretroviral Therapy Outcomes Among Active Injection Drug Users: The Role of Informal Caregiving and Household Factors.
- Intimate Partner Violence Perpetration Against Main Female Partners Among HIV-Positive Male Injection Drug Users.
- Correlates of Depression Among HIV-Positive Women and Men Who Inject Drugs.
- Are Feelings of Responsibility to Limit the Sexual Transmission of HIV Associated With Safer Sex Among HIV-Positive Injection Drug Users?
- Sexual Transmission Risk Behavior Reported Among Behaviorally Bisexual HIV-Positive Injection Drug-Using Men.

- Correlates of Lending Needles/Syringes Among HIV-Seropositive Injection Drug Users.
- Factors Associated With Antiretroviral Therapy Adherence and Medication Errors Among HIV-Infected Injection Drug Users.
- Participants' Descriptions of Social Support Within a Multisite Intervention for HIV-Seropositive Injection Drug Users.
- Acceptability of A-CASI by HIV-Positive IDUs in a Multisite, Randomized, Controlled Trial of Behavioral Intervention.
- Results From a Randomized Controlled Trial of a Peer-Mentoring Intervention to Reduce HIV Transmission and Increase Access to Care and Adherence to HIV Medications Among HIV-Seropositive Injection Drug Users.
- What We Can Learn From the INSPIRE Study About Improving Prevention and Clinical Care for Injection Drug Users Living With HIV.

FUTURE MEETINGS

Conference listing

The following meetings are taking place during 2008. Registration details, including for community and community press are included on the relevant website. A detailed listing of European and international meetings compiled by the European Opiate Addiction Treatment Association in available on their website:

http://www.europad.org/events.asp

26 - 28 March 2008, 6th European HIV Drug Resistance Workshop, Budapest

http://www.virology-education.com

7-9 April 2008, 9th International workshop on Clinical Pharmacology of HIV Therapy, New Orleans

http://www.virology-education.com

9-11 April 2008, 3rd International workshop on Clinical Pharmacology of Hepatitis Therapy, New Orleans

http://www.virology-education.com

11 – 15 May 2008 - 19th International IHRA Conference,Barcelona
Harm Reduction 2008: "Towards a Global Approach"
http://www.ihraconferences.net

10-14 June 2008, 17th International HIV Drug Resistance Workshop, Sitges

http://www.informedhorizons.com

19-21 June 2008 (dates tbc), 4th International workshop on HIV and Hepatitis Coinfection, Madrid

http://www.virology-education.com

1 - 2 August 2008, 3rd International workshop on HIV Transmission, Mexico City

http://www.virology-education.com

3-8 August 2008, 17th International AIDS Conference, Mexico City

http://www.aids2008.org/

25-28 October 2008, Washington, DC, ICAAC and IDSA joint meeting

http://www.icaac.org/

October 2008, 3rd International workshop on Hepatitis C, Resistance and New Compounds, Washington DC

http://www.virology-education.com

6-8 November 2008, 10th International Workshop on Adverse Drug Reactions and Lipodystrophy in HIV, London, UK

http://www.intmedpress.com

Millennium Gloucester Hotel in London, UK

9-13 November 2008, 8th Congress on Drug Therapy in HIV Infection, Glasgow

http://www.hiv8.com

PUBLICATIONS & SERVICES FROM i-BASE

i-Base website

The fully searchable website is designed to be fast to access, easy to use, and simple to navigate.

http://www.i-Base.info

All i-Base publications are available online, including editions of the treatment guides.

It can be used to order publications and regular subscriptions to be delivered by post or email (as PDF files).

The site also includes a web-based Q&A section for people to ask questions about their own treatment:

http://www.i-base.info/questions/index.html

Non-technical guides to treatment

i-Base produce five non-technical guides to treatment. All guides are available in print, PDF and online formats:

http://www.i-Base.info/guides

- **Introduction to combination therapy**
- **Guide to hepatitis C for people living with HIV: testing, coinfection, treatment and support**
- **Guide to changing treatment: what to do when your treatment fails**
- **Guide to HIV, pregnancy & women's health**
- **Guide to avoiding & managing side effects**

Translations of i-Base guides

Original material published by i-Base can be translated and reprinted, and has so far been produced in over 30 languages, including: Bosnian, Bulgarian, Chinese, Czech/Slovak, Croatian, French, Greek, Hindi, Indonesian, Italian, Kosovo, Macedonian, Nepali, Polish, Portuguese, Romanian, Russian, Serbian and Spanish.

More information about this process is available on the i-Base website.In addition, PDF files of some of the translated publications are available on the site.

Some of these translations are from earlier editions of the treatment guides, so check the publication date before relying on all information.

http://www.i-base.info/about/downloads.html

Treatment 'Passports'

These popular booklets are for HIV-positive people - whether newly diagnosed or positive for a long time - to keep a record of health and treatment history. Like all i-Base publications, they are available free as single copies, or in bulk.

HIV Treatment Bulletin (HTB)

A review of the latest research and other news in the field. HTB is published 10 times a year in a printed version, in a pdf file that we can email to you, and on our website.

The printed version is available at most HIV clinics in the UK and is available free by post.

Treatment information request service - 0808 800 6013

i-Base offers specialised treatment information for individuals, based on the latest research.

We can provide information and advice over the phone, and we can mail or email copies of the latest research studies relevant to the caller.

For details, call the i-Base treatment information free phone line on 0808 800 6013. The line is usually staffed by positive people and is open Mondays, Tuesdays and Wednesdays from 12 noon to 4pm. All calls are in confidence and are free from the UK.

Online Q&A service

A new 'question and answer' service has been added to the i-Base website. Questions can either be answered privately, or if you give permission, we will post the answers online (omitting any personally identifying information).

http://www.i-base.info/questions/index.html

Recent questions include:

- I kissed an HIV-positive man
- Will a bloated stomach on saquinavir/ritonavir improve?
- Why would test results change so much in a short time?
- How do I access treatment in the UK - I am from India?
- Recently diagnosed with HIV-2
- Can HIV cause a red face in the winter?
- What is the difference between HIV-1 and HIV-2?
- How accurate is the DUO test 27 days?
- Can I have a baby if I have AIDS?
- Can I do something to reduce the side effects?
- What is the longest late detection of HIV-infection?
- Chances of infecting partner with undetectable viral load?
- What are my Dad's chances of recovery?
- Why do some answers on i-Base use different words for similar testing questions?
- Is it true that HIV doesn't survive long outside the body?
- Can I take Atripla as a first line treatment?
- If you are infected by a viral disease, does that mean your CD4 counts are always low?
- Do you feel ok again after seroconversion?
- Do antibiotics interact with HIV meds?
- How long after a potential exposure can I donate blood?
- How is HIV transmitted by breastfeeding?
- What is seroconversion and what are the symptoms?
- Are enlarged lymph nodes painful, or related to HIV?
- Which test is used to detect an infection within 6 months?
- Can mouthwash or antibiotics affect HIV results from a mouth swab?

Assessing the treatment information needs African people in the UK living with HIV

This report by Winnie Sseruma and i-Base includes an analysis from workshops held last year and details African use and experience of current treatment information resources.

http://www.i-base.info/pdf/africantreatmentneeds.pdf

NEW: Training manual – revised, updated and now fully online

This training resource has been revised and updated and is now online in new format.

http://www.i-base.info/education/index.html

The Training Manual for Advocates provides entry-level curriculum relating to HIV and treatment.

It is made up of 8 modules for learning about aspects of HIV care has been updated and published online as an interactive resource. It provides entry-level curriculum relating to HIV and treatment.

http://www.i-base.info/manual/en/index.html

Sections include:

1. Immune system and CD4 count

2. Virology, HIV and viral load

3. Introduction to antiretrovirals (ARVs)

4. Side effects of ARVs

5. Opportunistic infections and coinfections

6. HIV and pregnancy

7. Drug users and HIV

8. Clinical trial design and the role of advocates

9. How to read science

Each module includes learning objectives, non-technical review material, test questions, an evaluation and a glossary.

We hope this will be useful for training advocates and other related healthcare workers as well as for HIV-positive people who want to know more about aspects of their healthcare.

The training manual was previously only available online as a PDF document and has been widely translated. Earlier editions are available in Russian, Portuguese, Hindi and Nepalese as are available as PDF files.

i-Base Book: "Why we must provide HIV treatment information"

Photography by Wolfgang Tillmans

i-Base has worked as a treatment literacy project for over six years. Over this time we have always produced copyright-free material and encouraged other organisations to use, translate and adapt our material. Through this work, we have been very lucky to develop links to many other advocacy projects outside the UK.

A recent meeting, held in Cape Town earlier this year, focused on how to raise the profile of treatment literacy. One result from the meeting is a publication "Why we must provide HIV treatment information".

With text provided by activists from 25 countries and 50 full colour photographs by Wolfgang Tillmans, this limited edition 100-page publication is being sold by i-Base to raise funds to help support our international treatment literacy projects.

UK CAB: reports and presentations

The UK Community Advisory Board (UK CAB) is a network for community treatment workers across the UK that has been meeting for three years. Each meeting includes two training lectures and a meeting with a pharmaceutical company or specialist researcher.

The CAB has a separate website, where reading material, reports and presentations from these meetings are posted.

http://www.ukcab.net

World CAB - reports on international drug pricing

Two reports from meetings between community advocates and pharmaceutical companies, that focused on pricing issues and global access to treatment, and that are now available online. Both are available to download as a PDF file from the i-Base website.

http://www.i-base.info/wcab/index.html

Find HTB on AEGiS

AEGiS.org - the longest established and largest global resource of online HIV information - includes HTB in the regular journals that it puts online. You can find us at:

http://www.aegis.org/pubs/i-base/2007

Order i-Base publications via the internet, post or fax

People with internet access can use our website to order and receive publications. You can access our publications online or subscribe to receive them by email or by post; and you can order single copies or bulk deliveries by using the forms at:

http//www.i-base.info/forms/index.htm

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HIV Treatment 'Passports' - Booklets for patients to record their own medical history

1 ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

Guide To HIV, Pregnancy and Women's Health *(July 2007)*

1 ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

Introduction to Combination Therapy *(June 2006)*

1 ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

Changing Treatment - Guide to Second-line and Salvage Therapy *(April 2007)*

1 ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

Guide To Avoiding and Managing Side Effects *(February 2005)*

1 ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

Guide to HIV and Hepatitis C coinfection *(May 2007)*

1 ☐ **5** ☐ **10** ☐ **25** ☐ **50** ☐ **Other** _____ _____ _____

Earlier versions of many treatment guides are available in other languages as PDF files on the website

Adherence planners and side effect diary sheets - In pads of 50 sheets for adherence support

1 Sheet ☐ **1 pad** ☐ **5 pads** ☐ **10 pads** ☐ **Other** ☐ _____ _____

Please fax this form back, post to the above address, or email a request to HIV i-Base:

020 7407 8489 (fax) subscriptions@i-Base.org.uk