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MONTHLY

Reducing HIV infections at circuit parties

100



Reducing HIV infections at circuit parties

Amin Ghaziani and Thomas D. Cook

Circuit parties are sexually charged, poly-drug-use-enhanced phenomena in the gay male community that may be linked to the transmission of HIV. This month's feature article is an excerpt from a forthcoming *JIAPAC* original paper examining the potential circuit party drug-sex link, and includes a sidebar about one of the most prevalent culprits: crystal methamphetamine.

Photo: Perry Smrz

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Qu'ils mangent du gâteau

José M. Zuniga

Countless allusions abound in literature and cinema to the infamous phrase, “Let them eat cake.” To hear this phrase is to immediately associate it with Marie-Antoinette, the French queen who, with her husband and many of their scarlet-heeled aristocratic brethren, was beheaded in the fiery days of the French Revolution.

A great irony resides in the fact that while the political philosopher Jean-Jacques Rousseau, in Book 6 of his *Confessions*, attributed the phrase “*Qu'ils mangent du gâteau*” to a great princess, his book was written two to three years before Marie-Antoinette’s 1770 arrival in France. He mentioned it in connection with an incident that occurred in 1740, when he stole wine while working as a tutor in Lyons and then had problems trying to scrounge up something to eat along with it. He concludes thusly: “Finally, I remembered the way out suggested by a great princess when told that the peasants had no bread: ‘Well, let them eat cake.’”

Indeed, history records that Marie-Antoinette actually took an active role in relieving the famine that struck Paris in the pre-revolutionary days. However, history is written by the victors...

Would that we could use a similar analogy to refute the actions of the last absolute monarch in Africa, Swaziland’s King Mswati III; a ruler mind-numbingly compared to Gandhi by his Prime Minister, Themba Dlamini. Sadly, the king able to crush opposition parties, ban newspapers, and ignore courts is proving powerless against the AIDS epidemic ravaging his kingdom. Far worse, though, his material excesses fly in the face of his kingdom’s



Photo: Getty Images

King Mswati III

plight: How to justify taking delivery of eight S-350 Mercedes-Benzes worth US\$108,000? Or the construction of new palaces to house his 11 wives and three fiancées? Or the need for a private jet?

The landlocked country tucked between Mozambique and South Africa was recently identified by the United Nations Programme on HIV/AIDS (UNAIDS) as having the world’s highest HIV infection rate, with 38.6 percent of pregnant mothers testing HIV positive. And an estimated 70 percent of his one million subjects live in dire poverty. Yet Mswati, who ascended to the throne in 1986 and rules under royal decree following a state of emergency declared 30 years ago, has an acquired taste for overindulgence. So much so that on his 37th birthday this month, he threw

himself a US\$1.5 million birthday bash... *Qu'ils mangent du gâteau?*

One of the United States of America’s founding fathers, Thomas Paine, authored a treatise in 1791 reflecting his belief in natural reason and natural rights, political equality, tolerance, civil liberties, and the dignity of man. *The Rights of Man* can be approached from its most telling points:

- Men are born, and always continue, free and equal in respect of their rights.
- The end result of all political affiliations is the preservation of the natural and inalienable rights of man; and these rights are liberty, property, security, and resistance of oppression.
- The nation is essentially the source of all sovereignty; neither any individual, nor any body of men, is entitled to any authority that is not expressly derived from the nation.

For those who dabble in political science, it is clear that these three points are similar to the “self-evident truths” expressed in the US Declaration of Independence. Yet, whether we elect to apply these beliefs to the most affluent nation on the planet or the most impoverished, they reflect an unflinching belief in the most fundamental right of man—one which Paine articulated in his revolutionary writings: “Who art thou, vain dust and ashes, by whatever name thou art called—whether a king, a bishop, a church, or a state—that obtrudest thine insignificance between the soul of man and his Maker?” ■

José M. Zuniga is President/CEO of the International Association of Physicians in AIDS Care (IAPAC), and Editor-in-Chief of the IAPAC Monthly.

1997



TOP 10

10 Most Important Developments in HIV Medicine



1. A year chock-full of HIV/AIDS treatment guidelines: International AIDS Society (IAS)-USA, US National Institutes of Health (NIH); US Department of Health and Human Services (DHHS); US Centers for Disease Control and Prevention (CDC)/Infectious Diseases Society of America (IDSA), and Society for Healthcare Epidemiology of America (SHEA) all issue guidelines ranging from the management of opportunistic infections to the delivery of antiretroviral therapy.

2. The year of documented clinical benefit of highly active antiretroviral therapy (HAART):

- Reduced hospital admissions and resource utilization
- Reduced mortality in the United States (12 percent)

3. Demonstration of the prognostic value of viral burden testing.

4. US AIDS Clinical Trials Group (ACTG) 320: The demonstration of virologic and clinical benefit with “triple therapy” (azidothymidine [AZT] + lamivudine [3TC] + indinavir [IDV] versus AZT + 3TC).



5. The US Food and Drug Administration (FDA) agrees that quantitative HIV RNA may be used as a primary endpoint in therapeutic trials of antiretroviral drugs.

6. The demonstration that human herpesvirus-8 (HHV-8) is implicated in myeloma.

7. The report of the first successful cultivation of HHV-8.

8. The vaccine effort got a shot in the arm when US President Bill Clinton announced his challenge to develop a vaccine for HIV prevention within 10 years.

9. The demonstration that HIV can be recovered in latently infected CD4 cells after more than 30 months of HAART with “no detectable virus.”



10. On World AIDS Day, the World Health Organization (WHO) announced that 16,000 persons acquire HIV infection daily; double the prior estimate, giving new dimension to the global AIDS crisis.

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Metabolic disturbances in the absence of HAART

Chris Gadd

Patients with more advanced HIV disease who are not taking highly active antiretroviral therapy (HAART) tend to have unfavorable changes in lipid and sugar levels, according to the results of a study presented in the March 2005 issue of *HIV Medicine*.

The study also found that HIV-positive women and African Americans had more favorable lipid profiles than men or other races, respectively. In contrast, greater age and higher body mass index (BMI) were linked to less favorable changes in blood fat and sugar levels.

Previous studies have demonstrated that HAART can cause changes in the levels of fat in the blood. These may be linked to the development of lipodystrophy and heart disease. Commonly reported changes include increases in total blood cholesterol, low-density lipoprotein (LDL) cholesterol, and triglycerides; as well as decreases in high-density lipoprotein (HDL) cholesterol. In addition, elevations in blood sugar levels and resistance to the hormone insulin have been observed, and are linked to the development of diabetes.

Despite these findings, little is known about the effects of demographic factors such as race and age on these metabolic changes. This makes studies of the effect of HAART difficult to interpret, as many have primarily enrolled Caucasian men.

Furthermore, the effect of HIV itself on metabolic disturbances may be difficult to distinguish from the effects of HAART on blood fat and sugar levels. Previous studies have found that HIV infection

tends to cause decreases in cholesterol levels and elevations in triglyceride levels. However, while early studies tended to concentrate on patients with advanced HIV disease prior to the advent of antiretroviral therapy, a more recent study of changes in blood fats after HIV infection included only male patients, the majority of whom had experience with various antiretroviral regimens at the start of the study.

To improve understanding of the effect of HIV and demographic factors on metabolic changes, researchers from the Community Program for Clinical Research on AIDS (CPCRA) in the United States measured lipid levels in 419 HIV-positive patients from 49 clinics. They also measured glucose and insulin levels in the patients' blood.

In contrast to previous studies, none of these patients had ever taken a protease inhibitor (PI) or nonnucleoside reverse transcriptase inhibitor (NNRTI), or had had more than four weeks' treatment with any nucleoside reverse transcriptase inhibitor (NRTI) or more than one week's treatment with lamivudine (3TC). The patient cohort also included 89 women (21 percent), 252 African Americans (60 percent) and 58 patients (14 percent) with a history of injecting drug use.

"Demographic and HIV disease characteristics influence lipid, glucose and insulin parameters in antiretroviral-naïve patients," the investigators conclude. "In patients with established HIV infection, deleterious lipid profiles were noted before HIV therapy was initiated. Patients with characteristics associated with more advanced HIV disease had unfavorable lipid profiles and evidence of insulin resistance."

They added that, "interpretation of the effects of various HIV treatment regimen[s]

and drugs on metabolic parameters must take into account the stage of HIV disease and the demographic characteristics of the population studied."

The mean age of the patients was 38.2 years, with a mean CD4 count of 216 cells/mm³ and mean viral load of 95,500 copies/ml. One hundred and eight (26 percent) of the patients had had an AIDS-defining event, the majority of these being *Pneumocystis jiroveci* pneumonia.

The researchers found that patients with lower CD4 counts and higher viral loads had lower levels of HDL cholesterol ($p < 0.01$). Higher viral loads were also associated with lower levels of LDL cholesterol ($p < 0.05$), as well as elevations in very low-density lipoprotein (VLDL) cholesterol and triglycerides ($p < 0.05$). Very low-density lipoprotein cholesterol carries fats around the body, and elevations can increase the risk of heart disease.

Patients with a history of an AIDS-defining illness also had higher total cholesterol levels ($p < 0.01$), VLDL cholesterol ($p < 0.04$), and triglycerides ($p < 0.05$). "This direct association was found to be restricted to patients with a history of [PCP] and was related to recent diagnosis of this condition," the researchers explained. "Our data thus demonstrated that low CD4 lymphocyte count, high HIV RNA level, and a history of AIDS-defining events, all markers of more advanced HIV disease, were all associated with higher concentrations of VLDL cholesterol and triglycerides."

When they analyzed the effect of HIV disease on blood glucose and insulin levels, the researchers found that patients with lower CD4 counts had lower insulin levels ($p < 0.05$) and more evidence of insulin resistance ($p < 0.05$), important factors in the development of diabetes.

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After analyzing demographic factors, they found that the women in the study had higher levels of HDL cholesterol ($p < 0.01$), as did African Americans ($p < 0.01$). In contrast, total and VLDL cholesterol and triglyceride levels were higher in older patients ($p < 0.05$) as well as those with a higher BMI ($p < 0.01$). High BMI was also linked to higher LDL cholesterol levels ($p < 0.01$), while patients with a history of

injecting drug use had lower LDL cholesterol levels ($p < 0.05$). The authors state: "History of intravenous drug use and BMI both significantly and independently influenced lipid parameters."

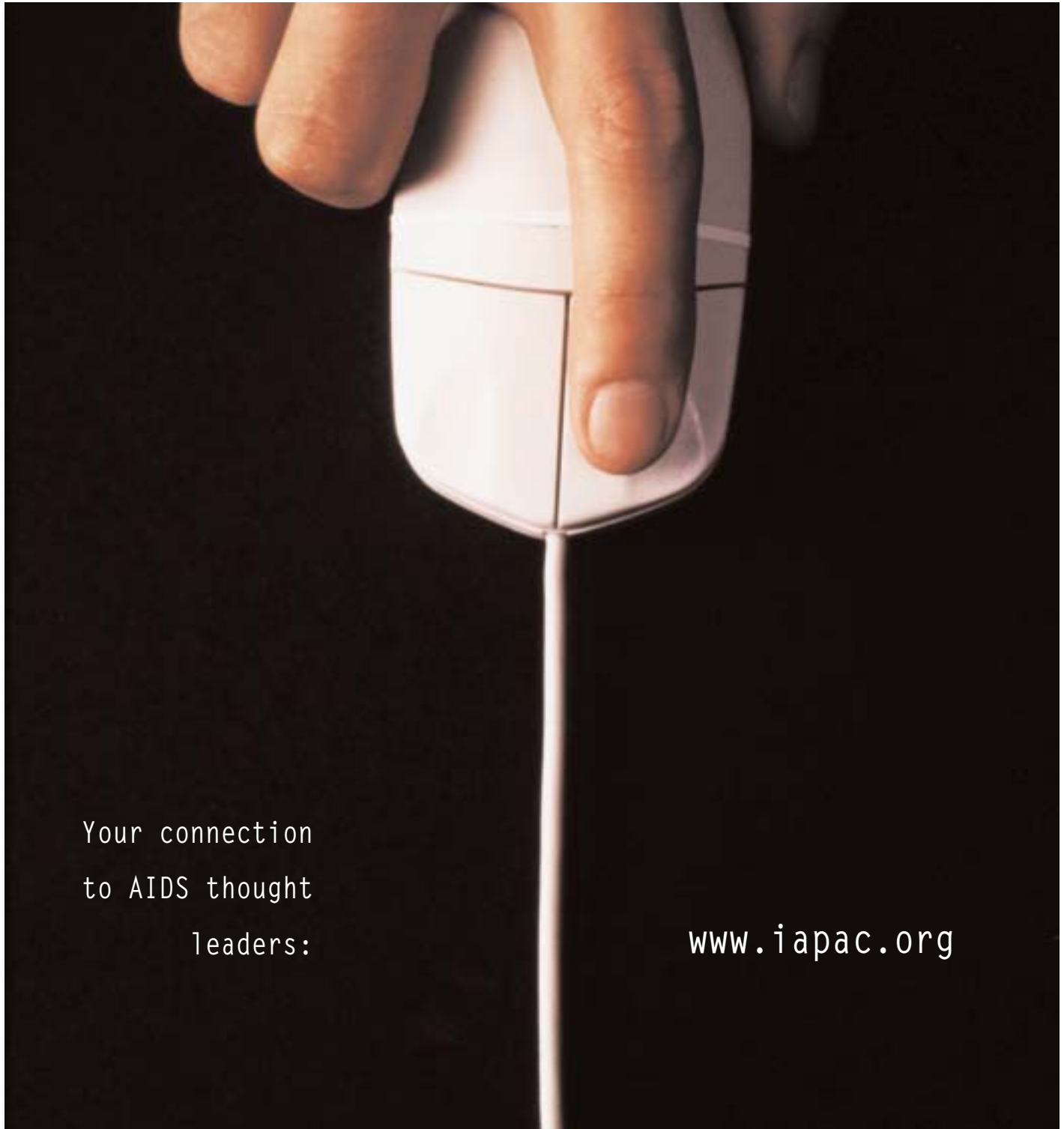
Analysis of glucose and insulin levels revealed a similar pattern. Women had higher insulin levels and insulin resistance than men ($p < 0.01$), whereas older people had higher glucose levels ($p < 0.05$). People

with higher BMI had higher glucose levels, insulin concentrations and insulin resistance ($p < 0.01$).

In contrast, however, African Americans had lower insulin levels and insulin resistance than other races ($p < 0.01$). ■

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Reducing HIV infections at circuit parties



*Amin Ghaziani and
Thomas D. Cook*

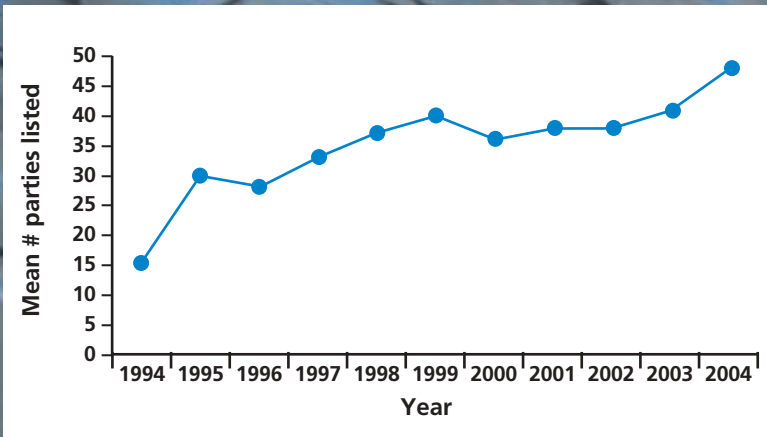
Circuit parties are weekend-long dance events where sexual activity and poly-drug use are generally prevalent. The parties are typically attended by up to 25,000 gay and bisexual men, who socialize without stop for periods sometimes exceeding 24 hours. The Black & Blue party in Montreal reported attendance by over 80,000 people during a recent party weekend.¹ The men dance to bass-pounding, electronic rhythms amid multi-colored lights and laser shows, often with exotic entertainers performing on stage, sometimes erotically. The participating men are on average Caucasian, in their late 20s to late 30s, college educated, and from middle- to upper-middle-class backgrounds. The parties themselves serve as “gay celebratory... events... important to many men,” who cite as a major reason for attending the “feeling of community” they find there.² This last sentiment is echoed in recent media depictions of circuit parties as “a symbol of freedom for the gay community” that “brings all aspects of the community together, people from all walks of life” so that circuit parties embody “our family, our gay family.”³

Circuit parties were started in the mid-1980s as part of the gay community’s attempt to raise awareness of HIV/AIDS and to gain funds to combat the disease.⁴⁻⁶ Although it is unconfirmed, circuit parties may have ironically become potential sites for HIV serotransmission,^{1,2,7-9} and have started to arouse public health concerns in the media.¹⁰⁻¹³ One possible explanation is that the parties cater to a high-risk demographic category—affluent, young, urban gay men who use club drugs heavily. Another is that a notable proportion of men attending the parties are HIV-positive, and, while there, they engage in higher rates of unprotected anal intercourse (UAI) than their HIV-negative counterparts, and are also likely to have a greater number of different sex partners.⁸

This paper will suggest that the idea of a link between circuit party attendance and HIV transmission is not entirely unfounded, even if it remains speculative, based on research on the drug-sex link and research that more directly applies to circuit parties. We begin with the observation that there is a “substantial drug culture” that “permeates the circuit party environment, a drug culture that is distinct from broader communities of gay and bisexual men.”² This drug culture manufactures “a setting where substance use is significantly more likely to occur.”¹ Circuit party attendees are more likely to ingest drugs at distant circuit parties as opposed to comparable gay venues such as regular dance clubs in their home cities.⁸ As many as 25 percent of party patrons self-identify as HIV-positive¹ in a context where use of certain drugs (eg, 3,4-methylenedioxymethamphetamine [ecstasy or MDMA], crystal methamphetamine) is statistically associated with risky sexual practices, such as UAI, sex with serodiscordant or serounknown partners, multiple partners, and UAI with multiple partners, which then exacerbates the risk of HIV transmission.^{2,7,8,14,15}



Figure 1. Average number of circuit parties listed in *Circuit Noize*



Research on men who have sex with men (MSM) has shown that drug use is related to sexual disinhibition and altered judgment, which itself increases the likelihood of engaging in any type of sexual activity but, more specifically, increases the likelihood of risk-taking behaviors such as UAI, and thus the transmission of a host of sexually transmitted infections (STIs), including but not limited to HIV.^{4,16-32} When considering what is already known, the claim of a possible relationship between party attendance and HIV infection is not unwarranted.

These concerns are aggravated when we consider the explosive growth, internationally, of the circuit.³³ *Circuit Noize* is the national publication exclusively targeted to the circuit party community.³⁴ As an indicator of institutional development, Figure 1 shows the number of parties listed in each issue's "party calendar," revealing an increase of 220 percent from 1994 to 2004.

According to the former publisher, *Circuit Noize* circulated 700 copies of its first issue. Two years later it circulated 50,000 copies, to every major city in the United States and Canada. It now advertises a major event at least every month. The increases from earlier years could be due to a number of factors that affect success of a publication, including wider distribution and better solicitation of advertisers. These and other explanations are also indicators of the prominent infrastructural growth of the circuit as a distinct subculture.³⁵⁻³⁷

The recent history of the Morning Party at Fire Island in New York also attests to the parties' staying power. For years, the Morning Party was sponsored by the Gay Men's Health Crisis (GMHC), a New York City-based AIDS service organization. But under mounting criticism about drug use and unsafe sex, GMHC withdrew its support.³⁸ Nevertheless, the event goes on basically unchanged, in part because circuit parties are profitable for the developers and entertainers,³⁹ and in part because they are attractive to individual gay men, for whom they promise community building and cultural identity promotion. We therefore liken these parties to a "Communitarian Janus." One of Janus's party faces promotes community building through shared activities in a distinct subculture, while the other entails public health risks stemming from and therefore undermining these very same community-enhancing activities.

Mansergh *et al*² cogently capture the risks of circuit parties as a Communitarian Janus: "Consider the potential impact of circuit party weekends on HIV infection rates... If we multiply the prevalence of sexual risk behavior by the median of [three] parties per year..., and if we consider the large number of men who attend circuit parties, as well as the growing popularity of such parties, then the likelihood of transmission of HIV... among party attendees

and secondary partners becomes a real public health concern."²


This article explores the two party faces of the circuit, beginning with a review of public health research on circuit parties. At the time of this writing, there were only five such studies, some of which shared datasets, each of which described different dimensions of the total phenomenon. Unfortunately, the articles do not explicitly address the topic of this paper. We therefore use these five studies and the vast literature on drug use and high-risk sexual behavior in MSM communities more generally, along with sociological and social psychological research, to propose an original explanatory causal model of why circuit parties may contribute to HIV infections. In doing so, we heed the recent counsel of scholars who suggest that, "developments in contemporary social theory can be integrated into public health practice."⁴⁰

Research on circuit parties

As discussed earlier, the links between drug use and high-risk sexual behavior, and sometimes also with HIV and other STIs, are well documented in the literature on MSM. However, since research into the drug-sex-infection nexus at circuit parties is comparatively rare, we provide here a brief description of the relevant studies.

Mansergh *et al*² described the demographics of party attendees as well as their frequency of attendance, motivation to attend, patterns of drug use, and patterns of sexual behavior, including the availability and use of condoms. Most respondents (95 percent) reported using psychoactive "club drugs" (excluding alcohol and Viagra) during their most recent circuit party weekend. Of these, 61 percent ingested three or more drugs in one night; 84 percent reported ingesting drugs on the dance floor, and 63 percent in the bathroom. Thus, multiple drug use is the norm, and drugs are consumed in different locations within the setting.

The authors also found high levels of sexual activity, with 67 percent of attendees reporting that they had anal or oral sex during a party weekend, and 49 percent reporting that they had only anal sex (insertive or



receptive). Only 21 percent reported uniformly safe anal sex; 28 percent said they had UAI, 9 percent of which had it with serodiscordant or serounknown partners. Twenty-nine percent had multiple sex partners during the party weekend and, of these, 47 percent reported UAI, 24 percent of which reported serodiscordant or serounknown UAI. Nine percent of the men reported having sex specifically at a circuit party event. Most men reported seeing that condoms were available at the party, but few reported taking them. The incidence of UAI increased with the number of partners and of drugs used.

Colfax *et al*⁸ used the same dataset as the Mansergh group² to examine the differential behavior of HIV-positive and -negative men during party weekends, and how differences between them vary by party type—whether during a local circuit party weekend (ie, one in their home town) or a distant circuit party weekend (ie, one located elsewhere), during a local dance club (non-circuit party) weekend, and a nonevent weekend (no circuit party or local dance club).

Fifty-one of the 295 men in the sample were HIV-positive (17 percent). Compared to HIV-negative men, they engaged in higher rates of UAI with partners of unknown or discordant serostatus. They also engaged in more UAI—31 percent to 39 percent depending on party type, versus 22 percent to 26 percent for HIV-negative men. Among HIV-positive men, unsafe sexual behavior was highest during out-of-town circuit party weekends, where 21 percent engaged in UAI with serodiscordant or serounknown partners. During local circuit party weekends, the rate was 14 percent. HIV-positive men were also more likely to engage in UAI with multiple partners during all event types (7 percent to 16 percent in contrast to 1 percent to 5 percent, for HIV-negative men). That HIV-positive men engaged in riskier sexual practices during party weekends is an important point, because HIV is spread through the joint mechanism of seropositivity and unsafe sex, and because the sexually charged, drug-fueled party atmosphere may increase sexual activity overall.

Colfax *et al*⁸ also found high drug use at circuit parties. The median number of

different drugs consumed was four during distant circuit party weekends, three during local circuit party weekends, two during local, dance club weekends, and one when not going to a club or circuit party (ie, nonevent weekend). Ecstasy and ketamine were used most frequently—by 80 percent and 66 percent of attendees, respectively. This is presumably because they enhance mood and atmosphere more than sexual performance, making them particularly consonant with the purpose of going to a party. Crystal methamphetamine alters both mood and sexual functions,⁴¹ and this may be why its use is in the intermediate range (43 percent at distant events). Colfax *et al*⁴² suggest that the higher rates of unsafe sex during distant circuit party weekends results partly from the higher levels of drug use, increased anonymity, disinhibitory effects, and a modified social-normative climate at these events as compared to other gay venues.

Mattison *et al*⁷ sampled three geographically diverse circuit parties during 1998 and 1999, each held in North America over a holiday weekend with up to 25,000 persons attending. The authors note that the parties were attended primarily by a relatively wealthy (mean annual income of US\$50,000) and well-educated (eg, 68 percent had at least a bachelor's degree) cohort of gay and bisexual men whose mean age was 33. Seventy percent of the sample was Caucasian, 10 percent Latino, 5 percent black, 5 percent Asian, and 3 percent "other." Eighty percent of the sample consisted of HIV-negative men, 13 percent were HIV-positive, 4 percent had been tested recently and were unsure of their status, and the final 3 percent had never been tested.

Individuals were asked about substance use at parties in the past 12 months. Seventy-nine percent had used alcohol, 72 percent ecstasy, 60 percent ketamine, 45 percent marijuana, 39 percent cocaine, 39 percent poppers, 36 percent crystal methamphetamine, and 28 percent gamma hydroxybutyrate (GHB). As in Colfax *et al*,⁸ the modal number of different drug types consumed during an event was four. A dose-response relationship was observed between the number of drugs used and the

likelihood of unsafe sex in the past 12 months, with 10 percent of those using one drug reporting unsafe sex compared to 26 percent of those who had ingested seven or eight drugs.

Respondents rated their reasons for attending the circuit party and were free to check multiple alternatives. Ninety-seven percent said they attended circuit parties "to celebrate and have fun," and the same percentage wanted "to dance and enjoy music." Ninety-five percent wanted "to be with friends"; 86 percent "to look and feel good"; and 73 percent "to have an intense gay experience." More importantly for our purposes, 68 percent said they wanted "to be wild and uninhibited"; 58 percent "to party and use drugs"; and 43 percent "to have sex." About 14 percent wanted "to forget about HIV/AIDS."

Mattison *et al*⁷ found that unsafe sex at a given party was associated with more frequent use of ecstasy, ketamine, and poppers. The trends for any or occasional use of GHB and crystal methamphetamine were in the same direction. Also, engaging in unsafe sex was higher among individuals who reported going to the party in order to

have sex, to be uninhibited and wild, and to look and feel good. That these reasons relate to sexual activity is not surprising. More puzzling is the question of why they should relate to unsafe sex. Some suggest that there is a general “sensation-seeking” personality/dispositional trait,²² whose components include attending parties to feel good, to be wild and uninhibited, to have sex, and to have it specifically without using condoms.

Ross, Mattison, and Franklin⁹ used the dataset collected by Mattison *et al*⁷ to examine broad categories of reasons for circuit party attendance and, given this, whether levels of risk (of drug consumption and unsafe sexual activity) are a function of reasons for attendance. An important contribution of this study is the organization into “two reliable dimensions that can constitute scales” of the associated reasons for party attendance discovered by Mattison *et al*.⁷ These they term “social and celebratory” and “sensation-seeking” reasons, respectively. Each of the two factors consists of five elaborated items. Social and celebratory motivations include “to celebrate, have fun”; “to be with friends”; “to dance, enjoy music”; “to look and feel good”; and “to escape.” Sensation-seeking reasons include “to have sex”; “to be uninhibited and wild”; “to have an intense gay experience”; “to party, use drugs”; and “to forget about HIV/AIDS for a while.”

Ross, Mattison, and Franklin’s results also reveal that, “levels of risk in gay circuit parties are a function of reasons for attendance, and that interventions that seek to reduce drug-related or sexual risk in these venues must be targeted differently.” They found that drug use and sex are more likely to be found in those patrons who attend circuit parties for sensation-seeking purposes rather than social and celebratory ones. Sensation-seeking party patrons were more likely to have ingested multiple drugs, more likely to report having unsafe sex in the past 12 months, and more likely to have had sex while high on one or more drugs, especially the combination of methamphetamines and GHB.

Lee *et al*¹ described the more general,

demographic characteristics of circuit party attendees. Confirming findings from the other existing studies on circuit parties, Lee *et al* also found that the average party patron is male (99.4 percent, in their sample), Caucasian (83.4 percent), HIV-negative (69.6 percent), gay (94.8 percent), well-educated (56.6 percent with a college degree; 33.1 percent with a graduate degree), employed (94.6 percent), and had attended an average of 3.8 parties over the past year. It is notable that 25 percent of their sample self-identified as HIV-positive, the highest self-report of the five existing studies.

Lee *et al*¹ found high prevalence of drug use on the day of the party (86 percent), with a mean of 2.36 different drugs ingested. The most commonly consumed substances included ecstasy (71 percent), ketamine (53 percent), methamphetamine (31 percent), alcohol (24 percent), cocaine (19 percent), and GHB (12 percent). Over half the respondents reported that they were more likely to use drugs at a circuit party than at comparable gay venues such as regular dance clubs. Lee *et al*¹ found that use of ecstasy at the party was highly correlated with concomitant use of ketamine (6.8 times more likely use), methamphetamine (10.9 times more likely use), and cocaine (8.1 times more likely use).

The researchers also examined the relationship between ecstasy use and sexual behavior and found that “a greater percentage of regular MDMA users reported engaging in receptive anal intercourse than non-regular MDMA users” (26 percent versus 10 percent). Given that ecstasy use is itself related to unsafe sexual practices,^{7,14} its relationship to receptive anal intercourse, one of the most risky sexual practices, is especially troubling. The researchers found no relationship between ingestion of ecstasy and condom use in the context of a circuit party, suggesting that failure to use a condom may be more directly influenced by either the ingestion of other club drugs, or the mixing of ecstasy with other club drugs.

Lee *et al*¹ focused on the role of ecstasy in the circuit subculture. Recent media reports on use of crystal methamphetamine

suggest it is reaching epidemic proportions, arguably making it the most commonly used drug at circuit parties today, more so than ecstasy.⁴³ Scholars have found a relationship between use of crystal methamphetamine and high-risk sexual practices associated with HIV infection.^{44,45} Crystal methamphetamine use increases HIV viral loads in seropositive individuals, especially in those taking highly active antiretroviral therapy (HAART).⁴⁶ The volatile relationship between crystal methamphetamine, risky sex, and HIV was recently brought to the public’s attention with the detection of a rare strain of HIV. This multidrug-resistant strain of HIV-1 producing rapid progression to AIDS was found in a New York City man who engaged in UAI with other men while high on crystal methamphetamine.^{47,48} These findings underscore the need to broaden studies of the drug-sex-infection nexus.

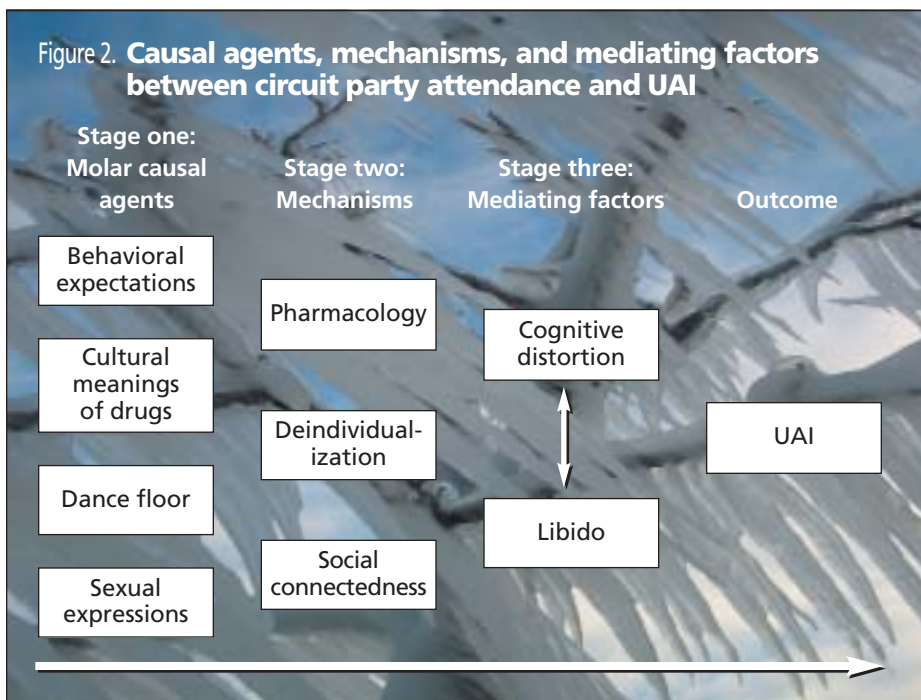
The published studies of circuit parties are only five in number, highlighting the need for further research in this context. They are all primarily descriptive and point to: a) sensation-seeking reasons—the desire to have sex, a wild time, and do drugs—as notable motivations to attend circuit parties; b) widespread drug consumption at parties, with multiple drug use being the norm; c) widespread sexual activity, with high prevalence of UAI, sex with multiple partners, and sex while high on club drugs; and d) notable attendance by HIV-positive patrons who, on average, exhibit less cautious sexual behavior than HIV-negative patrons. These findings point to the urgent public health need to intervene at circuit parties to help reduce risky sexual practices that increase the risk of HIV infection.

But why do circuit parties inadvertently promote unsafe sex? And how can researchers intervene to reduce rising rates of HIV infection at such events, given the unique and complicated setting of circuit parties?

Increased risk of HIV infection?

Evidence to date is not yet conclusive that circuit parties are directly responsible for increasing HIV transmission, though

Figure 2. **Causal agents, mechanisms, and mediating factors between circuit party attendance and UAI**



we have already discussed why this assumption is not unwarranted. These parties are regularly occurring, concentrated settings that provide opportunities for sexual interactions between HIV-positive and HIV-negative MSM. They may play an epidemiological role in transmitting HIV and other STIs across geographical regions and demographic groups, just as bath-houses in the 1960s and 1970s facilitated the spread of STIs and, in later years, HIV, across socioeconomic groups of MSM.⁴⁹

Based on what is known about circuit parties, and building on well-established, interdisciplinary knowledge from sociology, social psychology, and public health on drug use and sexual behavior, Figure 2 is proposed as an explanatory model of the causal processes that may intervene between party attendance and UAI. Because an empirically corroborated explanatory model of unsafe sex at circuit parties is not available, the model posited is still heuristic in nature. The model is, however, strongly anchored in existing empirical and theoretical accounts. As such, it is aligned with recent methodological counsel that urges scholars to more actively integrate social theory into public health practice.⁴⁰

The model assumes that the process

most causally proximal to risky sex is the availability of HIV-positive men who are willing to have unsafe sex, for whatever reasons. Causally prior to this are two factors: libido that is situationally elevated at circuit parties, and cognitive distortions that lead men to engage in sexual acts that, in other settings, they would know to be dangerous and unwise, and that they would likely avoid more often than they would at parties.¹⁶ It makes little sense to separate out the roles of situationally elevated libido and situationally distorted judgment since it is the two together that immediately precede unprotected sex.

The model then assumes three causal precursors to elevated libido and distorted judgment. One is the pharmacology of the particular drugs consumed at parties; another is the sense of deindividuation that arises in the context of a large crowd of men who tend to appear physically similar to one another and also come from similar social backgrounds; and the third is the enhanced community feelings that are engendered by sharing experiences with other members of the same self-described “tribe,” a cultural self-description we repeatedly encountered in our ethnographic fieldwork.

According to the model, these processes

are themselves set in motion by a constellation of four jointly acting forces. These are the expectations that men bring to parties about drugs and sex; some of the cultural meanings that are associated with how drugs are used at parties; certain dynamics of the dance floor; and the models of sexual activity that are present in the erotically charged crowd and the professional entertainment provided.

This paper does not enumerate all possible and specific pathways, with the assumption that this would be misplaced precision. Rather, this article contends that the general flow of causal influence moves from left to right in the model and, on average, involves all or most of the constructs listed. The discussion will therefore also move from left to right, from the more molar causal influences to the more proximal ones that are associated with elevated libido and diminished judgment in a context where many seropositive men are available, some of whom are willing to engage in risky sex. Of course, attendance at the party is a necessary condition for all of the postulated processes to occur.



Stage One: The Molar Causes. As described on page 103, over two thirds of party attendees report going to circuit parties “to be wild and uninhibited,” and nearly half go specifically “to have sex.” Within these motivational parameters, it can be deduced that the circuit party scene is highly sexualized. Given the well-established, tight link between behavioral intentions and actual behaviors as postulated by the theory of reasoned action,⁵⁰ it is no surprise that most party attendees engage in some type of sexual activity while at parties, and often with multiple sex partners. However, although there is evidence that men attend circuit parties expecting sex, there is no direct evidence that they attend expecting unsafe sex.

Circuit party research reveals poly-drug use as the norm. These drugs have pharmacological consequences. But they also play a social role, influencing interactions with other men. Because “a substantial drug culture permeates the circuit party environment,”⁵² drugs are often ritualistically taken in groups, becoming a shared subcultural experience. Social control is often exercised in these groups, as individuals sanction those for whom it is evidently too early to take another “hit” (ie, take another ecstasy pill or dose of GHB) or do another “bump” (ie, snort more crystal methamphetamine or ketamine). Such group activities build solidarity and prevent the grossest of drug abuses, thus contributing to the particular closeness and generalized trust that men report feeling toward each other at circuit parties.

Party producers put on many forms of entertainment, and almost all of them highlight male sexuality. For instance, Chicago’s 2003 Fireball included nude male dancers masturbating in metal cages fixed above and along the dance floor, and it was not uncommon during this party to see a few party attendees masturbating while on the floor. In 2005, Chicago’s Fireball displayed pornographic images of sex and masturbation. It is therefore logical to hypothesize a social modeling/learning connection between the behavior of entertainer/models and of circuit participants, all in the unique context created by the music, drugs, and crowd.³⁰

It is also logical to postulate a connection between the behavior of individuals and of those participants who model sexual acts on and around the dance floor and in nearby bathrooms. Sexual expressions are intrinsic to circuit parties, and cues about sex are everywhere. Indeed, party attendees present themselves to others in ways designed to make themselves appear sexually desirable. But while the mechanisms discussed thus far—including modeling—probably contribute to increased sexual activity, they do not necessarily skew that activity toward unsafe sex—that is, away from condom use and vigilance in discussing the serostatus of partners. The link to sex is more directly warranted and understood than the link to unsafe sex.


Stage Two: Mechanisms. We posit three mediating mechanisms between party attendance and unsafe sex. One is pharmacological, since club drugs play a central role in risky sexual activity at parties. In its pure form, ecstasy is a synthetic, psychoactive substance possessing stimulant and mildly hallucinogenic properties, and is activated primarily by the release of serotonin. Its hallucinogenic effects include feelings of peacefulness, acceptance, connectedness, attachment, and empathy, making it known as the “hug” or “love” drug.^{51,52} Party attendees “rolling” on ecstasy widely report the desire to touch and be touched, a pharmacologically stimulated link to rising libidos.

Crystal methamphetamine is a synthetic stimulant that operates primarily through the over-release of dopamine and also the over-release of serotonin and norepinephrine. This results in increased physical energy and libido, alertness, and feelings of euphoria.⁵² Crystal methamphetamine is used to prolong the party by enabling attendees to dance continuously for periods of 12 hours or more with little or no need for food or sleep, and also to enable the sexual encounters that occur in and around the dance floor.⁴⁴ Crystal methamphetamine is often deliberately mixed with GHB or gamma butyrolactone (GBL). By itself, GHB produces disinhibition, impaired judgment, increased sex drive, and, sometimes, increased energy.

However, party attendees report that the crystal-GHB mix dramatically raises libido levels and produces a feeling of relaxed euphoria (ie, cognitive distortion) that impels them to search out sensory-heightened sexual activity. Here there is a clearer link to unsafe sex, to the extent unsafe sex is thought to help achieve erotically charged physical/sexual experiences that are consonant with the experienced high.

Social psychologists have long known that large groups can reduce an individual’s sense of self, and that such deindividuation can loosen normative behavioral and moral constraints, while also increasing the likelihood of physiological arousal and of impulsive, atypical, and non-normative acts.⁵³⁻⁵⁶ The relationship between deindividuation and non-normative behavior is mediated by a sense of both reduced accountability and reduced self-awareness, each of which seems likely to occur in the very crowded scene at circuit parties. The degree of deindividuation is exacerbated by the stereotypic appearance of attendees. The “circuit boy” is often (though not exclusively) “a guy with a gym-toned body, dressed in athletic pants and tennis shoes, tattooed with a tribal insignia, holding on tightly to a glow stick or to a clan of other men, while dancing for hours, and even days, under the influence of recreational drugs like ecstasy, ketamine, crystal, and GHB.”⁵⁷ While there is diversity within the circuit context, the large uniformity of cultural expression helps mold tribal identity, though this may well be at the cost of unsafe sex.

The third and final mediating mechanism has to do with feelings of social connectedness and the search for community, experienced at the individual level, per ethnographic observations, as the desire for “authentic” or “liberated” interpersonal interactions that are often uninhibited and physical in nature. A link between social connectedness and unsafe sex is created here to the extent that libidos are elevated and cognitive distortions occur that impair participants’ abilities to negotiate condom use and to identify through conversation those prospective partners who are HIV-positive and then to clarify how to proceed sexually.



These negotiations are complicated by persisting negative beliefs about condoms in the gay community. They are thought to reduce pleasure and symbolize interpersonal distrust, thus influencing the chances of high-risk sexual behavior.^{58,59} In our fieldwork, we found that quality negotiations are further complicated because how “authentic” and/or “liberated” a physical interaction seems to be is assessed by how heightened the (chemically enhanced) sensory experience is between two or more party patrons—the more erotically charged and/or sensory overloaded the physical encounter is, the more it is esteemed and taken as an indicator of “authentic connection.” Thus, circuit parties may lead to unsafe sex through beliefs about the need for authentic social connections at parties, and also through beliefs that authenticity is linked to having sex without condoms, especially given persistent stigmas surrounding condom use.

Stage Three: Mediating Factors. As already suggested, the causal agents and mechanisms described in this paper impact on unsafe sex not just directly but also through their collective influence on freeing the libido and facilitating cognitive distortion. The effect on libido is fairly intuitive, given the drugs taken, the overt sexualization of the setting, and the initial and developing expectations of attendees. There must also be a component of cognitive distortion (ie, the skewing of rational decision-making capabilities). The education level of the circuit party population is generally high. Many, if not most, attendees know of the dangers of unprotected sex, and most also know that the setting celebrates and attracts HIV-positive men. Corroborating existing scholarship,¹⁶ we encountered some health professionals who counsel safe sex in their work while engaging in risky sex at parties. How can this contradiction be explained?

Participants report becoming so immersed in the party atmosphere that they forget about the immediate threat of HIV/AIDS or no longer care about it. They feel invincible, and engage in situationally sanctioned practices they would otherwise avoid. These attitudes are expressed in the language of party attendees who report “forgetting”

that they are HIV-positive^{7,9} or who in our fieldwork report that their sensory-enhanced, physical encounters “celebrate the tribe” despite sometimes being unsafe. The pharmacological properties of drugs often contribute to such feelings, especially crystal methamphetamine and its over-release of dopamine.

Conclusions

Circuit parties were begun in order to promote HIV/AIDS awareness and to stimulate gay community building and cultural identity formation. They inadvertently manufacture a subculture characterized by polydrug consumption and unsafe sex, often with multiple sex partners. Although not yet forcefully established, there may be a potential link between party weekends, HIV, and other STIs. We therefore conceptualize circuit parties as a Communitarian Janus. One of Janus’s party faces is associated with so many young, fairly affluent gay men celebrating and building community and cultural identity, and the other with the multiple health threats associated with drug use, party norms about unsafe sex, high rates of UAI, and the high participation rate and risky behaviors of HIV-positive men, all of which could possibly undermine community-building efforts and intentions.

The existing public health literature on circuit parties is sparse and, given its pioneering quality, understandably more descriptive than explanatory. This paper seeks to use the past descriptive literature in order to advance in two directions. The first is to causally explain a hypothesized link between party attendance and new HIV infections, and to this end we evolved a theoretically informed model in Figure 2. It postulates that unsafe sex is the product of the heavy representation of seropositive men who prefer more risky sex than do seronegative men, and who attend parties that titillate libidos and cognitively distort widely understood knowledge of what constitutes healthy gay sex. These proximal causes are set off by the pharmacological consequences of drugs known to affect sexual desire and cause cognitive distortions, the social psychological processes of

deindividuation promoted by the stereotypic appearance of thousands of young gay men; and sociological norms of social connectedness that are linked to beliefs about authenticity, condom use, and discussion of serostatus. In their turn, these processes may be activated by the behavioral expectations that party attendees bring with them, by community-wide norms of sexual expression, by the cultural meanings associated with ritualistic and collective drug use, and by the music, crowds, and entertainment at parties. ■

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Editor’s Note: This article is a preview of a paper entitled “Reducing HIV infections at circuit parties: From description to explanation and principles of intervention design,” to be published in the April/June 2005 edition of JIAPAC. The original paper was abstracted and adapted with permission, and edited for IAPAC Monthly style.

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Crystal meth use worsens HIV-related brain damage

Chris Gadd

Long-term heavy use of crystal methamphetamine can exacerbate the damage to brain cells caused by HIV, according to a study published earlier this year in the *American Journal of Psychiatry*. Although both methamphetamine use and HIV infection contributed to brain damage, the study showed that their effects were additive, and not due to a more complex interaction between HIV and drug use.

Crystal methamphetamine is a psychostimulant drug used by some HIV-positive and -negative people. It can be injected, smoked, or snorted. The use of crystal methamphetamine has been identified as an important factor in the spread of HIV, not only through unsafe injection practices, but also through its association with increased rates of unprotected sex in both men and women.

Studies have shown that long-term crystal methamphetamine users exhibit similar changes in behavior to patients with HIV-associated dementia. These include slowed reaction times and poor decision-making, memory, attention, and concentration skills.

As previous investigations have suggested that similar toxic effects in the brain cause these psychological effects, this study set out to determine how crystal methamphetamine use affected the development of brain abnormalities caused by HIV.

Investigators from Germany and the United States carried out brain scans on 68 HIV-positive and 75 HIV-negative volunteers. Twenty-four of the HIV-positive and 36 of the HIV-negative subjects had a history of crystal methamphetamine dependence or abuse. This was defined as crystal methamphetamine use for at least a year as the primary drug of abuse, with an average dose of at least 0.25 g per day on two or more days per week.

The investigators scanned three regions of each volunteer's brain using proton magnetic resonance spectroscopy. This allowed them to measure the levels of the metabolite *N*-acetylaspartate, a marker of neurons, the electrically active cells that transmit signals through the brain. They also measured levels of choline and *myo*-inositol, which are found in the brain's structural glial cells.

Volunteers with a history of crystal methamphetamine use showed lower concentrations of *N*-acetylaspartate in the basal ganglia (-4 percent, $p = 0.03$), an area of the brain involved in the coordination of movement. In agreement with previous studies, this indicated that there had been damage to neurons in this brain region.

In contrast, crystal methamphetamine users had higher levels of choline in the frontal white matter (5 percent, $p = 0.03$) and the frontal cortex (10 percent, $p = 0.008$). *Myo*-inositol levels were also 9 percent higher in the frontal cortex ($p = 0.009$), suggesting that inflammation had occurred in these areas of the brain, which are involved in thinking, planning, and decision-making.

HIV infection caused similar patterns of change. The HIV-positive subjects had lower levels of *N*-acetylaspartate in the frontal cortex (-5 percent, $p = 0.001$) and in the basal ganglia (-5 percent, $p = 0.004$) than the participants who were uninfected. They also had higher levels of *myo*-inositol in the frontal white matter (7 percent, $p = 0.01$).

In all three brain regions, there was an additive effect of crystal methamphetamine and HIV on the levels of *N*-acetylaspartate (basal ganglia: -9 percent, $p < 0.001$; frontal white matter: -6 percent, $p = 0.02$; frontal cortex: -6 percent, $p = 0.03$). There were no differences in HIV disease stage between the drug- and non-drug groups.

According to the investigators, "the HIV-positive subjects with a history of chronic methamphetamine use had the lowest concentration of *N*-acetylaspartate in all three brain regions studied, compared to the other three subject groups. This

finding suggests significant neuronal loss or dysfunction in these brain regions."

Similarly, HIV and crystal methamphetamine use had an additive effect on creatine levels in the basal ganglia (-7 percent, $p = 0.007$) and on *myo*-inositol in the frontal white matter (12 percent, $p = 0.02$).

The investigators speculate that the additive effect of HIV and crystal methamphetamine may be related to the drug's effect on the neurotransmitter dopamine. Crystal methamphetamine causes the release of massive amounts of dopamine from the ends of neurons, notably in the basal ganglia. This release of dopamine often causes the ends of the neurons to shrivel and eventually die back. The researchers hypothesize that this release of dopamine can also stimulate HIV replication and worsen the damage caused by the drug.

"As predicted, the region most affected was the basal ganglia, which has the highest density of dopaminergic nerve terminals," they explain. "One possible pathway to the combined neurotoxicity might be a methamphetamine-induced increase in extracellular dopamine, which in turn would activate HIV replication."

These results from brain scans of living volunteers mirror previous findings from animal experiments and *post mortem* studies of human brain. "Future studies using other non-invasive neuroimaging techniques... may provide further insights into the *in vivo* pathological changes associated with the combined effects of HIV and methamphetamine," the investigators conclude. ■

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US approves new HBV drug

Edwin J. Bernard

The US Food and Drug Administration (FDA) announced March 29, 2005, its approval of entecavir, which is marketed by Bristol-Myers Squibb (BMS) for the treatment of chronic hepatitis B virus (HBV) for HBV-monoinfected and HIV/HBV-coinfected patients who have previously received lamivudine (3TC).

The approval for monoinfected patients is based on data after one year of treatment in nucleoside reverse transcriptase inhibitor (NRTI)-treatment-naïve and 3TC-resistant adult patients with hepatitis B e antigen (HBeAg)-positive or HBeAg-negative chronic HBV infection with compensated liver disease.

The approval for coinfecting patients is based on more limited data from a randomized, double-blind, placebo-controlled study (AI463038, also known as ETV-038) of entecavir versus placebo in 68 individuals coinfecting with HIV and HBV, who experienced recurrence of HBV load while receiving 3TC-containing highly active antiretroviral therapy (HAART).

During the first 24 weeks of this study, coinfecting individuals continued their 3TC-containing HAART regimen, and were randomized to add either 1 mg entecavir once daily ($n = 51$) or placebo ($n = 17$) for 24 weeks. Results of this part of the study were presented at this year's 12th Conference on Retroviruses and Opportunistic Infections (CROI). For approval purposes, the FDA also included data from the 24-week open-label phase of the study, in which all participants received entecavir.

After 24 weeks, the mean HBV load fell $3.66 \log_{10}$ copies/mL with entecavir,

Editor's Note: Both articles featured in this month's Focus on Hepatitis are reprinted with permission from www.aidsmap.com, and were first e-published in March 2005.

while rising $0.11 \log_{10}$ copies/mL in the placebo group. Among patients assigned to receive entecavir, 6 percent had an HBV load below 300 copies/mL, compared with 0 percent on placebo. Thirty-four percent of participants on entecavir had alanine aminotransferase (ALT) normalization, compared with 8 percent of patients in the placebo group.

Unlike the other drugs used in HIV/HBV coinfection (3TC, adefovir [ADV], and tenofovir [TDF]), entecavir has no activity against HIV. Median HIV load level remained stable at approximately $2 \log_{10}$ copies/mL during the first 24 weeks of the study. This can be beneficial, since entecavir use cannot lead to HIV cross-resistance. In addition, entecavir does not interact with any protease inhibitors (PIs) or non-

nucleoside reverse transcriptase inhibitors (NNRTIs).

The recommended dose of entecavir for chronic HBV infection in NRTI-naïve adults and adolescents who are 16 years of age and older is 0.5 mg once daily. For those with a history of HBV viremia while receiving 3TC or those with known 3TC resistance mutations, the recommended dose is 1 mg once daily. Entecavir is also available in an oral solution containing 0.05 mg of entecavir per milliliter: 10 mL of the oral solution provides a 0.5 mg dose and 20 mL provides a 1 mg dose of entecavir. The FDA recommends that entecavir be taken on an empty stomach, at least two hours after a meal and two hours before the next meal. ■

EuroSIDA cohort: 9% coinfecting with HIV/HBV

Michael Carter

HIV-positive patients coinfecting with hepatitis B virus (HBV) are just as likely to have a good immunologic and virologic response to highly active antiretroviral therapy (HAART) as those infected with HIV alone, according to data from the EuroSIDA cohort published in the April 8, 2005, issue of the journal *AIDS*.

The international team of investigators also found that 9 percent of patients in the cohort were HIV/HBV-coinfecting, that all-cause and liver-related mortality was significantly higher among coinfecting patients, and that a strong immune response to HAART was associated with a significant reduction in the risk of death among coinfecting patients. The investigators also argue

that coinfecting individuals should take an antiretroviral regimen that includes drugs active against both HIV and HBV.

According to the investigators, "this study confirms that [HBV] infection increases significantly liver-related mortality in HIV-positive patients.

"This implies that every HIV-positive patient should be screened for [HBV] and advised for prevention. Interventions to decrease mortality related to liver disease in HIV-positive patients with chronic [HBV], such as early initiation of HAART targeted against both HBV and HIV, deserve further investigation."

Reference

Konopnicki D, Mocroft A, de Wit S, et al. Hepatitis B and HIV: Prevalence, AIDS progression, response to highly active antiretroviral therapy and increased mortality in EuroSIDA. *AIDS* 2005;19:593-601.



ABSTRACTS

Nephrology Dialysis Transplantation

Long-term renal safety of tenofovir disoproxil fumarate in antiretroviral-naïve HIV-1-infected patients: Data from a double-blind randomized active-controlled multicenter study

Izzedine H, Hulot JS, Vittecoq D, et al.

BACKGROUND: Tenofovir disoproxil fumarate (TDF) was developed for the treatment of human immunodeficiency virus (HIV) infection. However, controlled data are sparse on the long-term renal tolerability of TDF at the currently approved daily dose of 300 mg in treatment-naïve HIV-infected patients. **METHODS:** Over 144 weeks, this 600-patient, multicenter, randomized, placebo-controlled, double-blind trial compared stavudine (301 patients) and TDF (299 patients), both administered in combination with lamivudine and efavirenz, in antiretroviral-naïve patients. TDF or placebo and stavudine or placebo were administered in an open-label fashion. All medications were taken orally. At screening, all patients had serum creatinines <1.5 mg/dl, calculated creatinine clearances 60 ml/min and a serum phosphorus 2.2 mg/dl. **RESULTS:** The incidences of grades 1 (0.5 mg/dl increase from baseline), 2 (2.1-3.0 mg/dl) and 3 (3.1-6.0 mg/dl) serum creatinine elevations at week 144 were 4 percent, <1 percent, and 0 percent, respectively, in the TDF group and 2 percent, 0 percent, and <1 percent in the stavudine control group ($p = \text{NS}$). There were no grade 4 (>6 mg/dl) serum creatinine elevations. At week 144, there was no change from baseline in the mean (0.83 mg/dl) serum creatinine in the TDF group compared with a 0.1 mg/dl decrease from baseline (0.83 mg/dl) in the stavudine control group. The incidences of grades 1 (2.0-2.2 mg/dl), 2 (1.5-1.9 mg/dl), and 3 (1.0-1.4 mg/dl) hypophosphatemia at week 144 were 4 percent, 3 percent, and <1 percent, respectively, in the TDF group and 4 percent, 2 percent, and <1 percent in the control group ($p = \text{NS}$). No patient experienced grade 4 (<1.0 mg/dl) hypophosphatemia. At week 144, the decrease (Δ) of mean serum phosphorus levels from baseline in both groups was similar ($\Delta 0.2$ from 3.6 mg/dl for the TDF group, and 0.1 from 3.5 mg/dl for the stavudine control group). No patient developed Fanconi's syndrome or proximal renal tubular dysfunction during the study. **CONCLUSION:** Through 144 weeks, TDF and stavudine, each administered in combination with efavirenz and lamivudine, had similar renal safety profiles in treatment-naïve HIV-infected patients with normal renal function at baseline.

Nephrol Dial Transplant 2005;20(4):743-746.

AIDS

Gender differences in clinical progression of HIV-1-infected individuals during long-term highly active antiretroviral therapy

Nicastrì E, Angeletti C, Palmisano L, et al. of the Italian Antiretroviral Treatment Group.

OBJECTIVE: To assess gender differences in the long-term clinical, virological, and immunological outcomes during highly active antiretroviral therapy (HAART). **METHODS:** This longitudinal observational multicenter study followed 2,460 HIV-infected patients who had begun a protease inhibitor-based regimen for a median period of 43 months. Outcome measures were virological suppression (<500 copies/ml), confirmed virological rebound after suppression, and death or new AIDS-defining illness (ADI). **RESULTS:** At baseline, 690 female patients (28.0 percent) had significantly lower age, higher prevalence of heterosexual contact, and lower prevalence of intravenous drug use as risk factors for HIV infection compared with males. Furthermore, females had a lower number of AIDS-defining illnesses, higher CD4 cell counts and lower viral loads. No gender differences were reported in terms of proportion of patients achieving viral suppression or exhibiting rebound after achieving viral suppression. Female patients experienced reduced clinical progression during follow-up compared with males ($p = 0.008$) by Kaplan-Meier analysis; however this difference was not significant in an adjusted analysis. In a multivariate model, the interaction between gender and risk factor for HIV or viral load showed that female drug users and female patients with a baseline HIV RNA viral load of 10^4 - 10^5 copies/ml had a favorable clinical outcome compared with males ($p = 0.035$ and $p = 0.015$, respectively). **CONCLUSION:** No differences were found between genders in terms of virological and immunological outcomes during long-term HAART. Nevertheless, a lower risk of clinical progression was reported among female patients with intermediate baseline viral load than in males.

AIDS 2005;19(6):577-583.

Pediatric Infectious Disease Journal

Oral fluid human immunodeficiency virus tests: Improved access to diagnosis for infants in poorly resourced prevention of mother-to-child transmission programs

Sherman GG, Jones SA.

BACKGROUND: Perinatal exposure of infants in low resource settings generates the bulk of pediatric human immunodeficiency virus (HIV) disease globally. The HIV status of these infants is established by testing serum for anti-HIV antibodies at 12 months of age in prevention of mother-to-child transmission (PMTCT) programs because polymerase chain reaction testing is unavailable. The diagnostic accuracy of two oral fluid (OF) HIV tests has not been previously evaluated in children. **METHODS:** A serum and two OF HIV tests were performed at 12 months of age in a cohort of 321 vertically exposed children in a prospective, longitudinal study at a secondary level hospital in Johannesburg, South Africa during a 14-month period preceding October 2003. The three HIV tests were performed independently of each other by personnel blinded to the

child's true HIV infection status, the reference standard used for comparison. **RESULTS:** HIV testing was performed at a median age of 12.1 months. The true HIV infection status of 310 of 321 (97 percent) children was determined. In comparison with serum testing results, OF HIV tests reduced the percentage of children requiring repeat HIV tests from 45 percent to 8 to 12 percent. The abilities of OF and serum to predict an HIV-uninfected status were comparable with negative predictive values >99 percent. Interpretation of HIV tests in conjunction with simple clinical assessment further improved the predictive value of the test. **CONCLUSIONS:** OF HIV tests perform well in children and have the potential to increase accessibility and acceptability of HIV diagnosis for infants in the context of PMTCT programs in low-resource settings.

Pediatr Infect Dis J 2005;24(3):253-256.

Archives of Internal Medicine

Predictors and consequences of negative physician attitudes toward HIV-infected injection drug users

Ding L, Landon BE, Wilson IB, et al.

BACKGROUND: We evaluated physicians' training, experience, and practice characteristics and examined associations between their attitudes toward human immunodeficiency virus (HIV)-infected persons who are injection drug users (IDUs) and quality of care. **METHODS:** Cross-sectional surveys were conducted among a probability sample of noninstitutionalized HIV-infected individuals in the United States and their main HIV care physicians. Physician and practice characteristics, training, HIV knowledge, experience, attitudes toward HIV-infected IDUs, stress levels, and satisfaction with practice were assessed. The main quality-of-care measures were patient exposure to highly active antiretroviral therapy, reported problems, satisfaction with care, unmet needs, and perceived access to care. **RESULTS:** Nationally, 23.2 percent of HIV-infected patients had physicians with negative attitudes toward IDUs. Seeing more IDUs, having higher HIV treatment knowledge scores, and treating fewer patients per week were independently associated with more positive attitudes toward IDUs. Injection drug users who were cared for by physicians with negative attitudes had a significantly lower adjusted rate of exposure to highly active antiretroviral therapy by December 1996 (13.5 percent) than non-IDUs who were cared for by such physicians (36.1 percent) or IDUs who were cared for by physicians with positive attitudes (32.3 percent). Physician attitudes were not associated with other problems with care, satisfaction with care, unmet needs, or perceived access to care. **CONCLUSIONS:** Negative attitudes may lead to less than optimal care for IDUs and other marginalized populations. Providing education or experience-based exercises or ensuring that clinicians have adequate time to deal with complex problems might result in better attitudes and higher quality of care.

Arch Intern Med 2005;165(6):618-623.



IN THE LIFE



Lawrence McGlynn

For more than three years the *IAPAC Monthly* has featured members of the International Association of Physicians in AIDS Care (IAPAC), who are asked to bare their souls by answering a series of questions similar in nature to those asked in the famous *Proust Questionnaire*.

This month, *IAPAC Monthly* is proud to feature Lawrence McGlynn, who is Clinical Instructor in the Department of Psychiatry and Behavioral Sciences at Stanford University.

What proverb, colloquial expression, or quote best describes how you view the world and yourself in it?

Dream on until your dreams come true. — Aerosmith

What activities, avocations, or hobbies interest you? Do you have a hidden talent?

My hobbies include swimming, the beach, and music. What I would consider "hidden talents," others would consider noisy and irritating (so long piano...).

If you could live anywhere in the world, where would it be?

The San Francisco Bay Area, because this is where I grew

up and, to this day, I consider it one of the most beautiful places on earth. I saw how in the early 1980s my city took on a different feel—young men walking with canes, wasting, showing the ravages of the unwelcome visitor: HIV. It's a city that has changed greatly, as a result, but a city I will always love and call home.

Who are your mentors or real life heroes?

Mom, of course. A daughter of immigrants who raised four sons with patience, love, and understanding; always putting herself second. She will always be my hero.

With what historical figure do you most identify?

Peter Brady from the *Brady Bunch*. He was a middle child and always tried to do the best he could. He never strived to be the star, but was happy just being Peter.

Who are your favorite authors, painters, and/or composers?

For me, it's about music. Joy Division, Cocteau Twins, the Smiths and the words of the Beatles, Jefferson Airplane, and the Rolling Stones.

If you could have chosen to live during any time period in human history, which would it be?

Living prior to today seems to have involved a lot of work and fewer comforts. Since I don't know about the future, I'd say the present. I saw the 1960s as a young boy, the 1970s as an adolescent, and am having a great time in the 2000s.

If you did not have the option of becoming a physician, what would you have likely become, given the opportunity?

A musician. How wonderful it is for those who have the talent to move so many with their musical gifts.

In your opinion, what are the greatest achievements and failures of humanity?

Achievements: Advances in understanding our biology; our inherent compassion for others. Failures: War.

What is your prediction as to the future of our planet one full decade from present day?

I would predict further advances in the biological sciences, especially in virology and the behavioral sciences. I think there will still be a conflict in the Middle East, and terrorists will still try to steal happiness and security from the rest of us. I would predict, though, that the world's tolerance of terrorism will dwindle as we see more and more innocent lives taken in very cowardly ways. ■



SAY ANYTHING

e
This decision will permit a stabilization in the state of health of people living with HIV/AIDS, bring back patients lost to treatment, and create a keen interest within the population for voluntary testing campaigns.

Jean-Luc Mintchedji, an immunology specialist, in a March 31, 2005, Washington Times article about a new program created to distribute free antiretroviral drugs to 6,000 HIV-positive patients in Benin. More than 41,000 people have died of AIDS-related complications in Benin since 1985, when the first AIDS case was diagnosed in the country. Currently, it is estimated that 71,900 people are infected with HIV, almost 50 percent of them women between the ages of 15 and 49.

e
Buy Crystal. Get HIV Free.

Sign posted at several New York City community fora addressing the epidemic of crystal methamphetamine use in the gay community, as reported in an April 3, 2005, Associated Press report. Crystal methamphetamine is known to reduce sexual inhibitions and increase energy; both attributes may lead to an increase in HIV transmission. This issue has taken on increased significance since the February 11, 2005, New York City Department of Health and Mental Hygiene announcement about a New York City man diagnosed with a rapidly progressive multidrug-resistant strain of HIV, who self-reported unprotected sex with multiple partners following use of crystal methamphetamine.

e
Serious talk about the impact of HIV/AIDS on businesses is yet to get to the boardroom. The tone at the top is the key to success in addressing HIV/AIDS.

Charles Muchene, Kenya country director for PricewaterhouseCoopers (PWC), in an April 1, 2005, Reuters report about the Kenyan business sector's response to that country's AIDS epidemic. Although approximately 2 million Kenyans are currently infected with HIV, and more than 200,000 Kenyans die every year from AIDS-related complications, a PWC survey showed that businesses are not actively addressing the epidemic. Abel Nyagwa, a spokesperson for Kenya's National AIDS Control Program, countered that some positive changes have been made, including an increase in the number of businesses that offer antiretroviral therapy to their employees.

e
Just asserting the need to abstain, be faithful, and use condoms is not enough to protect women and girls from the ravages of the AIDS epidemic—we need more, and we need it now.

Geeta Rao Gupta, President of the International Center for Research on Women, during remarks she delivered April 13, 2005, to the US House of Representatives' Committee on International Relations. She was among several individuals asked to brief the committee about progress two years into the President's Emergency Plan for AIDS Relief (PEPFAR), through which 12 African and two Caribbean countries have been provided funding to implement HIV prevention interventions as well as expand access to antiretroviral therapy.

e
Other drugs are actually more effective [than nevirapine]... But there are huge parts of the developing world where there is nothing else right now, and most of the world has nothing at all, let alone nevirapine.


Mark Isaac, Vice President of the Elizabeth Glaser Pediatric AIDS Foundation, in a March 7, 2005, Reuters report about an Institute of Medicine (IOM) report on its investigation of the US National Institutes of Health (NIH)-subsidized HIVNET 012 trial. The trial, which was conducted in Uganda from 1997 to 1999, was labeled by a former NIH official as improperly conducted, with further claims that full disclosure of potential problems was not made to trial participants. The IOM found that the data used in the study and the conclusions drawn from the data were "sound and reliable," and that the trial was conducted ethically.

e
Just because folks are well informed doesn't mean they'll necessarily make the wisest choices in terms of their health.

Ronald Valdiserri, Deputy Director of the National Center for HIV, STD, and TB Prevention at the US Centers for Disease Control and Prevention (CDC), in an April 3, 2005, New York Times article. Valdiserri was discussing evidence that apathy is growing in the gay community with regard to HIV transmission. Various reasons have been cited for this change, including treatment optimism due to the success and availability of highly active antiretroviral therapy (HAART) in the developed world, drug use, loneliness, self-hatred, and alienation. There is disagreement over the best way to reverse this trend, with some experts suggesting that underlying factors affecting risk-taking behavior should be recognized and addressed, and others recommending strategies promoting personal responsibility, and stigmatization of behaviors that can cause HIV transmission.

The Rock appears as a courtesy of World Wrestling Federation Entertainment, Inc.
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WHY DOES THE ROCK WEAR THE BRACELET?

He wears it to raise desperately needed funds for HIV/AIDS care services, education and vaccine development. Over half a million people have chosen to wear The Bracelet. What about you? Available at: The Body Shop; Kenneth Cole; Virgin Megastore; Ben Bridge Jewelers and other fine retailers. Or visit us at WWW.UNTIL.ORG or call 1-800-88-UNTIL to order. 

Purchasing a UTAC bracelet contributes directly to the International Association of Physicians in AIDS Care (IAPAC) and its mission to improve access to quality treatment for all people living with HIV/AIDS. A full 25 percent of the price of each bracelet goes directly to IAPAC programming. Please be sure to mention IAPAC when shopping at www.until.org.