

Durban – Between the Lines

This year's XIIIth International AIDS Conference in Durban, South Africa was not the typical AIDS conference. Because of the pressing social needs faced by developing nations, the emphasis of the meeting was not primarily directed toward biomedical research and studies. Instead, the main topics of discussion included human rights, reducing the stigma faced by people living with HIV, prevention, vaccine research, access to care, reduced drug pricing and building medical and social infrastructure. Still, medical research was not ignored. This issue of *PI Perspective* represents a summary of some of the most significant findings presented at the conference. Topics include anti-HIV research, treatment interruption studies, women-specific issues, side effect warnings and the first ever report on the medical use of marijuana in people with HIV.

Some of the most important clinical care findings were discussions about strategies for combating HIV disease. New data were presented giving support to the notion that anti-HIV strategies need not always include a protease inhibitor, or even a non-nucleoside RT inhibitor like nevirapine (Viramune) or efavirenz (Sustiva). Instead, the new data suggest that the number of potent drugs in a combination (a minimum of three), rather than the mix of drug classes or the specific drugs, may be the critical factor in achieving success. See the article of Anti-HIV Drugs Update on page 3 of this issue for a description of studies showing good, if preliminary, results from simple combinations of three nucleoside drugs. One such triple drug combination will soon be available in a single

pill, two of which are taken twice daily as a person's complete anti-HIV regimen.

A critical wrinkle in treatment strategy is the growing debate about the proper time to start therapy. Though researchers at the Durban Conference only presented two new observational studies rather than rigid controlled studies, one seemed to support the notion that delaying treatment until relatively later stages of HIV disease can be done without harm. If so, this may shorten the time when a person is exposed to the risk of drug side effects or developing resistance to existing drugs while also reducing the overall cost of treatment.

Following shortly behind this discussion is a debate about the proper time to change therapy. Conventional wisdom for

the last four years has argued that a person should change therapy as soon as viral load becomes detectable or begins to rise significantly. More recent studies have begun to question the necessity of this approach, which, if nothing else, accelerates the rate at which people cycle through the limited list of available drugs. More discussion of this topic will come in issue 32 of *PI Perspective*.

Several new approaches were reported to the subject of STI (Structured Treatment Interruption). One even has a new name, called "Structured Intermittent Therapy," though it is still just an extension of the existing STI concept. The National Institute of Allergy and Infectious Diseases latest studies are testing simple, short cycles of treatment in hopes of perhaps reducing the cumulative risk of side effects, increasing ease of adherence and lowering the cost of treatment. A European group offers a peek at early data from a study in which people repeat several cycles of "eight weeks on, two weeks off" treatment, followed by withdrawal of further

Can we sit by and watch whole nations wiped out from disease? Can we afford to ignore a plague that will do more damage than centuries of warfare in but a few decades?

treatment until viral load exceeds 5,000 copies of HIV RNA or a 25% drop in CD4+ cell count. These are described in the article on

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Structured Treatment Interruptions beginning on page 5.

A long awaited, first-ever US study of medical marijuana in people with HIV was widely misreported in the media, which claimed that marijuana use had been proven safe for people with AIDS. See the article on Medical Marijuana on page 8 for an accurate picture of what the study did and didn't show.

While concerns about the human rights, social needs and role of women in the epidemic dominated the conference's attention to women's issues, some groups reported new findings on treatment and opportunistic infections in women. Evidence was offered that hepatitis C virus (HCV) can be transmitted in childbirth and from a mother to child through breast-feeding, adding to the already widespread discussion of breast-feeding issues and HIV. During the conference, much of South Africa reverberated with a debate about how best to slow the currently out of control rate of mother-to-child HIV transmission.

An interesting study of the use of prednisone to try to prevent rashes associated with the drug nevirapine served as a reminder to all that things aren't always the way they seem. It has long seemed obvious to try to reduce the risk of nevirapine rash with prednisone, since prednisone is routinely used to treat the rash when it occurs. For the surprising finding of this study, see the related article on page 6.

Commentary

Despite its weaknesses and unsolved problems, AIDS research is continuing to make progress against the disease. The far bigger task before us today, perhaps, is to overcome the economic and social barriers that prevent progress from being available to all those living with HIV.

Despite the early perceptions that the Durban conference would disintegrate into a shouting match between AIDS specialists and a tiny worldwide group of so-called "AIDS denialists," once the conference opened the collective wisdom of all those who contributed to it prevailed. The spotlight of world attention was turned away from a few disturbing characters pursuing

their own publicity and instead focused on the devastating need for care, treatment, prevention, increased human rights and public health infrastructure for millions of people in developing countries now living with HIV.

In light of past failures to cope with more manageable diseases such as malaria and TB, it is clear that to bring the problem of HIV

The National Institute of Allergy and Infectious Diseases latest studies are testing simple, short cycles of treatment in hopes of perhaps reducing the cumulative risk of side effects, increasing ease of adherence and lowering the cost of treatment.

under control the healthcare delivery systems in developing nations and the apathy of developed nations must be addressed. Either the world pulls together to help solve these problems or we will all continue to live with the consequences. Can we sit by and watch whole nations wiped out from disease? Can we afford to ignore a plague that will do more damage than centuries of warfare in but a few decades? Every person on the planet who is unwilling to accept such outcomes must find a way to contribute to the solution.

National HIV/AIDS Treatment Hotline

Project Inform's toll-free hotline provides HIV/AIDS treatment information to people living with HIV, their healthcare and service providers, and family members.

1-800-822-7422

Anti-HIV Drugs Update

Several studies of abacavir (Ziagen) were presented at the recent International Conference on AIDS in Durban. Most of the results are preliminary and are based only on interim analysis, but they do extend our knowledge of the use of the drug. They suggest that short-term use of a three-drug combination containing abacavir may be as effective as a three-drug combination including a protease inhibitor. If these results hold up in longer term use, it will suggest there are many reasonable options for achieving good success with an initial three drug regimen and perhaps it doesn't matter whether the combination employs a protease inhibitor, a non-nucleoside drug or three drugs from the nucleoside class.

Encouraging results were also presented from a study using lopinavir (Kaletra) among people who have previously taken multiple protease inhibitor-containing regimens.

Abacavir Studies

One abacavir study involved 195 people who had not previously taken anti-HIV therapies and who had an average viral load of around 16,000 copies HIV RNA and CD4+ cell counts of about 400. Participants received either Combivir (AZT

this study was 750mg three times a day. The preliminary results after 24 weeks are shown in Table 1.

In short, there was no significant difference. Moreover, the results were the same for people who started with either a high or low viral load. A previous study had shown that people who had over 100,000 copies HIV RNA at study entry did not respond as well to abacavir compared to those with lower viral loads.

A similar study involved 342 people who had not previously taken anti-HIV therapies and who had an average viral load of around 63,000 copies HIV RNA and CD4+ cell counts averaging 300. In this study, participants received Combivir + abaca-

vir or Combivir + indinavir (Crixivan). The preliminary results after 24 weeks are shown in Table 2.

At the very least, there was no significant difference and even some evidence of a small trend in favor of the abacavir regimen. This does not prove, however, that the abacavir regimen was more potent than the indinavir regimen. This study collected information on adherence—the degree to which participants took their drugs as ordered by the study. The data showed that perhaps more than any other factor, ease of use of the abacavir-containing regimen (two pills twice a day) resulted in substantially better adherence compared to the indinavir-containing regimen, which greatly influenced the outcome of this study.

Another study reported on results from using abacavir as part of a four-drug regimen. People received either a four-drug regimen of Combivir + abacavir + amprenavir (Agenerase) or a three-drug regimen of Combivir + nelfinavir. Combivir is a combination of AZT and 3TC in a single pill and thus counts as two drugs. The study followed 302 people who had not previously taken anti-HIV therapies and had an average viral load of about 40,000 copies HIV RNA and CD4+ cell counts of about 350. The final results, in terms of the percentage of people who sustained viral load under the limit of detection after 64 weeks are shown in Table 3.

The most disappointing aspect of this study is the poor response rate in both groups. There may be a number of contributing factors to this. Some of this is due to the use of a strict *intent to treat* analysis, which presents a worst-case analysis of the results. People receiving the four-drug combination experienced a lot of side effects, especially nausea, vomiting, diarrhea and rash, leading many people to drop out and perhaps others to deliberately miss doses of the drugs. Another factor may have been the difficulty many people report when using amprenavir. Use of the drug requires taking many large and difficult-to-swallow pills. Poor adherence may have eliminated any possible advantage from the use of the fourth drug. Additionally, as Project Inform reported in *PI Perspective* #29, there are in-

Table 1 Study of 195 People after 24 Weeks

Drug Combination	HIV RNA <50 copies	HIV RNA <400 copies	CD4+ cell increase
CBV + ABV	67%	72%	91
CBV + NFV	66%	71%	65

+3TC) + nelfinavir (Viracept) or Combivir

Table 2 Study of 342 People after 24 Weeks

Drug Combination	HIV RNA <50 copies	HIV RNA <400 copies	CD4+cell increase	Discontinued Drug	<1 missed dose/week
CBV + ABV	63%	68%	114	8%	74%
CBV + IDV	50%	57%	107	12%	45%

+ abacavir. The dose of nelfinavir used in

Table 3 Study of 302 People after 64 Weeks

Drug Combination	HIV RNA <400 copies	HIV RNA <40 copies
CBV + ABV + APV	41%	37%
CBV + NFV	44%	34%

- ABV = Abacavir
- APV = Amprenavir
- CBV = Combivir
- IDV = Indinavir
- NFV = Nelfinavir

creasing concerns regarding the long-term potency of nelfinavir.

Another concern is that ten percent of people on the four-drug regimen developed signs of a known problem with abacavir called hypersensitivity. Signs and symptoms of hypersensitivity usually include fever,

The data showed that perhaps more than any other factor, ease of use of the abacavir-containing regimen (two pills twice a day) resulted in substantially better adherence...which greatly influenced the outcome of this study.

rash, fatigue, nausea, vomiting, diarrhea, abdominal pain or respiratory symptoms such as pharyngitis (inflammation of the pharynx), difficulty in breathing or cough. People who develop or are thought to have these hypersensitivity symptoms should stop taking abacavir and should not try restarting the drug. However, there have been recent reports of people developing hypersensitivity reactions within hours to weeks of restarting abacavir even though they had no signs of hypersensitivity to the drug previously. People considering restarting abacavir should be particularly mindful of these symptoms and abacavir should be stopped if any of these hypersensitivity symptoms develop.

Kaletra (formerly ABT-378 or lopinavir)

Encouraging results were recently presented from a small study using lopinavir (Kaletra) in people who have been on multiple protease inhibitor regimens but have not previously received a non-nucleoside reverse transcriptase inhibitor (NNRTI). Lopinavir is a new protease inhibitor that is co-formulated with a low dose of ritonavir (Norvir). Each capsule contains 133mg of a protease inhibitor that was called ABT-378 and 33mg of ritonavir. Fifty-seven people with an average viral load of about 32,000 copies and average CD4+ cell count of 270 participated in this study. The majority had some degree of resistance to three or more of the currently approved

protease inhibitors. All participants started out on three lopinavir capsules (twice daily) in combination with efavirenz (Sustiva) and any nucleoside analogue drugs (NRTIs) of their choice. After fourteen days, half of the volunteers continued on this regimen while the other half continued on efavirenz and NRTIs but had their lopinavir dose increased to four capsules. The results after 24 weeks are:

The results seen from this study among people who have been on multiple protease inhibitors are better than those seen from any previous studies. It is not possible to determine how much of the anti-HIV effect is due to lopinavir or efavirenz, since none of the participants had previously taken NNRTIs. However, at least one earlier study

quite encouraging and seem consistent with earlier studies. But it remains to be seen whether the results will hold up in the long-term. What is abundantly clear is that the simpler dosing of an abacavir + Combivir combination results in better adherence, an important consideration in the 'real world' setting. However, there is increasing concern over the risk for hypersensitivity to abacavir especially in light of the recent reports where people developed hypersensitivity reactions after restarting the drug even though they had no previous signs of hypersensitivity.

All of the studies with lopinavir have been very encouraging and the drug is likely to benefit people who have not previously been on anti-HIV therapies as well as those

Study of 270 People on Lopinavir after 24 weeks

Drug Combination	HIV RNA <400 copies	CD4+ cell increase
3 capsules LPV+EFV+NRTIs	69%	48
4 capsules LPV+EFV+NRTIs	82%	41

LPV = Lopinavir; EFV = Efavirenz

in a similar, highly drug-resistant population also started efavirenz with two other new drugs but had little success. One important finding from this study is that efavirenz significantly decreases lopinavir levels and the higher dose (four capsules) of lopinavir should be used when efavirenz is included in the drug combination. As a result of this finding all of the volunteers in the study are now receiving the higher lopinavir dose. Be sure to read earlier reports in *PI Perspective* to understand what is different about lopinavir and why it might work even in protease inhibitor resistant people, even though it is technically *cross-resistant* to some other such drugs.

The Food and Drug Administration is likely to approve lopinavir in the fall of 2000 and it should be available in pharmacies shortly thereafter. Because lopinavir has a small quantity of ritonavir in it, people who have had reactions to ritonavir should use care when taking lopinavir.

Commentary

The short-term results with abacavir are

who have been on extensive previous therapy. It is important that, if possible, lopinavir be used in combination with one or two new drugs in order to get the maximum benefit.

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New Developments in STIs and SIT

As more and more researchers have come to acknowledge that current treatments are incapable of eradicating HIV, growing attention has been focused on structured treatment interruptions (STIs) and structured intermittent therapy (SIT). New strategies will apparently be required to deal with issues around long-term use of anti-HIV therapies, including side effects, adherence, treatment fatigue and the lifetime costs of the anti-HIV drugs. If ways can be found to make treatment a temporary or intermittent requirement, many of these problems might be resolved.

Most of the STI studies so far have been small and exploratory in nature, primarily seeking to determine the safety of such a strategy. Results are emerging from one larger European STI study, which is looking at the safety as well as the effectiveness of this kind of approach to treatment.

A slight variation on previous studies, called SIT (Structured Intermittent Therapy), seeks to determine whether carefully planned bursts of intermittent therapy might sustain viral control while reducing the cost of treatment. Early results of two such studies have been reported by the National Institutes of Health (NIH). The first study enrolled eight people who started on cycles of seven days on anti-HIV therapy [d4T+3TC+indinavir (Crixivan) + low dose ritonavir (Norvir)] and seven days off therapy. The seven-day cycle was selected because previous studies have shown that—among people receiving optimal anti-HIV therapy—it generally takes at least seven days before viral loads climb back up to detectable levels over 500 copies HIV RNA after therapy is discontinued. “Failure” in this study is defined as having a viral load above 500 copies HIV RNA on two consecutive tests or more than a 25% drop in CD4+ cell counts on two consecutive measurements.

After 14 weeks, seven out of the eight participants continued to maintain viral loads below 500 copies; the one person who did not had forgotten to take his medications with him on vacation. While these

results are very preliminary, they are encouraging and warrant further exploration.

The second SIT study only enrolled three people on a cycle of two days on therapy (same regimen as above) and five days off. All participants had maintained viral loads below 500 copies for at least six months before starting the new treatment cycles. Results from this study have not been as encouraging with only one person maintaining viral loads below 500 copies HIV RNA after 14 weeks. The other two participants both had detectable viral loads at some point during the off therapy period. However, once anti-HIV therapy was restarted both had viral loads return to undetectable levels. Based on the disappointing results, this study will not be continued.

Further preliminary results have been presented from the Swiss Spanish Intermittent Treatment Trial (SSITT). We previously reported on this ongoing study in *PI Perspective* 30. The study includes 122 people with viral loads below 50 copies HIV RNA and CD4+ cell counts above 300. It is evaluating cycles of eight weeks of anti-HIV therapy followed by two weeks off therapy, for a total of four cycles. At the end of the four cycles (week 40) everyone stops anti-HIV therapy, which is then only restarted if viral loads rise above 5,000 copies at week 52.

During the first two-week interruption, 28 people had no detectable viral load, in other words all had less than 50 copies HIV RNA during the two weeks off anti-HIV therapy. However, fifteen people had a high

rebound in viral load (reaching over 100,000 copies HIV RNA) during the interruption. A preliminary analysis of the first 56 people who completed all four cycles showed no general trends in patterns of response. Almost equal numbers of people had widely differing responses during each interruption (some had roughly the same viral load levels during each interruption, others had viral loads that increased with each interruption, still others had viral loads that decreased with each interruption). Of note, there were eight people with no viral load rebounds, whatsoever, during the four interruptions. There is no known reason why these eight people responded differently than the rest of the group. The final results from this study are expected by the end of this year.

Another ongoing STI study is being conducted at the NIH. Seventy people are participating with half taking an STI and the other half taking continuous anti-HIV therapy. The STI cycle for this study is two months on and one month off therapy. Early results suggest that there is a trend towards a lower rebound of viral load with each interruption. These results are, at least for now, different than what has been seen in the SSITT study.

Commentary

The results from NIH’s small SIT study are certainly encouraging but it must be stressed that the study is too small to draw any firm conclusions. If these results are confirmed in larger studies, they suggest that it may be possible to only have to take anti-HIV therapies every other week, which might help with adherence, may reduce the likelihood of developing side effects and will cut the cost of treatment in half.

Further analysis of the results from the SSITT study and the STI study from the NIH is needed to try to understand whether there is a reason some people seem more likely to benefit from this kind of treatment strategy or whether their success is merely a coincidence.

■

Drug ID Chart

GENERIC NAME	TRADE NAME
Protease Inhibitors	
amprenavir	Agenerase*
indinavir	Crixivan*
lopinavir	Kaletra*
nelfinavir	Viracept*
saquinavir hard gel capsule	Invirase*
saquinavir soft gel capsule	Fortovase*
ritonavir	Norvir*
NNRTIs (Non-Nucleoside Reverse Transcriptase Inhibitors)	
delavirdine	Rescriptor*
efavirenz	Sustiva*
nevirapine	Viramune*
NARTIs (Nucleoside Analog Reverse Transcriptase Inhibitors)	
abacavir	Ziagen*
zidovudine	Retrovir*
zidovudine+lamivudine	Combivir*
zalcitabine	Hivid*
didanosine	Videx*
stavudine	Zerit*
lamivudine	Epivir*
NtRTIs (Nucleotide Analog Reverse Transcriptase Inhibitors)	
tenofovir	
Cellular Factor Inhibitors	
hydroxyurea	Hydrea*



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www.projectinform.org

Nevirapine, Prednisone and Rash

Findings from a recent study show that people taking prednisone with nevirapine (Viramune) were more likely to develop nevirapine-related rash compared to people not taking prednisone. Prednisone is commonly used to treat rash, a potentially harmful side effect of nevirapine. Researchers theorized that pre-treating people with prednisone might minimize rash. This contrary finding is different from reported anecdotes of experiences in the community.

The six-week study included 138 people. About half took the standard course of nevirapine (two weeks of 200mg nevirapine once a day and then 200mg twice a day), and the other half received the standard course of nevirapine with prednisone.

Of those taking nevirapine alone, 19% developed rash compared to 36% of those taking prednisone and nevirapine. Surprisingly, there was little difference in the incidence of rash between the two groups in people who had not taken anti-HIV therapies. There was a big difference among people who had previously taken anti-HIV therapies (18% vs. 43%). Furthermore, there were more reports of serious rash among people taking prednisone.

There were no differences in change in viral loads or CD4+ cell counts at the end of the study between the two groups.

This study serves as an important warning that anecdotal reports may not always be

reliable and what sounds logical sometimes turns out not to be. It seemed perfectly reasonable to expect that prednisone would reduce the incidence of rash, but in fact it appeared to make things worse. Moreover, the study suggests that the risk of developing nevirapine-related rash increases among people who have previously used anti-HIV therapy before compared to those starting nevirapine as part of their first regimen. While certainly everyone should be aware of and monitor for this side effect when starting a regimen with nevirapine, people currently using anti-HIV therapy but starting a new regimen with nevirapine should be particularly aware of the increased risk. Anecdotal reports also claim that another drug, Benadryl, is effective in reducing the likelihood of developing nevirapine-associated rash. It remains to be seen whether this belief holds up in a study. ■

Viral Load Blips

Many people taking anti-HIV therapies are able to reduce their viral loads to below the limits of detection on the currently approved tests. However, many also experience an occasional viral load 'blip', where viral load briefly becomes detectable and then falls back below the limit of detection. The significance of the blips was not known, but physicians often feared that they might be early signs of impending viral resistance and drug failure. Several reports at the International AIDS Conference, however, came to the conclusion that an occasional blip has little or no impact on the long-term control of viral load.

One study followed 241 people who had received AZT + 3TC + indinavir (Crixivan) for about one and a half years. During that period, 97 people had at least one viral load blip (between 50 and 200 copies HIV RNA); of these, 24 had two blips. The study found no relationship between the blips and later failure to control viral load, which for this study was defined as two consecutive viral loads above 200 copies HIV RNA. Nine out of the 97 people (9.3%) with blips and twenty out of the 144 people (13.9%) without blips had increasing viral loads during the follow-up period. Statistically, there was no difference in the rate of drug failure between those who did and did not experience the blips. ■

Women at Durban E

Globally, women and girls comprise the growing majority of people living with HIV. Reflecting this shift in the epidemic was an increased focus on women's issues at the 13th International Conference on AIDS. In all of its sessions, the conference grappled with many of the issues facing women and girls living with, and at risk for, HIV. Appropriately, many of the discussions focused on the plight of women in sub-Saharan Africa and other resource-poor areas. Nearly all sessions highlighted the inequities in human rights, HIV care and resources between sexes, classes and nations.

While there were no groundbreaking developments in basic science or the treatment and care of HIV+ women, the conference did break ground by providing attendees with a clear understanding of just how much this disease impacts women in the developing world. Moreover, it left attendees with a better sense of the difficult work that lies ahead and a renewed desire to undertake that work.

A Focus on Prevention

Preventing mother-to-child HIV transmission was one of the major themes of the conference. Results from several studies suggest that very short courses of therapy with either nevirapine (Viramune), or AZT (Retrovir, zidovudine), or AZT and 3TC (Epivir, lamivudine, the combination of AZT and 3TC is Combivir), are able to lower transmission rates by about 50%. With better access to therapy, a significant reduction in vertical transmission rates in resource poor countries is possible.

The Achilles heel of preventing mother-to-child HIV transmission remains breast-feeding—a necessity for many women around the world. Two major studies report a decrease in the protective effect of short-course anti-HIV therapy to reduce transmission as a result of breast-feeding. By 12 to 18 months after birth, transmission rates rose to 24% and then 30%, respectively, as babies became infected via breast-feeding. Thus, strategies to reduce mother-to-child transmission must address related social and

economic issues, such as feeding children.

Several studies are now looking at different strategies for safer breast-feeding. Early results from one study suggest that *mixed* breast-feeding—breast milk supplemented with cereal, juice, water and so forth—has higher risk of transmission compared to *exclusive* breast-feeding. The HIV transmission rates at 15 months were 19.4% in formula-fed infants, 24.7% in infants exclusively breast-fed and 35% in mixed-fed infants. More study is needed to determine the reason for these surprising results.

Challenges to stem the unabated spread of HIV among women garnered considerably less attention than decreasing mother-to-child transmission. Many sessions described the social, cultural and economic factors that must be addressed to decrease transmission rates among women. However, few sessions were able to offer concrete and presently attainable responses to address the problems.

In the future, one potentially effective tool may be microbicides, which include gels and lubricants that hopefully destroy HIV on contact. The goal with microbicides is to provide people with something they can apply, like a vaginal or rectal suppository, that would help them prevent infection. This approach might be particularly useful for people who have a difficult time negotiating safer sex and/or people in resource poor countries where obstacles exist to condom availability or use. If safe and effective microbicides are developed, they may one day

be a standard part of HIV prevention.

There were several sessions on microbicides, much of which highlighted some negative data linked to the use of nonoxonyl-9, a spermicide found in many lubricants as well as lubricated condoms. Fortunately, a number of other microbicides are being studied now, including topical solutions of anti-HIV therapies. Several other products are also in late-stage development. Hopefully, products will soon be on the market to help reduce sexual transmission of HIV and other diseases.

Treatment and Care

While new data were presented on new therapies and strategies for anti-HIV treatment, there was little specific to women.

Study results presented at the conference largely confirmed much of what we already know. These included studies reporting that

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women have different side effect patterns with certain drugs, that body composition changes may appear differently in women, that human papilloma virus (HPV, the virus associated with cervical and anal cancer), including anal HPV, is a persistent problem for positive women and that viral load and viral dynamics may differ between the sexes.

Comprehensive coverage of these and other topics specific to positive women, presented at the recent Durban conference, will be in the forthcoming issue of *WISE Words*, Project Inform's treatment newsletter for women. To receive *WISE Words*, call Project Inform's Hotline at 1-800-822-7422 or visit www.projectinform.org.

Medical Marijuana – Is it Safe?

Many people have used medical marijuana to manage symptoms of HIV infection and side effects of therapies. Medical marijuana users assert that the drug is useful in treating nausea, increasing appetite or as a mild analgesic (to help with headaches or mild pain). However, people living with HIV have been left with unclear information as to the risks and benefits of medical marijuana use.

A recent study, presented at the Durban Conference, lead to headline news claiming “Medical Marijuana is Safe for HIV Patients.” While the study showed that after 21 days the use of medical marijuana did not increase HIV levels, conclusions about the safety of medical marijuana were overstated by the mainstream media.

The study, conducted at the University of California in San Francisco (UCSF) is the first medical marijuana study in people with HIV to be funded by the U.S. Government. Data were presented on 62 people who had completed the 21 day in-patient study. Three times daily, before meals, volunteers received either medical marijuana (smoked/ inhaled), dronabinol (Marinol, a pill containing the active ingredient in marijuana) or a placebo. After 21 days there were no dif-

ferences in HIV levels among those receiving marijuana, dronabinol and placebo. Use of either marijuana or dronabinol resulted in greater weight gain and increased food intake than use of placebo.

Information on the impact of marijuana on CD4+ cell counts and marijuana-HIV drug interactions was not presented. The investigator anticipates this information to be available and presented at a meeting in Toronto later this year.

Commentary

The study was not designed to assess the overall safety of marijuana use for people with HIV, contrary to the implications of the media headlines. Safety of a drug needs to be established through much longer studies looking at both the short- and

long-term use of a therapy. It would be irresponsible to suggest that a 21 day study could establish the safety of any drug that is used continually. Further, the safety of interactions between marijuana and other drugs/substances were not established by the study. The use of marijuana in addition to tobacco, for example, is shown to dramatically increase the risk of head and neck cancers. Other research shows that cancer-causing agents in marijuana are much stronger than those found in tobacco. Finally, there is a concern that marijuana bought on the “street” may contain many unknown contaminants, including insecticides or fungus.

The limitations of the current study are well known to researchers at UCSF and they were not responsible for the overstatements made in the media. The group at UCSF plan to develop studies to further assess the safety and utility of marijuana in people living with HIV. For now, the only thing that can be concluded is that short-term marijuana use did not have an effect on HIV levels and that use of either marijuana or dronabinol resulted in greater weight gain than a placebo. This is a far cry from offering proof of the safety of marijuana use. In short, the jury is still out.






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