A I D S TREATMENT N E W S

Issue Number 376
December 28, 2001

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

Contents

AIDS Treatment News

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

Editor and Publisher: John S. James
Associate Editors: Tadd T. Tobias, R.N.

Statement of Purpose:

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

Subscription Information: Call 800-TREAT-1-2

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

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

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

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

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

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

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

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

ISSN # 1052-4207

HIV Resistance: Data and Spin

John S. James

On December 18 the first report was presented from a new study of the prevalence of drug-resistant HIV in U.S. patients in early 1999.[1] This study found that somewhere between 50 and 78 percent of these patients (depending on how you count patients whose viral resistance could not be measured) had some degree of reduced susceptibility to at least one antiretroviral. White, gay, middle class, insured patients had the most resistance, on the average, while those with less access to care had less. The national press eagerly picked up that story; and when we got home from the ICAAC conference in Chicago where the preliminary report was presented, we found that people all over the country had heard it -- and little else from the conference.

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

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

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

How the Study Was Done

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

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

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

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

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

Comment

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

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

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

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

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

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

References

1. Richman DD, Bozzette S, Morton S, Chien S, Wrin T, Dawson K, and Hellmann N. The prevalence of antiretroviral drug resistance in the U.S. 41st International Conference on Antimicrobial Agents and Chemotherapy, Chicago, December 18 [abstract LB-17].

2. Bozzettee SA, Berry SH, Duan N, Richman D and others. The care of HIV-infected adults in the United States. *The New England Journal of Medicine*. December 24, 1998; volume 339, number 26, pages 1897-1904.

Barcelona Conference Abstract, Scholarship Deadlines Early 2002

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

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

* January 21: Abstract submissions online (http://www.aids2002.com);

* February 1: Scholarship applications.

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

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

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

Speakers include:

* Kweisi Mfume, president/CEO of The National Association for the Advancement of Colored People;

* Beny J. Primm, M.D., The Addiction Research and Treatment Corporation;

* Celia J. Maxwell, M.D., FACP, Howard University;

* Anthony S. Fauci, M.D., National Institutes of Health;

* Valerie Stone, M.D., Brown University;

* Phill Wilson, African-American HIV/AIDS Policy Training Institute;

* Robert Fullilove, Ph.D., Columbia University

* Glenn Treisman, M.D., Ph.D., Johns Hopkins University.

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

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

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

AIDS Treatment News Denialist Series

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

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

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

The series:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Buyers' Club List, December 2001

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

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

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

Arizona

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

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

California

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

Colorado

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

District of Columbia

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

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

Georgia

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

Massachusetts

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

New York

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

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

Texas

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

AIDS Treatment News Index, 2001