



Issue Number 376
December 28, 2001

Published 18 times a year by
John S. James
AIDS Treatment News
1233 Locust St., 5th floor
Philadelphia, PA 19107
800-TREAT-1-2
Email: aidsnews@aidsnews.org

Contents

HIV Resistance: Data and Spin 2
National press stories largely misinterpreted the new study which found high levels of HIV drug resistance in U.S. patients.

Barcelona Conference Abstract, Scholarship Deadlines Early 2002 4
Online abstract submissions for the XIV International AIDS conference in Barcelona (July 7-12, 2002) need to be received by January 21 (note time zones); deadline is January 14 for paper or disk abstract submissions to be received. Scholarship applications are due February 1.

African-Americans and AIDS Conference, February 25-26, Washington..... 4
Nationally prominent speakers will address this year's conference.

AIDS Treatment News Denialist Series 5
During the last year and a half *AIDS Treatment News* has published a series of articles answering fringe theories (that HIV is harmless, HIV doesn't exist, people should not be tested for HIV or take antiretrovirals if positive, etc.) Here are the references and links to all the articles in our series.

Medical Marijuana Grants: Application Deadlines January 15, May 1, and September 1 5
The Marijuana Policy Project announced grants up to \$50,000 for projects on law reform, especially medical marijuana.

Buyers' Club List, December 2001..... 6
Our annual list of AIDS-related buyers' clubs and contact information.

AIDS Treatment News Index, 2001 7
Annual index of this year's articles

AIDS Treatment News

Subscription and Editorial Office:

AIDS Treatment News
Philadelphia FIGHT
1233 Locust St., 5th floor
Philadelphia, PA 19107
800-TREAT-1-2 toll-free U.S. and Canada
fax: 215-985-4952
email: aidsnews@aidsnews.org

Editor and Publisher: John S. James

Associate Editors: Tadd T. Tobias, R.N.

Statement of Purpose:

AIDS Treatment News reports on experimental and standard treatments, especially those available now. We interview physicians, scientists, other health professionals, and persons with AIDS or HIV; we also collect information from meetings and conferences, medical journals, and computer databases. Long-term survivors have usually tried many different treatments, and found combinations which work for them. *AIDS Treatment News* does not recommend particular therapies, but seeks to increase the options available.

Subscription Information: Call 800-TREAT-1-2

Businesses, Institutions, Professional offices: \$325/year. Includes early delivery of an extra copy by email.

Nonprofit community organizations: \$150/year. Includes early delivery of an extra copy by email.

Individuals: \$140/year, or \$80 for six months.

Special discount for persons with financial difficulties: \$54/year, or \$30 for six months. If you cannot afford a subscription, please write or call.

Outside the U.S., Canada, or Mexico, add air mail postage of \$20/year, or \$10 for six months.

Back issues, and discounts for multiple subscriptions, are available; contact our office for details.

Please send U.S. funds: personal check or bank draft, international postal money order, or travelers checks. VISA, Mastercard, and purchase orders also accepted.

To protect your privacy, we mail first class without mentioning AIDS on the envelope, and we keep our subscriber list confidential.

ISSN # 1052-4207

Copyright 2001 by John S. James. To assure accuracy, *AIDS Treatment News* requires permission for republishing articles. Readers may make up to 20 photocopies for persons with AIDS or HIV; if you want to reprint more, call or write to us. Bulk orders and bulk subscriptions are available. Our address and phone number must be included in any reprint. Brief passages may be quoted for review.

HIV Resistance: Data and Spin

John S. James

On December 18 the first report was presented from a new study of the prevalence of drug-resistant HIV in U.S. patients in early 1999.¹ This study found that somewhere between 50 and 78 percent of these patients (depending on how you count patients whose viral resistance could not be measured) had some degree of reduced susceptibility to at least one antiretroviral. White, gay, middle class, insured patients had the most resistance, on the average, while those with less access to care had less. The national press eagerly picked up that story; and when we got home from the ICAAC conference in Chicago where the preliminary report was presented, we found that people all over the country had heard it -- and little else from the conference.

A closer look shows that while the study results are valid (though not as surprising as they might appear), the central messages that carried the press story appear to be misinterpretations -- ones that could have future consequences for society's political will to deal with the HIV epidemic, both in the U.S. and abroad:

1. The main message that went out through the press is that drugs are not working because of resistance. In fact, as one of the researchers noted to *AIDS Treatment News*, the good news is that treatments are still saving lives despite viral drug resistance. And most of the press ignored the fact, brought out at a press conference at ICAAC, that many of the patients found to have resistant virus started antiretrovirals years ago with inadequate regimens, and added new drugs one at a time as they became available in the 1990s -- conditions that facilitate resistance development. Patients starting treatment today do not use drugs that way.

2. The publicly available abstract of the study, as well as statements to the press, correctly reported that resistance was associated with markers of access to care. (Those with good access to medical care usually started treatment earlier, and therefore had more time to develop resistance -- and also they often started with the suboptimal two-drug or one-drug regimens.) But the emotional subtext that sold the newspapers was the implication that gay white men, despite all their advantages, were not doing their part to control the epidemic.

How the Study Was Done

This resistance study used samples collected in a major national survey of HIV care in the U.S., the HCSUS study (HIV Cost and Services Utilization Study).² The importance of HCSUS is that while most studies describe the particular patients who are available for the researchers (through a particular medical institution or clinical trial, for example), HCSUS carefully selected a sample to be as representative as possible of all HIV-positive persons receiving medical care in the U.S. (except in the military, in prison, or in a hospital emergency department), in the first two months of 1996. HCSUS randomly selected 4042 patients and interviewed 76% of them. It found that in January and February of 1996, about 230,000 HIV-infected adults received medical care.² HCSUS also found that "the patient population was disproportionately male, black, and poor," that many Americans with HIV were receiving care less than twice a year, and that the total cost of medical care for Americans with HIV was less than 1% of all direct personal health expenditures.²

In the new resistance study, over 1900 plasma samples obtained from HCSUS volunteers about three years later (in late 1998 to early 1999) were analyzed using the ViroLogic PhenoSense resistance test. Sixty-three percent of these samples had a viral load of over 500 copies of HIV, and 89% of those had resistance test results (those with a viral load lower than 500 cannot be tested for resistance with standard tests). Of those who could be tested, 78% had reduced susceptibility to at least one antiretroviral.

There was confusion in news reports over whether resistance was found in 78% of the patients, or in about half of them. This is because the most conservative calculation assumed no resistance in any of the patients who could not be tested for resistance. Therefore, 78% (of those successfully tested who were found to be resistant to at least one antiretroviral) times 63% (of those eligible for resistance testing since they had a viral load of over 500 copies), gives 49% of the total study population in which reduced susceptibility to at least one antiretroviral was documented. (This calculation is approximate, because in the actual study weighting factors were used to make the sample of patients studied be more representative of the U.S. HIV patient population.) Those who could not be tested probably tended to have less resistance than the others (since most had a low viral load, indicating the drugs were probably working well), but certainly persons with viral load under 500

can have drug-resistant virus.

This study did not collect adherence information except for self-reports, and does not have enough data to look at adherence.

AIDS Treatment News talked with Dr. Nick Hellmann of Virologic, one of the authors of the resistance report. He noted that despite this viral resistance, the death rate in the U.S. has still been kept relatively low since modern combination treatment was introduced. He suspects that part of the reason is that unlike bacteria, HIV usually pays a significant price for drug resistance, and is likely to become less able to replicate and cause rapid worsening of disease. He noted that while it might be possible for HIV to evolve to be both highly resistant and highly pathogenic, this appears to be uncommon.

Comment

This study did indeed find more resistance (HIV with reduced susceptibility to antiretrovirals) than expected. But much of this result is not really surprising given the study design. The patients selected were all in care in the U.S. in early 1996, but had their blood drawn and virus tested three years later in late 1998 to early 1999. With this sampling, many of the patients would have been on antiretrovirals for a long time, giving more time for resistance to occur. Since all were in care in early 1996 and known at that time to have HIV, it is likely that many of them started on suboptimal therapies. This selection (plus the fact that resistance was tested for many drugs, and just one positive test led to the volunteer being counted as having resistant virus) may partly explain why this study found much more resistance than other studies.

The groups that started treatment earlier -- including gay men, and those with insurance -- had more resistance, probably because they had more time for it to develop (as well as more chance of having been exposed to the two-drug or one-drug antiretroviral regimens no longer in use).

Could the new publicity on high prevalence of resistance contribute to the arguments against providing antiretroviral treatment in Africa? This study only looked at the U.S. But it is reasonable to assume that if treatment is introduced correctly in African countries, the results of this U.S. study would not apply. There will be less resistance than in the U.S., if patients are started on modern regimens and managed correctly.

Also, the kinds of HIV that are not native to the U.S.

(but have been common for years in Africa and other parts of the world) have not spread here to any large extent. Quite likely the major reason is those at risk of HIV in the U.S. are far more likely to get infected by a native virus, which probably blocks infection by other HIV strains. So the media image of resistant "superviruses" spreading from Africa throughout the world is contrary to the facts observed for years.

The right message to take from this study is that viral resistance is a serious problem, and people should be more careful to use antiretrovirals correctly. It is also important to prevent transmission of resistant virus to persons who are HIV-negative. For those already infected, generally it is best to have HIV fully suppressed whenever antiretrovirals are used, so that there is little or no viral replication, and resistant virus cannot evolve. But for many patients this goal is not feasible. For these patients and for everyone else with HIV, we need new drugs that are more effective, less toxic, and less susceptible to viral resistance. We especially need new classes of treatments, including new targets for antiretrovirals, and immune-based therapies to help the body itself control HIV.

References

1. Richman DD, Bozzette S, Morton S, Chien S, Wrin T, Dawson K, and Hellmann N. The prevalence of antiretroviral drug resistance in the U.S. 41st International Conference on Antimicrobial Agents and Chemotherapy, Chicago, December 18 [abstract LB-17].
2. Bozzette SA, Berry SH, Duan N, Richman D and others. The care of HIV-infected adults in the United States. *The New England Journal of Medicine*. December 24, 1998; volume 339, number 26, pages 1897-1904.

Barcelona Conference Abstract, Scholarship Deadlines Early 2002

The following deadlines are rapidly approaching for the XIV International AIDS Conference, Barcelona, Spain, July 7-12, 2002:

- * January 14: Abstract submissions if by paper or disk;
- * January 21: Abstract submissions online

(<http://www.aids2002.com>);

- * February 1: Scholarship applications.

See <http://www.aids2002.com> for application forms and more information.

African-Americans and AIDS Conference, February 25-26, Washington

The 2002 National Conference on African-Americans and AIDS will be held at the DC Renaissance Hotel in Washington, D.C.

Speakers include:

- * Kweisi Mfume, president/CEO of The National Association for the Advancement of Colored People;
- * Beny J. Primm, M.D., The Addiction Research and Treatment Corporation;
- * Celia J. Maxwell, M.D., FACP, Howard University;
- * Anthony S. Fauci, M.D., National Institutes of Health;
- * Valerie Stone, M.D., Brown University;
- * Phill Wilson, African-American HIV/AIDS Policy Training Institute;
- * Robert Fullilove, Ph.D., Columbia University
- * Glenn Treisman, M.D., Ph.D., Johns Hopkins University.

"This Conference is designed for clinicians who care for African-American patients infected with HIV/AIDS, nurses, pharmacists, HIV/AIDS service organization professionals, social workers, healthcare media, legislators, and other allied health professionals concerned about HIV/AIDS in African-Americans."

This year the conference must charge a \$50 admission fee, which includes breakfast and lunch. There are some scholarships for people with HIV. Up to 15 hours of Category 1 CME credit will be available.

For more information, including a full list of speakers, see <http://www.ncaaa.net>.

AIDS Treatment News **Denialist Series**

In our last issue we completed our series of articles, mostly by Bruce Mirken, answering the "AIDS denialist" assertions that HIV is harmless (or does not exist), HIV treatment should be avoided, HIV-related medical tests are inaccurate and useless, etc. Here we have collected the references and links to our articles so that the whole series can be found more easily.

The first article in this series appeared in April 2000, and the last article in December 2001. The first two articles below are deliberately out of sequence, so that our summary of what the series is about can be listed first. The series actually began in the issue before the summary.

As we stated in the summary, "Our concern is not the ideas--we agree that all sorts of ideas should be explored and debated--but rather the direct translation of casual speculation and debating points into the medical care of patients with life-threatening illness."

The series:

"AIDS Denialists: How to Respond," by John S. James, *AIDS Treatment News* #342, May 5, 2000
<http://www.aids.org/immunet/atn.nsf/page/a-342-10>

"Answering the AIDS Denialists: CD4 (T-Cell) Counts, and Viral Load," by Bruce Mirken, *AIDS Treatment News* #341
<http://www.aids.org/immunet/atn.nsf/page/a-341-02>

"AIDS Treatment Improves Survival: Answering the 'AIDS Denialists,' by Bruce Mirken, *AIDS Treatment News* #350
<http://www.aids.org/immunet/atn.nsf/page/i-350>

"HIV Treatment and Survival: Easy Language Version," by Bruce Mirken, *AIDS Treatment News* #354
<http://www.aids.org/immunet/atn.nsf/page/a-354-08>
(This flyer shortens and simplifies the survival article in issue #350. Agencies can reproduce it as an easy-to-read background for clients.)

"Answering the AIDS Denialists: Is AIDS Real?," by Bruce Mirken, *AIDS Treatment News* #356
<http://www.aids.org/immunet/atn.nsf/page/a-356-06>

"Viral Load and T-Cell (CD4) Counts: Why They Matter," by Bruce Mirken, *AIDS Treatment News* #364
<http://www.aids.org/immunet/atn.nsf/page/a-364-09>
(Easy language version of the CD4 and viral load article in issue #341, above.)

"HIV Testing 101 (Part 1 of 2)," by Bruce Mirken, *AIDS Treatment News* #374
<http://www.aids.org/immunet/atn.nsf/page/a-374-05>

"HIV Testing 101 (Part 2 of 2)," by Bruce Mirken, *AIDS Treatment News* #375
<http://www.aids.org/immunet/atn.nsf/page/a-375-04>

The following articles are not part of the same series, but are related:

"Treatment Interruption: Experts Sound Cautious Note at San Francisco Forum; Meeting Proceeds Despite Disruption," by Bruce Mirken, *AIDS Treatment News* #341
<http://www.aids.org/immunet/atn.nsf/page/a-341-01>
(This meeting on treatment interruption was invaded by about a dozen AIDS denialists, resulting in minor injury to a member of the staff of Project Inform, the meeting organizer.)

"Durban Declaration on HIV and AIDS," *AIDS Treatment News* #346
<http://www.aids.org/immunet/atn.nsf/page/a-346-03>

"Africa: Interview with South African High Court Justice Edwin Cameron," by Bruce Mirken, *AIDS Treatment News* #368
<http://www.aids.org/immunet/atn.nsf/page/a-368-03>

Medical Marijuana Grants: Application Deadlines January 15, May 1, and September 1

On January 3 the Marijuana Policy Project in Washington D.C. announced that grants up to \$50,000 will be awarded to "organizations and projects that articulate effective tactics and strategies to regulate marijuana similarly to alcohol and to make marijuana available for medical use. Grants will not be awarded to hemp-related projects, state ballot initiatives, or political campaigns." (But a major focus will be changing marijuana laws in specific jurisdictions -- especially passing medical marijuana bills in Maryland, New Mexico, and Vermont.)

The deadline for the first round of grant submissions is January 15, 2002, and the first round checks will be issued by March 31, 2002. For those who miss the January 15 deadline, the deadlines for the next rounds are scheduled for May 1 and September 1.

For more information and instructions for applying, see <http://www.mpp.org/grants/index.html>. Or contact the grants department of the Marijuana Policy Project, 202-462-5747 ext. 270.

Buyers' Club List, December 2001

AIDS Treatment News publishes a buyers' club list each December. For a short overview and introduction to the meaning, history, and services of these organizations, see *AIDS Treatment News* #309, December 18, 1998.

We focus on buyers' clubs specializing in HIV (we also included Rainbow Grocery in San Francisco, because of its extensive selection of supplements and excellent information about them). All the organizations listed below are nonprofit. Most can provide products by mail order. Most have fact sheets or other information, and some have a nutritionist or other expert available at certain times to answer questions. Some offer financial assistance with purchases if necessary. Most are open to the public, but some require membership (which may require an annual fee, or be restricted geographically or in other ways). Call ahead for current information.

We have not listed medical marijuana buyers' clubs here. The best way to find out about any in your area is by referral from a local AIDS service organization, support group, or healthcare professional.

Arizona

Being Alive Buyers' Club
<http://www.apaz.org/> (click "Buyer's Club")
edgarr@apaz.org
1427 North Third St., Phoenix AZ 85004
602-253-2437, fax: 602-253-5577

Travis Wright Memorial Buyers' Club
Southern Arizona AIDS Foundation Buyers' Club
<http://www.saaf.org/BChome.htm>
info@saaf.org
375 S. Euclid Ave, Tucson AZ 85719
800-771-9054 or 520-628-7223
fax: 520-628-7222; TTY: 800/367-8937

California

Rainbow Grocery Cooperative (20% PWA discount, with the Helping Hand card)
<http://www.rainbowgrocery.org/> (no products online 12/01)
vitamins@rainbowgrocery.org
1745 Folsom St., San Francisco CA 94103
415-863-0620

Colorado

Denver Buyers' Club (PWA Coalition Colorado)
1290 Williams St., Suite 102
Mailing address: P.O. Box 300339, Denver CO 80203-0339
303-329-9379, fax: 303-329-9381, pwacolo@aol.com
www.pwacoalitionofcolorado.com (starting Feb. 2002)
Bilingual Spanish/English TTY: thru operator

District of Columbia

Carl Vogel Center
<http://www.carlvogelcenter.org>
cvc@erols.com
1012 14th St. NW, Suite 707, Washington DC 20005
202-638-0750, fax: 202-638-0749

Membership: annual cost \$25 (includes a BIA test, reduced prices for massage acupuncture, educational symposium, newsletter, reduced prices for supplements).

Georgia

AIDS Treatment Initiatives
<http://www.aidstreatment.org>
info@aidstreatment.org
159 Ralph McGill Blvd. NE Suite 510, Atlanta GA 30308-3311
888-874-4845 or 404-659-2437
fax: 404-659-2438

Massachusetts

Treatment Information Network's/Boston Buyers' Club
<http://www.vitetime.com/>
bosbuyrclb@aol.com
Boston Living Center, 29 Stanhope St., 3rd Floor
Boston MA 02116
800-435-5586, or 617-266-2223
fax: 617-450-9412

New York

DAAIR (Direct Access Alternative Information Resources)
<http://www.daaair.org>
email: info@daair.org
31 East 30th St. #2A, New York NY 10016
888-951-5433 or 212-725-6994
fax: 212-689-6471

Note: The largest buyers' club. Membership by sliding scale, \$5, \$10, or \$25 per year; new members receive treatment information pack. Also, "Preventing and Managing Side Effects and HIV Symptoms" is available at <http://www.daaair.org> (no membership required -- click the Countering Toxicities button on the home page), or by mail by request if necessary.

Texas

Houston Buyers' Club
<http://www.houstonbuyersclub.com/>
hbc@neosoft.com
3400 Montrose Blvd. #605, Houston TX 77006
800-350-2392
713-520-5288, fax: 713-521-7419
Note: *How to Manage Side Effects*, a 48-page booklet by Lark Lands, Michael Mooney, Nelson Vergel, and others is available without charge. You can request a copy by phone, mail, or email.

AIDS Treatment News

Index, 2001

20th year of AIDS	364	d4T+ddI	358
911	371	Denialists	364
Abacavir	373	Denialists	374
Access, international (see Global epidemic)		Denialists	375
ACT UP Philadelphia	367	Denialists, <i>AIDS Treatment News</i> series	376
ADAP program	366	Developing countries (see Access, international)	
ADAP program	371	Direct action	364
Africa (see also South Africa)		Doctors Without Borders (see MSF)	
Africa -- home care	361	Doha	371
Africa	359	Drug donations	361
Africa	360	Efavirenz	362
Africa	363	Efavirenz	373
Africa	371	European parliament	363
Africa	372	Fact sheets	358
Africa	373	FDA	362
African American conference	376	FDA	369
African Americans	359	Fibrosis	370
Agenerase	373	Funding -- international (see Global epidemic)	
AIDS research -- 20 views	368	Garlic	375
AIDS Treatment Activist Coalition	370	GB virus C	372
AIDSWatch	362	Gilead Sciences (see Tenofovir)	
<i>AmFAR HIV/AIDS Treatment Directory</i>	363	GlaxoSmithKline	360
<i>AmFAR Treatment Insider</i>	362	GlaxoSmithKline	371
Amprenavir	373	GlaxoSmithKline	372
Antibodies and HIV	365	Global epidemic	362
Antibody testing	374	Global epidemic	363
Antibody testing	375	Global epidemic	367
Antiretrovirals list	372	Global epidemic	369
ATAC	370	Global epidemic	370
Barcelona (see International AIDS Conference)		Global epidemic	372
Bioterrorism--immune research	373	Global epidemic	373
Bone disease	366	Guidelines	361
Brazil	359	Heart disease	370
Bristol-Myers Squibb	361	Hepatitis C	359
Buenos Aires conference	368	Hepatitis C	371
Buenos Aires conference	369	Hepatitis	375
Burkina Faso	363	HIV drugs	372
Busch, Barry	367	HIV incidence	359
Buyers' club list	376	HIV prevention	364
Cameron, Justice Edwin	368	HIV resistance	368
CD4 count	364	HIV testing, part I of II	374
Civil society	365	HIV testing, part II of II	375
Cohen, Jon	367	Homocysteine	370
Coinfection (HIV and HCV)	371	IAPAC	369
Conference reports on Web	373	IAS Conference	368
Counterfeit drugs	365	IAS Conference	369
		ICAAC conference	375
		ICAAC conference	376
		Immune-based treatment	360
		Innate immune system	373
		Intellectual property -- patent proposal	366

Intellectual property (see also Global epidemic)		Saquinavir	375
Intellectual property	359	Scondras, David	371
Intellectual property	360	Social organization	367
Intellectual property	363	South Africa	359
Intellectual property	371	South Africa	360
Interaction, garlic & saquinavir	375	South Africa	361
Intermittent treatment	375	South Africa	364
International (see Global epidemic)		South Africa	368
International AIDS Candlelight Memorial	364	South Africa	374
International AIDS Conference	372	STI (structured treatment interruption)	369
International AIDS Conference	376	Structured intermittent therapy	375
Johns Hopkins Report	361	Sustiva	362
Kaletra	362	Sustiva	373
Kaletra	373	Syringe prescription	364
Liver (see Hepatitis)		T-20	373
Liver fibrosis	370	TAC (Treatment Action Campaign)	374
Malawi	371	TAG (Treatment Action Group)	364
Marijuana Policy Project	376	TAG (Treatment Action Group)	369
Maternal infant transmission	364	T-cell (CD4) count	364
Maternal transmission lawsuit	374	Tenofovir	360
Medical marijuana	376	Tenofovir	364
Medscape	369	Tenofovir	370
Merck	361	Tenofovir	372
Merck	367	Tenofovir approved	373
Mirken, Bruce	376	Therapeutic drug monitoring	363
Mitochondrial toxicity	366	Trade rules	371
MSF	361	Treatment access	359
Names reporting	367	Treatment guidelines (see Guidelines)	361
NATAF	370	Treatment interruption	369
Nevirapine	358	Treatment vs. prevention controversy	362
Nevirapine	374	Treatment vs. prevention controversy	365
New Mexico AIDS InfoNet	358	Tuberculosis guidelines	371
North American AIDS Treatment Action Forum	370	Twinning organizations	363
Pediatric AIDS	374	UNGASS	359
Pharmacokinetics	375	UNGASS	365
Pipeline (HIV drugs)	372	UNGASS	366
Post-exposure prophylaxis	358	UNGASS	367
Pregnancy	358	United Nations (see UNGASS)	
Protease inhibitors	370	Vaccines	359
Protease inhibitors	375	Vaccines	367
Research -- 20 views	368	Viral load 6-day changes	374
Resistance conference	368	Viral load	364
Resistance prevalence	376	Viramune	374
Resistance tests	374	ViroLogic	376
Retroviruses conference 2001	359	Women, treatment	368
Retroviruses conference 2001	361	Women, treatment	372
Retroviruses conference 2002	372	World AIDS Day	373
Richman, Douglas	376	Ziagen	373
Salvage therapy	362		
San Francisco	359		
Saquinavir	373		