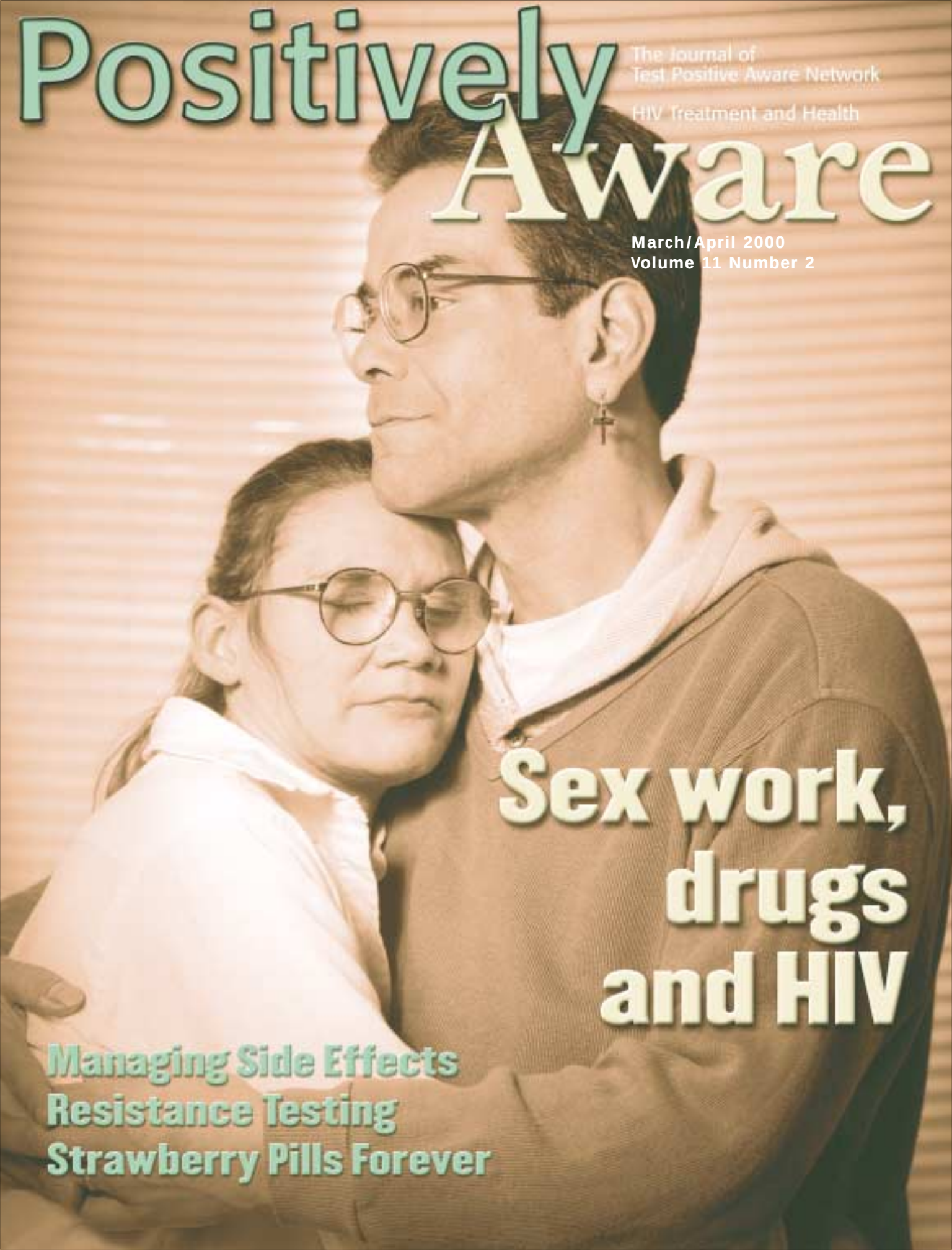

Positively Aware

The Journal of Test Positive Aware Network
HIV Treatment and Health
March/April 2000
Volume 11 Number 2

Sex work, drugs and HIV

Managing Side Effects
Resistance Testing
Strawberry Pills Forever

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COVER STORY

ARTICLES

ARTICLES continued

DEPARTMENTS

This issue is dedicated in memory of our editor,
Steve Whitson, Ph.D.
1961—2000

A model, photograph, or author's HIV status should not be assumed based on their appearance in Positively Aware.

You can view these (and other stories from previous issues) online at http://www.tpan.com

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Editor's Note

In Loving Memory…

Positively Aware *readers: Steve Whitson, editor of this publication, died of a heart attack on January 20. Ironically, it was not his HIV that ultimately claimed his life. Please accept this very personal farewell to my partner, lover, teacher and best friend…I can think of no other way to write this column than as an open letter to Steve.*

Dear Steve:

I have no idea where to begin—how can I possibly tell you goodbye when I'm not ready to admit that you are gone. Nothing will ever be the same again. You are gone and you have taken the best part of me with you. There is no more Phil & Steve…no more united front against the world…no one to watch my back. You no longer can nag me about taking my pills or keep me informed of the latest advances in HIV treatment. You can no longer be there to protect me.

From the moment you agreed to be the guest editor of Positively Aware—just over two years ago—I knew I had stumbled upon the perfect match for the job. You were the natural choice to assume the position full-time. You accepted all challenges in stride and took Positively Aware to a higher level. You assumed responsibility for a terrific grassroots magazine (thanks to former editors Bob Hultz, Steve McGuire and Brett Grodeck) and made it an even better, nationally respected publication. You delivered potentially confusing, highly technical HIV information in a way that we could all understand. You made living with HIV a little easier for us all.

You are the most intelligent man I have ever met, yet you were always quiet and unassuming in your knowledge. You were equally at home at a physician's seminar as you were talking one-on-one with a friend about what they should know about their own HIV. I wish everyone could have known "my" Steve. Under that sometimes gruff, always-intimidating exterior was a wonderfully giving man—fiercely proud and protective of his friends, as well as his community. You touched so many lives and you will be greatly missed.

In the far too short time we shared, we knew more love and respect than most people will know in a lifetime. You rescued me from a life of loneliness and cynicism. I will love you forever. You will be with me always and I don't know how I will live without you. I love you, honey.

Phillip Matthews
Former executive director of Test Positive Aware Network
and Steve Whitson's partner

From TPAN

Help Reauthorize the Ryan White CARE Act

This year is an important year for those of us living with HIV in the United States. The centerpiece of federal funding for support services to persons living with HIV–the Ryan White CARE Act–is up for renewal (reauthorization). This one piece of legislation provides funding for a wide range of services for people living with HIV, including mental health services, case management, outpatient medical care, dental care, medications, and food and nutritional services. The continuation of this legislation is critical to all of us. It is presently set to expire on September 30, 2000.

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted in 1991 and reauthorized in 1996. Hundreds of millions of dollars are provided to organizations around the country ($1.4 billion in 1999). One of the strengths of the CARE Act has been the fact that money is given to local communities or states who then set the priorities for service funding and delivery. This allows for the funds to address issues of greatest concerns within each community. It recognizes that the HIV epidemic in the United States is not one uniform epidemic, but rather a collection of many local epidemics, each one a little different, each one with its own set of priorities. This flexibility has allowed the funds provided to be used much more effectively than if priorities were set in Washington, DC.

Short of real and meaningful reform of our health care system, this is probably the most important piece of legislation affecting the services that we will have available to us as HIV-positive people. I urge you to write a short, handwritten letter on this matter to your representatives in the U.S. House and Senate. Tell them how important this legislation is to people living with HIV. Let them know that local control of funds is important for the most efficient use of the dollars. And let them know that more funding is needed. The increases in funding have not kept up with the increased number of people living with HIV. The services provided under the Ryan White CARE Act are not luxuries, they are necessary, basic services for thousands of Americans living with HIV.

Don't be fooled into thinking the reauthorization is a "done deal." There are many elected officials, members of Congress, who have indicated they want to radically change or reduce this legislation. And there are others who seem poised to introduce negative amendments that could severely hinder the delivery of services.

Readers of *Positively Aware* can make a difference! Elected officials do take notice of correspondence from voters. I urge each of you to write a brief letter. And if possible, get family members and friends to write letters, too. Let's see if we can generate 5,000 letters to Congress. Let Congress know we want continuation of this legislation. Let Congress know we need continuation, and expansion, of this legislation.

Dennis Hartke
Executive Director

PS: If you do write a letter, please let us know. All we need to know is who you wrote to. Send us an e-mail (TPANPosAware@aol.com), a fax (773-404-1040) or drop a note in the mail.

Readers Forum

Positively Aware will treat all communications (letters, faxes, e-mail, etc.) as letters to the editor unless otherwise instructed. We reserve the right to edit for length, style or clarity.

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Women's cover story

Thank you for talking with us about addressing your use of "Our Bodies, Ourselves" on the cover of the recent edition of *Positively Aware* without permission. I read the article; it's quite good and reflects a perspective that the Boston Women's Health Book Collective shares. You can imagine, however, that we like to be careful about what our name becomes connected to, and we do ask that other groups request our permission in advance. Thanks for making sure that this happens in the future.

Best of luck with your good work.

Claudine Mussuto,
BWHBC

Note: The Boston Women's Health Book Collective owns the title "Our Bodies, Ourselves." *This is no small matter. Our apologies for taking the name without permission, and our thanks to the collective for its generosity regarding this oversight.*

Humor

Thank you, thank you, and thank you for Jim Pickett's article entitled, "Triple Your Pleasure, Triple Your Fun: Deconstructing HIV Drug Ads." I can't remember the last time I laughed aloud several times reading an AIDS article. Such a deliciously twisted sense of humor! He should be given a raise for his brilliant, piercing insight.

And Jim, keep up with the writing, and good health to you!

Jack,
Houston

Steve Whitson

I was shocked and saddened to learn of Steve Whitson's sudden death. Steve was one of the first people I met when I moved to Chicago four years ago (we lived in the same apartment building), and the way he has faced his own struggle with HIV by sharing vital information with other people through his articles in *Positively Aware* and in his day-to-day personal interactions has been an inspiration to me ever since.

I was basically closeted about my HIV status when I first moved to this city. Although I had hoped that this community would be more progressive in its attitudes toward HIV than my home state of North Carolina, I often have been disappointed that a city of Chicago's size could have such a small town approach to a virus that is still claiming too many people too soon in their lives. Steve was a ray of light through the fog of misinformation and stereotypes that still hangs over this city and much of the nation–including over many people within the lesbian and gay community.

It was due in part to Steve's example–and that of his partner, Phil Matthews–that I eventually was able to open up about my HIV status to friends and even my employers. They have taught me that you don't have to just "live with HIV," but that you can thrive in spite of–and perhaps even as a result of–your body's struggle with the virus. Like my own struggle with HIV, Steve taught me many valuable lessons about not giving up on life due to the many curveballs that it can throw you.

I will miss you, Steve, and the struggle against HIV and AIDS has lost a great advocate in your passing. My heart goes out to Phil, the staff of *Positively Aware* and Test Positive Aware Network, and all those others who were lucky enough to be closer to Steve than I had the opportunity to be.

C. Douglas,
Chicago

I am responding to your sad news of the loss of Steve Whitson and thanking you, from the bottom of my heart, for allowing me to use his work in my class.

Like many readers must be, I am in shock. I certainly regret not having corresponded earlier. He won my sincere admiration and respect. That "pit bull" ability to express realities in such an eye-opening manner. It is rare that someone puts their talents to use in a way that benefits so many and society as a whole. That is a most remarkable legacy, especially for someone whose profession was to teach.

I would like to express my gratitude for your generosity and deep sadness for your loss at *Positively Aware.*

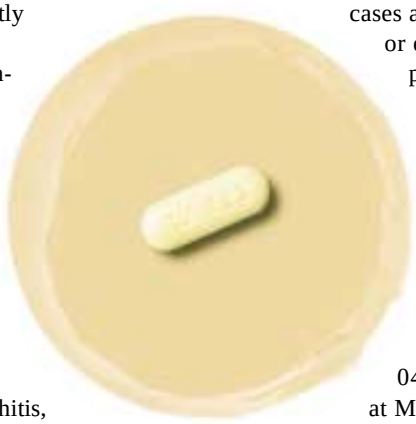
Barbara Sweet,
via the Internet

News Briefs

by Enid Vázquez

New Ziagen warning

How a cough can kill you: when it's part of an allergic reaction to the HIV med Ziagen (abacavir). The Food and Drug Administration (FDA) recently added respiratory problems such as cough, sore throat and difficulty breathing to the warning on Ziagen's label (see the package insert–that folded up paper with the small type). These symptoms are now recognized as signs that a person may be having a hypersensitivity (allergic) reaction to the drug. According to the FDA, "Deaths have been reported in patients receiving Ziagen who were initially diagnosed with an acute respiratory disease (pneumonia, bronchitis, or flu-like illness) and who were later recognized to have had a hypersensitivity reaction to abacavir that included respiratory symptoms." Ziagen manufacturer Glaxo Wellcome reported that 11 deaths have occurred out of 1,000 people who experienced hypersensitivity. More than 60,000 people have taken the drug, the company reported.



The respiratory symptoms occurred in one out of five people experiencing hypersensitivity (about 6% of all people on the drug). If hypersensitivity occurs, Ziagen must be stopped permanently. Attempts to go back on the drug (called "rechallenging") lead to severe illness and could cause death. Symptoms return within hours and are more severe. Looking at 112 people who were re-challenged, dangerously low blood pressure occurred in 24% and abnormally fast heartbeat (tachycardia) occurred in 11%.

The most common signs of Ziagen hypersensitivity are fever, malaise (discomfort, as with the flu), rash, fatigue, and gastrointestinal problems such as nausea, vomiting, diarrhea or stomach pain. As seen from the FDA statement, misdiagnosis may occur. According to Dr. Seth Hetherington, head of clinical research for Ziagen, "The golden rule is: if you can't tell the difference between an acute illness and a hypersensitivity reaction, you have to stop abacavir." (See "Ziagen hypersensitivity" below.)

Ziagen hypersensitivity

A review of hypersensitivity (allergic reaction) to Ziagen (abacavir) by the drug's manufacturer noted that there were 1,015 cases among the 26,769 people taking it during studies or expanded access (before it became available in pharmacies). More than 98% of people had at least fever and/or rash, but 30% did not have rash at all. Symptoms became more severe over several days. Early symptoms tend to include fever, gastrointestinal problems (such as stomach pain or diarrhea ?), or malaise (overall feeling of discomfort, as with the flu). Rash was more common later on. (See "New Ziagen warning" elsewhere in News Briefs.) To report hypersensitivity cases, call the manufacturer at (800) 270–0425 or the Food and Drug Administration (FDA) at Medwatch, (800) 532–4440.

7th Conference on Retroviruses and Opportunistic Infections

This major HIV/AIDS conference took place in San Francisco January 29–February 2. Some highlights follow. Visit www.retrovirus.com for complete information. Also see www.medscape.com, www.thebody.com and www.HIVandHepatitis.com for summaries (in addition to other HIV magazines and newsletters).

Oral sex

New information on oral sex drove people wild at the Retrovirus Conference. Basically, researchers noted a higher than expected risk of HIV from unprotected oral sex on a man–7.8%. However, critics noted that people tend to lie about their risk factors. Then again, the researchers said they eliminated lying and other problems as much as possible. Moreover, they believe that because people think oral sex has little or no risk of HIV, they engage in it more often, thereby increasing their risk through sheer number of contacts. Bottom line: unprotected oral sex has always been a risk, but always much lower than unprotected anal or vaginal sex.

CMV pills

French researchers urged the U.S. Public Health Service (PHS) to change its guidelines on opportunistic infections–those diseases that attack when the immune system is weakened. The guidelines say that prevention drugs for cytomegalovirus (CMV) can be stopped for people whose T-cells go back above 200 for at least six months–if they never had CMV. But for people who have had an episode of CMV, it wasn't sure whether or not they could stop taking drugs used to prevent a second episode. Therefore, now French doctors say that a review of an adequately large number of people from European HIV studies show that yes, these people too can stop taking prophylaxis for CMV. CMV is a serious complication of AIDS often leading to loss of vision, blindness or death. It occurs more commonly at T-cell counts under 50.

Fewer deaths

Once again, fewer deaths were found among people with HIV taking HAART (highly active antiretroviral therapy). But French researchers noted that mortality was still 8.7 times higher than in the general population. Among people with HIV, women had a higher mortality rate. There were also deaths from causes other than complications of AIDS. Moreover, there were deaths in people who had undetectable viral load (the level of HIV in their blood).

Superinfection

It's finally been documented: two people with HIV can pass on a new HIV strain to each other. So-called "superinfection" (from "super" meaning one on top of the other, as in "superimpose") was shown in this case because both men attended the same medical clinic in Ottawa, Canada, so that blood samples could be compared.

Camps for kids

The Lutheran Social Services of the National Capital Area (LSS) seeks donations for a camp for children with HIV who live in the D.C. area. The camp will be run by Project Safe Haven, a non-profit organization dedicated to improving the social well-being of children and youth living with the virus, or affected by it. Donations can be sent to Office of Stewardship, Lutheran Social Services, 4406 Georgia Avenue, NW, Washington, DC 20011. For more information, call Danielle Walter at LSS, (202) 723–3000 ext. 291. Camp Safe Haven operates a one-week camp in Martha's Vineyard every April, as well as other camps, mostly throughout the East Coast. Call (508) 693–1767, write P.O. Box 24, Vineyard Haven, MA 02568 or visit www.charityweb.net/safehaven.

Treatment interruptions

What used to be "stop-and-go" therapy is now called "strategic treatment interruption," or STI, to emphasize the need to be careful. The strategy arose primarily from information about the Berlin patient. This man started therapy early in infection, then had to stop for several weeks. He went back on treatment, but again had to stop after a few weeks. Afterwards, he never again had detectable viral load (HIV in the blood), despite never again taking antiviral drugs. Can HIV drugs be used off-and-on as a sort of vaccine against the virus? More studies are needed–don't try this at home! Reseachers emphasize the need to use STI under controlled, closely monitored studies only.

St. John's wort decreases blood levels of HIV drugs

The Food and Drug Administration (FDA) in February issued a warning that St. John's wort has been found to lower blood levels of Crixivan (indinavir) HIV protease inhibitor, and probably, therefore, other protease inhibitors (Agenerase, saquinavir, Norvir, and Viracept) as well as non-nucleoside reverse transcriptase inhibitors (Rescriptor, Sustiva, and Viramune). The herb is used to relieve depression. It should not be used by people taking any of these HIV medications because it may cause the drugs to be ineffective.

Effect of drugs on infants

One study found that uninfected children of HIV-positive moms still suffered some damage to their immune systems. However, this may be because they were effectively able to fight off HIV, which hurt their immune cells in the process. The findings came from 19 infants who had all been exposed to AZT to prevent infection and 42 older children who had not been exposed to AZT (their average age was around seven).

San Francisco PEP

That's post-exposure prophylaxis, also known as "the morning after pill" for HIV. (In reality,, it's usually many pills for many weeks). The still often controversial program saw 401 people in its first 16 months. One concern before the program started was that the "worried well" would clog it up. These are people who seek attention (sometimes obsessively) even though they're at low risk. Instead, PEP users tended to have high risk. For example, 57% of gay men who entered the program had had unprotected receptive anal sex. There was an average of 33 hours between exposure and starting PEP–animal studies suggest that PEP should begin within 36 hours. Most people (88%) were given Combivir for 28 days. Combivir is a combination of Retrovir (AZT) and Epivir (3TC), taken as one tablet twice a day. The simplified regimen was completed by 78% of participants.

There were no seroconversions to HIV, but researchers stressed that the program cannot be expected to reduce the rate of transmission in San Francisco, estimated at 500 new infections a year. The program's main benefit, they say, is lowering future risk for participants, thanks to appropriate counseling. A total of 12% of participants came back for a second PEP within six months. The vast majority of participants were unlikely to have multiple sex partners and did not use the program as a way to have unsafe sex.

Anti-HIV drugs = more risky business

A study by the U.S. Centers for Disease Control (CDC) and the University of California-San Francisco found that people who believe HIV drugs can control the virus are more likely to take greater risks of infection. Comparing different risk groups, researchers found that 40% of injection drug users were less concerned about becoming infected, compared to 30% of heterosexuals who had attended a clinic for treatment of sexually transmitted diseases (a higher risk group than those not in need of STD services) and 25% of MSM (men who have sex with men–thus called to include men who do not identify as gay). For those same groups, the percentage of people who reported being "less careful" were 25%, 15% and 13%, respectively. The report also noted that, "Of the 71% of MSM who had recent non-primary partners, more of those who reported being less concerned [about infection] had engaged in unprotected receptive anal intercourse (65% vs. 41%), as had those who reported being less careful (71% vs. 29%)." The researchers concluded that "prevention programs should consider balancing risk reduction and treatment information with improved knowledge of the uncertainties of the long-term success of HAART [highly active antiretroviral therapy]." Added the CDC in a press release, "Many may not realize the complexity and toxicity of these regimens." The results came from more than 600 people in each of the three groups. Overall–combining the three risk groups–31% were less concerned about infection and 17% (almost one in five people) were less careful about sex or drug use.

Don’t always reveal your status—here’s why

by Justin Hayford

“Silence = Death.” Few phrases have galvanized the AIDS community more effectively. Although ACT UP’s 15-year-old slogan has been reproduced on countless buttons, stickers, T-shirts and banners around the world, it has never lost its urgency, especially as HIV has spread into sectors of society traditionally denied a voice in any public forum. From the first days of the epidemic, people living with HIV have spoken out, setting the terms of their own struggle, helping to bring about a revolution in health care, media coverage and government decision-making. And when it comes to ending AIDS, we need all the revolutions we can get.

But it is important to distinguish between the political clamor we all must continue to raise and the personal disclosures about which we must sometimes be cautious. Although it may sound like political heresy, sometimes the best thing you can do is keep quiet.

Too often, people with HIV are erroneously told they must disclose their HIV status to employers, landlords, school officials or family members. Worse, they are told this incorrect information by people purporting to be their advocates–case managers, social workers or doctors. From the perspective of the AIDS Legal Council of Chicago, these people are giving bad legal advice. No law requires you to tell any of those people that you are HIV positive. The only people who should be told are the people with whom you have sex or share needles. But otherwise, if you want to keep your health status to yourself, that is your prerogative.

So if your doctor tells you that you have to inform your boss about your HIV status, stop and think for a moment. Would you take medical advice from an attorney? Then why take legal advice from a physician?

Stop and think too about the possible consequences of disclosing your HIV status. Over its ten-year history, the AIDS Legal Council of Chicago has worked with hundreds of people who suffered great social harm for making just this simple disclosure. A gold-coast professional called his landlord from the hospital to explain that his rent would be a few days late due to his new AIDS diagnosis; he returned home to find his locks changed, his possessions boxed, and the tires on his car slashed. A suburban mother asked her sister-in-law to take care of her son while she was in the hospital for an HIV-related condition; the sister-in-law decided no person with AIDS was fit to care for a child and refused to give him back. A Chicago travel agent told his office staff about his HIV status because “they were like family;” he was fired shortly thereafter when he took a few sick days.

Many people hear stories such as these and immediately think, “You’ve got a great lawsuit.” Truth be told, a great lawsuit isn’t necessarily better than a home or a job. The Council stands ready to protect the rights of people with HIV, but we know that lawsuits are neither easy nor pleasant. Often it is difficult to prove that discrimination took place; employers, landlords and the like have learned to cover their tracks. Even if the discrimination is blatant, there may be no money to collect–either because the person you’re suing is poor, or because the particular act of discrimination is not one for which the law allows money damages. Sometimes, there is no legal remedy at all. You can’t sue co-workers when they stop inviting you to lunch. You can’t sue customers when they take their business elsewhere. You can’t sue your sister when she refuses to let you hold her new baby.

I don’t mean to suggest that everyone who is HIV positive should go back “in the closet.” We must never return to the days of fear and shame. In the face of societal intolerance, many people with HIV have bravely refused to keep quiet. Their heroic efforts have contributed significantly to the struggle against discrimination.

But no one can be a hero in every situation. And even the greatest heroes choose their battles carefully. If you don’t want others to know about your HIV status, you have every right to your privacy.

You may choose to disclose your HIV status for lots of good reasons–whether as part of an important political battle, or as a personal commitment to truth and openness. But before you disclose your HIV status for legal reasons, thinking you will be better protected in the workplace, for example, please call us at the AIDS Legal Council or speak to another attorney first.

Being open about HIV is essential to combating society’s intolerance and misunderstanding. Those with the courage to speak out should be commended. But true courage is never doctrinaire. Each person should be allowed to decide if and when it is safe to disclose his or her HIV status. We must not scorn those who choose to remain silent in order to keep food on their tables and a roof over their heads. Sometimes, silence equals life.

AIDS in the Twilight Zone

Interview by Jim Pickett

Photography by Russell McGonagle

I met Tony Palmisano and his girlfriend Tina Campos in December of '99 at the Uptown site of the Community Outreach Intervention Project (COIP) in Chicago, an organization that works primarily with intravenous drug users, often considered the unreachable. COIP educates them about their addictions, HIV, hepatitis and other diseases, and helps them access services, get clean, and get a handle on their lives. Tony is 45, Tina, 34, and both are HIV+ recovering drug addicts who have worked in the sex industry for many years. Tina also has cerebral palsy. They've been sober for the last 5-6 months, spurred on by an ultimatum from Tina who finally decided she was "through with all this, done"–meaning blowing all their money on drugs, meaning the "dope fiend ways" of lies, guilt, anger, and violence. Not to mention that the previous 16 months Tony had her "jumping in and out of cars," pimping her to support their habits, and that had become intolerable as well. Tony soon changed. They are now back together and working on staying clean and healthy, day by day. The couple proudly showed me their rings and matching tattoos, signifying their commitment to one another, and openly shared their stories with me. Tony was especially eloquent and insightful on the nature of his addictions, HIV, and the price the sex industry exacts from its workers.

Tony–When I was 12 years-old I ran away from an abusive home and dysfunctional family, a physically, mentally, emotionally, and sexually abusive stepmother. It was 1966, the hippie revolution was on, and when I ran away from home, I went basically from the frying pan to the fire, I hit the streets of Chicago's Old Town/Rush Street area. I wasn't out of the house more than ten days and I got involved in IV drug abuse and the sex industry. I hustled on a daily basis from the time I was 12 to the time I was 17, when I got married to my first wife. I was a baby and I made a baby. That lasted all of a year and a half. By the time I was 19 I was hustling again. I hit the streets and started shooting stimulants. It was a means to an end actually, ya know. When you did stimulants you didn't have to spend as much money on food. You're not hungry, and you didn't have to worry about where to sleep because you were going to be awake for days. It was like a double-edged sword. And also, if you're involved in the sex industry and you're wired, I mean, it will enhance your performance a bit, cuz you can get it up, but you ain't getting off, which helps, and you can do more tricks in less time because you can knock 'em out quicker cuz you're accelerated, stimulated.

Jim–What's it like being so young in that industry?

Tony–It had its good points believe it or not, because as I said, I'd gone through this abusive family situation when I was a kid, and to have anybody tell me that lie, 'I love you,' ya know, to hold me, even though it was a trick and it was just for the moment, I felt like somebody. I mean it was a self-esteem factor that I wasn't getting at home. They told me the lies that I wanted to hear, the stuff I never heard at home, and I was a star for a minute.

Jim–It was comforting.

Tony–Yeah, exactly. Ya know, and there's the fact that I was bisexual in nature 'til I was 30 years-old. When my father died and I was 30, that was my first exposure to quote unquote treatment. After being in jail 8 1/2 months I went to a rehab program another nine months. It was the first time I actually had come down since I was 12, and I realized I had an emotional, psychological dependency on females. So I was basically hetero, but I had this bisexual bit my whole life, ya know, it was like, well hey, if it felt good... there was no real preference.

Jim–Women were more the emotional side and with men it was more the sex.

Tony–Sex, lust, camaraderie, brotherhood, fatherhood, ya know, the whole macho bonding process. So the party stopped briefly when I was 30. I was released from rehab and promptly relapsed four months after being released. Got back into IV abuse, started dealing, stealing, all around hustling. Um, ya know the song by Guns 'n Roses 'Welcome to the Jungle'? Ya know that part that says 'We are the ones who can provide whatever you may need, if you got the money honey, we got your disease'? That was me. This was my jungle.

Jim–When did HIV enter the picture?

Tony–Oh, I've been positive, it'll be seven years this coming June. When I got got out of rehab I got into a relationship with a girl who was working for a professional escort service. And, ya know, there wasn't really a lot known about AIDS at that point. She tested positive when the only known medica-

tion was AZT. I didn't change my sexual habits, we shared needles. Originally when I came out of Gateway and relapsed, me and this girl, Judy–God rest her–and four other couples, we shared a studio apartment on Wilson [Avenue]. We had a jar that sat on top of the refrigerator with 10, 12 outfits [syringes] soaking in water, ya know. We were constantly in and out of the house, do another hit, go out and catch a couple more tricks, go out and steal, deal a little, come back do a hit. Nobody knew whose outfit was what. We all figured well, fuck it, we're all gonna die anyway. They got this thing called AIDS, we figured it was produced by the government and they were trying to kill us all. And ya know, being as strung out as we were and involved in the outlaw economics, we figured, like if you're in the sex industry and not using condoms, gonorrhea is an occupational hazard, so this was just another occupational hazard. And Judy, my ex-old lady who passed away, was the first one of the bunch who tested up positive. Within a year four more of us tested up positive.

Jim—So AIDS was just one of many things that could get you.

Tony–That's it, that's it, ya know if you didn't get Dahmerized, and you didn't get the clap, and you didn't go crazy from untreated syphilis, ya know, if ya didn't get arrested, there are so many ways to go out. When you're living that street life, I mean the easiest thing to lose out there is your life. Second easiest thing to lose is your money. Third easiest thing to lose is your heart, soul, mind, and your dreams, cuz it all goes, everything. Your value system, everything. You pawn your dreams and there are people out there that'll feed on 'em.

Jim—When you sell it, you lose it.

Tony–Yeah, exactly. Hell, my first suicide attempt was 14 years-old, I'd been hustling full time in the streets for 2 years and I had gotten to the point where I had played so many fantasy roles to so many different people, on the straight and gay side of the fence, that I didn't know who the fuck I was anymore. I had a hundred people that all would swear they loved me, they all knew how to tell that lie, and they all wanted to fuck me or suck me or have me fuck or suck them, but none of 'em really knew me, ya know. It's like, when you're involved in that industry, you retreat to this little corner in your head where no matter what happens they don't really touch you. It's a lonely, dark little corner, but that's where you exist from. That's the only place you have left to live because you've sold or pawned or given away everything else. You lose your identity in the process. It wasn't until I got sober at the age of 30 that I really started to realize who the hell I was, and then it was more a process of realizing who I wasn't, and guessing at who I was. Ya know, like ya talk about adult children of alcoholics and people from dysfunctional families, we guess at what normal is, we have no fucking idea. I remember when I was in treatment, I was telling about living in New Town [a community area] and having a queen for a lover and being out there hustling. This suburban kid with a lightweight drug problem compared to mine was talking about how he would go down there on the weekends. It was like, 'I'd take a walk on the wild side,' ya know, but then he said, 'I'd go home Sunday.' It was like, fuck, he had a life. He said to me, 'You poor son of a bitch, you lived in that twilight zone?' I said yeah man, that was my life. But it was the first time I ever looked at it from that perspective, and I thought, *fuck.*

Jim—You never got to go 'home.' Never got to feel warm, safe...

Tony–Home was that little corner in my head that I could retreat into, that was the only home I knew. And it was very sterile. I mean there were no feelings, there were no negative thoughts. There was nothing.

Jim—Is that what the heroin did?

Tony–Most definitely, heroin, alcohol, cocaine, even marijuana. You've heard the term 'spaced out'? It's space, the space in between your thoughts. You simply aren't thinking about anything. You're not thinking about anything you're not feeling anything, there's just space. And in that space is where I called home. That's where I could rest, nobody could touch me, nothing could get me, no intrusive thoughts, no negative feelings. And from that viewpoint, the threat of dying from AIDS, well fuck, I'm dying anyway! I've been dying my whole life! What happens when I die? I go back to that sweet oblivion, I go back to being what I was before I was born, hell, that was attractive.

Jim—You're released from it all.

Tony–Like I said, when I was 14, my first suicide attempt, man, ya know, even if it was just a piece of the grave, it would all stop, it would all just go away.

Jim—No more chasing, no more running.

Tony–The race was over. The allure, the attraction is there. And I think any real addict, or chronic alcoholic, anybody that's chronic, even if it's sexual addiction, ya know, the thing is that you're purchasing death on the installment plan. Anybody that will stick a needle in their arm with an unknown powder, no guarantee on dosage or purity, you don't know what the hell you've got, but you're gonna jack that stuff into your vein? I mean c'mon, that's a death wish. It's not apparent to a lot of people, I mean ya know, killing ourselves to live. There were idiots like me that would throw just a little bit more in that spoon, every time thinking is this the one that's gonna put me over? Maybe... nah, I know I'm not going to be that lucky, my father told me only the good die young, I'm gonna live to be old. When I tested positive I remember a worker here, when I came out of the office, he said, 'Well kid?' And I looked at him and said I finally got what the fuck I wanted, man. I'm part of the club now. Everybody else that I knew and loved was either dead or dying, ya know. If it wasn't from AIDS, they were all at the end stages of their addiction. People's livers were going out, people were going crazy, people were getting blown up in dirty deals.

Jim—So how do you approach being sober now, how do you do that day to day?

Tony–It's really not that difficult. It's just like I guess when I was a baby and I was learning how to walk, those first steps are faltering. When I was in the program I had this real, thorough knowledge of the psychodynamics involved. Ya know the 12 steps, the whole psychology of addiction. I mean I had the therapeutics upside down inside out. But spiritually, I was still dead. In the program they talk about making a decision to turn your life over to a power greater than yourself. They had

a helluva time proving to me that there was a concept like God, and then once they could prove to me, okay, God exists, then this all couldn't of happened. I remember my counselor said, 'Well, you're 30, you've had seven suicide attempts, right? You really wanted to die or were you just attention getting?' I said no man, that first time when I was 14, there was nobody home. I had a shit load of barbiturates, drank a fifth of tequila, turned on the gas, blew out the pilot lights and slashed my wrists. He said 'And?' I said I passed out and the next thing I know I'm listening to bam bam at the door. I thought it was my heartbeat in my ears–here it's the fire department kicking in the door cuz the landlord smelled the gas, right? He said, 'So despite your own best efforts at self-destruction, you're still here.' I said yeah. He said, 'There's a power greater than you, now shut the fuck up and get back in the kitchen.' I said yeah, but now ya gotta convince me that He or She, whatever, this God, ya gotta convince me that He gives a shit what goes on down here on Earth. I felt like Elie Wiesel, man, where is God now? If there was a God, how could this stuff happen? In my mind that made no sense at all.

Jim–How do you make sense of it?

Tony–What I learned to do was humble myself to a spiritual–not a religious but spiritual–component in my life. There was that little corner in the back of my head, somebody made that for me. I didn't know it was there until I crawled into it one day, but somebody put it there, some power. When I wake up now the first thing that I do is thank God that I woke up. When I was a dope fiend it was like, 'Argh, good God, morning!' Chasing, chasing something that's already got you by the throat. I used to tell people I don't have an addiction problem, my only problem is mo' and they'd say, 'Mo'?' And I'd say once I get a little, I need mo'!

Jim–What changed?

Tony–Because something inside me surrendered. I'm positive and my T-cells dropped below 200 again. This is the third time over the years, and I probably have a limited amount of time. I wanted to be somebody just one more time. I don't think I've ever been as fully human as fully alive as fully feeling as fully caring as I'm ever gonna be, I don't think I reached that yet, ya know. But it's like, what a tragedy it would have been. What was that about 'better to have loved and lost, than never loved at all?' What a tragedy that would be to have lived but never really lived, just merely existed. When I meet my maker, what's gonna be my excuse? What did I do with my blessings? Oh hell, you love me? Good, get out there and sell pussy. Oh, you love me? Good, give me your money. Oh, you love me? Good, give me your drugs. Drug addicts and alcoholics are addictive people. We don't have relationships, we take hostages, and then we ransom them or sell them, because that is what we have done to ourselves. We held ourselves hostage to our addiction. You don't know how to do anything else.

The preceding was excerpted from a larger collection of stories profiling Chicagoland people living with HIV, entitled The Faces of AIDS, *being published by the Chicago Department of Public Health. The anticipated release date is the summer of 2000.*

HIV, Drugs and Feeling Like Crap

by George Carter

The meds are working. Your viral load is undetectable. Your T-cell count is good. Yet you feel like something the cat dragged in. Maybe you feel okay but you look like hell (at least as far as you're concerned). Or maybe you're not on drugs–because you're still relatively healthy and you want to wait, or you're scared of side effects. There is more to life than T-cells and drugs. Just as you've taken care of your health and life confronting HIV disease, now you must also try to figure out how to get the best use from the drugs without them disfiguring or killing you.

In order to make educated guesses, we must understand what's going on–both with HIV disease and how AIDS treatments may damage the body. For that, there are a lot of data. Those data reveal a complex and dynamic set of problems that begin the moment one becomes infected.

The virus

Let's first briefly look at HIV disease itself. In the clinic, blood is drawn and the amount of virus (viral load) is determined. This certainly tells us that something is happening–e.g., a high viral load is not good. But this number fails to tell us *where* in the body HIV is causing damage.

HIV hangs out in lymph tissue. The intestines, for example, have lots of lymph vessels and tissue. HIV in the intestines impairs gut function, resulting in vitamin and mineral deficiencies. It can also cause diarrhea. In some people, this happens more than in others. But in many people with HIV, it is seen early in the disease and can grow worse with progression to AIDS. By the time AIDS is diagnosed, most everyone will have decreased levels of most vitamins and minerals in their blood. Important nutrients such as vitamins C, B6, B12 and E, minerals like selenium, zinc and magnesium, and peptides (which make up protein) like glutathione can be lost and these losses are strongly related with faster progression.

HIV proteins can directly interfere with cells like neurons, causing peripheral neuropathy or dementia. Some have found that HIV proteins like gp120 and protease can cause neuronal damage and that antioxidants may help to prevent this damage. Thus, HIV gets into different "compartments" and can cause damage in various ways.

The body

Aside from HIV, we can also look at how the body is responding. The other major blood measure that people look at is the T-cell count (or CD4+ T lymphocytes). Again, to rely on this number alone paints too simple a picture.

The standard model is that HIV infects a T-cell, replicates and then all the new viruses burst out and kill the cell. Well, this model is also true–but it's not the whole story. There are many other cell types that HIV infects. Also, a lot of uninfected cells are killed and healthy tissues are damaged.

One mechanism that may explain this damage is oxidative stress, which causes increased amounts of free radicals to form–chemicals that can damage your body's tissues. Normally, the body has ways to keep free radical generation balanced. But, as we age, these systems are impaired. Excessive alcohol drinking, smoking, pollution and bad diet are other ways free radicals can be produced. And when you add HIV into the mix, there is more oxidative stress. This in turn causes cells to secrete proteins (inflammatory cytokines) which in turn causes more T-cells to be activated. HIV just loves this activation since it turns on the cellular machinery, causing more HIV to be made. So more HIV causes more of a response from the body which causes more oxidative stress–a vicious cycle is set up. And unfortunately, HAART (highly active antiretroviral therapy) can add to these problems.

One of the ways we know that oxidative stress is an important player is by studies that look at one of the body's own antioxidant defense mechanisms, a small peptide known as glutathione. This substance is found in every cell in the body. Studies have shown that when the level is low, progression to AIDS is faster. Others have shown a strong correlation between this low level of glutathione and a slower growth rate in kids with HIV. Antioxidant defenses may be important to prevent AIDS-related cancer developing.

Don't forget, many other blood work markers are very important. For example, there are many things you can do if your liver enzymes or other liver function tests are too high. The first step, of course, is to work with your doctor to find out why they are out of range (e.g., with high liver enzymes, is it hepatitis B or C infection? the drugs? etc.) There is more to HIV than viral load and T-cell count!

The drugs

When you throw in the drugs used to fight HIV, some of these problems can be worsened. While the drugs are clearly working to keep people alive and protected from illnesses, the longer you

use them, the greater the risk that more dangerous side effects can develop. Aside from health risks, having a decent quality of life is important–unless you have a special fetish for certain forms of misery!

The better we understand exactly what causes these symptoms to develop, the more specific and, hopefully, effective interventions may be individually tailored to prevent or offset side effects. For example, we know that Videx (ddI) can cause specific damage to the pancreas. Retrovir (AZT) can cause ragged red muscle fiber damage known as myopathy. A lot of the underlying damage in both these organs, pancreas and muscles, can be linked to both increased oxidative stress and damage to the mitochondria of the cells that make up these organs.

Mitochondria are the cells' powerhouse, producing a chemical called adenosine triphosphate (ATP) which is necessary for a whole host of cell functions. Without it, your heart would stop beating, your muscles stop working. There are many mitochondria in each cell of the body. Each mitochondrion has its own DNA it uses to produce more of the proteins to form new mitochondria as cells divide. Some active cells, like muscle cells with a high turnover rate, have more mitochondria. ATP is produced through a series of exquisitely balanced chemical reactions that produce a lot of free radicals. If the body's antioxidant defense systems are thrown into chaos by HIV, this balance is upset and the radicals get loose.

The nucleoside analog drugs (or nukes) appear to cause damage to the mitochondria in a two step process, first increasing the amount of oxidative stress and then damaging the ability of the mitochondrial DNA to replicate. (These drugs include AZT, Zerit, Epivir, Hivid, Videx and Ziagen.) Mitochondrial toxicity is the latest idea to explain what is widely known as lipodystrophy, a collection of problems caused or worsened by HAART that may include increased belly or breast fat, humps, loss of fat in the face, arms, and legs, and increases in blood fats and cholesterol.

How do you protect your mitochondria? One widely discussed approach is to switch your drug regimen. Obviously, if the drugs aren't working to keep the HIV undetectable and your T-cells stable, then that is a time to switch. Switching may also be necessary if side effects are becoming dangerous or life threatening. It is not an easy decision. All nukes can damage mitochondria. And protease inhibitors (Agenerase, Crixivan, Fortovase, Invirase, Norvir, and Viracept) and the non-nucleoside analogs (Rescriptor, Sustiva, and Viramune) clearly cause problems, as well.

A comprehensive antioxidant program before and during HIV drug therapy is another important approach. Of course, the first place to get nutrients is from your diet. This may mean making some substantial changes. Cutting out (or at least cutting back) the junk food you eat. Eating more fruits and vegetables of all different sorts. Getting plenty of pure water every day. Not drinking colas so much. Unfortunately, even though people often take in more calories, diet alone is not adequate.

The following antioxidants are good ones that adults with HIV should consider. Such a program provides the basic building blocks the body needs to fight HIV as well as to specifically protect mitochondria and other cells and tissues by replenishing antioxidant defense systems like glutathione. If this is too costly, one should at least use a potent multivitamin daily, one that contains a good level of magnesium and calcium. If you have high liver enzymes or a hepatitis co-infection, consider a multi without iron. See what your state's Medicaid covers.

George M. Carter is the Director for Treatment Information Development for DAAIR in New York City. He has been managing his hepatitis C infection solely (so far) through the use of micronutrients and herbs. (©1999 by George M. Carter)

Further reading:

Direct AIDS Alternative Information Resources (DAAIR): www.daair.org or call for a wide range of information sheets, including an extensive review on managing side effects, (800) 951-LIFE (5433).

Houston Buyer's Club: Request their "How To Manage Side Effects" pamphlet, (800) 350-2392.

Supplement	Dose (before drugs)	Dose (on drugs)
Multivitamin	2/day	3/day
Carnitine[1]	1 g/day	3-6 grams/day
B complex	1/day	1/day
Vitamin C	2-3 g/day	4-6 g/day (or more)
Vitamin E[2]	200-400 IU/day	400-800 IU/day
Coenzyme Q10	60-90 mg/day	90-150 mg/day
Alpha Lipoic Acid	300 mg/day	400-600 mg/day
N-acetylcysteine (NAC)	1 g/day	3 g/day
Selenium[3]	400 micrograms/day	800 micrograms/day

1) Acetylcarnitine may be better. Carnitine may be prescribed as Carnitor.

2) Mixed, natural tocopherols are probably the best form. Skip taking extra vitamin E if you are using the drug Agenerase (amprenavir).

3) Check the amount of selenium in your multi first. Do not exceed 800 micrograms/day of selenium.

Preventing or Managing Drug Side Effects

by George M. Carter

It takes guts

In the previous article, we reviewed the effects both HIV and the drugs can have on the body in general terms. Now let's turn to the guts of the problem: what doctors call gastroenterology. This field of medicine studies the structure and diseases of the stomach, intestines, esophagus, liver, gall bladder and pancreas. Each of these organs can suffer serious problems resulting from HIV, opportunistic infections (OIs) or the medicines used to treat them. Here, we briefly tour the body from mouth to butt.

This is just a brief overview. The suggestions here are based on the philosophy of first trying interventions that are the least toxic/most helpful to the body, then using more toxic, costly drugs. Every body is different, so it may take some experimentation to find the best approach for you. If the situation is serious, going directly to standard medical intervention may be best.

Mouth

Your GI tract actually starts with your mouth. As food enters, digestion begins: saliva is produced, you chew (thoroughly!) and swallow. But watch what goes in your mouth. Aside from the joys of oral sex, studies show people with HIV take in more calories. Higher levels of fat in the blood (cholesterol, triglycerides) make watching what you eat all the more important. Diet will be discussed in more detail in the forthcoming article on lipodystrophy. In general, try to limit the amount of junk food, colas, etc. Eat more whole grains, fruits and vegetables. If you eat meat, more deep sea fish and broiled meats and less fried ones. Prepare good food well and enjoy it. Indeed, addressing diet is part of handling many of the problems discussed below.

People with HIV often have gum and/or teeth problems. These should be closely watched and treated. Brush often and floss. Consider placing your toothbrush in a solution of hydrogen peroxide to keep it free of bacteria. Get sores (like cold sores or herpes) diagnosed and treated.

In order to eat anything, you have to want to. Sometimes, though, your appetite may be put off by HIV or the drugs. You need to eat. There are a variety of ways to stimulate your appetite. Marijuana or the drug Marinol is one way, but this is not for everyone. Herbs classified as bitters include gentian and dandelion. They stimulate gastric secretion and have a long history of safe use for stimulating appetite. Cinnamon, coriander, Iceland moss and fenugreek have all been used to help increase appetite. Also, certain nutrients like B vitamins, carotenoids and zinc along with carnitine can help an impaired sense of smell or taste which might diminish your appetite. You should also avoid smoking or consuming caffeine before eating as these can reduce your appetite.

Esophagus/stomach

After chewing, food and fluids go down the esophagus to the stomach. Here, the process of digestion swings into full gear. The stomach secretes hydrochloric acid (HCl) to break food down further. A condition known as hypochlorhydria (where the amount of HCl in the stomach is reduced) is fairly common in HIV. This problem may be remedied by taking a supplement called betaine hydrochloride, which provides acid for the stomach. Again, bitters, which stimulate gastric secretion, may help. Also, stop smoking. Esophageal cancer is every bit as horrifying as AIDS.

Intestines, large and small

From the stomach, the digesting food and fluids go into the duodenum, the entrance to the small intestine. The pancreas produces enzymes that help to further break down food. The environment shifts from the acid of the stomach to the alkaline environment of the intestines. Food is pushed along and nutrients are absorbed by little hair-like structures that line the small intestine known as villi. It then goes into the large intestine where fluids are absorbed and the fibrous part gathers together to form great big honking turds that eventually wind up in the toilet.

Villi are damaged by HIV which hangs out in the lymph system. The lymph system includes a network of vessels like those

that carry blood and are found inside the villi. The Gut-Associated Lymphoid Tissue (GALT) is one of the largest parts of the immune system, containing 40-60% of lymphocytes and a huge reservoir of HIV. Infections like CMV, candidiasis as well as medicines can cause a condition known as villous atrophy, where the villi become stunted. Normally, these hairlike projections "turn over" or develop anew every 5-6 days. If the villi are stunted, you have less absorption of nutrients. Which is one of the reasons many studies have shown that the levels of vitamins and minerals are lower in people with HIV and get even lower by the time AIDS develops. One way to deal with this is to use the amino acid glutamine. Studies of surgery patients show that further damage to villi can be halted by the addition of glutamine. A dose of 20-40 grams a day may be needed.

Another problem that can arise is the loss of bacteria that the intestines need. These good bacteria may be wiped out when antibiotics are used. Supplements of acidophilus and bifidus (sometimes found in fortified yogurt) can help to restore this balance. Just remember to wait a couple hours after taking an antibiotic or you'll eliminate their benefit!

Another problem that can arise is the loss of bacteria that the intestines need. These good bacteria may be wiped out when antibiotics are used.

One very important problem that can arise with drugs and infections is an increase in gas and flatulence. The first thing to do is address your diet. Find out if you have a lactose intolerance (and avoid dairy or take a lactaid type product). Some beans are not known as the "musical fruit" for nothing, while others, like aduki or garbanzo beans, may result in less flatulence.

A variety of herbs can help. Gentian, peppermint, allspice, anise, ginger, lovage and lavender have all been used to reduce farting. Mixtures of Chinese herbs known as DigestEase or Quiet Digestion (from Health Concerns) may provide relief.

Liver

The liver is one of the largest and most important organs in the body. It fills up the area on your right side from under the lower part of your ribs curving down toward your pelvis. The liver has many functions, including filtering and sorting absorbed nutrients and drugs (metabolism), helping to detoxify drugs, synthesizing and secreting proteins, bilirubin metabolism and glycogen storage.

Damage to the liver is assessed in various ways. Commonly, one sees an increase in liver enzymes such as ALT (SGPT) or AST (SGOT). Other blood markers of liver function include alkaline phosphatase, bilirubin, albumin and GGT. In addition, it is important to get tested for hepatitis virus infections. If you haven't been exposed to Hepatitis A or B, get a vaccine. There is no vaccine for Hep C yet.

Many drugs damage the liver. The most important and common is alcohol. All the HIV drugs can damage the liver. Norvir (ritonavir) is one of the worst offenders, causing severe hepatotoxicity in 30% of users as opposed to 10% overall for those using other drugs.

There are a variety of natural interventions, many of which have undergone some human clinical testing. The best and safest of these is the herb milk thistle which contains silymarin. Other liver helpful herbs include the licorice extract glycyrrhizin (it may increase your blood pressure or reduce potassium; eat more bananas), picrorhiza, dandelion, schizandra and Reishi mushroom. Vitamin E (800 IU of mixed tocopherols per day), omega-3 fatty acids, N-acetylcysteine (NAC), lecithin and alpha lipoic acid have all been shown to improve liver function. Another Chinese herbal formula known as Ecliptex (from Health Concerns) helped reduce this author's liver enzymes to normal levels.

Gallbladder

This organ is nestled in the liver. It produces a concentrated form of bile acids (sent in by the liver), which it releases into the duodenum (in response to cholecystokinin) as part of the digestive processes.

Protease inhibitors may increase the level of bilirubin in the blood. (Bilirubin is the yellowish pigment in bile associated with jaundice.) While it's generally not bad enough to stop the drug (except perhaps in infants and kids), this should not be ignored.

The first thing to address is diet. Cut down or eliminate greasy foods. However, eliminating fat is not a good idea, so get the right amounts of "good" fats. Plenty of fluids taken in daily is vital, filtered water being the best fluid! Fiber, particularly from oats, may also help as it improves digestive functioning. The

herb fumitory has been used to treat gallbladder discomfort. Artichoke and curcumin have been used to improve bile flow from the liver into the gallbladder as well as for lowering cholesterol. Peppermint leaf tea may also help (but not peppermint oil). If your gallbladder has been removed or you have persistent trouble with low bile output, bile salts may aid digestion.

Gall stones come in different varieties: brown, black and cholesterol stones. Some have suggested the use of apple juice or apple cider vinegar (diluted) to help soften stones. This can be followed by a lemon juice/olive oil flush to get rid of them. The problem, however, is if the stones remain somewhat large and get stuck in the bile ducts, surgery may be needed. Others suggest using epsom salts before the oil/lemon to open the ducts. Foods that might help include apples, cherries, grapes, carrots, apricots, leeks and tomatoes. Standard interventions include ultrasound and surgery, along with weight loss and eating less saturated fats.

One thing to avoid if you have gallbladder attacks is coffee–with or without caffeine. It causes contractions. Herbs to avoid when you have stones include artichoke leaf, boldo leaf, cardamom seed, chicory, devil's claw root, ginger root, peppermint leaf and oil and turmeric root. Excess weight, estrogen, female gender and older age are risk factors.

The endocrine functions relate to the release of insulin to help the body handle dietary intake of sugars (like glucose)

Pancreas

The pancreas is a long, wrinkly organ located just below the stomach. Its two main functions are endocrine and exocrine activities. The endocrine functions relate to the release of insulin to help the body handle dietary intake of sugar (like glucose). The pancreas also secretes enzymes into the duodenum which further helps the body to break down foods; this constitutes its exocrine function.

Pancreatitis can be acute or chronic. Symptoms can include pain, fever and, in more severe cases, intestinal obstruction, low blood pressure and heart problems (tachycardia). The acute form may be caused by alcohol, pancreatic cancer, passage of a gallstone, drugs like ddI or sulfonamides, infections like CMV or EBV as well as hyperlipidemia. The chronic form may be caused by alcohol, heredity, aging, cystic fibrosis, among other things. Severe forms can be fatal.

We also know that HIV drugs can cause insulin resistance, and can increase the risk of diabetes (along with being overweight), which can be a hallmark, along with pain and weight loss, of chronic pancreatitis. Aside from levels of amylase in saliva and other blood tests, various imaging techniques (like CT scans) may be used to diagnose pancreatitis.

The first best treatment is to stop drinking!

Pancreatic enzymes are often prescribed in cases of chronic pancreatitis to help offset the loss of such enzymes during an attack. A good basic antioxidant program may help reduce inflammatory responses damaging to the pancreas–but this probably has its best effect preventing the problem, so start early.

The real poop

At the end of food's journey, a fair amount ends up in the toilet, of course. But don't just flush it, check it out. It should be a nice, medium, dark brown color and good consistency. Lighter, grayer or yellowish stool may indicate liver or gallbladder problems. Very dark brown or black stools may indicate other problems such as blood or liver problems. These should be carefully evaluated.

You'll know if you have diarrhea. And there are a lot of things you can do to help minimize it. First, though, get a proper diagnosis to eliminate parasites (Giardia, for example) or other problems. For many, diarrhea happens after starting the protease inhibitor drugs.

There are many ways to address diarrhea, including diet (BRAT: Bananas, Rice, Applesauce and Toast) and the amino acid, glutamine. Herbs that have tannins help control diarrhea and include green or black tea, bilberry, agrimony, blueberries (fruits or leaves), raspberry leaves and savory. Certain forms of fiber like psyllium or oats are very important. Vitamins such as A (beta carotene) and E with selenium are important. If these don't work, then consider drugs like Imodium, etc.

George M. Carter is the Director for Treatment Information Development for DAAIR in New York City. He has been managing his hepatitis C infection solely (so far) through the use of micronutrients and herbs.

Interleukin-2: Immune Boost, or Bust?

By Bob Munk

Interleukin-2 (IL-2) is a protein produced by the immune system. IL-2 is a cytokine, a chemical messenger that plays an important role in mobilizing the immune response to an invading germ. IL-2 stimulates CD4+ (T-helper) cells to multiply and mature, releasing additional cytokines that stimulate other immune cells, including CD8+ (T-killer) cells and natural killer (NK) cells.

The activity of IL-2 was discovered in 1976. The molecule was identified a few years later. Researchers identified the gene that produces IL-2 and cloned it, which allows the production of IL-2 for treatments. It has been approved to treat some kinds of cancers, but it continues to have ups and downs in studies for HIV disease.

IL-2 was used to stimulate T-cells in people with HIV even before the development of effective antiretroviral therapies. In the late 1980s, studies used several different doses given by intravenous infusion. CD4+ cell increases were not too large, and didn't last long. HIV viral loads increased after each cycle, returning to baseline in about a month. In addition, the IL-2 infusions caused fever and serious flu-like symptoms.

In the mid-1990s, with viral load controlled by HAART, IL-2 made a comeback. It was again tested using daily IV infusions. With HAART, there were no measurable increases in viral load. A cycle of 5 days of IL-2 infusions using 12 to 18 million international units (MIU) became the standard, with dose reductions as needed when side effects were too severe.

Subcutaneous (just below the skin) injections were tried as a way of reducing IL-2's side effects and making it possible for patients to treat themselves at home. Doses of 5 to 9 MIU were studied, injected twice a day during 5-day cycles.

Another disappointment is that people who start out with lower T-cell counts get less benefit from IL-2, and have more serious side effects.

Overall, side effects were reduced, although many patients had some irritation where they injected the IL-2.

More T-cells, but how good are they?

After several dosing cycles, IL-2 produces T-cell counts 3 or 4 times as high as baseline, or as high as 1,000, and a reduction in the abnormal activation of T-cells. These benefits appear to be maintained even with less frequent follow-up cycles.

Not all the news is good, however. For one thing, IL-2 doesn't fill any gaps in the immune defenses. Cliff Lane, a key IL-2 researcher at the National Institutes of Health (NIH), uses a "Scrabble" analogy to describe T-cell repertoire. The full set of alphabet tiles represents a normal immune system. As your T-cell count goes down and you lose "tiles", you might run out of some letters. If you use IL-2, these "lost" letters don't come back, but you will have more copies of any letters you still had. Another disappointment is that people who start out with lower T-cell counts get less benefit from IL-2, and have more serious side effects.

Researchers at the NIH also thought that IL-2 could help them deal with "reservoirs" of infection. Current antiviral drugs have no effect on these reservoirs, where HIV can hide out and re-emerge quickly if medications are stopped. The researchers thought that IL-2 could "flush out" these reservoirs by activating the infected T-cells so that antiviral drugs would reach them. Unfortunately, in late October they announced that their experiment had failed. Even in patients with undetectable viral loads using extremely sensitive tests, and even after using IL-2, the viral load came back when medications were stopped.

Looking for clinical benefits

Although many studies confirm IL-2's ability to produce big increases in T-cells, no one knows whether those counts will translate into fewer opportunistic infections or longer life. Clinical trials had to be designed to answer this question. Two major international studies of IL-2 have been designed and are enrolling patients:

- Chiron Corporation, which manufactures IL-2, designed the "SILCAAT" study for people with T-cell counts between 50 and 299 and viral loads below 10,000 copies. The study will enroll 1,400 participants who will all receive regular antiviral therapy. The treatment group will get IL-2; the control group will not. Patients will be followed for up to 6 years.

- The National Institutes of Health is funding the international "Esprit" study of IL-2 for people with more than 350 T-cells. This $43 million study is the most expensive clinical trial in history. It will enroll 4,000 participants at 210 research sites in 18 countries and follow them for up to 6 years. Again, all participants will receive antiviral therapy, and the treatment group will also receive IL-2.

Both of these studies allow physicians to freely change the antiviral therapy of patients during the trial. IL-2 doses can be reduced for participants with serious side effects or increased if there is not a significant increase in CD4+ counts. Also, the timing of IL-2 cycles after the first few can be extended as long as CD4+ counts are high enough.

The timing of IL-2 cycles after the first few can be extended as long as CD4+ counts are high enough.

Are we on the right track?

The SILCAAT and Esprit studies should eventually tell us whether using IL-2 results in clinical benefit. But the discoverer of the IL-2 molecule thinks these studies aren't using IL-2 in the best possible way. In an interview published in *AIDS Treatment News*, Dr. Kendall Smith explained that daily low-dose injections of IL-2 were enough to stimulate T-helper cells without "waking up" too many natural killer cells. The T-helpers fight the HIV infection, but the natural killer cells are responsible for IL-2's nasty side effects.

After a year or two of daily low-dose injections, along with HAART, Dr. Smith's patients saw their CD4 counts return to the normal range. Then Dr. Smith asked them to consider stopping their antiviral medications, while continuing IL-2. So far, 9 patients have done so. As expected, the virus came back and viral loads increased for about two weeks. But then, the immune systems of every patient–with help from their daily IL-2–kicked in and knocked out about 90% of the virus. Their viral loads stabilized at lower levels than before they started HAART. Five patients have since re-started antiviral therapy, but 4 have been off drugs for as long as 9 months.

It's not nice to mess with Mother Nature

IL-2 is a good example of the challenges involved in using the body's own chemical defenses. Our immune systems represent a very complicated balance and interaction of various types of cells and cytokines like IL-2. When we take one of those elements out of context, we have to do a lot of research to figure out the best way to use it, or whether it even has benefits when used by itself.

Update on the Ryan White CARE Act

by Charles Clifton

Since 1996 there has been a significant decline in deaths from AIDS. A primary factor contributing to this decline is the services thousands of low-to-moderate HIV-positive individuals receive from the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. As of June 1998, more than 660,000 men, women and children have been diagnosed with AIDS in the United States. Of that number over 400,000 have died of the disease. Current trends indicate that between 650,000 to 900,000 people in the U.S. are living with HIV, but do not yet have AIDS, and 40,000 new HIV infections occur each year. The Ryan White CARE Act, originally enacted in 1990 and reauthorized in 1996, is probably the single most important piece of federal legislation enacted affecting the healthcare needs and concerns of people living with HIV. It will expire on September 30, 2000.

The Ryan White CARE Act is probably the single most important piece of federal legislation enacted affecting the healthcare needs and concerns of people living with HIV.

The CARE Act supports a crucial spectrum of services for persons living with HIV who have little or no access to some basic healthcare necessities. These services include–but are not limited to–AIDS medications (AIDS Drug Assistance Programs, or ADAP), primary medical care, viral load testing, and food and nutritional services. As it presently operates, the CARE Act is a collaborative effort that brings federal, state and local governments to the same table with persons living with and impacted by HIV and AIDS, health care providers and not-for-profit community based organizations. These groups and individuals work together to ensure that specific local health related needs and concerns are being addressed. While the current structure of the CARE Act has successfully improved the quality and quantity of life for HIV-positive individuals, there is still much to accomplish.

Statistics released in the January 14th issue of the CDC's *Morbidity and Mortality Weekly Report* show that men of color now represent the majority of HIV/AIDS cases among gay and bisexual men, exceeding the number of cases among white gay and bisexual men for the first time. The CDC report shows that AIDS cases among men of color increased from 31% in 1989 to 52% of AIDS cases in 1998. "The face of AIDS among gay and bisexual men is changing," said Helene Gayle, M.D., director of the CDC's National Center for HIV, STD and TB Prevention. "African-American and Hispanic men must recognize that this is not a disease that only affects white, gay men–gay and bisexual men of all races are affected."

Researchers now recognize that this epidemic has grown disproportionately among communities of color and difficult to reach populations, including African-Americans, Latinos, women and youth. The CDC report also cites several possible economic factors contributing to the disproportionate grown of HIV and AIDS in communities of color, such as high rates of poverty, unemployment and a lack of access to adequate health care. In 1998, 60% of the 500,000 individuals who received primary medical care and support services provided by the CARE Act were people of color.

Significant inroads have occurred to reduce inpatient care costs and increase healthcare access for underserved populations, by provisions established by the Ryan White CARE Act. However, much work remains to be done. The CARE Act must be reauthorized in 2000 for many reasons. HIV/AIDS care continues to grow more complex and people live longer. As a result the cost of HIV care, drug therapy assistance and case management threatens to cripple local and

state health care systems. To ensure that health care and support services as established by the CARE Act can continue to meet the growing needs of individuals living with HIV/AIDS and communities disproportionately impacted by the disease, funding must be increased for every part of the Ryan White CARE Act.

As programs and services established under the Ryan White CARE Act take center stage in Washington during this election year, this piece of federal legislation in all likelihood will be one of the most important debates on Capitol Hill affecting the lives of HIV–positive people. Early indications show reauthorization will not be an easy process. Some members of Congress are in favor of radically reducing the delivery of services under the CARE Act. Additional information on the CARE Act, the reauthorization process and congressional opposition can be obtained from the following web sites:

AIDS Action–http://www.aidsaction.org and
NASTAD–http://www.nastad.org

However there is something you can do NOW. Please take time to write a short, handwritten personal letter. You can write something along the lines of the one on this page. Urge your Senators and U.S. Representatives to support swift reauthorization of the Ryan White CARE Act.

The services provided under the Ryan White CARE Act continue to make it possible for thousands of Americans with HIV and AIDS access appropriate care and treatment services, resulting in more productive lives. This access is threatened if reauthorization is blocked in Congress. It is imperative that your representative is made aware that you understand how important these services are for HIV-positive people and that you appreciate his/her continued support for the Ryan White CARE Act.

(Thank you to David Ernesto Munar, Director of Public Policy, AIDS Foundation of Chicago, for information and suggestions used in this update.)

Charles Clifton is the director the MOCHA 2000 project for Test Positive Aware Network, the publisher of Positively Aware. *The MOCHA (Men of Color HIV/AIDS) 2000 project is a collaborative effort among several Chicago HIV service organizations and the Chicago Department of Public Health seeking to identify and provide prevention efforts in communities of color.*

12/5/99

Dear Senator Fitzgerald:

In the spring of 1987 my partner Antonio was diagnosed with AIDS. In October of 1987 Antonio died after being hospitalized with pneumonia. Prior to his first illness in April we had no idea that Antonio had HIV or AIDS. Still suffering from denial and out of fear of rejection Antonio and I kept his illness a secret from all of our friends and family. He died in isolation.

In 1987 Antonio and I did not have access to and knowledge of agencies that provided health and support services. Today these agencies provide a crucial service to people infected and affected by HIV and AIDS.

I urge you and Congress to support AIDS care, prevention, housing and research programs. Despite the great progress that has been made, as a Black gay man I know first hand that AIDS is not over in my communities, and much work remains to be done.

Sincerely,

Charles E. Clifton

Charles Clifton

Mapping Out Your Treatment Journey

A look at resistance testing

by Frank Pizzoli

If you don't know where you're going, any road will take you there.

Sixteen anti-HIV drugs are now available. Another dozen agents are projected for review by the Food and Drug Administration (FDA) in the next several years. Beginning or maintaining HAART (highly active anti-retroviral therapy) is a journey made less risky–but not risk free–with advances in genotype (GT) and phenotype (PT) resistance tests.

Not yet FDA approved, these tests can potentially identify drug regimens that would be more effective for a particular person. The idea is to establish a "sequencing" of drugs in order to maximize available drugs' anti-HIV qualities and prolong treatment benefits for as long as possible. While test results are useful, neither test can tell with certainty who will gain most benefit from particular drug combinations.

Genotype testing determines any changes, called mutations, to the part of HIV's genetic structure that makes key proteins. Viral samples are inspected for the presence of specific viral mutations known to be resistant to certain drugs. The reverse transcriptase gene is the target for nucleoside analogs (Hivid, Videx, Zerit, Epivir, Ziagen, and Retrovir, or AZT) and non-nucleoside analogs (Rescriptor, Sustiva, and Viramune). The protease genes are attacked by protease inhibitors (Agenerase, Crixivan, Fortovase, Invirase, Norvir, and Viracept).

Phenotype resistance is a more direct measure of viral resistance to specific HIV drugs. It examines the amount of drug needed to inhibit HIV growth. In its natural state, HIV is a "wild type virus" and is usually not resistant to particular HIV drugs. This allows them to suppress replication of the virus. Resistant virus requires higher levels of existing drugs to achieve an equal amount of suppression.

Both tests identify genetic HIV sequences in individuals' blood samples and then compares them to a "registry" that holds the "true" genetic HIV sequence. Deviations from the "true" sequence correspond to resistance to certain HIV drugs. Knowing these differences is important information when people begin treatment or for those whose drug combination has become resistant to their regimen. In a perfect world, people would combine GT to establish the specific "type" of virus in their blood with PT to determine the effective "amount" of particular anti-HIV drugs they need to take.

Just beginning

Individuals beginning HAART face challenging decisions: to begin with or delay the use of protease inhibitors or non-nucleosides, or both. Resistance testing might be especially useful in helping individuals identify if their viral type is responsive or resistant to PIs or NNRTIs, and which ones.

Resistance tests also help individuals identify if they have been infected with a virus already resistant to antiretrovirals. The possibility for this is higher in cities like New York or San Francisco where many people have been treated extensively, and may therefore be shedding a "mutated" virus. Resistance tests can be done before treatment starts to avoid using drugs that are unlikely to be effective.

Likewise, with needlestick exposure or possible maternal transmission, the virus may be tested to ensure it is not already resistant to certain drugs. Of course, treatment may need to begin before test results are available.

Although these tests may help with treatment decisions, individuals must carefully compare their own HIV history and characteristics with known treatment outcomes. For example, results from Merck Study 035 indicate that success with PIs in first-line treatment is durable: 30 patients received Retrovir (AZT) with Epivir and the company's protease inhibitor Crixivan for three years, and 20 of the 30 still have a viral load below 50 copies.

Another study concluded that PI-containing regimens "had a greater effect on the lymph nodes than those containing nucleoside analogs alone despite comparable levels of suppression" of HIV. Although these regimens are durable for study participants, this combination may not be able to fight down all viral types, making resistance testing an attractive choice.

Other results show that individuals on PIs may have HIV levels rebound after achieving undetectable viral loads, but that this virus causes less immune destruction. This explains why individuals whose viral load rebounds on PIs do not always experience declining CD4 cell counts. Individuals whose resistance tests indicate PI effectiveness may want to begin with a PI combination, hoping to diminish the virus's strength over time.

Although many clinicians consider PIs optimal first-line therapy, it is possible to lower viral load without their use. If an individual's unique HIV genetic code isn't resistant to non-PI drug combinations, a protease-sparing regimen

may be useful in controlling viral load. This approach saves PIs for future use, if and when individuals become resistant to an initial drug combination.

Experienced individuals

In several retrospective studies (looking back at what happened) of treatment-experienced people, baseline GT and PT results predicted response to new therapy. Although prospective studies are still needed, these results begin to validate the tests' usefulness. For example, when a combination treatment fails to control the virus, a resistance test may help decide what new combination might work. In this scenario, the test must be done while the patient is still taking the failing drugs, since without the drugs resistant virus is likely to be replaced by the original non-resistant virus. It then declines to very low levels that the tests will not detect. Yet, the virus will be ready to come back almost immediately if the drug is started again.

Keep in mind that recent studies suggest that PI resistance may not be an issue for individuals who experience viral rebound while on PI-containing regimens. The predominant virus that rebounds is often resistant to the other drugs in the combination, but not the PI. In this case the other drugs can be switched or another drug added as an attempt at therapy "intensification." This is a classic example of how resistance testing might be used to identify and monitor particular drug sequences.

The next round

People with drug resistance have a lot of variables to wrestle with. For example, someone is taking all their drugs on schedule and observing food requirements, and yet the regimen has failed. Assuming that you are absorbing enough of the drug to get an effective level in the body, the most likely cause of drug failure is anti-retroviral resistance.

If resistant, the "next round" of drugs will depend heavily on previous drug exposure and likely include a PI or two, and an NNRTI, or both. Several studies show success with the inclusion of an NNRTI in subsequent regimens, especially if someone has never taken an NNRTI. For example, one study showed that these people achieve lower HIV viral loads at 24 weeks than do patients who have previously used an NNRTI. The small sample also indicated that 83% of the NNRTI-naive individuals see a 0.5 log decrease in viral load while only 66% of NNRTI-experienced people see the same result. The use of more PI-sparing regimens as first-line HAART may allow for NNRTI-naive individuals to have a reasonable chance at treatment success when searching for the next combination.

Please note that NNRTIs originally were thought by most to have less antiviral potency and durability when compared with the PIs. On-going trials are calling into question those assumptions. The DuPont 006 study now has 48-week data showing that patients who start with high viral loads (over 100,000 copies) can have sustained viral suppression on a protease-sparing regimen of the company's non-nucleoside analog drug Sustiva in combination with AZT/Epivir. Consequently, resistance testing may be vital for individuals whose drug treatment plan is failing in order to properly identify remaining drug combination choices.

Because individual reactions and resistance to various drug regimens vary widely, physicians familiar with the tests warn that using the tests to identify remaining useful anti-HIV drugs is best done "sooner" than "later."

Pros and cons

GT is a less complex, less expensive test ($300–$500 per test) with results more rapidly available. Beware that some mutations counteract each other, so results may not be able to truly determine drug resistance. For drug-resistant individuals who have stopped therapy, GT may still be able to identify mutant virus. This test may be more accurate for nucleoside analogs and non-nucleoside analogs, and less useful for PIs that do not always show consistent mutation patterns. For accurate GT results, viral load must be above 1,000 copies.

People with drug resistance have a lot of variables to wrestle with.

PT is a more complex, more expensive test ($800–$1,000) with results taking longer than GT. On the plus side, HIV mutations are generally interpretable for all anti-HIV drugs. PT results work best with a viral load of 5,000 copies.

So, resistance testing can be used either to select the best initial therapy or to realign existing therapy. When you decide you're ready to rumble with HIV, perhaps GT and PT may help you go a few extra rounds in the ring.

Freelance writer Frank Pizzoli is founder and executive director of Positive Opportunities in Harrisburg, Pennsylvania, an HIV-employment service where drug choices, effectiveness and adherence really matter. E-mail fpizzoli@aol.com

Strawberry Pills Forever

by Jim Pickett

Everyone these days is being asked to think outside the box. Ya know, come up with new and fresh ways of looking at the same 'ole thing, see things from a non-traditional perspective, be creative, inventive.

So I thought, why not me? I can do that.

And so I've a few new millennium suggestions for the Research and Development arms of the world's big drug companies, like, both of them, or whatever the total is now. I'm aware that R&D doesn't get the big funds that Public Relations and Marketing enjoys, but I feel confident that these ideas, if well-funded and nurtured along with tender loving care, will make another trillion, minimum, because they'll be meeting the needs and desires of consumers on the front line like me.

I'll begin with an idea involving the emotions, and work my way through the five senses as a means of exploring this issue in a thorough, systematic, yet imaginative way.

Check this out–"protexan"–pronounced "pro-tuh-zan." What is it? It's my plan for a new combination drug, a protease inhibitor fused with Xanax. This new drug will make you feel blissed out, a little loopy maybe, kinda toasty and giggly, and you won't really care that your kidneys are failing, or that you can't see your shoes anymore from that paunch. Hey, it's just more of you to love! And because you will quickly become addicted to this innovative new super drug, your 100% perfect compliance will leave your doctors gasping, the marketing guys creaming, and the bottom line growing. Everyone wins.

Sight. We like to see beauty, we don't like to see ugly, right? According to Vogue, "beauty is in," so let's work on the color palette here, shall we? My current (dis)array of pharmaceuticals range from a sterile white, very Helmut Lang on a bad day, to a rather repulsive shade of beige, a horrific sort of bland. Let's make them pretty! Let's infuse character and style and life, let's do like fashion does and create "color stories" to go along with our HAART. For those days when I'm feeling nautical, I'll don a sailor suit and I'll pop the pills in seafoam and salt grey. When I'm feeling bold and confident, I'll break out the shoulder pads and have my orbs in fire engine red, which, by the way, is the new black, and when "tease" and "tarty" are my watchwords, I'll throw down my prescription in sheer, not quite transparent, but almost. Naughty! Designers interpret the same outfits in different shades, you can get a toaster in any color you want, why can't Glaxo give me Agenerase in paisley? I have so much that would go perfectly with, and for those of us who are more style-challenged, we can have a Martha Stewart-style creature do a hit show educating us all on how to mix and match our meds for a truly lovely presentation.

Sound. We associate special times in our lives with songs. Whenever I hear Cher's "Half Breed," I think of the six-year-old me doing that very number dressed in one of my mother's slips, a long towel or blanket wrapped around my head for Cher hair, lying vampishly atop my dresser and expertly lip syncing "...the white man always called me Indian squaw..." as my brother Kevin gamely sat in front of a half-opened drawer and pretended to be Sonny playing the piano, bless his heart. Let's transfer that warm fuzzy to our pill bottles. They could be programmed somehow (let someone else figure that out) to play our favorite song when we open the cap. It could be "Half Breed," Al Green's "Love and Happiness," "God Bless America," the Kate Smith version, "Muskrat Love," or an instant classic from that scrappy little pop vixen Britney Spears. And it could be changed ad nauseum, just like your answering machine message. Ker-ching!

Ker-ching! I think we got a hit on our hands here. Hear! Hear!

Taste and Smell. I don't know about you, but my pills stink and they taste bad, like sewer chemicals. They stink going in and they stink coming out, and not just in the poopy way, but also in our sweat and on our breath, as I was horrified to discover when my boyfriend mentioned he can smell it on my skin, and he can taste my triple combo when we make out. He says he doesn't mind, but how nice would it be if he could smell and taste something scrumpdiddlyicious, like a double whopper or a pan pizza, or something minty and refreshing, or even Listeriney would be okay. There are several ways to go about this one. The drugs could be bonded with a Tic Tac sorta deal, so they'd taste wintergreen both going down and when you're breathing heavy. Or they could come with nostalgia tastes/smells, like raw onions atop a grilled burger on a lazy summer afternoon, or warm Tollhouse cookies. Or they could smell like CK1 or some sporty fragrance–don't know how they'd correspondingly taste, but it could be worked out. The mind reels with the possibilities. Clean! Fresh! Sexy! Delicious! Mouth watering!

Touch. The importance of this sense cannot be underestimated. Again, things either feel good to us, or they feel bad. I don't particularly care for how my horse pills feel, their waxy, gelatinous texture is high on the ick factor in my palm, going down, and I really don't like how they make me feel on the inside either. Now this recommendation is what they call "really out of the box," but I hope you stay with me, as I hope the R&D goons do as well, because this has the potential to be real big. I was supping on falafel with another heavily treated visionary recently when we stumbled upon an inspiration for a new delivery method for our mounds of meds. Why, we thought, don't we take all our pills for the day and have them formulated into a sort of dildo/suppository kinda deal. We'd simply insert the dosed dildo in the morning and the drugs would be time-released throughout the day. Hello! Please sir, may I have another? Of course, we realized that we are "versatile" gay men, and our good feelings may not, in fact, be everyone's good feelings, but hey, straight men have prostates too, umkay? Right? Learn to love them! The gals, who don't have a prostate, can have nice times with their booties too I'm sure, so why not? And just maybe since the drugs won't be absorbed in the stomach anymore, we'll have no more tum tum troubles. Who can complain?

I don't know, but I hazard to predict a lot of happy faces and record-breaking compliance with this innovation. And with the others of course. Now it's time to advance to go and start working on the execution of these proposals. As a matter of fact, I just happen to be sitting on a prototype this very moment. That's me, smiling all the way to the patent office.