A DAY WITH HIV IN AMERICA

3:17 P.M., CHICAGO: Jimmy Simpson, HIV-positive 27 years
WELCOME TO CHICAGO
More than 3,000 attendees converge on the Windy City as the U.S. Conference on AIDS comes to Chicago, Nov. 10-13. Positively AWARE is proud to be a media sponsor of the conference.

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ON THE COVER: JIMMY SIMPSON, HIV-POSITIVE, PHOTOGRAPHED BY JOSHUA THORNE FOR A DAY WITH HIV IN AMERICA, SEPT. 21: “I DECIDED 27 YEARS AGO THAT I WAS NOT READY TO DIE. SO I DID WHAT MY DOCTOR SAID, EAT RIGHT, TAKE YOUR MEDS, AND NEVER MISS AN APPOINTMENT.”
ONLINE

EXCLUSIVELY ON POSITIVELYAWARE.COM

Money and HIV
Financial reality and survival strategies.

Leading the way
An interview with Dr. Susan Little about San Diego’s innovative testing campaign.
www.positivelyaware.com/2011/11_07/little.shtml

DIGITAL EDITION
Read the print version of POSITIVELY AWARE on your computer.
http://issuu.com/positivelyaware

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A gay with HIV in America

WELCOME TO THE WINDY CITY! THIS YEAR’S UNITED States Conference on AIDS (USCA), sponsored by the National Minority AIDS Council (NMAC), is being held here in Chicago, for the first time in its fifteen-year history. For those of us in Chicago, in Illinois, and throughout the Midwest, it’s been a long time coming.

But it also could not be a more important time for what’s being billed as the “largest annual AIDS-related gathering in the country.” It takes place right here in the home town of President Barack Obama, whose administration helped to craft and release the country’s first National HIV/AIDS Strategy just a little over a year ago—and it leads the way for the World AIDS Conference being held in Washington, D.C. in 2012.

The theme of this year’s USCA is “Make Change Real: Unite. Speak. Act.” It speaks to the power of advocacy, and how we all play a role in creating change at the local, state, and federal level, in our communities, at work, and with families and friends. Each year the conference selects a target population upon which to focus their message and programming—last year in Orlando it was youth and HIV, this year it’s gay and bisexual men.

As a gay man living with HIV for over 20 years, it’s somewhat validating to be recognized as the group most affected by the HIV/AIDS epidemic in this country, but it’s certainly no badge of honor. In some ways, growing up gay in the ’60s and ’70s was more challenging than dealing with my HIV. But having worked in the HIV arena for 19 years, I constantly struggle with the fact that there are 56,000 new infections in the U.S. each year, the majority of which occur among gay men. While the group most affected is young African American gay men, where the infection rate rose to an alarming 43% in 2009, black women are 15 times more likely to acquire HIV than white women. I have to ask myself, what is it we’re doing wrong? Why is this still happening? Are we failing yet another generation?

There is much cause for hope, however, with gatherings such as this one in Chicago, where those who are doing the work come together to share, learn, and network with one another, to learn from each others’ failures, and build upon one another’s successes. I have no doubt that we will come away from this conference with a renewed sense of hope and strength, recharged, and with new ideas to take back to our communities and organizations to put into place and create change.

Unfortunately, as each year passes, it appears as though my battery’s charge doesn’t last quite as long as the preceding one. Soon it will be time for a new generation to develop the strategies, to sound the horn, to wave the banner, and to lead the charge—that is, if we’ve faithfully carried out our mission and done our job to mentor and educate those who will come after us. If we do that much, then passing the torch should be a breeze.

Hopefully, we will one day get to a place where the horn will be silenced, the banner laid down to rest, and the battle will be over. Renewed interest and advances in the search for a cure, innovative prevention methods, new drug development, and vaccine research is encouraging and gives us hope. But none of them will mean diddly-squat if we don’t have the wherewithal and the means to implement these advances, to identify those who need them most, and to develop strategies to get individuals into care, and keep them in care.

One way to reduce the barriers to care and shore up retention is to break down the stigma surrounding HIV, and that’s exactly what A Day with HIV in America seeks to do. In this, the second annual photo essay, you will see images of everyday people living with and affected by HIV, who came together on one, single day to share their stories. Gay, straight. Negative, positive. All shapes, colors, genders, and sizes—speaking with one voice. Making change real. You can too, by stopping by the Positively Aware booth at USCA. Or visit us online at www.positivelyaware.com and www.adaywithhivinamerica.com. And go to our Facebook page and follow us on Twitter.

Share your stories about life with HIV, and start to tear away at the stigma, and create a better world for those who follow, because we are all living with HIV.

Take care of yourself, and each other.
I was 24 when I received my diagnosis seven years ago. At the time, I was a “functional” crack addict, holding down a job and concealing my addiction, even though I was not eating and losing weight due to my smoking sprees and orgies where I had unprotected sex. It wasn’t a surprise to hear that I was HIV-positive, but I laughed hysterically at the nurse who told me because I was so deep in denial.

But I was lucky. Even though I was cowardly enough to tell my mother over the phone so I wouldn’t have to face her devastation, both she and my late aunt Dolores stood by me. My mother was inexhaustible in her quest for knowledge, surfing the Internet, as well as asking numerous questions of HIV specialists. My aunt, in the medical field herself, referred me to my HIV doctor, James Sullivan. Dr. Sullivan has been great, prescribing Atripla and making sure I understand the importance of taking my medication every day.

Then I found TPAN and Positively Aware. Having learned from my mother’s example, I’ve pursued knowledge of this disease and taken advantage of the educational programs at TPAN—TEAM (Treatment Education Adherence Management) and POWER (Positive Outcomes for Wellness, Education, and Recovery)—and I’ve become an avid reader of Positively Aware. Thanks to TPAN, I’ve now learned enough about HIV to know it isn’t a death sentence and I have the tools I need to stay clean and healthy.

I volunteer at TPAN now, as well as with other organizations within the HIV and LGBT communities in Chicago, and I find myself on steady ground, clean and sober for four years, with a good T-cell count and viral load, and sharing both my story and the knowledge I’ve gained in the last few years. I am passionate about breaking the hold that stigma has, especially within the African American community, knowing that we are only hurting ourselves by letting it continue. I hope that by talking about it, I can fight the stigma attached to HIV, as well as the spread of the disease itself.

I can’t blame anyone but myself for becoming HIV-positive, but I give credit to all those who’ve helped me get to the point where I know I can control my HIV and live a long life of purpose and satisfaction. Thanks for providing the information and inspiration that PA brings.

Jermaine Ballenger
Chicago, IL

TEACHING HIV 101

I work for the Department of Corrections in Massachusetts and would like to tell you how very much the HIV 101 issue will help me with my Health Awareness classes. I have given copies of the “Unfolding Picture” and “It’s in Your Blood” articles to my present Health Awareness class, who are training to become peer educators. This gives them such a great way of understanding and relating to each subject, so they may use these articles to teach other inmates in the future. I have found so many useful articles from your publications.

Thank you again for producing such a great asset to the better understanding of HIV and AIDS, and all that is associated with them.

T. Horton
HIV Counselor & Educator
Bridgewater, MA

COLORADO CRAVING

I am HIV-positive and currently in the Colorado Department of Corrections. Ironically, CDOC is hands-down one of the best places for treatment of HIV. The HIV doc here is not restricted by cost or other variables in administering our treatment.

I’m writing to tell you that PA is my lifeline to accurate info about drugs. I find myself craving each and every new issue. The magazine has helped me to decide to start on meds.

The PA impact is felt nationwide. Thanks!

Eric
Canon City, CO

LEGAL BLIND

We were happy to see the article by Roger McCaffrey-Boss in the September/October edition on legal issues affecting people with HIV, but chagrined that neither the article nor either of the resource lists mentioned the assistance available from the AIDS Legal Council of Chicago (ALCC) and other legal services providers who are dedicated to preserving and protecting the rights of people with HIV. Our website, www.aidslegal.com, has a wide range of materials available—not just links to the laws themselves, but also legal guides on a wide range of topics and self-help materials that range from a letter you can send when someone is disclosing your status to the form a physician can fill out to get presumptive benefits started while a Social Security application is pending.

CONTINUED ON PAGE 11 >>
When ISENTRESS has been given with other anti-HIV drugs, side effects included nausea, headache, kidney damage.

This is because on rare occasions muscle problems can be serious and can lead to kidney damage.

Call your doctor right away if you notice any signs or symptoms of an infection after starting ISENTRESS.

 opportunist infections may occur as the medicines work to treat the HIV infection and strengthen the immune system.

A condition called Immune Reconstitution Syndrome can happen in some patients with advanced HIV infection (AIDS) when anti-HIV treatment is started. Signs and symptoms of inflammation from opportunistic infections may occur as the medicines work to treat the HIV infection and strengthen the immune system. Call your doctor right away if you notice any signs or symptoms of an infection after starting ISENTRESS.

Contact your doctor immediately if you experience unexplained muscle pain, tenderness, or weakness while taking ISENTRESS. This is because on rare occasions muscle problems can be serious and can lead to kidney damage.

When ISENTRESS has been given with other anti-HIV drugs, side effects included nausea, headache, tiredness, weakness, trouble sleeping, stomach pain, dizziness, depression, and suicidal thoughts and actions. Mild rash occurred more often in patients taking ISENTRESS plus Prezista than with either drug alone.
I am a go-getter.
I am romantic.
I am a world traveler.
I am HIV positive.

You are special, unique, and different from anyone else. And so is your path to managing HIV. When you’re ready to start HIV therapy, talk to your doctor about a medication that may fit your needs and lifestyle.

In clinical studies lasting 96 weeks, patients being treated with HIV medication for the first time who took ISENTRESS plus Truvada:

- Had a low rate of side effects
  - The most common side effect of moderate to severe intensity (that interfered with or kept patients from performing daily activities) was trouble sleeping
  - This side effect occurred more often in patients taking ISENTRESS plus Truvada (4%) versus Sustiva plus Truvada (3%)
- Experienced less effect on LDL cholesterol (“bad” cholesterol)
  - Cholesterol increased an average of 7 mg/dL with ISENTRESS plus Truvada versus 21 mg/dL with Sustiva plus Truvada
  - When they began the study, the average LDL cholesterol of patients on ISENTRESS plus Truvada was 96 mg/dL versus 93 mg/dL for those on Sustiva plus Truvada

Ask your doctor about ISENTRESS.
Not sure where to start? Visit isentress.com/questions

People taking ISENTRESS may still develop infections, including opportunistic infections or other conditions that occur with HIV infection.

Tell your doctor about all of your medical conditions, including if you have any allergies, are pregnant or plan to become pregnant, or are breast-feeding or plan to breast-feed. ISENTRESS is not recommended for use during pregnancy. Women with HIV should not breast-feed because their babies could be infected with HIV through their breast milk.

Tell your doctor about all the medicines you take, including prescription medicines like rifampin (a medicine used to treat infections such as tuberculosis), non-prescription medicines, vitamins, and herbal supplements.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

For more information about ISENTRESS, please read the Patient Information on the following page.

Need help paying for ISENTRESS? Call 1-866-350-9232
Patient Information

ISENTRESS® (eye sen tris) (raltegravir) Tablets

Read the patient information that comes with ISENTRESS® before you start taking it and each time you get a refill. There may be new information. This leaflet is a summary of the information for patients. Your doctor or pharmacist can give you additional information. This leaflet does not take the place of talking with your doctor about your medical condition or your treatment.

What is ISENTRESS?
• ISENTRESS is an anti-HIV (antiretroviral) medicine used for the treatment of HIV. The term HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). ISENTRESS is used along with other anti-HIV medicines. ISENTRESS will NOT cure HIV infection.
• People taking ISENTRESS may still develop infections, including opportunistic infections or other conditions that happen with HIV infection.
• Stay under the care of your doctor during treatment with ISENTRESS.
• The safety and effectiveness of ISENTRESS in children has not been studied.

ISENTRESS must be used with other anti-HIV medicines.

How does ISENTRESS work?
ISENTRESS blocks an enzyme which the virus (HIV) needs in order to make more virus. The enzyme that ISENTRESS blocks is called HIV integrase.

When used with other anti-HIV medicines, ISENTRESS may do two things:
1. Reduce the amount of HIV in your blood. This is called your “viral load”.
2. Increase the number of white blood cells called CD4 (T) cells.

ISENTRESS may not have these effects in all patients.

Does ISENTRESS lower the chance of passing HIV to other people? No. ISENTRESS does not reduce the chance of passing HIV to others through sexual contact, sharing needles, or being exposed to your blood.

• Continue to practice safer sex.
• Use latex or polyurethane condoms or other barrier methods to lower the chance of sexual contact with any body fluids. This includes semen from a man, vaginal secretions from a woman, or blood.
• Never re-use or share needles.

Ask your doctor if you have any questions about safer sex or how to prevent passing HIV to other people.

What should I tell my doctor before and during treatment with ISENTRESS? Tell your doctor about all of your medical conditions. Include any of the following that applies to you:
• You have any allergies.
• You are pregnant or plan to become pregnant.
  - ISENTRESS is not recommended for use during pregnancy.
  - ISENTRESS has not been studied in pregnant women. If you take ISENTRESS while you are pregnant, talk to your doctor about how you can be included in the Antiretroviral Pregnancy Registry.
• You are breast-feeding or plan to breast-feed.
  - It is recommended that HIV-infected women should not breast-feed their infants. This is because their babies could be infected with HIV through their breast milk.
  - Talk with your doctor about the best way to feed your baby.

Tell your doctor about all the medicines you take. Include the following:
• prescription medicines, including rifampin (a medicine used to treat some infections such as tuberculosis)
• non-prescription medicines
• vitamins
• herbal supplements

Know the medicines you take.
• Keep a list of your medicines. Show the list to your doctor and pharmacist when you get a new medicine.

How should I take ISENTRESS?
Take ISENTRESS exactly as your doctor has prescribed. The recommended dose is as follows:
• Take only one 400-mg tablet at a time.
• Take it twice a day.
• Take it by mouth.
• Take it with or without food.

Do not change your dose or stop taking ISENTRESS or your other anti-HIV medicines without first talking with your doctor.

IMPORTANT: Take ISENTRESS exactly as your doctor prescribed and at the right time of day because if you don’t:
• The amount of virus (HIV) in your blood may increase if the medicine is stopped for even a short period of time.
• The virus may develop resistance to ISENTRESS and become harder to treat.
• Your medicines may stop working to fight HIV.
• The activity of ISENTRESS may be reduced (due to resistance).

If you fail to take ISENTRESS the way you should, here’s what to do:
• If you miss a dose, take it as soon as you remember. If you do not remember until it is time for your next dose, skip the missed dose and go back to your regular schedule. Do NOT take two tablets of ISENTRESS at the same time. In other words, do NOT take a double dose.
• If you take too much ISENTRESS, call your doctor or local Poison Control Center.

Be sure to keep a supply of your anti-HIV medicines.
• When your ISENTRESS supply starts to run low, get more from your doctor or pharmacy.
• Do not wait until your medicine runs out to get more.

What are the possible side effects of ISENTRESS?
When ISENTRESS has been given with other anti-HIV drugs, side effects included:
• nausea
• headache
• tiredness
• weakness
• trouble sleeping
• stomach pain
• dizziness
• depression
• suicidal thoughts and actions

Other side effects include: rash, severe skin reactions, feeling anxious, paranoia, low blood platelet count, diarrhea, liver failure.

A condition called Immune Reconstitution Syndrome can happen in some patients with advanced HIV infection (AIDS) when combination antiretroviral treatment is started. Signs and symptoms of inflammation from opportunistic infections that a person has or had may occur as the medicines work to treat the HIV infection and help to strengthen the immune system. Call your doctor right away if you notice any signs or symptoms of an infection after starting ISENTRESS with other anti-HIV medicines.

Contact your doctor promptly if you experience unexplained muscle pain, tenderness, or weakness while taking ISENTRESS. This is because on rare occasions, muscle problems can be serious and can lead to kidney damage.

Rash occurred more often in patients taking ISENTRESS and darunavir together than with either drug separately, but was generally mild.

Tell your doctor if you have any side effects that bother you. These are not all the side effects of ISENTRESS. For more information, ask your doctor or pharmacist.

How should I store ISENTRESS?
• Store ISENTRESS at room temperature (68 to 77°F).
• Keep ISENTRESS and all medicines out of the reach of children.

General information about the use of ISENTRESS
Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets.
• Do not use ISENTRESS for a condition for which it was not prescribed.
• Do not give ISENTRESS to other people, even if they have the same symptoms you have. It may harm them.

This leaflet gives you the most important information about ISENTRESS. If you would like to know more, talk with your doctor.
• You can ask your doctor or pharmacist for additional information about ISENTRESS that is written for health professionals.
• For more information go to www.ISENTRESS.com or call 1-800-622-4477.

What are the ingredients in ISENTRESS?
Active ingredient: Each film-coated tablet contains 400 mg of raltegravir.
Inactive ingredients: Microcrystalline cellulose, lactose monohydrate, calcium phosphate dibasic anhydrous, hypromellose 2208, polyoxamer 407 (contains 0.01% butylated hydroxytoluene as antioxidant), sodium stearyl fumarate, magnesium stearate. In addition, the film coating contains the following inactive ingredients: polyvinyl alcohol, titanium dioxide, polyethylene glycol 3350, talc, red iron oxide and black iron oxide.

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Continued from Page 7 >>

Also, the AIDS Coordinating Committee of the American Bar Association maintains a directory of HIV legal services programs in every state. It is available online at www.americanbar.org/content/dam/aba/images/aids_coordinating_project/aids_directory.pdf

EDITOR’S NOTE: Thanks to Ms. Fisher for bringing this to our attention. Both the ALCC and the American Bar Association links were added to the online version of the article and the resource list.

POSITIVE ANSWER
I am 26 years old and I’ve been HIV-positive for two years. I’m not on meds and my T-cell count is 580, viral load about 100,000. It has been higher, but also as low as 10,000. My partner, who is HIV-positive as well, has taught me so much about this disease and introduced me to POSITIVELY AWARE. I don’t know what I ever would have done without both of you. Thank you for your help, support, and for always being there, whether it’s POSITIVELY AWARE with an answer to a question I need to know or my partner with a shoulder to cry on. We can continue to fight this disease together.

Daven Crenshaw
Leesburg, NJ

CLARIFICATION: 19% of HIV-positives in the U.S. have undetectable viral load

In the September+October Editor’s Note, it was stated “that only 19% of people on antiretroviral treatment have a suppressed viral load” which was inaccurate. It should have said that 19% of HIV-positive people in the U.S. have an undetectable viral load.

This is based on a study in the March 15 edition of Clinical Infectious Diseases, which argued that the test-and-treat strategy would not be enough to control the epidemic in this country.

According to a review in AIDSMap by Michael Carter, “Late diagnosis, low levels of referral and retention in specialist HIV care, and sub-optimal adherence to antiretroviral therapy all undermined the potential for test-and-treat to eradicate transmission of the virus.”

In addition, one-fifth of individuals with HIV in the U.S. are still undiagnosed, and even being in care did not guarantee that patients would be on the best therapy.

After taking into account all of the factors the investigators calculated that only 210,000 HIV-positive patients in the U.S. have an undetectable viral load, which constitutes just 19% of the 1.1 million HIV-infected population.

POSITIVELY AWARE regrets the error.

Your Comments:
"You only have one life to live. I refused to be a victim and dealt with it full force."

"This experience challenged my personal will to live, forgive, and tested my religious philosophy (Buddhist)."

"I was a single mother of an 8-year-old girl. I needed to stay healthy and see her into adulthood. She’s getting married this month."

"Reckless abandon, feeling that death was not far off so I might as well go crazy...that was 26 years ago :)

"I think it was a bit of all of the above, but mostly I had hope, plus a great support system from family and friends that made all the difference in the world."

"Get busy livin’ or get busy dyin’—sums up my attitude!"

This Issue’s Poll Question:
Do you think the new health care reforms will help, hurt, or not affect the fight against HIV in the U.S.?

Cast Your Vote at PositivelyAware.com

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A model, photographer, or author’s HIV status should not be assumed based on their appearance in Positively Aware, association with TPAN, or contributions to this journal.

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**New arrivals: Complera and Edurant**

This summer, the Food and Drug Administration (FDA) approved two new HIV medications, Edurant (rilpivirine) and Complera, a triple-drug combination and complete regimen in one pill taken once daily—the second such medication on the market, Atripla being the first. Complera consists of Edurant and Truvada (a combination of Viread [tenofovir DF] and Emtriva [emtricitabine]). Atripla consists of Sustiva (efavirenz) and Truvada. Edurant and Sustiva are from the drug class called non-nucleoside reverse transcriptase inhibitors (NNRTIs, or non-nukes).

Complera is the most-awaited of the two. Tony Mills, MD, Director of Medical Research, Anthony Mills MD, Inc. and a participating investigator in ongoing Complera studies, said in a press release, “The concept of a single-tablet regimen has become a goal in HIV drug development, and the standard of care in medical practice in the United States. However, no one therapy is appropriate for all patients. Given its efficacy, safety, and convenience, the availability of Complera represents an exciting milestone in addressing the individual needs of patients new to HIV therapy.”

Complera was studied against Atripla, which is perhaps the most widely prescribed HIV medication in the United States for people taking antiviral therapy for the first time (treatment-naïve). So how does Complera stand up to this powerhouse?

On the negative side, despite similar efficacy, there was more virologic failure and greater likelihood of developing drug resistance with Complera. On the plus side, Complera was more tolerable. Together, Complera’s tolerability and resistance profile may be better than was shown in these studies. Until true head-to-head data is available, however, caution about starting treatment with Complera may prevail. For now, the consensus is that Complera is an option for people starting out with lower viral loads.

**Efficacy and Virologic Failure**

Overall, 83% of the 550 study participants on Complera achieved undetectable viral loads (less than 50 copies per mL) at week 48, compared to 81% of the 546 individuals on Atripla. For people who started with a viral load of between 100,000 to 500,000, efficacy was again the same for Complera and Atripla, 78%. At above 500,000, however, efficacy was 66% for Complera and 72% for Atripla.

Even though overall Complera was non-inferior (a standard required by the FDA) to Atripla, when looking at virologic failure, Complera did worse. The overall virologic failure (detectable viral load levels) rate for Complera was 13% vs. 8% for Atripla. The proportion of people who discontinued treatment due to virologic failure was 5% for Complera vs. 1% for Atripla.

The virologic failure rate varied by the viral load level of study participants at the beginning. For those who started with less than 100,000, the virologic failure rate was 5% with Complera and 3% with Atripla; at 100,000 to 500,000 it was 20% for Complera and 11% for Atripla; and above 500,000 it was 30% for Complera and 18% for Atripla.

**Study Design**

Remember, however, that the studies were not using the fixed dose formulations now on the market. Instead, to maintain a high research standard of double blinding, where neither the participants nor the researchers know what medications were given, study participants were to take either rilpivirine or a rilpivirine placebo (inactive pill) with a meal during the day and a Sustiva pill or placebo on an empty stomach at night, all along with a Truvada dose at some point. It’s a great way to conduct research, but it puts both Complera and Atripla at a disadvantage, with multiple pills and twice-daily dosing.

The FDA looked at the THRIVE and ECHO studies, comparing the drugs to one another, and reported combined data with the approval. Separate data showed that the fixed dose formula was bioequivalent to the drugs taken by themselves, meaning that it achieved the same levels in the blood. Some participants also used background regimens other than Truvada (such as Combivir). For the sake of simplicity, the results reported here have been attributed to Complera or Atripla.

**Resistance Profile**

There was more development of drug resistance with virologic failure for Complera than Atripla. This is important because generally, the greater the resistance risk, the less desirable the drug or the regimen.

Cross-resistance (when drug resistance to one medication confers resistance to another one in the same drug class) was more likely with Edurant than with Sustiva. Edurant cross-resistance was seen with Intelence, Sustiva, and Viramune. One treatment goal is to use medication that has the least chance of developing cross-resistance, with the idea being that you can move on to other drugs in that class if necessary. Therefore, starting therapy with Complera may limit your chances of moving on to other regimens based on a non-nucleoside,
a choice you are more likely to have if you start therapy with Atripla instead.

In addition, virologic failure with Complera also conferred more resistance to the antivirals Epivir, Emtriva, and Viread, all important backbone drugs for HIV therapy. Of the people with virologic failures in the Complera group, 44% (34/77) had genotypic and phenotypic resistance to Edurant (meaning that the drug will no longer work well for them). This compared to 23% (10/43) of the virologic failures in the Atripla group who had genotypic and phenotypic resistance to Sustiva. Moreover, phenotypic and/or genotypic resistance to Emtriva and Viread emerged in 51% (39/77) and 9% (7/77) of the virologic failures, respectively, in the Complera arms compared to 12% (5/43) and 7% (3/43) in the Atripla arms.

Of the 34 individuals with virologic failure and resistance to Complera, 31 (91%) were also resistant to Intelence and Sustiva, and 22 (65%) were resistant to Viramune. In the Atripla group, none of the 10 Sustiva-resistant virologic failures were resistant to Intelence at failure.

**SIDE EFFECTS**

More people discontinued treatment due to adverse events with Atripla than with Complera; 2% in the Complera arm and 5% in the Atripla arm.

The most common adverse reactions leading to discontinuation were psychiatric disorders (1.5% of individuals on Complera, vs. 2.2% participants on Atripla) and rash (0.2% on Complera, vs. 1.8% on Atripla). Depression was slightly greater with Complera, 8% vs. 6% for Atripla. However, depression of at least moderate intensity (grades 2–4) was 1% for Complera and 2% for Atripla.

On the plus side, Complera had fewer lipid problems than Atripla. Increases in total cholesterol of 200–239 mg/dL were seen in 13% of people on Complera vs. 29% of people on Atripla. Increases of 240–300 mg/dL were seen in 4% of Complera vs. 15% of Atripla participants. Increases above 300 mg/dL were seen in 1% of people on Complera vs. 2% of people on Atripla. Increased LDL (“bad” cholesterol) levels were also double with Atripla over what was seen with Complera.

A head-to-head study is underway, using the actual fixed dose Complera pill vs. Atripla. Data from that study is expected by year’s end.

**DRUG INTERACTIONS**

Antacids are tricky with Complera and should be taken at least two hours before or after a Complera dose. H$_2$ receptor antagonists, such as Pepcid, Tagamet, and Zantac, should be taken 12 hours before or four hours after a Complera dose. Proton pump inhibitors (PPIs), such as Nexium, Prevacid, and Prilosec, should not be taken.

Nor should Complera be taken with the herb St. John’s wort, commonly used for depression.

Also, methadone levels are reduced by Complera and people on methadone should be monitored for side effects.

As with Atripla, Complera cannot be dose-adjusted as necessary for people with kidney problems.

Beware of taking extra doses. Higher doses (three pills, for example) are associated with the risk of prolonged QT intervals, a heart condition.

Remember to check for hepatitis B before starting Complera, since the Emtriva and Viread it contains is effective against this virus and flare-ups may occur upon discontinuation of treatment.

See the drug label for more information on interactions, side effects, and use in pregnant women, and for children.
In August, the FDA approved the combination of Pegasys (peginterferon alfa-2a) and Copegus (ribavirin) for the treatment of chronic hepatitis C virus (HCV) in pediatric patients ages 5–17 who have not been previously treated with interferon alpha. In one study, 114 previously untreated pediatric patients in that age range were randomized to receive either combination treatment of Pegasys/Copegus (P/C) or Pegasys/placebo. As shown in adults, the combination of Pegasys/Copegus provided significantly better sustained virologic response rates compared to treatment with Pegasys alone. The SVR rate for study participants receiving P/C was 53% compared to 20% in the group receiving just Pegasys. Patients with the harder-to-treat genotype 1 receiving P/C demonstrated SVR of 47% while the smaller subgroup with non-genotype 1 had a higher SVR of 80%. Pediatric patients treated with therapy experienced a delay in gaining weight and height after 48 weeks of therapy compared with baseline, but two years after treatment, most of them had returned to normal baseline growth curve percentiles for weight and height.

Also in August, the FDA approved changes to the product labeling for Pegasys and Copegus. The following new recommendations for dosing of Pegasys and Copegus in patients with renal impairment have been added to product labeling based on a clinical study of 50 chronic hepatitis C subjects with moderate or severe renal impairment or end stage renal disease, and on pharmacokinetic modeling or simulation. Though the FDA’s announcement contained extensive and detailed information on the study and various factors involved in the dose change, it can be summarized by the following: “Based on the pharmacokinetic and safety results from this trial, patients with creatinine clearance less than or equal to 50 mL/min should receive a reduced dose of Copegus; and patients with creatinine clearance less than 30 mL/min should receive a reduced dose of Pegasys. The clinical and hematologic status of patients with creatinine clearance less than or equal to 50 mL/min receiving Copegus should be carefully monitored. Patients with clinically significant laboratory abnormalities or adverse reactions which are persistently severe or worsening should have therapy withdrawn.”

Gilead Sciences announced in August that its experimental four-in-one HIV drug regimen, called the Quad, met its primary objective of demonstrating non-inferiority to the medication Atripla at 48 weeks. “Achieving non-inferiority to the current standard of care in HIV therapy is a major developmental milestone for our Quad regimen,” said Norbert Bischofberger, PhD, in a press release. He is Executive Vice President for Research and Development and Chief Scientific Officer for Gilead Sciences. “We are very pleased with these results, which are in line with our expectations and allow us to begin preparations for a U.S. regulatory filing in the first quarter of 2012.”

A study investigating HIV prevention in women discontinued the use of tenofovir pills (brand name Viread). However, a combination of tenofovir with another HIV medication, emtricitabine (together under the brand name Truvada), will continue to be studied, as well as a tenofovir gel used vaginally. Recent successes with PrEP included the use of Viread in women. Altogether, Viread and Truvada for men, women, and transgender women, and tenofovir gel used vaginally have reduced risk of HIV by 42% to 93%. Research will continue to examine the setbacks. Begun in September 2009, the VOICE study, or MTN-003, involves more than 5,000 HIV-uninfected women in South Africa, Uganda, and Zimbabwe.
ORGAN TRANSPLANTS

QUESTION: I received a group e-mail from a friend recently asking me to consider being an organ donor. I responded that in 1985, when I tested positive, I regretfully had to forfeit the desire to be an organ donor. My friend promptly wrote back that some medical facilities will take organs from HIV-positive patients for certain recipients. Is this so? What is the current status on organ donation for HIV-positive people?

ANSWER: This question presents a scenario that we might have expected to change in recent years with so many HIV/AIDS patients living longer, healthier lives.

There are currently over 112,000 people in the U.S. on the waiting list for an organ transplant and several hundred of them are HIV-positive. The Cleveland Clinic performed the first heart transplant on an HIV-positive patient in 2001 and then through 2010, the United Network of Organ Sharing recorded almost 800 HIV-positive organ recipients out of 295,345 total recipients, although the HIV status was not recorded for about 30% of this total. Currently, many transplant centers in the U.S. will perform transplants on HIV-positive patients, including the University of Pittsburgh, where one of my patients successfully underwent a liver transplant more than five years ago.

The current ban on organ donation by HIV-positive people has been in place since 1988. The web site of the Department of Health and Human Services (DHHS) specifically states, “All people, regardless of age, should consider themselves potential organ and tissue donors. There are a few absolute exclusions (HIV infection, active cancer, systemic infection) and no strict upper or lower age limits.” Twenty-three years later, this law remains in effect.

Recently, four groups (American Society of Transplant Surgeons, Association for Organ Procurement, United Network for OrganSharing, and the American Society of Transplantation) released a statement calling for a change in the 1988 law. In addition, federal health officials and physicians, including transplant surgeons, have called for repeal of the ban.

A recent paper published in the June 2011 issue of the American Journal of Transplantation by Boyarsky and colleagues at Johns Hopkins estimated that there are more than 500 HIV-positive potential donors each year in the United States. Dorry Segev, MD, a co-author of this study, stated, “The clock is ticking more quickly for those who are HIV-positive and we have a huge organ shortage. Every HIV-infected one we use is a new organ that takes one more person off the list.”

On the negative side are the risks of HIV transmission. The New York City Department of Health and Mental Hygiene reported this past March that a patient contracted HIV after receiving a kidney transplant in 2009 from a donor who was HIV-positive but not tested close enough to the time of the surgery. There were also four organ recipients in Chicago in 2007 who contracted HIV from the same deceased donor whose HIV status was erroneously noted to be negative. These cases will not help the cause of promoting organ donation by HIV-positive individuals. On the other hand, they illustrate the need to appropriately screen all potential organ donors for HIV.

One model that makes sense would be to have organs from HIV-positive donors given to transplant patients who are also positive. Indeed, such a scenario took place in 2008 in South Africa where four HIV-positive patients received kidneys from two deceased HIV-positive donors. According to the report, all four were doing well at one year after the transplant. A concern noted by some, however, would be the transmission of a more virulent strain of HIV to an organ recipient. On the other hand, the hope would be that viral replication would still be controlled by potent antiretroviral therapy. My expectation is that there will be a change in the National Organ Transplantation Act. Indeed, the CDC is expected to soon issue new guidelines that will encourage research protocols involving transplantation of organs from HIV-positive donors to HIV-positive recipients. And in 2004, the first law of its kind in the U.S. was passed in Illinois, allowing people who are HIV-positive to donate organs to others with HIV.

In a recent New York Times article, Dr. Matthew Kuehnert, director of the CDC’s office of blood, organ, and tissue safety, stated, “We would like to see as many safe transplants as possible...there is no reason why HIV-positive patients should not get transplants and that HIV-positive donors can’t be used.”
PA first reported on the 6th IAS Conference on Pathogenesis, Treatment and Prevention in the September+October issue. Following are additional highlights from this year’s conference. For more online-only reports, go to www.positivelyaware.com; to view session webcasts, visit www.ias2011.org.

GAY COUPLES AT RISK

Atlanta researchers found a high rate of HIV in gay male couples who thought both partners were HIV-negative.

“About 20%, or one in five couples, had a serodiscordant status, where one partner is negative and the other is positive,” reported lead researcher Dr. Patrick Sullivan during a late breaker presentation. In 3% [three couples], both partners were HIV-positive. Overall, one out of nine men in the study had a previously undiagnosed HIV infection.

Researchers from Atlanta’s Emory University were studying HIV testing and counseling in gay male couples as opposed to individuals. They reported looking at couples voluntary counseling and testing (CVCT), which they said has never been tested in gay men, though it is an effective intervention in South African heterosexual couples, shown to have decreased HIV transmission by 50%.

All together, said Sullivan, “Couples testing and counseling reached a population of MSM [men who have sex with men] with much higher undiagnosed HIV prevalence than traditional CVCT.”

All of these men must have tested negative for HIV within the past year in order to be eligible for the study. The couples needed to have been together for at least three months; half of them were together for more than a year and half were a couple for less than 13 months. According to the team’s research abstract, “A couple’s testing service attracted men with a high frequency of undiagnosed HIV infection. Men in steady relationships may perceive less need for HIV testing, but according to our data, CVCT may be an important service to engage coupled men for HIV testing.”

The team noted that heterosexual couples in South Africa and gay male couples here share two similarities in the epidemic: there is high prevalence and committed partners are a significant driver of HIV infection. In addition, Sullivan noted that some HIV-positive people may be unlikely to disclose a positive status to partners. “In our own work, only about half of MSM report discussing their status or that of their partners before first having sex,” Sullivan said. In addition, he said, “Previous research has shown that most U.S. male couples have some agreement about whether outside partners are allowed and if so, under what conditions.”

The Emory researchers enrolled 97 couples (194 men). The majority, 77% (150 men) were black, 14% (27) were white, and 5% (9) were Latino, owing to the population served by AID Atlanta, an HIV service organization which helped the researchers enroll participants (good job, AID Atlanta). They pointed out that the results cannot be generalized to other couples. Couples in which men reported being coerced to test or having been subjected to violence were tested separately instead of together. According to the research abstract, “The necessity of exclusionary criteria should be evaluated before the service is routinely provided.”

The findings are preliminary and the study continued to enroll participants.

The study results came on the heels of a Centers for Disease Control and Prevention (CDC) report on HIV testing for MSM.

According to the June 3 issue of Morbidity and Mortality Weekly, in one survey of more than 7,000 men, of the 19% (1,330) of MSM who tested HIV-positive, 44% (585) were unaware of their infection. According to the report, the similar rate of infection found among MSM whether their behavior was considered high-risk or not suggests that more frequent testing of every three to six months “might be warranted among all sexually active MSM, regardless of their risk behaviors.” Currently, the recommendation is for high-risk MSM to test this often (those men with multiple or anonymous partners, methamphetamine use, who have sex in conjunction with illicit drugs, or whose partners meet these criteria).

As one caveat, both the Emory researchers and the CDC report noted that HIV testing and status may have been under- or over-reported. Interestingly, at a discussion of the news from IAS, doctors mentioned that they have patients who use HIV testing as a way to disclose their positive status to a new partner.

HIV PROTECTION FOR BREASTFED INFANTS

Although breastfeeding by HIV-positive women is discouraged in resource-rich countries, it has been shown to protect infants from death in poorer countries. Without the protective elements in mother’s milk, these infants have a higher risk of dying from unsafe water and lack of health care or other sanitation. The question then becomes how to protect the child from becoming HIV-infected while breastfeeding.

Researchers pooled the results of five randomized studies using the HIV drug nevirapine to prevent transmission in breastfed infants. Overall, there was a 71% risk of getting HIV in infants...
given nevirapine. Some of the infants were given nevirapine along with zidovudine (AZT, brand name Retrovir). In the U.S., nevirapine is sold under the brand name Viramune.

Abstract WELBC03 was presented by Dr. Charles Van der Horst of the University of North Carolina, Chapel Hill. Longer duration of nevirapine use was associated with a greater reduction in risk of HIV infection. The data was taken from 5,396 mother-infant pairs in which the infant was HIV-negative at birth.

Two years ago, the World Health Organization (WHO) added the use of HIV medications to prevent mother-to-child transmission during breastfeeding, in the latest update of its treatment guidelines, based on the most current data at that time.

DOES PrEP STOP HIV IN ITS TRACKS?

Last year, studies CAPRISA 004 and iPrEx found large decreases in the risk of HIV infection with the use of the HIV medication tenofovir, taken orally or topically (via skin). Such a strategy is called PrEP, for pre-exposure prophylaxis (prevention). At IAS, a poster presentation on the two studies suggested the possibility that tenofovir also may have stopped HIV infection while it was in progress.

In Poster MOLBPE035, CAPRISA and iPrEx researchers presented data on study participants who seroconverted to HIV. They went back to blood samples collected before these participants had been randomized in the study. Of the 20 individuals with acute pre-seroconversion HIV infection before randomization (out of 266 participants who had seroconverted), the majority (17) were in the study arms that had been given placebo instead of tenofovir. According to the poster, “Assignment to receive active topical or oral PrEP was associated with an 83% decrease in the detection of acute pre-seroconversion HIV infection at baseline: the reasons for the difference are unclear.”

Acute pre-seroconversion infection was defined as having HIV RNA detection through viral load testing along with two negative antibody rapid tests. Antibodies, the body’s response to pathogens such as HIV entering the body, take a while to develop.

According to the report, the efficacy data presented last year excluded these 20 individuals who were seroconverting before the studies began, and their data is “investigated in this report to understand how PrEP might affect the earliest stages of infection.”

BONE FRACTURES

Certain drug side effects or medical conditions found in people with HIV are continuously receiving a lot of attention, and bone problems are among them. In an analysis from the U.S. Veterans Administration (VA), researchers once again found evidence that HIV treatment may have a negative effect on bones. One thing was clear, however: the risk of HIV therapy causing bone problems was minimal compared to traditional risk factors such as older age, diabetes, smoking, Caucasian race, and hepatitis C infection.

The researchers were especially interested in the cumulative effect of therapy on fractures—does the risk of fracture go up with a longer duration on HIV treatment? They were also particularly interested in the effect of Viread (tenofovir), which has been associated with loss of bone mineral density. Viread is also found in Truvada, Atripla, and Complera.

The VA looked at two time frames for this analysis—1988 to 1995 and 1996 to 2009, the era of HAART (highly active antiretroviral therapy). They looked at the medical records of 56,660 patients with HIV. Of these, 951 experienced a fracture of the wrist, hip, or first vertebra (in the spine) over the entire two time periods. Most of those fractures occurred in the HAART era, 572 cases in 32,439 patients.

The analysis looked at osteoporotic fractures (OF), those of bones that are weakened by osteoporosis. Of note, these fractures were inferred, not confirmed, using a record coding system that the VA has validated. Moreover, they point out that they did not actually look at bone mineral density (BMD) itself, which has been the primary concern in HIV. Decreased BMD, indicating osteoporosis, has been associated with HIV therapy and with the virus itself.

Over the entire time frame, the risk of fracture with exposure to antiretrovirals was statistically significant for Viread and boosted protease inhibitors (PIs). However, when factoring in other risk factors (such as hepatitis C) or other antivirals, that association went away. In the HAART era alone, the association with Viread use continued when looking at the risk by itself or in multivariate analysis with either traditional risk factors or traditional risk factors plus the use of other antivirals. All in all, there was a cumulative 12% to 16% greater risk of OF per year of Viread use.

Presenter Dr. Roger Bedimo of the University of Texas Southwestern Medical Center said, “The significant increase seen in the HAART era is not necessarily cause and effect.” The research team hypothesized that the cause of the increased risk of OF was aging made possible by longer survival with HAART.

The presentation was complex. To see the slides and hear the audio, see http://pag.ias2011.org/flash.aspx?pid=314
Actual patient living with HIV since 2000

HIV-RELATED EXCESS BELLY FAT.

You HAVE Your HIV under control. Now, on to important risk information:

Do not use EGRIFTA® if you:

• Have pituitary gland tumor, pituitary gland surgery or other problems related to your pituitary gland
• Have or had a history of active cancer (either newly diagnosed or recurrent)
• Are allergic to tesamorelin or any of the ingredients in EGRIFTA®, including mannitol or sterile water
• Are pregnant or become pregnant

Before using EGRIFTA®, tell your healthcare provider if you:

• Have or have had cancer
• Have diabetes
• Are breastfeeding or plan to breastfeed
• Have kidney or liver problems
• Have any other medical condition
• Take prescription or non-prescription medicines, vitamins, or herbal supplements

EGRIFTA® may cause serious side effects, including:

• Serious allergic reaction. Stop using EGRIFTA® and get emergency help right away if you have any of the following symptoms: rash over your body, hives, swelling of your face or throat, shortness of breath or trouble breathing, fast heartbeat, feeling of faintness or fainting
• Swelling (fluid retention). EGRIFTA® can cause swelling in some parts of your body. Call your healthcare provider if you have an increase in joint pain, or pain or numbness in your hands or wrist (carpal tunnel syndrome)
• Increase in glucose (blood sugar) intolerance and diabetes
• Injection-site reactions, such as redness, itching, pain, irritation, bleeding, rash, and swelling. Change (rotate) your injection site to help lower your risk for injection-site reactions

The most common side effects of EGRIFTA® include:

• Joint pain
• Pain in legs and arms
• Swelling in your legs
• Muscle soreness
• Tingling

EGRIFTA® will NOT cure HIV or lower your chance of passing HIV to others. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see Consumer Brief Summary of EGRIFTA® on following page.

Ask your healthcare provider if EGRIFTA®, the first and only FDA-approved medicine for HIV-related excess belly fat, may be right for you.

For more information, visit www.egrifta.com or call the AXIS Center at 1-877-714-AXIS (2947).

Indication: EGRIFTA® is a daily injectable prescription medicine to reduce the excess in abdominal fat in HIV-infected patients with lipodystrophy.

Limitations of use:

• The impact and safety of EGRIFTA® on cardiovascular health has not been studied
• EGRIFTA® is not indicated for weight-loss management
• It's not known whether taking EGRIFTA® helps improve compliance with antiretroviral medications
• EGRIFTA® is not recommended to be used in children

In two separate clinical trials of HIV-infected people with lipodystrophy, each lasting 6 months, EGRIFTA® reduced HIV-related excess belly fat by an average of 18% in the first trial, and 14% in the second trial. This reduction in excess belly fat resulted in an approximate 1-inch reduction in waist size. Individual results may vary.

On average, patients on EGRIFTA® did not lose weight.

Like HIV, HIV-related excess belly fat is a chronic condition. In clinical studies:

• People who used EGRIFTA® continuously for 1 year maintained their results over this time period
• People who stopped taking EGRIFTA® after 6 months had their HIV-related excess belly fat come back

EGRIFTA® is believed to work with your own body to produce natural growth hormone to reduce your excess belly fat.
YOU HAVE YOUR HIV UNDER CONTROL. NOW, ON TO HIV-RELATED EXCESS BELLY FAT.

In two separate clinical trials of HIV-infected people with lipodystrophy, each lasting 6 months, EGRAFTA® reduced HIV-related excess belly fat by an average of 18% in the first trial, and 14% in the second trial. This reduction in excess belly fat resulted in an approximate 1-inch reduction in waist size. Individual results may vary. On average, patients on EGRAFTA® did not lose weight.

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- EGRAFTA® is not recommended to be used in children

**Important Risk Information:**
**Do not use EGRAFTA® if you:**
- Have pituitary gland tumor, pituitary gland surgery or other problems related to your pituitary gland
- Have or had a history of active cancer (either newly diagnosed or recurrent)
- Are allergic to tesamorelin or any of the ingredients in EGRAFTA®, including mannitol or sterile water
- Are pregnant or become pregnant

**Before using EGRAFTA®, tell your healthcare provider if you:**
- Have or have had cancer
- Have diabetes
- Are breastfeeding or plan to breastfeed
- Have kidney or liver problems
- Have any other medical condition
- Take prescription or non-prescription medicines, vitamins, or herbal supplements

**EGRAFTA® may cause serious side effects, including:**
- Injection-site reactions, such as redness, itching, pain, irritation, bleeding, rash, and swelling. Change (rotate) your injection site to help lower your risk for injection-site reactions

**The most common side effects of EGRAFTA® include:**
- joint pain
- pain in legs and arms
- swelling in your legs
- muscle soreness
- tingling
- numbness and pricking
- nausea
- vomiting
- rash
- itching

EGRAFTA® will NOT cure HIV or lower your chance of passing HIV to others.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

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**For more information, visit www.egrifta.com or call the AXIS Center at 1-877-714-AXIS (2947).**
Consumer Brief Summary for EGRIFTA® (tesamorelin for injection)

EGRIFTA® (eh-GRIF-tuh) (tesamorelin for injection) for subcutaneous use

Read the Patient Information that comes with EGRIFTA® before you start to take it and each time you get a refill. There may be new information. This leaflet does not take the place of talking to your healthcare provider about your medical condition or your treatment.

What is EGRIFTA®?
• EGRIFTA® is an injectable prescription medicine to reduce the excess in abdominal fat in HIV-infected patients with lipodystrophy. EGRIFTA® contains a growth hormone-releasing factor (GRF).
• The impact and safety of EGRIFTA® on cardiovascular health has not been studied.
• EGRIFTA® is not indicated for weight loss management.
• It is not known whether taking EGRIFTA® improves compliance with antiretroviral medications.
• It is not known if EGRIFTA® is safe and effective in children. EGRIFTA® is not recommended to be used in children.

Who should not use EGRIFTA®?
Do not use EGRIFTA® if you:
• have pituitary gland tumor, pituitary gland surgery or other problems related to your pituitary gland
• have or had a history of active cancer (either newly diagnosed or recurrent)
• are allergic to tesamorelin or any of the ingredients in EGRIFTA®. See the end of this leaflet for a complete list of ingredients in EGRIFTA®
• are pregnant or become pregnant. If you become pregnant, stop using EGRIFTA® and talk with your healthcare provider. See “What should I tell my healthcare provider before using EGRIFTA®?”

What should I tell my healthcare provider before using EGRIFTA®?
Before using EGRIFTA®, tell your healthcare provider if you:
• have or have had cancer
• have diabetes
• are breastfeeding or plan to breastfeeding. It is not known if EGRIFTA® passes into your breast milk. The Centers for Disease Control and Prevention (CDC) recommends that HIV-infected mothers not breastfeed to avoid the risk of passing HIV infection to your baby. Talk with your healthcare provider about the best way to feed your baby if you are taking EGRIFTA®
• have kidney or liver problems
• have any other medical condition

Tell your healthcare provider about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements. EGRIFTA® may affect the way other medicines work, and other medicines may affect how EGRIFTA® works.

How should I use EGRIFTA®?
• Read the detailed “Instructions for Use” that comes with EGRIFTA® before you start using EGRIFTA®. Your healthcare provider will show you how to inject EGRIFTA®.
• Use EGRIFTA® exactly as prescribed by your healthcare provider.
• Inject EGRIFTA® under the skin (subcutaneously) of your stomach area (abdomen).
• Change (rotate) the injection site on your stomach area (abdomen) with each dose.
• Do not inject EGRIFTA® into scar tissue, bruises or your navel.
• Do not share needles or syringes with other people. Sharing of needles can result in the transmission of infectious diseases, such as HIV.

What are the possible side effects of EGRIFTA®?
EGRIFTA® may cause serious side effects including:
• Serious allergic reaction. Some people taking EGRIFTA® may have an allergic reaction. Stop using EGRIFTA® and get emergency help right away if you have any of the following symptoms:
  – a rash over your body
  – hives
  – swelling of your face or throat
  – shortness of breath or trouble breathing
  – fast heartbeat
  – feeling of faintness or fainting
• Swelling (fluid retention). EGRIFTA® can cause swelling in some parts of your body. Call your healthcare provider if you have an increase in joint pain, or pain or numbness in your hands or wrist (carpal tunnel syndrome).
• Increase in glucose (blood sugar) intolerance and diabetes. Your healthcare provider will measure your blood sugar periodically.
• Injection-site reactions. Change (rotate) your injection site to help lower your risk for injection-site reactions. Call your healthcare provider for medical advice if you have the following symptoms around the area of the injection site:
  – redness
  – itching
  – pain
  – irritation

The most common side effects of EGRIFTA® include:
• joint pain
• pain in legs and arms
• swelling in your legs
• muscle soreness
• tingling, numbness and pricking

Tell your healthcare provider if you have any side effect that bothers you or that does not go away.
These are not all the possible side effects of EGRIFTA®. For more information, ask your healthcare provider or pharmacist.

Keep EGRIFTA® and all medicines out of the reach of children.

General information about the safe and effective use of EGRIFTA®:
Medicines are sometimes prescribed for purposes other than those listed in a Patient Information leaflet. Do not use EGRIFTA® for a condition for which it was not prescribed.

Do not give EGRIFTA® to other people, even if they have the same symptoms you have. It may harm them.

Do not share your EGRIFTA® syringe with another person, even if the needle is changed. Do not share your EGRIFTA® needles with another person.

This Patient Information leaflet summarizes the most important information about EGRIFTA®. If you would like more information, talk with your healthcare provider. You can ask your healthcare provider or pharmacist for information about EGRIFTA® that is written for healthcare professionals.

For more information about EGRIFTA®, go to www.EGRIFTA.com or contact the AXIS Center toll-free at 1-877-714-2947.

What are the ingredients in EGRIFTA®?
Active ingredient: tesamorelin
Inactive ingredients: mannitol and Sterile Water for Injection

EMD Serono
Living science, transforming lives

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W HETHER YOU’RE POSITIVE or negative, we all live with HIV. That’s the point raised by A Day with HIV in America, Positively Aware’s photo essay project aimed at confronting the stigma of HIV. Dozens of images were submitted from across the U.S.—and from Canada—as people took snapshots to capture a moment of their lives on Sept. 21 to mark A Day with HIV, now in its second year.

Some people took a simple self-portrait. Others used the photo opportunity to make a point or tell a story. In New York, HIV/AIDS educator Jack Mackenroth spent A Day with HIV wearing a t-shirt emblazoned with the word Positive.

“It was an interesting experience to see how I felt and how others reacted,” Mackenroth said. “I believe that visibility is the key to fighting the stigma of HIV. I had the photo taken by a complete stranger in a very public place on purpose to force them to question the word and what it meant.”

In Orlando, at a national convention of her church, the Rev. Andrena Ingram wore a shirt that said, HIV Positive. There were 2,000 attendees for lunch. “As I walked through the crowd, eyes saw me, then glanced away,” said the HIV-positive pastor from Philadelphia.

More than one person used their picture to publicly reveal their status. “Today, I hope that I can challenge stigma and the isolating, silencing attitudes. By being an example, I can start to erode misconceptions and dismantle stigma,” said Susanna.

Others spoke in more quiet voices, but the moments they shared were no less powerful: A young man celebrating his first birthday since discovering he is HIV-positive. An HIV-positive, single mother wishing her son good night. A 26-year survivor injecting himself with insulin to fight the diabetes brought on by his HIV. Two friends—one positive, the other, negative—sharing a kiss. Compelling moments in everyday lives. That’s what a day with HIV is.

Photo submissions will be posted to the project’s website, www.adaywithhiv.com.

—Rick Guasco
26 | NOVEMBER/DECEMBER 2011

8:00 AM, INDIANA | Kenneth, “This is the first time I have ever submitted a picture of myself acknowledging to the world that I live with HIV. This is my daily routine: waking up and looking into my pill box.”

9:30 AM, POMPANO BEACH, FL | Kristine Koffler: “I met my companion Michael O’Brien six months ago. I have been HIV-positive for 12 years. He is negative. We are working to keep it that way.”

10:00 AM, NEW BEDFORD, CT | Richard Ferri, PhD, ANP, ACRN, FAAN: “I am an HIV-positive AIDS primary care specialist practicing at the Greater New Bedford Community Health Center. The only thing we use a red ribbon for is a tourniquet. A day in my life is simple: gym, prayer, work.”

10:30 AM, CHICAGO | Illinois State Representative Greg Harris, who is HIV-positive, attending a hearing of the Insurance Exchange Legislative committee. “I’m 47, and have been positive for 17 years. I look at it as a blessing, as it’s taught me so much about myself, other people, and life.”

10:30 AM, VACAVILLE, CA | Amanda Proctor and her partner adopted Phillip this year: “[Phillip’s] bio-mother was infected during pregnancy and he showed up positive at 6 months old. He is now almost 2 and has been undetectable and as healthy as can be since the beginning of this year. We wanted to submit a picture of him to show that children in the U.S. are still being born HIV-positive.”

11:22 AM, CHICAGO | David C. Parker: “I’m 47, and have been positive for 17 years. I look at it as a blessing, as it’s taught me so much about myself, other people, and life.”
11:13 AM, DALLAS | Velietta Dickens Rogers: “This is what I do to keep me going. I enjoy being around other artists. I am self-taught, and won two art contests this year. I found The Stewpot Art Program in downtown Dallas, and it has brought me out of the seclusion of my house, where I had been for 18 years (after being diagnosed with AIDS). Learning to live around others with no shame about my status has made all the difference.”

2:00 PM, NEW YORK | Jayson Conner: “The sky’s the limit!”

12:10 PM, ORLANDO, FL | Rev. Andrena Ingram, HIV-positive, attending a luncheon at a church conference with over 2,000 participants: “As I moved through the crowd, eyes saw me, and then glanced away. HIV is alive and well, and in your midst.”

1:30 PM, OSHAWA, ONTARIO, CANADA | Mark Hammann, putting up a “Libido Insurance” HIV awareness campaign poster outside the AIDS Committee of Durham Region (ACDR): “I was diagnosed with AIDS in 1997 and went on U.S. disability for 10 years before moving to Canada. Since 2007 I’ve been working at the ACDR where I am manager of education services. My health is stable and I’m happy to be working in the fight against this pandemic.”
1:53 PM, SAN FRANCISCO | Suzanne, Jim, and Mathew at Magnet, the lab of the San Francisco AIDS Foundation’s gay men’s health center. Magnet conducts thousands of HIV and STD tests a year in addition to holding numerous community events.

4:17 PM, NEW YORK | Warren Tong takes a break from his work as associate editor of TheBody.com.

2:00 PM, ATLANTA | José Quiles, HIV-negative: “This is me at work at Pride Medical in Atlanta. I am blessed to have a job that I love. While it is far from glamorous, I get to help people in their fight against HIV. I also get to educate them and help fight the stigma associated with being HIV-positive. I asked my co-worker to take a shot at me working with a patient. I try to make a difference every day.”

4:00 PM, LOS ANGELES | Black Treatment Advocates Network: “BTAN Los Angeles is guided by the premise that when people understand the science of HIV, they are less likely to participate in stigmatizing behavior, more likely to get treatment, better able to adhere to their regimens, and better positioned to influence policy.”

4:30 PM CINCINNATI, OH | Mark Hayden: “Walking my buddy Sammy helps relieve the stress of work and grad school.”
5:00 PM, PHOENIX | Isaac, born HIV-positive (and with a currently undetectable viral load), makes a splash.

5:10 PM, LOS ANGELES | The staff of the Magic Johnson Foundation: “We are on the cusp of celebrating the 20th anniversary, on Nov. 7, of Magic’s HIV announcement and the founding of MJF.

5:23 PM, CHICAGO | Donte (aka DJ Masisi), HIV-positive since 2009, sneaks a bite of basil flowers in his garden.

5:30 PM, WILTON MANORS, FL | Dab Garner, HIV-positive 29 years, is an AIDS activist and creator of Dab the AIDS Bear. He also volunteers at Fusion @ Wilton Manors, an LGBT organization.

5:00 PM, LARGO, FLORIDA | Priscilla McCarthy with her husband Gregory celebrating their tenth anniversary: “We moved to Florida in Sept. 2000. My husband proposed to me later that year and we started planning a wedding. Ten days after 9/11, we were married on a local dinner cruise and honeymooned locally.”
5:00 PM, New York

Jack Mackenroth, HIV-positive: “I wore that shirt for the entire day. I believe that visibility is the key to fighting the stigma of HIV. I had the photo taken by a complete stranger in a very public place on purpose to force them to question the word and what it meant. I felt proud.”

5:50 PM, The Bronx, New York

Susanna waits for the train home after a long day working at a city hospital psychiatric unit in the Bronx: “I love the phrase, ‘Learn Acting’ in the background. Having HIV and not being public about it sometimes feels like I am acting. Sadly, stigma exists. Today I hope that by being a powerful example, I can start to erode misconceptions and dismantle stigma by standing up and saying this is a day with HIV in America.”

5:30 PM, Eugene, OR

Cree Gordon, 26, has been HIV-positive for more than six years; his friend Mathias is negative: “I call my picture, ‘Opposites Attract.’ Though we are not together, we are good friends and I came up with the idea to show that caring about someone with HIV should not be scary.”

7:26 PM, Costa Mesa, CA

Ian-Mathew Alvarez; “This picture of me (shaved head), my husband Travis, and my mom Rosie was taken at a lounge called The Tin Lizzie Saloon. Both Travis and I are positive. My mom and whole family are very supportive and adore us, so we chose to include her in the photo.”
8:00 PM, OKLAHOMA CITY | Cody rides the Sizzler at the Oklahoma State Fair, celebrating his 26th birthday. This was his first birthday since learning that he is HIV-positive.

9:12 PM, LEE’S SUMMIT, MO | Donna Dane: “This picture was taken while telling my son goodnight. I am an HIV-positive single mom. My son was born prior to my pozitivity.”

10:45 PM, DURHAM, NC | Ron Hudson, HIV-positive 26 years, injects himself with insulin to fight the diabetes he acquired at age 40 while taking ARVs: “As more and more of us survive longer, we are dealing with other issues beyond HIV.” Hudson’s friend, Thomas Sherratt, took this photo.

11:00 PM, SALEM, OR | Jonathan Reitan, HIV-positive for more than five years, finds comfort from the fatigue and dizziness brought on by his daily meds in the arms of his lover, Jonathon Broadwater, who is HIV-negative.
Me and HIV

A participant in A Day with HIV in America writes to prove that it does get better

BY JEFFREY NEWMAN

WHEN I CREATED A GROUP ON FACEBOOK CALLED “HIV and AIDS—Get the Facts, Curb the Ignorance, Proving It Gets Better,” the last thing I expected to do was talk about my experience as someone with HIV. But, people need to know that there’s hope and life outside of HIV. I’m proof that, as Dan Savage would say, “it gets better.”

In February, 2001, my best friend and then boyfriend got really sick. He already had a compromised immune system, so it didn’t sound off any huge alarms. On Valentine’s Day eve, I ended up rushing him to the ER, and he was hospitalized for a week. The doctors initially ruled out HIV, so it wasn’t on our radar at all.

A few days after he was released from the hospital, the nurse practitioner at our doctor’s office called to say I needed to bring Stephen in. And in the flash of that moment, I had a suspicion about what was coming. Unfortunately, Stephen didn’t and the cab ride to the doctor’s office didn’t seem the right place to raise the possibility. Plus, I figured, this is our trusted, compassionate doctor who’s been treating us for years; he will be gentle and comforting. So, you can imagine Stephen’s utter shock when the nurse practitioner walked in and blurted out, “Well, your results are back and you’re HIV-positive.” Talk about ripping the Band-Aid off.

Stephen literally collapsed on the floor. We had to carry him out to a cab. Then he lay in a self-induced comatose state for four days in his apartment, with the lights turned off convinced rapture was upon us. I sat in the corner of his living room, in a frenzy at his computer for 96 hours, searching the Web for answers.

Despite spending my entire HIV-negative adult life as a champion of AIDS causes, wearing red ribbon pins, and chairing the AIDS Walk in Miami in 1995, I realized I didn’t know nearly as much as I thought I did. Actually, the only thing I knew was that my boyfriend was freaking out and I had to be the strong, supportive, loving, and optimistic, glass-is-half-full boyfriend.

There was no Facebook or social networking sites. The Internet was still in its infancy. AOL was where the action was; so I logged into every chat room that I could find to learn as much as possible about HIV. What I learned was that there were a lot more people out there living very happy, successful, and healthy lives who were HIV-positive than I realized. Turns out some of them were friends of mine. So much for the theory that you can tell a person has it just by looking at them.

When I found out I was HIV-positive, I never had that OMG moment that most people do. When my boyfriend found out, it nearly destroyed him. He thought it was a death sentence. But I had knowledge, and that was power. I knew that the landscape had changed and so had the outlook for people who tested positive for HIV. Everything I read, every person I spoke to, and every doctor I consulted, all said the same: People were no longer dying from HIV or AIDS. It was not a death sentence. I also knew that just because we were HIV-positive, it did not mean we had AIDS or that we were going to die.

Unlike my boyfriend, I didn’t have a nurse come into the room and give me my news. I found out from a doctor on my cell phone while I was at the grocery store. There was no one around to tell me it was going to be okay. And more importantly, there was no time for dark and gloomy thoughts. First, I had perishables—I had to get my groceries home. And second, I already knew it was manageable and I knew that for my boyfriend and for my family, I had to be the voice of reason, hope and optimism.

A couple of months later, 9/11 happened. Stephen and I stood and watched as buildings came crumbling down and more than 3,000 lives were taken in minutes. It really put things into perspective for me. If Stephen and I could survive a terrorist attack (his office was near the World Trade Center and I was to have a job interview there later that morning), we could certainly beat HIV.

I should also add in that my parents treated news about my HIV like they did with learning I was gay. My dad got up, put his arms around me and told me they...
loved me no matter what. And if either one of them ever felt anything negative about either situation, they’ve never told me. They’ve only offered me unconditional love and support.

I have never once thought of myself as living with a terminal illness. I don’t believe it will be what kills me. It’s been just over 10 years since I was diagnosed, and I’m healthier than I’ve ever been. Being HIV-positive does not define who I am. It doesn’t define my relationships with friends, family, or my partner. And it certainly doesn’t cloud my view of the world as being the glass half full.

In many ways, my life today is 100 times better since being diagnosed. It was freeing and liberating. It got me out of my comfort zone and allowed me to re-examine my perfect, no-complications perception of how my life is supposed to be. It allowed me to experience life in ways I may not have otherwise been courageous enough to do. Life has gotten better. It continues to get better. The world is bright if you look at it the right way.

Life is full of twists and turns. You might feel isolated and alone, but you’re not. There are people out here who understand what you’re going through and are willing to help you through it.

It’s okay to be scared. It’s okay to be human. And most importantly, it’s okay not to be okay. That’s part of the process with anything in life.

Those of us living with HIV need to lead by example. Stand up. Put a face to it, and help take the stigma off of it. Put your hand out to help those struggling. And for those who are HIV-negative, you need to live life with an open, unconditional, accepting heart.

Together, we have an enormous power to “be the change we want to see in the world.” We have the ability to inspire and get the message out there for people to get the facts, ignore the myths, and prove that life gets better.

JEFFREY NEWMAN is a journalist of 20 years, having written for most of the major gay media, including The Advocate, POZ, and the Windy City Times. You can find his Facebook group at www.facebook.com/groups/21167322265914/ and visit his website, www.jeffreynewman.com.
What is the state of the HIV/AIDS epidemic among men who have sex with men (MSM) in the U.S.?

A 2008 report released by the Centers for Disease Control and Prevention (CDC) showed that MSM accounted for 46% of all new HIV infections and HIV infection rates among young MSM increased at a rate of about 12% each year between 2001 and 2006. This report further noted that MSM were the only risk group who experienced an increase in infection rates during this time. In fact, according to a recent study by researchers at the University of Pittsburgh, even if the rate of HIV infection among MSM remains at the current level, by the time a group of young MSM (18 years old) reach the age of 40, 41% of them will be HIV-positive. We cannot make any progress in fighting the HIV/AIDS epidemic in the U.S. unless we find ways to lower rates of HIV transmission among MSM.

How do other health disparities among MSM relate to risk for HIV/AIDS?

A growing set of recent scientific papers had shown that health problems among MSM are interconnected and function as a group to increase HIV risk in this population. Because they are sexual minorities, gay, bisexual, and other MSM experience massive minority stress and social marginalization (for example, widespread bullying, gay-bashing, and other forms of violent harassment). Studies suggest that these negative experiences increase a person’s risk for multiple health issues, including depression, anxiety, drug use, and sexual risk behaviors. This process happens over time as people are exposed to discrimination and social marginalization. These experiences cause stress to the individual, resulting in lowered self-esteem, increased emotional distress, and a sense of social isolation, all of which cause a person to be more vulnerable to serious emotional and physical health problems.

According to the CDC, a syndemic is, "Two or more afflictions, interacting synergistically, contributing to excess..."
burden of disease in a population.” In other words, negative health conditions are thought to interact to form a syndemic: synergistic epidemics that, together, can lower a person’s overall health and make him or her more susceptible to disease. For example, health problems such as drug use, depression, and domestic violence have been found to interact so that their impact on the overall health of the person is greater than what we might expect from looking at each affliction separately.

While many studies involving MSM have shown interconnections between health problems, such as drug use and high-risk sex, two recent studies have focused on syndemic conditions in samples of adult MSM and young MSM. These two studies showed that as the number of psychosocial conditions (such as depression, anxiety, and experience of abuse) a person has increases, so will his likelihood of having unprotected anal sex, as well as his likelihood of becoming infected with HIV. It has been suggested that this set of co-occurring psychosocial health problems operating together as a syndemic may actually be driving the HIV epidemic among MSM, while also working to raise the levels of other health problems among MSM.

If syndemics are so widespread, then why are so many MSM doing so well? Men who have sex with men exist in a world where adversity and marginalization are everywhere. Many MSM grew up in a world hearing that they were abnormal or even immoral. They live in a world where they are denied equal rights. As previously mentioned, this type of second-class citizenship can lead to health problems for many people. However, even though the vast majority of MSM have experienced some form of adversity, the majority have not experienced the harmful effects of those experiences to the point of developing health problems. Rather, most men survive adversity and are somehow protected from the negative consequences of those experiences. This capacity for a person to successfully cope with adversity is called “resilience.”

Resilience requires two components: 1) exposure to adversity and 2) success in overcoming adversity. Resilience Theory states that there are traits, skills, and support systems that help people thrive despite difficult conditions. The theory further acknowledges that all people have the capacity for resilience, but, in order for resilience to be fully developed, protective factors must be present that offset the impact of adversity.

Protective factors that are present in an MSM at a young age may grow stronger as he matures. For instance, pride is a quality that is often associated with sexual minority communities. Despite the negative messages that MSM hear about their sexuality, many learn to cast off shame and internalized homophobia, and take pride in their sexuality and in their communities. This process may increase resilience. For example, data from a longstanding research study involving MSM from several cities showed that exposure to homophobia and gay-related victimization (such as gay-bashing and harassment) were associated with internalized homophobia during the time the men were coming out. However, homophobic experiences were not significantly associated with the men’s current levels of internalized homophobia. This suggests that the men were able to overcome internalized homophobia as they matured and, in the process, improved their health. Understanding more about how MSM exhibit resilience could teach us a lot about how to raise levels of health in our communities.

How could a focus on the strengths and resiliencies found among MSM offer new approaches to HIV prevention? In a review of the effectiveness of HIV prevention interventions targeting MSM, one researcher found that these interventions resulted in a 23% reduction in the odds of engaging in unprotected anal intercourse. This suggests that current prevention paradigms are effectively addressing some degree of risk. Nonetheless, there is little or no evidence that health disparities between MSM and non-MSM are diminishing, nor is the risk of HIV infection decreasing among MSM. In order to minimize or eliminate health disparities, the effectiveness of current prevention efforts will need to be increased. Resilience Theory offers a means to accomplish this.

The content and impact of strengths-based approaches to HIV prevention support the idea that health promotion may be as important as risk reduction in the elimination of health disparities. Strengths-based programs are driven by the philosophy that resilience and competency-building are critical in supporting healthy development. Strengths-based programs encourage community building, belief in the future, self-efficacy, positive identity, spirituality, and self-determination, among many others. A comprehensive review of strengths-based programs found that this type of prevention intervention improves interpersonal skills, strengthens relationships, and increases self-control, self-efficacy, academic achievement, problem solving, and other competencies. These programs may also help people lower drug and alcohol use, violence, and high-risk sexual behavior, and these effects tend to be sustained over time. However, strengths-based approaches to improving health among MSM remain understudied and not well understood.

How can we move the field forward? It has been 30 years since HIV began to decimate the MSM population. Since then, health disparities among MSM have been forced into the forefront of LGBT consciousness. Although some work has been
done to address these disparities, major health disparities still exist among men who have sex with men.

Future studies are needed to expand our knowledge of the ecological context of health risk among a highly vulnerable population. To accomplish this, it will first be important to expand the scope of prevention research to focus on protective factors as well as risk factors. We can learn a lot from those who have faced adversity and thrive, relative to those who have experienced the negative outcomes that prevention programs aim to avoid. Second, there is a need to examine protective factors beyond those at the individual level. Resilience Theory suggests that community and interpersonal protective factors are needed in order for an individual to develop resilience. To the extent that this view is correct, a narrow focus on individual level risk and protective factors will not be likely to eliminate health disparities. Finally, there needs to be a focus on identifying modifiable protective factors so that they can be directly applied to prevention and health promotion programs.

Many MSM health studies have demonstrated an association between health risk behaviors and individual personality characteristics such as sensation-seeking or impulsivity. While knowledge of these factors is necessary for our understanding of prevention, the particular factors themselves are very difficult to affect through effective interventions. It is more feasible to effect change on the interpersonal or community level by developing a mentoring program or setting up community centers, or by making policy-level changes like the adoption of anti-bullying legislation, or federal laws that recognize sexual minorities as full and equal citizens (e.g., same-sex marriage and adoption laws).

It has long been acknowledged that sexual minorities face health disparities, not because of who they are, but because of the environment in which they live. All the same, prevention efforts tend to focus on changing the individual with messages about more condom use, less substance use, and so on. Although data show that MSM exhibit considerable strength in reducing or avoiding health-related risks, this strength has been under-emphasized in public health prevention work. These factors may be of particular importance as we enter an era of combination prevention, in which behavioral and biomedical interventions are combined to lower risk of HIV transmission by lowering background rates of community viral loads. A focus on resiliencies may support, for instance, adherent use of biomedical interventions among MSM. Resilience Theory and strengths-based approaches to prevention provide a framework to advance prevention and health promotion by identifying new techniques that will increase the effectiveness of current public health models and improve the health of MSM.

**How do we train the next generation of health care workers interested in LGBT health?**

LGBT populations face numerous health disparities, of which HIV/AIDS is only the most widely recognized. The extent and breadth of these health disparities requires a new generation of health professionals trained to address these issues among a wide variety of LGBT populations. Accordingly, the Graduate School of Public Health at the University of Pittsburgh initiated the first certificate program in LGBT Health in the United States in 2006. The mission of the LGBT Public Health Certificate is to provide students with a comprehensive understanding of the special public health challenges of LGBT populations and the scientific tools necessary to intervene to prevent these problems. These skills include the design, implementation, and evaluation of programs to improve health levels among LGBT populations, as well as the ability to conduct intervention and epidemiological research and policy analysis to enhance the health and well-being of individuals related to sexual orientation and/or gender identity/presentation. In addition, students participate in annual Summer Institutes which bring together national experts in various aspects of LGBT health. Summer Institutes have, to date, focused on violence against LGBT youth; chronic diseases among lesbians; trans health; and resiliency among MSM.

Currently, the program has about 20 students, who are studying a broad range of health problems among LGBT populations. All of the students in the program are fulfilling the requirements for the Certificate while they are completing MPH or DrPH/PhD degrees at the University of Pittsburgh. Doctoral students in the program are encouraged to work with professors to produce papers for publication, and have so far published about 35 papers as a result of these collaborative efforts. Graduates from the program are already taking positions with organizations that are conducting research and/or providing service to LGBT populations. We look forward to seeing the ongoing contributions of students and graduates of the program in terms of addressing key health issues among LGBT populations.

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A basic assumption underlying current approaches to HIV prevention is that the best way to lower HIV infection rates among MSM is to reduce rates of HIV sexual risk-taking. Most studies that have measured rates of HIV prevalence among black MSM find rates of HIV infection that are sometimes several times higher than those found among other MSM populations. Does this mean that black MSM have rates of sexual risk-taking that are several times higher than those found among other MSM populations?

Greg Millett, then with the CDC’s Division of HIV/AIDS Prevention, conducted a set of careful literature reviews to address this question. Millett tested whether African American MSM were more likely to be at sexual risk for HIV; less likely to disclose sexual identity; more likely to use recreational drugs, to have a history of STDs, to get HIV tested, or to have sex with a known HIV-positive partner; and, if positive, less likely to be on antiretroviral treatment.

What he found was that African American MSM were not more likely to have higher rates of sexual risk-taking, to use recreational drugs, to have sex with a known HIV-positive person, or to get tested less frequently, but they were more likely to not identify as gay; to have a history of having an STD; and, if positive, less likely to be on antiretroviral medications.

Millett’s findings suggest that being part of a population that engages in medical care less frequently may better explain high rates of HIV infection than just sexual risk-taking. Put another way, lower access to medical care raises the proportion of African American MSM who have high HIV viremia (viral load), which then results in more HIV transmission to uninfected partners. High prevalence rates of men with elevated HIV viral loads within the tightly bound sexual networks often found among African American MSM magnify risk for HIV transmission even among men who rarely take sexual risks. Millett’s analysis thus suggests that it is not simple levels of risk-taking that best explain higher HIV prevalence rates among African American MSM, but rather the context in which these men take occasional sexual risks. This suggests that strategies designed to lower community viral load through combination prevention approaches (i.e., combining behavioral and biomedical interventions with a special focus on men at highest risk) may be particularly effective among African American MSM. This could be accomplished by working with communities of black MSM to share these findings, to dispel the idea that the HIV epidemic is somehow caused by widespread sexual irresponsibility, and to work with African American MSM and service providers to find ways to help black MSM gain access to medical care so that levels of health at the individual and community level are improved.
Mental health impacts the full spectrum of HIV. It can determine who is at risk for acquiring the virus (people with a history of trauma or depressive disorders are more likely to become infected) and, after sero-conversion, it affects quality of life, medication adherence, levels of social support, and even the progression of the illness. Consider the following three cases:

Steve had been living with HIV for 20 years and experienced the demise not only of his good health but nearly everything that defined him. His career as an attorney abruptly unraveled which, in turn, eroded his financial independence. His marriage dissolved because his wife couldn’t adjust to the demands of caretaking when he was extremely ill. He was forced onto disability, which left him bitter and judgmental about himself and others living with HIV. But the most significant loss of all was his sense of hope. He felt doomed to suffer medical complications and social indignities until he finally succumbed to the virus. His medication adherence became sporadic and on most days, despite being medically stable, he verbalized despair and no desire to keep living.

Angela was stunned when the counselor at the testing site told her she was HIV-positive. Although just 30 years old, she had survived several traumatic incidents in her life, including sexual abuse and witnessing violence in her home while growing up. She had always been able to tap into some internal strength to keep moving forward, but her positive HIV test result completely swept away her emotional foundation. For reasons unclear even to her, she felt herself becoming numb at the testing center and had stayed that way for nearly two months. She was having trouble sleeping, couldn’t concentrate, was crying every day, and memories of all the prior trauma she thought had been resolved began flooding into her daily life. She felt overwhelmed and emotionally paralyzed.

Brian and his partner Paul had been in a relationship for six months. Early in their life as a couple they had gotten tested...
together for HIV and both were negative. They decided to remain monogamous and began having unprotected sex with each other. After six months, they went for an HIV test and were horrified to learn that Paul’s test came back positive. Despite his own negative result, Brian began to notice strange aches and pains and was certain his lymph nodes were swollen. He felt compassion for Paul, but he secretly wondered if he could remain in the relationship. Brian found himself becoming obsessed with his own health, his partner’s wellbeing, and their future. He began to experience shortness of breath, difficulty going out in public, and on many days, panic that left him housebound. The stronger these feelings became, the more he retreated from Paul and the world in general.

UNDERSTANDING MENTAL HEALTH

The ability to maintain emotional and behavioral health is the result of many complex factors ranging from biology to culture. Genetics determine the potential for certain emotional disorders onto which we add life experiences that shape our personalities and create unique profiles of emotional resilience. Elements of culture, such as spiritual beliefs and ideas about death, further impact our capacity for handling emotions, as do recreational or prescribed drugs that can numb feelings, affect thoughts and dreams, and propel our moods up or down.

A mental health diagnosis, for someone living with HIV, can add another layer to existing shame and stigma, which remains a potent force 30 years into the AIDS epidemic. Homosexuality or condemnation by one’s spiritual community adds even more stigma, undermining the self-concept of vulnerable individuals to the point of collapse.

Mental health disorders impact everything from quality of life to physical health, and healing involves building emotional resilience to the greatest extent possible. Although this requires commitment, support, and often medication and/or psychotherapy, most people who make the journey discover
Depressive disorders are frequently difficult to diagnose because their broad cluster of symptoms can also occur as a result of HIV itself, opportunistic infections, or co-morbidities such as hepatitis C.

newed compassion not only for themselves but for others as well.

ADJUSTING TO A NEW DIAGNOSIS OF HIV/AIDS

Learning that you are HIV-positive is a life-changing moment. Anyone who has had this experience remembers the exact circumstances and their emotional and physical reactions trying to comprehend and assimilate this news. A lifetime of prior events guides our subconscious response at that moment of emotional shock. Reactions can include tears, inappropriate laughter, a flattening of affect (feelings or emotions expressed by physical gestures and body language), relief (“I knew this was coming”), or total numbing of feelings. At first, some people may be unable to comprehend the news (“that’s impossible”), while others, such as Angela mentioned above, may experience a reawakening of prior trauma. Anyone in this position is vulnerable and requires emotional support. Rash decisions should be discouraged and assistance should be offered to enable any emerging feelings to be identified and expressed.

Assimilating this shock is a process of acceptance that varies with each individual. Feelings such as sadness, anger, or fear are completely normal, even if delayed. This is identified by the Diagnostic and Statistical Manual IV-TR (the standard set of guidelines published by the American Psychiatric Association) as an “Adjustment Disorder.” There is no way to predict who might develop such a reaction, which is diagnosed through a variety of symptoms such as depressed mood, physical complaints, and agitation. Such adjustment reactions typically do not last longer than six months, although in the case of a chronic illness such as HIV/AIDS, the duration may vary. Supportive psychotherapy, including expression of feelings and assisting in the identification and creation of a support system, is usually sufficient to resolve an adjustment disorder and early intervention can prevent the development of more significant anxiety and depressive problems.

COMMON MENTAL HEALTH ISSUES ASSOCIATED WITH HIV

A variety of mental health problems can be experienced by people living with HIV/AIDS. The following section describes the more typical diagnostic categories and their associated interventions.

Neurologic complications of HIV—

While antiretroviral therapies have greatly reduced their prevalence, more than half of HIV-positive patients do experience some form of neurologic dysfunction ranging from mild to very severe. The most typical of these disorders is MCMD (minor cognitive motor disorder), characterized by mild impairment which may totally escape detection. MCMD does not necessarily progress to dementia. A more serious form is HAD (HIV-associated dementia), which includes cognitive dysfunction (problems with concentration, memory, and attention), declining motor performance (strength, dexterity, coordination), and behavioral changes. Both HAD and HAD are diagnoses of exclusion, meaning other potential causes such as substance abuse or medication must be ruled out. Recent studies indicate that the risk of dementia related to cerebral atrophy may be associated with the CD4 nadir (the lowest point) rather than current CD4 levels. While there are no specific treatments, antiretroviral therapy along with other interventions, such as structured routines, memory aids, and good nutrition, may greatly reduce symptoms. Other HIV-related neurologic disorders include encephalitis, meningitis, neuropathy, and the very rare but lethal PML (progressive multifocal leukoencephalopathy).

Mood disorders—

Mood disorders, or conditions that affect an individual’s mood, include those that result in depressive symptoms (major depressive disorder and dysthymia) and those with intermittent mania which can be frequently accompanied by a depressive phase (bipolar disorder). Depressive disorders are one of the most common mental health concerns among HIV patients. While they can appear or become more severe following an HIV diagnosis, symptoms can increase at any time due to medical complications, loss of a loved one, or other psychosocial stressors. Certain subgroups of individuals living with HIV are at greater risk for mood disorders. Major depressive disorder, for example, occurs more frequently in substance abusers, older patients, and females with a history of abuse (as in the case of Angela noted above).

Major depressive disorder (MDD) creates a pervasive low mood which inhibits the ability to experience pleasure. It has a prevalence as high as 36% among individuals living with HIV. People experiencing depression may be preoccupied with thoughts or feelings of worthlessness, regret, hopelessness, and despair. A second, milder type of depression called dysthymia, in which symptoms are chronic but less severe than with major depressive disorder, is also prevalent.

Depressive disorders are frequently difficult to diagnose because their broad cluster of symptoms (increased or decreased sleep and/or appetite, low mood, low energy, etc.) can also occur as a result of HIV itself, various opportunistic infections, or co-morbidities such as hepatitis C. If undiagnosed, major depressive disorder can lead either to an increased risk of HIV transmission, or among those already positive, a lack of adherence to HIV medication regimens or relapse of substance abuse.

Suicide is a serious risk for someone experiencing ongoing MDD and any suicidal thoughts and/or plan must be immediately addressed. In one recent study, 26% of people with HIV reported suicidal thoughts at some time in their life, and 13% reported a suicide attempt. Those who attempted suicide were more likely...
to also have a problem with substance abuse. These statistics underscore the need to address concurrent mental health and addiction problems in people living with HIV.

There are no laboratory tests for depression, but there are several widely-used screening tools that are used to identify those at risk for the disorder. Once diagnosed, a number of medications are effective at treating depression. The most common are called SSRIs (selective serotonin re-uptake inhibitors) that are generally well-tolerated by HIV-positive people, but which can take two to four weeks before patients begin to feel relief from their depressive symptoms. While they are helpful for depression, they can cause a reduction of sexual desire and delayed ejaculation. Besides SSRIs, there are several other classes of antidepressant medications that are also effective.

Some HIV drugs, such as Norvir (ritonavir), can interact with certain SSRIs and create blood levels which are too high. When monitored, however, both SSRIs and an older class of antidepressants called tricyclics are safe when combined with HIV medications. Herbal remedies for depression represent another significant drug interaction risk with HIV medications. For example, St. John’s Wort should not be used as it can cause a drop in blood levels of the antiviral. Patients should always discuss all their medications, including herbs, with their physician.

Psychotherapy is an effective treatment for depression. In fact, research suggests that the most powerful intervention is a combination of pharmacological and psychotherapeutic approaches. A psychotherapist works with patients to teach them specific skills to modify thoughts and behaviors, as well as other types of interpersonal therapy which can focus on issues of loss and grief, acceptance, and identity. Group modalities, as well, are a powerful way to break the isolation typical of HIV and provide a forum in which patients can both give and receive support.

Anxiety disorders—
Anxiety disorders are common among those living with HIV. One recent study found that as many as 45% of HIV-positive individuals also had an anxiety disorder. Surprisingly, these rates were highest among those on antiretroviral medications with an undetectable viral load. Anxiety disorders significantly impact an individual’s quality of life and have an adverse effect on adherence to medications and other treatment interventions. There is also evidence that chronic anxiety affects hormonal balance in such a way that immune function is impeded.

Symptoms of anxiety range from those that are barely noticeable to paralyzing panic attacks, making them difficult at times to diagnose. Many symptoms are physiological, such as a racing pulse, chest pain, sweating, and hyperventilation. Brian, mentioned above, experienced disabling symptoms of panic based on his fear of having become infected by his partner Paul. Anxiety disorders frequently occur with other mood disorders. For example, as many as half of individuals who experience panic disorder also experience MDD. Women experience anxiety disorders, particularly panic disorder, more frequently than men.

Post-traumatic stress disorder (PTSD) can result from witnessing or experiencing an event beyond what would be considered normal and which involves the threat of death or actual injury. As noted earlier, a history of abuse can increase the risk of PTSD among persons living with HIV. Symptoms, such as those described for Angela, include frightening physiological reactions, nightmares, and other symptoms of emotional shock. PTSD can result in social withdrawal and a sense of a fore-shortened future.

Treatment for anxiety disorders often includes pharmacological interventions. Specific SSRIs (noted above for treatment of depression) are effective for certain anxiety disorders, including obsessive-compulsive disorder (OCD). Other medications are approved to treat anxiety, including buspirone and some beta blockers. Benzodiazepines can be effective at resolving acute symptoms of anxiety but, because of their addictive potential, should only be used in the short-term and with great caution in anyone with a history of substance abuse. Benzodiazepine withdrawal is dangerous and should always occur under the direction of a physician.

Psychotherapy is also an effective means of treating anxiety disorders. Cognitive behavioral therapy can greatly reduce symptoms of anxiety by focusing on thought patterns and the “here and now.” Therapy can also teach various stress management techniques that significantly improve one’s ability to engage in social and medical activities. Specialized treatment techniques such as hypnotherapy and EMDR (eye movement desensitization and reprocessing), among others, are effective for treating PTSD.

In addition to medication and therapy, anyone experiencing symptoms of anxiety should refrain from ingesting caffeine. Symptoms can also be controlled through increased exercise and relaxation procedures such as deep breathing and meditation.

Substance abuse—
The use of recreational drugs along with the abuse of prescription medication, particularly benzodiazepines and opiates, is intimately bound to HIV and mental health. Addiction increases both the risk of acquiring HIV and greatly complicates the medical and psychological management of living with the virus. The desire to numb feelings or escape into fantasy, despite potential life-threatening complications, is seductive for many with HIV. The grief of cumulative losses, shame, fear, and other overwhelming feelings can easily propel someone to the short-term relief of a mood-altering substance.

While a comprehensive discussion of substance abuse is beyond the scope of this article, it is important to note how
HIV, mental health, and substance abuse converge into syndemics, or simultaneous epidemics, each impacting the other. One striking example is the methamphetamine epidemic among gay men. Meth is an amphetamine that works on the pleasure center of the brain, releasing a torrent of dopamine that quickly washes away any feelings of inhibition and even depression. It also triggers intense sexual thoughts that can result in high-risk sexual marathons.

While meth is a risk factor for becoming HIV-positive, it creates havoc among those who have already sero-converted. I work with many gay men in their 40s and 50s who have lived with the virus for years. Many have begun to feel less energetic, less attractive, less sexual, and socially isolated. Meth washes away these concerns, creating an artificial sense of confidence and empowerment. A significant number of meth users soon become drawn into a vortex of increased drug use and severe social, medical, and sometimes legal consequences. Many stop taking their antiretroviral medications, which can create drug resistance. The depletion of dopamine can result in severe depression and feelings of hopelessness which can persist well into recovery because the brain requires months to “rewire” neural pathways damaged by the drug.

There are many resources available to anyone seeking assistance for substance abuse. Medications can reduce cravings for certain types of drugs. Support groups, whether twelve-step or alternative, such as SMART Recovery, have saved thousands of lives. Counseling can assist with underlying issues as well as the development of relapse prevention plans. Recognizing substance abuse and taking steps to reduce its harm can have a tremendous impact on HIV-related mental health concerns.

**BUILDING EMOTIONAL RESILIENCE**

HIV presents formidable barriers to achieving and maintaining emotional well-being. Despite these challenges, there are steps that anyone living with HIV can take to promote their own mental health and quality of life. Here are a few that can build emotional resilience:

**Collaborate with your healthcare providers**—
Carefully monitor your emotional state and share any concerns with your physician or other providers. Certain disorders require pharmacological intervention. If your depressed, manic, or anxious moods seem beyond your control, you might benefit from medication that could give you a stable foundation on which to implement the other suggestions in this section.

**Identify and express feelings**—
Living with HIV produces a number of negative emotions which must be identified and released. Whether at the initial diagnosis, when making the decision to begin meds, or during a medical setback, an emotional process ensues which can include a swirl of anger, denial, and sadness. Because holding on to these feelings aggravates both physical and mental conditions, it is important to find ways to release them through verbal expression, physical exercise, creative endeavors, or any other means possible.

**Maintain social support**—
HIV, in many cases, creates increased isolation and loneliness. Physical mobility, feeling ill, shame, and depression can all contribute to a withdrawal from society. It is critical to fight the urge to isolate and to re-establish connections with others. Social contact promotes healing at a number of levels and benefits not only the individual but everyone they come in contact with.

**Live consciously**—
Each of us needs emotional nourishment to heal. Many people derive strength from their spiritual life. Others find that nature, or work in the garden, or playing with their pet can ground them and re-establish emotional balance. Maintaining an awareness of our inner thoughts and feelings assists us in overcoming stigma, shame, and other negative emotions, and in expanding our connection with others and our role in a larger healing community.

**Practice daily self care**—
Daily healthy routines are not only beneficial in and of themselves, but they subtly affirm our inner sense of value and worth. A healthy diet, adequate sleep, minimal use of mood altering substances, and physical exercise all contribute enormously to mental health. Remaining focused on the present and not letting our thoughts drift too frequently into the past or the future can greatly reduce stress. If negative emotions take hold, a simple act, such as creating a list of things for which we are grateful, can often bring us back into balance. Any actions that reinforce personal empowerment are beneficial for our health and our emotions.

Living with HIV creates challenges to mental health that cannot be underestimated, yet the power to create positive feelings, healthy relationships, and an inner sense of peace lies within each of us. When we maintain our emotional balance, HIV can remain just one piece of the rich emotional mosaic of our lives.

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GO TO POSITIVELYAWARE.COM FOR REFERENCES.
Be proactive about anal health

BY GARY BUCHER, MD, FAAFP

I HAVE WITNESSED AND TAKEN PART IN THE MANY CHANGES in HIV care over the past 25 years. At the beginning of the epidemic, silence and fear was the name of the game. It took HIV activists taking control of their health care destiny to force the medical community to treat the disease and the patient.

HIV is now a chronic treatable disease, but it has a whole new set of issues regarding conditions related to premature aging, long-term side effects due to medications, and the development of other problems surrounding long-term immune dysfunction. Chronic anal human papilloma virus (HPV) infection is one such disease that has increasingly become a risk factor for developing anal cancer. HIV-positive people should know about the risk and take charge of getting screened and treated for pre-cancerous lesions.

Being proactive about anal health is another box you need to check off in the quest for optimizing your health. Assessing the anal area may not be any more comfortable for the clinician than it is for the patient, but if not done thoroughly, lots of valuable information can be missed regarding your anal health. There are just as many doctors who are uneasy about discussing anal sex or anal symptoms and performing an annual digital (finger) anorectal exam (DARE) as there are patients who shy away from discussing bottoming, any anal symptoms they may have, or having a digital anorectal exam performed on them. If you aren’t getting an annual anal Pap smear, you should, at a minimum, be getting a thorough digital anorectal exam. If not, you need to ask your doctor for one or both of them.

The DARE needs to be performed slowly and deliberately, with special attention being given not only to the prostate in men, but to the external perianal area and the 1-2 inches of the tissue inside the anus. The clinician should feel for any tender areas, thickened lesions, shallow indentations,
firm masses, or other abnormalities. I also ask the patient if they have performed an anal self-exam by using their finger to feel around for any lumps or bumps inside their anus. This can help guide me when I perform the digital anorectal exam.

Anal Pap smears are performed in a similar fashion to cervical Pap smears, with the area being swabbed to collect cells, which are then examined under a microscope. They can detect abnormal cells (anal dysplasia), but the anal Pap smear may be less likely to correlate with the degree of anal dysplasia that can be seen on a biopsy of an anal lesion revealed by high resolution anoscopy (HRA). Because such specificity is lacking, and there haven’t been any evidence-based clinical trials to evaluate anal cancer screening methods in preventing anal cancer, many clinicians feel that anal Pap smears should not be done at this time. However, I agree with other experts in the field who have proposed yearly anal Pap smears for all HIV-positive individuals. If the anal Pap is normal, continued annual screening is suggested. Experts also recommend anal Pap smears every one to two years for other high-risk groups and if normal, continued screening every two or three years. If any abnormal cells are detected, HRA with biopsy is recommended. However, these guidelines may be limited by the need to train a greater number of clinicians in performing HRAs and biopsies. It is also important for these screening tests to be administered in a non-hospital setting, to maximize patient compliance with screening and follow-up.

High-risk HPV subtypes, especially 16 and 18, are associated with cervical, anal, penile, vulvar, vaginal, and oral cancers. Cervical cancer is an AIDS-defining malignancy and its incidence has been decreasing with aggressive screening and treatment of pre-cancerous lesions or higher grade cervical dysplasia. Cervical cancer affected 35-40 per 100,000 women in the general population prior to cervical cancer screening and treatment and has now decreased to about 8-10 per 100,000.

Though most genital and oral cancers are caused by high risk HPV, these cancers are not increasing as fast as anal cancer in HIV-positive individuals and other high-risk groups. Compared to the more common lung cancer, penile, vaginal, and vulvar cancers are rare—between 0.42 and 1.8 per 100,000. Oral cancer affects an average of six men and 1.76 women per 100,000.

Anal cancer in the general population is still very rare and affects more women than men. The incidence in men is 1.14/100,000 compared to 1.76/100,000 in women. Individuals at increased risk for developing anal cancer include HIV-positive men and women; HIV-negative men who have sex with men (MSM); women with a history of cervical, vaginal, or vulvar cancer or cervical dysplasia; chronically immunosuppressed organ transplant patients; men and women with a history of anal warts; and people who smoke tobacco. But anal cancer, a non-AIDS-defining malignancy, is increasing in the HIV population and other high-risk groups. The incidence of anal cancer in HIV-positive MSM is now much higher than the incidence of cervical cancer was in the general population before screening and treatment became the standard of care. Some studies have shown that the rate ranges from 70-175 per 100,000 HIV-positive MSM. There is a two-fold increase in anal cancer in HIV-positive women age 40 or older than in women that age in the general population.

Like HIV, there is also a stigma associated with anal cancer compared to other forms of cancer. The most recent high-profile person with anal cancer was Farrah Fawcett and many people did not even know that she died from it. Though screening tests can find early signs of disease in people who are not yet sick, that stigma may keep people from getting screened the same way it keeps people from getting tested for HIV. The fact that there is no consensus from the medical community about the need for anal cancer screenings is an additional obstacle.

The New York State Department of Health’s AIDS Institute is the only body that recommends screening with anal Pap smears and digital anorectal exams. It makes sense to perform anal cancer screening in selected high-risk groups, given the increased rates of pre-cancerous anal dysplasia and anal cancer in these groups. Unfortunately, routine screening guidelines have not yet been established by most major medical organizations, such as the American Academy of HIV Medicine, American Cancer Society, American College of Colon and Rectal Surgeons, or the International Antiviral Society (IAS-USA).

It took about eight years for cervical cancer screening and the treatment of pre-cancerous cervical lesions to become standard of care. There weren’t any controlled clinical trials conducted to show that cancer screening with Pap smears prevented cervical cancer. What was seen over the course of many years is that cervical cancer rates decreased because of screening and treatment of pre-cancerous lesions. High-risk groups for developing anal cancer should not wait to be screened and treated for high-grade anal dysplasia or these pre-cancerous lesions. Take charge of your anal health. Ask for your DARE exam and your anal Pap smear! If you have any abnormality on either, make sure you get a thorough high resolution anoscopy and treatment for any pre-cancerous lesions.

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When I first heard the ubiquitous, public health-speak “MSM,” I thought it was a joke. I mean, really. And we’re all so used to “LGBT” by now that even straight politicians use it. But recently, an e-mail appeared with the following: LGBTQI2-S (Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirited). Seriously???

I understand that, for academic and clinical purposes, perhaps such strings of letters and numbers might provide a way to categorize people that cuts down on word count and typing effort, but it seems to me it also obscures the fact that the people being categorized are indeed people.

I’ve often argued that the recent advances in civil rights for gay and lesbian people are because the younger generation (and those of us oldies with open minds) understands that being gay is not entirely about what you do with your genitalia, but more about how you live your life and who you choose to live it with.

Back in the ’80s, when Carol Shaw began a movement towards fat acceptance with BBW (Big Beautiful Woman) magazine, I weighed over 300 pounds. Even then, though I indulged occasionally in the fantasy presented by BBW, I knew the difference between fantasy and reality. I refused to be called a BBW—the notion that all large women are beautiful is as absurd as the idea that all women of any size are beautiful (let’s face it, ladies, some of us must rely on having, as my grandmother put it, “other things to recommend you”)—and I refused to define myself by my weight. I was, and am, a lot more than numbers on a scale (or a glucose meter, for that matter), just as my dear friend Sal, who calls himself “a big ‘mo,” is way more than an “MSM.”

Some maintain that those to whom the MSM label refers are completely oblivious to the fact that it is applied to them by social workers, medical providers, counselors, and academics. But if they do know and they accept it, what does that say about their self-identity? If they somehow prefer those three letters to the other three, is it any wonder that it’s their very population that is seeing the highest incidence of new infections? No matter how they think of themselves on the categorization continuum, too many either don’t know or don’t want to know their HIV status, perhaps in part because they don’t even fully know or accept themselves.

How do we as a society hope to achieve true acceptance of all varieties of humankind when we insist on inventing “dividers” that keep us from knowing and appreciating ourselves and each other?

I’ve never slept with a woman, mostly because I find my “sisters” to be way less trustworthy than the men in my life, but once in the summer of 1982, while working at a regional theatre, I got drunk at a wrap party with a woman named Nan and we had a lovely long kiss. I had no inclination to go further, but I’ll tell you this much—if we had indeed spent the night in orgasmic bliss together, there is no way on Earth I would ever allow “WSW” to define me.

In the end, aren’t we all basically PSP (People Who Have Sex with People), even if only with ourselves?

Breathe deep, live long.
Talk with your doctor and consider all the factors about starting treatment. HIV treatment is now recommended for everyone with a T-cell count of 500 or less and should be considered when T-cells are higher than 500, according to the DHHS* and the IAS-USA†. Starting treatment early may help protect your immune system and vital organs. Today’s medicines may have fewer, more manageable side effects. They may help you live a longer, healthier life. Receive helpful information about living with HIV that you should know. Call toll free 1-888-447-1728, or visit TREATHIVNOW.COM.

*DHHS = Department of Health and Human Services  †IAS-USA = International AIDS Society USA.
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