

PositiveLiving

a magazine for people living with hiv/aids december 2006



Partnership approach

(l-r) Robert Mitchell, Tony Abbott and Susan Paxton at the Sydney World AIDS Day launch.

WORLD AIDS DAY 2006

Many faces, *different* stories

The 19th World AIDS was marked across Australia on December 1, with speeches, concerts, and warnings about increasing numbers of new infections.

Speaking at the Sydney launch of the annual commemoration, NAPWA President Robert Mitchell said "Australians living with HIV/AIDS are a diverse population, including children, youth, adult men and women, and now our senior citizens. Just as the age range is broad, so too is the breadth of our needs and experiences. We all have unique perspectives about living with HIV/AIDS, and whether you are newly diagnosed, or have been living with HIV for twenty years,

these perspectives are necessary for hearing the stories and understanding the complex human dimensions that this virus has brought into our communities and our lives."

Mitchell spoke of the critical importance of the involvement of people living with HIV/AIDS to the Australian response. "The personal actions that lead us to become more informed, more active in the HIV response, more involved in representing and advocating for positive people and shaping policies and programs ... continue to be the way that HIV positive people contribute and proudly stand as equal in the partnership which is the guiding model of National AIDS Strategy," he said.

The principle of involvement of positive people was not mere

rhetoric, Mitchell argued, calling the partnership approach "the singular platform of the national response which arguably has given Australia one of the best HIV responses in the world."

Federal health minister Tony Abbott, at the same event, said the government was deeply concerned about a trend towards higher numbers of HIV notifications, and hinted at a change in government policies to head off a resurgent epidemic.

"All of us are very concerned about the recent increase in HIV/AIDS notifications. This obviously does suggest we need to have a rethink about our policies," Mr Abbott said. "Nine hundred or so new cases is a public health problem of the first magnitude and that's

why we need to do more."

Mr Abbott said he would ask for expert advice from the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH) before unveiling any new initiatives to combat HIV/AIDS, possibly including a new national safe sex campaign.

HIV-positive activist and academic Dr Susan Paxton also spoke at the Sydney launch. Dr Paxton told the crowd that her diagnosis was the greatest challenge she had ever had to face, and spoke of the discrimination surrounding HIV, often at the hands of health professionals. After her health deteriorated and she started treatment, Paxton decided to 'go public' with her HIV status at the urging of her

10-year-old son, who thought it might be 'good for her health'.

"I did go public, and it was good for me," Paxton said. "I'm really fortunate that I responded optimally to HIV medication and I continue to be very healthy, and I'm proud to say that last week my son finished his year 12 exams. I am one of the lucky ones."

Paxton believes that young people are "not getting the message" about HIV and that Australia's position as a world leader in responding to HIV has deteriorated.

"Each year, thousands of young Australians become sexually active. A responsible government must provide every opportunity to ensure that each of these young people can lead healthy and informed lives," she said.

INSIDE

How will the changes to eligibility for the Disability Support Pension affect you?

Read our in-depth guide on page 5

Australians 'don't discuss' HIV: study

A national survey of 1100 people conducted by Galaxy research has found that 60 percent of respondents had not discussed HIV/AIDS in the last 12 months, because they did not believe the disease affects them. "Increasingly, the community perception in Australia is that HIV is a diminishing problem," said Dr Roger Garsia, chairman of the NSW Ministerial Advisory Committee on HIV and Sexually Transmissible Infections. But, noted Garsia, "on a daily basis, people are being infected with HIV in our community."

Trethowan bows out

After ten years at the helm, the CEO of the AIDS Trust of Australia, Terry Trethowan, has announced his departure from the organisation. "It has been a labour of love in a tough job, but the time has come to move on" said Terry in a statement. "I will miss the Trust and all the wonderful people who I have had the pleasure of working with; I wish the Trust well in all its future endeavours." Trethowan's resignation came as the Trust announced it had distributed more than \$630,000 in the previous year, including over \$200,000 to AIDS Councils and PLWHA organisations, and \$27,000 to support Camp Goodtime.

HIV+ women often receive poor gyno care

A European study has found that many HIV-positive women receive suboptimal gynaecological care, despite living in one of the richest countries in the world. The Swiss HIV Cohort study found that too few of the 2150 women in the trial had regular gynaecological examinations and PAP smears, but noted that positive women are at increased risk of a range of gynaecological conditions. The current recommendation for positive women is that they should have a gynaecological check-up, including a PAP test, once a year. —*Aidsmap*

AIDS likely to be third leading cause of death by 2030

AIDS-related illnesses are likely to become the third leading cause of death globally within 25 years, after heart disease and stroke, according to the World Health Organisation. AIDS is currently the fourth-worst killer, with respiratory infections in third place. The report also found that, unlike today when causes of death in developed and developing countries are quite different, within three decades the causes of death will be similar around the globe, although AIDS will continue to be more prevalent in poor countries.

South Africa embraces abstinence

The South African government has announced ambitious plans to cut the rate of new infections by half within five years, by encouraging young people to abstain from sex. The draft plan unveiled to mark World AIDS Day also called for comprehensive care and treatment to be made available to 80 percent of those who need it, but was criticised for being short on detail about how the goals will be achieved. "South Africa has received a lot of negative publicity recently, and while this dramatic shift in government policy must be commended, too many people have yet to see any difference in their daily struggle to fight the illness," said Siphon Mthathi from the Treatment Action Campaign.

Strategies for coping with multiple drug resistance

BY PAUL KIDD

Finding effective treatment options for people who have taken many treatments and have multiple resistance mutations continues to be a significant challenge for HIV clinicians, and their patients. At the 2006 ASHM Conference, Alice Pau from the National Institutes of Health in the US presented a roundup of current thinking about how to deal with this troublesome situation.

In recent years there has been a clear shift in direction in HIV drug development, away from developing first-line therapies and towards drugs for treatment-experienced patients. This makes sense as people with HIV live longer on treatment and second-line and salvage regimens become more important, but Pau questioned whether the loss of emphasis on improved first-line therapies was helpful.

"For some reason the pharmaceutical companies are satisfied with efficacy that is really less than desirable," she said. In clinical trials, antiretrovirals intended for first-line use are typically able to get viral load down to undetectable in about 60-70 percent of patients after 48 weeks on treatment. "What about the others?" asked Pau. "Will they develop multiple drug resistance?" Clearly this is a problem which will be with us for some time.

Multiple drug resistance is fairly common – an American study published in 1998 found that 13 percent of patients with detectable viral loads had triple class resistance, meaning they were resistant to at least one drug in each of the three main treatment classes. Drug resistance is an issue for people who have never taken treatments, too: an Australian study (also presented at ASHM) found that in Victoria, 14 percent of newly-diagnosed people already had resistance to at least one drug, and 2.7 percent had multiple drug resistance at diagnosis.

Multiple drug resistance can be a self-fulfilling process: people with resistant virus are likely to have detectable virus, and this in turn leads to the development of new resistance mutations, which blunt the response to treatment, increase the viral load and so on. The end-point of such a scenario

is disease progression and the evolution of a very difficult-to-treat virus in that individual – a nightmare scenario.

Constructing a viable treatment regimen

Pau says the first step should be identifying the drugs to which you're resistant. This can be done by looking at your treatment history, and increasingly through resistance testing. The availability of resistance testing in Australia varies (it's not covered by Medicare) and so the use of these tests depends on local funding and they are far from routine.

Once your doctor has a picture of which drugs you're resistant to, the next step is to try to put together an 'optimised background regimen' of at least two existing drugs, before deciding whether to add any of the newer therapies.

The fusion inhibitor T-20 (enfuvirtide, Fuzeon) is one option that should be considered. T-20 is available on the PBS and has proven a powerful tool, producing sustained reductions in viral load and CD4 count increases. Much has been made of T-20's inconvenient administration (self-injection twice daily) but in practice most people find they are able to manage the drug's routine. T-20 appears to have a synergistic effect with tipranavir, darunavir and integrase inhibitors, Pau said.

The newest protease inhibitors, tipranavir (Aptivus) and darunavir (Prezista), are available in Australia under special access schemes. Both of these drugs have been developed with resistant virus in mind, and have been the subject of extensive clinical trials in pre-treated patients.

Tipranavir has been around a bit longer than darunavir, and has been used in a larger number of patients worldwide. Pau noted some of the factors associated with a better response to tipranavir, including lower viral load at the time treatment is started, and co-administration with T-20.

Side effects have become a significant concern with tipranavir, and may be more serious than those experienced by people taking darunavir. Liver toxicity and serious bleeding in

the brain have both been associated with this drug.

Darunavir is designed to be effective against HIV with resistance to other PIs, but Pau said "not all patients will respond to darunavir, and resistance can develop." Darunavir and tipranavir do have a limited amount of cross-resistance.

The newest non-nucleoside drug, etravirine, is also a new possibility for people with limited options. It remains active against viral strains which have become resistant to the other non-nucleosides, and in clinical trials about one-third of heavily pre-treated patients had a significant viral load response.

Coming from a whole new class, MK-0518 is the first integrase inhibitor to be available outside clinical trials. It has performed extremely well in clinical trials, with about 80 percent of patients achieving substantial viral load reductions.

You can read more about etravirine and MK-0518 on page 7 of this issue of *PL*.

Looking further into the future, another new group of drugs which could expand the options for those with multi-drug resistance are the CCR5 antagonists, vicriviroc and maraviroc. While there are questions about whether these drugs will be suitable for everybody, they show promise. An expanded access program for maraviroc has been announced in Europe, but these drugs are not yet available in Australia except in clinical trials.

In summary, Pau said the number of options available for treating people with multiple drug resistance is improving. "Maximal viral suppression [undetectable viral load] may be possible in some patients," she said, but the durability of this is unknown. We don't know enough about the possible development of resistance in the future, and we need better, more "user-friendly" regimens.

In the meantime, she said, avoiding the development of multi-class resistance remains the best approach: "Adherence is the key."

■ A referenced version of this article is available on our website www.napwa.org.au.

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US PLANS TO EASE HIV TRAVEL RESTRICTIONS

BY PAUL KIDD

In a statement to mark World AIDS Day, US President George W. Bush has announced an easing of the long-standing rule barring HIV-positive people from travelling to the United States.

The announcement contained only limited information about how the change in policy will be implemented, or when the changes will come into effect. PL understands that President Bush will issue an executive order granting a 'Categorical Waiver' to HIV-positive people entering the US for tourism or business reasons for up to 60 days.

The reference to a 'Categorical Waiver' in the White House statement suggests that it will still be necessary for positive people to declare their HIV status, perhaps at the point of entry to the US, to stay within the law.

"The President considers the participation of people living with HIV/AIDS a critical element in the global HIV/AIDS response," the

White House statement said. "A categorical waiver would enable HIV-positive people to enter the United States for short visits through a streamlined process."

US Global AIDS Coordinator Mark Dybul, in an interview with the *San Francisco Chronicle*, said the Bush administration is "very serious about fighting discrimination on AIDS."

HIV-positive people have been banned from travel to the US since 1987 under a restriction originally proposed by right-wing fundamentalist Christian senator Jesse Helms. Attempts by President Clinton to repeal the ban were countered by legislation passed in 1993. The ban led to a widespread boycott of the 1990 International AIDS Conference, held in San Francisco; the global meeting has not been held in the US since.

Activists welcomed the decision, calling it a step in the right direction, but argued that it does not go far enough. "We shouldn't have to get a waiver, period," said Eric Sawyer, a

co-founder of ACT-UP New York.

Dr Donald Abrams, one of the organisers of the 1990 International AIDS Conference, described the move as "a humane and positive thing," but was uncertain whether it would be enough to bring the International AIDS Conference back to the US.

The current arrangements do permit positive people to travel legally to the US in certain circumstances if they first obtain a waiver, but applications for these waivers are notoriously slow and cumbersome – a personal interview at the US embassy or consulate is required, and the individual's passport must be surrendered while the application is considered, a process often taking several months.

The ban on HIV travel and the difficulty of obtaining a waiver have led many positive people travelling to the US to either risk detection of medications and subsequent deportation, or to take treatment breaks while travelling overseas, possibly with negative health consequences.



Stella Maris, who is HIV-positive, speaks during a candlelight vigil in Jakarta, Indonesia, on World AIDS Day. The World Health Organisation has warned that AIDS is "not under control" in Indonesia, with the Indonesian government predicting that up to a million people may be infected by 2010. HIV has already infected an estimated 169,000 to 216,000 in the nation of 220 million. PHOTO AAP IMAGE/AP PHOTO/DITA ALANGKARA

Gene therapy shows promise in early clinical trial Using HIV to fight HIV

US researchers have reported that an experiment using a genetically-modified HIV virus worked better than expected, suggesting a possible new way of combating HIV.

The small Phase-1 trial involved just five people who had a single infusion of the treatment, leading the investigators to caution that the findings need further exploration, however they said the results show that therapies of this type are a promising field for future investigation.

"The goal of this Phase-1 trial was safety and feasibility and the results established that," said Dr Carl June of

the University of Pennsylvania School of Medicine, who led the study. "But the results also hint at something much more."

The treatment seemed to have a "vaccine-like effect," he said, keeping viral loads down and raising CD4 counts in four of the five participants. After treatment, "the immune system was better in most of the patients than when they enrolled," he said. "We are trying to study the mechanism."

The researchers developed the treatment by first removing part of the HIV virus, reducing it to about half its normal size. The protein

envelope surrounding the virus was then reversed, in a process called antisense. The modified virus was then used to infect CD4 cells taken from trial volunteers, and the CD4 cells were transfused back into the patients, leading the newly-infected cells to produce defective copies of HIV. More than three years later, there is no evidence of any ill effects from the treatment.

A Phase-2 trial is now underway in people with HIV, and Dr June also hopes the technology could be used in HIV-negative people to prevent infection. —PNAS, Reuters

THIS issue

ASHM 2006

Key findings from the recent 2006 Australian Society for HIV Medicine Conference – including startling findings from an Australian trial of Sculptra injections for facial lipoatrophy **4**

Q+A on welfare reform

The government's changes to eligibility for the Disability Support Pension are now in place. David Menadue's in-depth guide explains how the changes will affect you, if you're on the DSP or planning to apply **5**

New treatments available on SAS

Two new and promising anti-HIV drugs have recently become available via the Special Assistance Scheme for people with limited treatment options. Kirsty Machon explains the background for MK-0518 and etravirine **7**

REGULARS

Backgrounder 8
Treatment briefs 8

The PLWHA Broadsheet will return next issue.

Verbatim

There's a huge amount coming into Australia who have diseases – they've got AIDS. They are of no benefit to this country whatsoever; they'll never be able to work.

Pauline Hanson, in a widely-reported outburst against African immigrants on 6 December while announcing her intention to seek a return to parliament. The comments drew strong criticism from Liberal MP Bruce Baird, who said the fish-and-chip shop owner was "simply fanning the flames of prejudice for her own political gain."

The concept that STIs and HIV are spread [in poorer countries] purely because people are having multiple partners is wrong. It is more about the lack of education and harm-reduction.

Steve Wesselingh, executive director of Australia's Burnet Institute, in response to a report in *The Lancet* that said that the average age at which young people first have sex is increasing in developed countries.

There is a human calamity here. It's a lot more important than the war in Iraq, the war in Afghanistan and nuclear worries from Iran and North Korea.

UN special envoy on HIV/AIDS, Stephen Lewis, in a Reuters interview from Malawi in October. "These things of peace and security must be dealt with," Lewis said. "But when you have got a pandemic which has already taken 25 million lives and has gripped 40 million others the world has to understand that human priorities cannot be sacrificed in the obsession with conflict."

FIGUREthis

1 in 10

The proportion of gay men in London who are HIV-positive, according to figures released by the UK Health Protection Agency in November. The report said that nationwide, 1 in 25 Britons have HIV, and noted worrying rises in sexually-transmissible infections

42%

The proportion of new HIV infections in Uganda occurring within married couples, according to data released in early December. The figures starkly contrast with Uganda's model of promoting abstinence and monogamy ahead of condom use. Casual sex accounted for just 14 percent of cases, the report said.

US\$12 billion

The annual cost of future treatment for the 40,000 people newly infected with HIV in the United States, according to estimates released by the CDC. The agency estimated the lifetime cost of treatment per person at US\$618,900, basing the estimates on an average life expectancy of 24.2 years after infection. The cost of HIV treatments in the US is substantially higher than other countries.

The annual conference of the Australasian Society for HIV Medicine (ASHM) was held in Melbourne in November.

PAUL KIDD summarises some key developments.

Facial fat wasting (lipoatrophy) continues to be a significant concern for many people with HIV/AIDS, so one of the most eagerly-awaited presentations at ASHM concerned the FLASH trial, an Australian study investigating the effectiveness of injected poly-lactic acid (Sculptra, once known as New-Fill). While anecdotal evidence from people who have undergone this treatment has mostly been positive, there is limited clinical trial data showing its effectiveness, and the Australian trial was designed to address this.

Surprisingly, the trial failed to find a significant clinically-measurable benefit for the treatment, despite positive subjective assessments by both participants and the treating doctors.

A total of 100 people were enrolled into the trial, all of whom had moderate to severe facial fat loss associated with HIV antiretroviral toxicity. Participants had to have been HIV-positive over a long period and be stable on their current treatment, or off treatment with no plans to restart within 24 weeks, and had to have clinical signs of lipodystrophy at at least one other site apart from the face.

Participants were randomised into two arms – an immediate treatment arm and a deferred treatment arm, which acted as the control group. Participants in the immediate treatment arm received a course of four Sculptra injections at the start of the trial, while those in the deferred arm were treated after 24 weeks. The analysis presented at ASHM compared participants in the immediate treatment arm with those in the deferred treatment arm at 24 weeks (i.e. after the first group had finished their treatment but before the second group had started theirs). A further analysis is planned at week 96, when both groups have been treated.

Researchers used spiral CT scans to measure the change in subcutaneous tissue volume before and after the treatment, as well as asking patients and their doctors to give a subjective assessment of the effectiveness of the procedure in improving their appearance. The study design set a target of increasing facial tissue volume by at least 10 percent (as measured by spiral CT) as the criteria for successful treatment.

The results after 24 weeks showed that just 8 percent of those who had undergone the treatment had an increase in total facial tissue volume of 10 percent or more, compared with 5 percent of the untreated group. The difference between the groups was not statistically significant, leading researchers to conclude that the treatment did not increase the facial tissue volume, although it did prevent deterioration in the affected areas. There was a detectable



ASHM 2006 Melbourne

improvement in tissue volume around the injection sites; however this did not translate into a substantial gain in the total facial tissue volume.

The CT scan results contrast starkly, however, with the subjective assessments of participants and their doctors, with more than 80 percent of patients saying their appearance had improved after the injections. A similar proportion of doctors said they believed the patients' appearance had improved. By contrast, fewer than 20 percent of patients in the untreated group thought their appearance had improved.

Making sense of these apparently contradictory findings is difficult, not least because this is the first trial to use the spiral CT technology to measure facial tissue volume in this way. The strong endorsement of the treatment's efficacy by participants and their doctors cannot be ignored – after all this is essentially a cosmetic procedure and subjective assessments are important. But equally important is the need to objectively demonstrate the effectiveness of the treatment (particularly given its high cost), not least if public funding for the procedure is to be gained.

Treatment interruptions

Wafaa El-Sadr, of Columbia University in the US, presented a review of the implications of the SMART study. This is the large international study comparing continuous treatment with treatment breaks guided by CD4 count. The study was halted early in 2006 after it became apparent that there was a significantly greater risk of developing AIDS or dying in the group taking treatment breaks.

El-Sadr presented data from subgroup analyses which confirmed the study's earlier finding: regardless of nadir CD4 count, baseline CD4 count, baseline viral load, prior AIDS, hepatitis coinfection or previous antiretroviral use, the risk of disease progression and death was higher among those

taking treatment breaks compared with those who stayed on treatment continuously. Surveys of quality of life also favoured the continuous treatment group, she said.

"There was no evidence for superiority of drug conservation [treatment breaks] in any of the subgroups evaluated," she said.

While none of these subgroup analyses identified a group for whom treatment breaks were safe, some groups did even more poorly than others, El-Sadr explained. People with higher CD4 counts at the start of the trial, those with higher CD4 percentages, those with viral load below 400 copies and black participants were more likely to experience disease progression if they took treatment breaks.

El-Sadr also discussed the results of Staccato, a recent, smaller study which did find a benefit in treatment breaks. While the Staccato findings do not contradict the SMART study, El-Sadr acknowledged that the different findings opened up new questions. In particular, what might the result have been had SMART set a higher CD4 threshold for stopping and starting treatment breaks, as Staccato had done? While there is "no evidence" the results would have been different, this does pose a possible question for a future study, she said.

Despite the disappointing results of the SMART trial, El-Sadr hasn't given up on treatment breaks. "There needs to be further studies to try and find an effective interruption strategy – if we can find one," she said.

Apricitabine

Susan Cox gave a presentation on apricitabine (ATC), a new nucleoside drug being developed by Avexa, an Australian company. ATC is structurally similar to the existing drugs 3TC and FTC, with a similarly low toxicity profile, but is designed to remain active against several common resistant viral strains and to have a high barrier to resistance.

A small 10-day study of apricitabine monotherapy found that the drug produced significant decreases in viral load at all the doses studied, including among those with pre-existing resistance mutations. A Phase-2 study (AVX-201) is currently underway in Australia and Argentina, with twice-daily doses of 600mg and 800mg. To date the drug appears to be well-tolerated, Cox said, with the most common side effects being headache, nasal congestion, and gastrointestinal upset. Apricitabine use doesn't lead to significant mitochondrial toxicity or liver toxicity, the conference was told, and appears to have few interactions with other antiretrovirals.

Cox's conclusion was that apricitabine appears to be effective for moderately or heavily pre-treated patients, especially those who are resistant to 3TC or FTC, perhaps in combination with CCR5 antagonists or other future entry inhibitors. A Phase-3 trial is expected to begin in 2007.

Metabolic complications

Kathy Petoumenos presented an update from D:A:D, a large observational cohort study focusing on the risk of myocardial infarction (heart attack) in people with HIV. Previous reports from this study have shown a strong link between antiretroviral use and increased risk of heart attack.

Up to 2005, a total of 345 heart attacks were recorded (40 of which were second or subsequent events) among the 23,400-plus participants in the study. The researchers have calculated that the risk of experiencing a heart attack increases by about 16 percent for each year on HAART, although Petoumenos noted that the number of heart attacks over the five years of the study was "fairly stable" despite increasing exposure to treatment.

Much of the increased risk can be explained by the

increased blood lipids (cholesterol and triglycerides) seen in people on HAART – high blood lipids have long been known to be a risk factor for heart disease. But this doesn't completely explain the number of heart attacks observed in people on HAART. The precise mechanism by which this occurs is not known, however it appears to be particular to protease inhibitors.

In particular, non-nucleosides do not appear to significantly increase the risk of heart attack. "We found no evidence that increased NNRTI exposure is associated with risk of [heart attack]," she concluded.

Another presentation, by Handan Wand, looked at the incidence of metabolic syndrome (MS) among people with HIV. MS refers to a 'cluster' of related conditions, including high blood pressure, increased blood lipids, high blood sugar and low levels of HDL 'good' cholesterol, usually in combination with fat accumulation around the belly. All of these are potential risk factors for heart disease. Between 23-25 percent of the Australian population has MS.

Wand's report was based on data from INITIO, a cohort study involving 881 HIV-positive participants starting treatment for the first time. At the beginning of the study (i.e. before starting treatment) the prevalence of MS in the cohort was about 9 percent, however after three years on treatment this figure more than doubled. Again, the risk was highest among people taking protease inhibitors – the risk of developing MS within three years was between 64 and 69 percent higher for those taking PI-based combinations compared with those on NNRTIs.

Positive people can take some comfort in the fact that, for most people, the risk of suffering a heart attack is still fairly low, even after many years on treatment. However those with other risk factors for HIV – such as smoking, high blood pressure, being overweight, having a family history of heart disease or being over 50 – these results will be of concern; you may wish to discuss with your doctor strategies to reduce the risk.

Adherence

Dr David Baker presented an outline of the OneDA study, which is looking at ways to improve treatment adherence among Australian patients. This 48-week study is looking at whether treatments simplification (switching to less complex regimes, typically with fewer pills or dose times) improves adherence. Baker presented preliminary (week 4) data with adherence measured using four different methods (electronic MEMS caps, patient questionnaires, physician assessment and therapeutic drug monitoring).

Participants had 89.6 percent adherence, measured by MEMS caps, over the 4-week period, slightly down on the 95 percent recommended adherence rate but higher than the rate in some overseas studies. The study is ongoing.

■ A referenced version of this article can be found on our website www.napwa.org.au



Q+A

ON welfare changes

By David Menadue

In July 2006, some dramatic changes occurred in the rules for eligibility for the Disability Support Pension (DSP) which have major implications for people with HIV who experience any health problems that may affect their ability to work in full-time employment. Under the very prescriptive banner of 'Welfare to Work', the federal government radically changed the eligibility criteria for the DSP: new applicants will have to prove they cannot work more than 15 hours a week. Previously, the DSP was available to those who were unable to work more than 30 hours a week.

The changes were announced in early 2005 and, possibly in response to an outcry from disability groups or concern about the logistics of changing current DSP holders onto a new system, the government decided to 'grandfather' those who were already on the DSP so that the old conditions would continue to apply for them into the future, regardless of the changes. When the legislation passed on 11 May 2005, the 'grandfathered' group had their existing rights and entitlements protected (with a few small changes – see below).

People applying for the DSP from 11 May 2005 to 30 June 2006 were initially assessed under the old (30-hour) rules while being informed that they will be re-assessed under the

new (15-hour) rules when their review comes around (usually after two years).

As a consequence of all this, there are now three different categories of people on the DSP depending on when you were placed on it. This article examines the effect of the changes on each of these groups.

On its website, Centrelink says "The aim of the Budget measures for people with a disability is to ensure that these people are able to participate in the workforce as far as they are capable. The changes place a greater emphasis on what people can do, rather than what they can't do."

The National Association of Community Legal Centres (NACLC), however, describes the reforms as "the most

significant downgrading of income support in the Social Security system since the Social Security Act was introduced in 1947."

NACLC is particularly critical of the Government's forcing people with disabilities and those with episodic illnesses such as HIV onto the unemployment benefit (Newstart) if they can work more than 15 hours a week, with a consequent loss of income (Newstart recipients receive \$45 less per week than those on the DSP) and an extra requirement to look for work, regardless of whether they are symptomatic or not. "The pressure to look for work and accept work could lead to a worsening of a person's medical condition . . . it requires the

person to disclose their medical condition to a Job Network agency [and] once the condition has been disclosed it may lead to a person's illness being disclosed to prospective employers," the report says. NACLC also highlights the likely difficulties in finding employers willing to offer positions with flexible working conditions to people with episodic illness.

HOW WILL THE NEW RULES AFFECT PEOPLE WHO WERE ON THE DSP PRIOR TO 11 MAY 2005?

They will be largely unaffected by the changes. When their periodic review with Centrelink comes along they will be still assessed on their ability to work 30 hours a week or more. If

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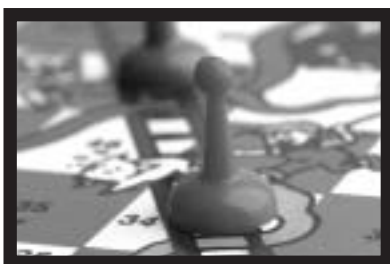
they are currently doing part-time work or decide to do part-time work in the future, they will still be able to do this subject to their ability to work no more than 30 hours a week. Their DSP income will go down proportionately with any rise in other regular income as was the case previously.

Anyone who is 'grandfathered' on the DSP can venture back into the workforce either full-time or part-time and return to the pension within a two-year period. People in this situation will remain under the old (30-hour) rules as long as they return to the pension within two years; this provides some peace of mind for DSP recipients who want to work but are worried they may not be able to do so long-term. After more than two years' off the DSP due to employment though, people will need to re-apply under the new (15-hour) rules if they need to go back on the pension.

The right to return to the DSP within two years is supposed to be automatic, and does not require new medical and Centrelink assessments as in the past, however it seems that people who have voluntarily returned to work are being required to undergo Job Capacity Assessments (JCAs) and, in some cases, have been kicked off the DSP if the assessors regard them as being able to work 30 hours or more. This is a real disincentive for these people to return to work (unless they can be sure that their capacity is below the 30 hours per week threshold). Disability groups regard this development as a broken promise – the government said that no one under the old system would be worse off and affected by the new changes. People wishing to return to work should monitor these issues and talk with their local welfare rights organisation where possible.

In the past, people on the DSP – particularly people with a condition like HIV/AIDS – were not always reviewed on a regular basis. Some were called in for a review every two years, some every five years and some seem to have not been called in to Centrelink at all. This started to change even before these new rules were brought in, with people on the DSP reporting much more regular reviews. We understand there are now more than 140 actions that can trigger a Centrelink review and these are not available for public scrutiny. We know that changes to a bank account, going overseas without informing Centrelink, information from the Taxation Office showing extra income and other such things can trigger a review, but for most people the review process is likely to be triggered just because a two year period is up.

Grandfathered DSP recipients can still receive the Pensioner Education Supplement and Education Re-entry Payment if they meet Centrelink's criteria. But there are fewer opportunities now for people voluntarily accessing Job Network and the Commonwealth Rehabilitation Service (CRS) for funding for courses, as the aim of these services now is to get people back to work. David Wallace from the Bobby



Goldsmith Foundation in Sydney says "courses with what might be described as 'soft outcomes' intended to improve an individual's self-confidence, self-esteem or to reduce their social isolation are not considered, even though we know there are significant barriers for people with HIV to return to the workforce after many years dealing with their illness." A study course must be directed to employment, and must not be long duration (usually only a TAFE term) – with an exception for those in the last year of a degree that might help them gain a job.

These recipients are still eligible for the Mobility Allowance if they are doing regular volunteer work. This can be paid to those people who decide to do at least eight hours per week of voluntary or paid work or a combination of paid work and training and who cannot use public transport without extra help because of their disability, injury or illness.

HOW WILL THE NEW RULES AFFECT PEOPLE PLACED ON A DSP ON OR AFTER 11 MAY 2005 AND BEFORE JULY 2006?

Although these people were assessed as being eligible for the DSP against their ability to work 30 hours or more, their eligibility will now be assessed on their ability to work 15 hours or more. The only people who are exempt from these assessments are those who are classified as having a 'manifest disability' or if certain special circumstances exist. Centrelink has confirmed that Category 4 AIDS is still regarded as a manifest disability although this will need to be monitored into the future with the change in health status of many people with AIDS.

On review the Job Capacity Assessors subcontracted by Centrelink will be required to assess the impact of HIV on a person's capacity to work. These people may be doctors, psychologists, occupational therapists, social workers or from another allied health field. The Department of Human Services, which controls these assessments, argues that the discipline of the assessor is not important to the quality of the assessment made, however welfare groups have argued that a mismatch between assessor and client can be a serious problem – for example, can a person with a mental illness be accurately assessed by an occupational therapist?

Graham Douglas-Meyer, NAPWA's Social Wellbeing and Policy Convenor, says "We have long held concerns about the ability of Job Capacity Assessors to understand the true impact of HIV on people's lives. A person may present as physically fit but can be dealing with significant treatment side effects, low energy levels, depression and other psychological issues related to their condition. A doctor from

Q+A on welfare changes

Health Services Australia who takes a treating doctor's report into account when making an assessment of a person with HIV might be better informed than someone from another allied health field but even this is not necessarily the case. NAPWA has tried to run information sessions for assessors but has generally been unsuccessful."

David Wallace says people should think about taking an advocate with them to these reviews, particularly if they are in this group of DSP recipients. "They could be in a precarious position and may need some advocacy to help their case, including arguments around less than 15-hour capacity, particularly if they are not feeling particularly self-confident or well at the time."

Confidentiality of medical records is another issue. Clearly it is important for a person with HIV to have their treating doctor's report taken into account, as this should affect decisions about capacity to work or the potential for episodes of illness in the future. However this has confidentiality implications for people with HIV who don't want to disclose their status. A Centrelink spokesperson told PL that their staff would never disclose information about a client to a third party if the client did not wish this information passed on, but will the Job Network staff who refer them to future employers treat this information confidentially? It seems unnecessary for potential future employers to know this information but if they are given it, will it affect their employment decisions? On the other hand if Job Network staff are not privy to this information, will people with HIV be given inappropriate job placements that may affect their health?

If people from this group are assessed as having the capacity to work at least 15 hours a week, they will be transferred to Newstart (or Youth Allowance) and will receive a lower payment (currently \$205 per week on Newstart, compared with \$250 per week on the DSP). They will be required to look for work within their capacity and face harsher income and assets tests than on the DSP. A pensioner can earn \$62 a week before their payment starts to be reduced because of other income, whereas a person on Newstart can only earn \$31 a week before this happens. There are no additional allowances for children as there are on the DSP. A person on Newstart will find it quicker to get to the stage where they no longer qualify for any social security payment or the PBS concession card than they would on the DSP.

HOW WILL THE NEW RULES AFFECT PEOPLE WHO APPLY FOR A DSP AFTER 1 JULY 2006?

It will be harder for people to

be placed on the DSP under the new rules. For people with HIV, their treating doctor's opinion used to be a strong influence on assessors as to whether a person should be eligible for the DSP, but unless the individual presenting is clearly quite ill (such as having been diagnosed with a Category 4 illness) there is concern that the doctor's report will be less influential. We will have to wait and see if the Job Capacity Assessments become more rigorous for people with HIV or not, compared with the past.

David Wallace also points out that some doctors are less likely to write a report to help a person onto the DSP given a perception that HIV is more manageable these days. "This is a good reason to find an HIV-experienced doctor who understands the ups and downs which HIV is likely to bring into your life."

All people assessed as capable of working more than 15 hours a week will be placed on Newstart or the Youth Allowance. They will have to satisfy the Centrelink activity test – this means regularly demonstrating that you are actively looking for work, attending job interviews and accepting suitable offers of work, or undergoing approved training courses. Failure to meet the activity test can lead to the payment being stopped for a period of time.

Many of the activity test requirements will be organised through the Job Network or employment provider you are allotted. People may also be referred to a disability employment network provider or vocational rehabilitation service, depending on the amount of assistance they are thought to require. The agencies' job is to help you find suitable employment. Newstart recipients are also expected to carry a Job Diary with them to job interviews and to have these signed by the interviewer. People with only a partial capacity to work may be able to get activity test concessions (such as reduced job search requirements) and a higher rate of the Employment Entry Payment (paid after people have been in employment for four weeks).

People placed on Newstart (Incapacitated) are exempt from the above Activity Requirements. To get onto this allowance (once you have been placed on Newstart) you will require a doctor's certificate to state that you are incapacitated and unable to carry out these requirements because of your health. To continue receiving Newstart (Incapacitated), you will have to return to your doctor every six weeks to have this certificate renewed. Individuals can only be transferred to the DSP when a Job Capacity Assessment and a treating doctor's report both conclude that an individual will not be able to work for more than 15 hours for more than two years.

■ For advice or assistance in dealing with Centrelink, contact your local welfare rights organisation – contact details can be found online at www.welfare.org.au.

Two new drugs have recently become available through the Special Access Scheme, providing new alternatives for people with few other treatment options. **KIRSTY MACHON** reports.

It wasn't so long ago that the HIV drug development 'pipeline' seemed depressingly empty. While the number of HIV drugs has expanded fairly steadily over the decade since the arrival of combination therapy, until the arrival of T-20 a couple of years ago all these medications had come from the same three classes of drugs.

The oldest drugs – the nucleoside analogue reverse transcriptase inhibitors (NRTIs) such as AZT, 3TC, d4T and ddI, have been around for close to twenty years now. Until the mid-1990s, they were the only anti-HIV treatments available. NRTI monotherapy usually produced modest improvements in people's CD4 count, but only for a limited time, and deaths from AIDS were still depressingly common.

Then, in 1995 and 1996, two new classes emerged which could be combined with the NRTIs in what was then dubbed 'cocktail therapy'. The non-nucleoside analogue reverse transcriptase inhibitors (NNRTIs) and protease inhibitors revolutionised HIV medicine and brought many positive people back from the brink. Before long, we started to think of HIV infection as a treatable, manageable condition, not a terminal illness, and we waited eagerly for the next quantum leap in HIV medicine.

And we waited.

For several years, it seemed there were few new ideas in the drug pipeline. Even as it became apparent that combinations of the existing three classes of drugs could not remain effective forever, treatment-limiting side effects and absurd pill burdens took their toll. More frustratingly, the virus continued to adapt, becoming resistant to the drugs and often, such as in the case of the non-nucleosides, resistant to other drugs in the same class, wiping out valuable treatment options.

While new drugs have become available over the years, most of these have offered only marginal gains over older treatments, and (with the exception of T-20) none have come from an entirely new class. Clinicians, researchers and treatment advocates all agree that the development of better drugs and new drug classes is essential if we are to continue the successes of the last decade.

HIV treatments research has therefore had two main areas of interest. There's been a huge focus on developing drugs which target entirely different parts of the HIV life cycle (like T-20, which prevents the virus fusing with host cells). Of equal interest has been the search for so-called second and third generation drugs from existing classes, which aim to overcome the failings of current drugs in terms of tolerability, efficacy and effectiveness against resistant virus.



New Tricks

The good news is that some of this research is now starting to pay off.

Two new drugs, both currently in Phase-3 clinical trials, have recently become available in Australia through the Special Access Scheme, which allows people with limited treatment options and at high risk of HIV disease progression to access new drugs before they are licensed. The two new arrivals reflect the two major targets of recent research: one, MK-0518, is from an entirely new class, and the other, etravirine or TMC-125, is a next-generation non-nucleoside which promises to work for people who've previously developed resistance to NNRTIs.

MK-0518

To infect a human host cell, HIV undertakes a complex enterprise. It must attach to the cell, fuse with it, and finally 'reprogram' the human cell with its own genetic material, producing new copies of itself and going on to infect more cells with new viral particles.

Theoretically, we can target this life cycle and attempt to interfere with HIV replication at any of a number of different points, often by inhibiting the enzymes which are crucial to a particular stage of the virus's development. Nucleoside and non-nucleoside drugs work by targeting an enzyme called reverse transcriptase, for example, while protease inhibitors target a different enzyme called protease.

MK-0518 works by inhibiting another enzyme, integrase, which HIV uses to integrate its genetic material with the host cell. Without this enzyme, HIV can't reprogram the human host cell's DNA, and

its life cycle is cut short. Integrase inhibitors have long been a kind of 'holy grail' for HIV drug development, and their arrival (MK-0518 is only one, albeit the most advanced, of several in development) represents an important development: used in combination with drugs from the other classes, this approach provides a fresh front for attacking HIV, which may help control it more effectively.

MK-0518, being developed by Merck, is now in Phase-3 clinical studies in Australia and around the world. It has not yet been licensed for use in Australia or elsewhere, and is currently only available to those participating in the clinical trials and those who qualify for the restricted Special Access Scheme. Like all other anti-HIV drugs, it is taken in combination with other treatments.

To date, the experience with this drug has largely been in people who are already treatment-experienced and have taken a variety of previous HIV treatments, although some studies as first-line therapy (for people haven't taken HIV drugs before) are also underway. So far, it's been shown to have an impressive effect against HIV, whether or not it is used with T-20, with over 70 percent of participants in Phase-2 studies having undetectable HIV viral loads after taking the drug for six months.

Particularly encouraging has been the news of how well this drug appears to be tolerated. There have been no serious adverse side effects attributed to this drug in studies so far, and the common side effects of many HIV drugs, such as nausea, headache and diarrhoea, occurred in very low numbers of people. In fact, its

side effect profile was very similar to that of the people on the placebo arm (their current combination plus a dummy pill).

All this has led to speculation that MK-0518, assuming it passes the final clinical trial and regulatory hurdles, is likely to be an important new treatment alternative. Results from Phase-3 studies, as well as treatment-naive studies, will be reported over the next 12 months.

ACCESSING MK-0518

A Special Access Scheme (SAS) has been negotiated between NAPWA and the manufacturer of MK-0518, Merck Sharp & Dohme. The scheme is designed to make MK-0518 available to people with HIV who urgently need it, and not all positive people will be eligible. To qualify for the SAS, you must have a CD4 (T-cell) count of less than 200, and be unable to construct a viable treatment regimen from currently-licensed and available antiretroviral drugs, due to virological failure (current drugs aren't effectively suppressing your HIV), or due to intolerance or toxicities.

ETRAVIRINE (TMC-125)

The non-nucleosides nevirapine (Viramune) and efavirenz (Stocrin) are widely used in Australia; they are attractive as first-line therapy because they're highly effective against HIV and, for many people, easier to take and more tolerable than some of the protease inhibitors. A major downside, however, has been cross-resistance within the class: if you use one of these drugs and develop resistance to it, you will also be resistant to all other existing non-nucleosides.

A long-term goal of research has been to develop a non-nucleoside drug which remains effective against virus that has resistance to other non-nukes, and which does not develop resistance so readily, or in the same way, as the currently licensed drugs. TMC-125, known generically as etravirine, is being developed by Tibotec with that aim in mind. Etravirine has a striking and promising characteristic: it has been engineered to incorporate a degree of 'molecular flexibility' – as the virus changes and begins to evade the drug, the drug's chemical shape can also 'change', making it harder for HIV to get around.

Etravirine has been designed to be effective in people with pre-existing resistance to nevirapine and efavirenz. Clinical trials so far have been promising in this regard, with investigators noting that etravirine does indeed have good antiviral activity against HIV in people with prior use of and resistance to the other two drugs. A Phase-3 trial is currently underway.

To date, the most common side effects reported with etravirine have included diarrhoea, headache and nausea, but these occurred at the same rate in those taking etravirine as those taking their background combination plus a placebo. Dizziness, flatulence and diarrhoea were reported during the first few days of treatment with etravirine, but these effects were usually mild and usually resolved or disappeared after a few days. Skin rash, a common side effect of both efavirenz and nevirapine, was no more common in those taking etravirine compared to people taking placebo.

One concern with the drug, however, is its potential to interact with other treatments, with studies suggesting that etravirine can interfere with and lower the blood levels of some protease inhibitors. The company is conducting a number of interaction studies with key HIV and non-HIV medications as part of the licensing process.

ACCESSING ETRAVIRINE

A Special Access Scheme (SAS), negotiated by NAPWA in partnership with the manufacturer Janssen-Cilag, is now open to allow early access to etravirine. The SAS is designed to make etravirine available to people who urgently need it, and not all positive people will qualify. To be eligible for the program, you must be unable to construct viable combinations of treatment from the currently licensed and available antiretroviral drugs, due to virological failure (current drugs aren't effectively suppressing your HIV), or due to intolerance or toxicities.

Currently, the two drugs cannot be used at the same time, until further information about how they may interact together becomes available.

If you would like to know more, or think you may be eligible for one of these programs, you can discuss this with your HIV doctor. If you meet the criteria, your doctor can arrange for you to be enrolled.



Exploring the HIV net

The internet is a great source of information about HIV/AIDS and a great way to connect with others, but not all the information and people on the net can be trusted. What are some useful HIV/AIDS sites?

The growth of the internet over the last fifteen years has changed the way we do research, communicate with others and entertain ourselves. For people living with HIV, the net offers opportunities too, but it's wise to be cautious – not all the information you find on the net can be trusted: it can be out of date, misguided or just downright false.

In the December 2004 edition of *Backgrounder*, we outlined some simple strategies for establishing whether information found online is trustworthy. You can find that article on the NAPWA website, but here's some of the key points again:

- Use your common sense, and don't get fooled by slick-looking websites with bogus information.
- Look for sites with claims backed up by real evidence – scientifically conducted clinical trials – and be sceptical of anecdotal 'evidence', personal stories and wild claims.
- Information should be clearly dated and the author's details given.
- Clinical trial data published in a respected, peer-reviewed journal is trustworthy, especially if it's fairly recent. Unpublished data, obscure publications and publication dates years in the past should be questioned.
- Be suspicious of wildly inflated and hyped language – things like conspiracy theories, bagging the pharmaceutical industry or claims of magical cures.
- If you're unsure whether a source is trustworthy, ask your treatments officer, doctor or PLWHA organisation what they make of it.

OK, what are some good sites where you'll find reliable, trustworthy information?

FIRST STOPS

A good place to start is the NAPWA website (www.napwa.org.au). As well as an

archive of articles from *PL*, the NAPWA website has fact sheets from the AIDS Treatment Project Australia, educational resources produced by NAPWA and AFAO, information about NAPWA's work and a comprehensive links page. Another useful feature on the NAPWA site is a search facility which allows you to do a Google search restricted to NAPWA-recommended websites.

The AFAO website (www.afao.org.au) is another site with heaps of Australian-focused information including educational resources for people living with HIV.

State and Territory AIDS Councils and PLWHA groups have a wide range of information on their sites, and the PLWHA websites have listings of events and support groups for their state. If you haven't made contact with your local PLWHA group, having a look round their website gives you a good idea of the services on offer. Queensland Positive People (www.qpp.org.au) even has an online discussion forum where you can chat with other positive people anonymously. Links to these organisations can be found on the NAPWA website (www.napwa.org.au/?q=links).

Positive heterosexuals will want to check the websites for Straight Arrows in Victoria (www.straightarrows.org.au) and Positive Heterosexuals in

NSW (www.pozhet.org.au – currently offline). Positive Women Victoria (www.positivewomen.org.au) also has a comprehensive site.

TREATMENTS INFO

Apart from the NAPWA site, there aren't a lot of Australian-based websites dealing with HIV treatments in-depth. The Australasian Society for HIV Medicine (ASHM) has a good selection of fact sheets in a manual called Positive Information for Patients (www.ashm.org.au/hiv-pip). This resource covers a diverse range of subjects but is only updated occasionally.

Fortunately, there are several overseas websites that have built up a strong reputation in this area. Not all the information will be relevant, particularly where individual drugs have been approved overseas but not in Australia, however these sites provide a wealth of information which is carefully researched and reliable.

Perhaps the best known is Aidsmap (www.aidsmap.com), an award-winning UK-based site which is updated almost every day with the latest treatments news. As well as an encyclopaedic coverage of anti-HIV drugs, this site has useful fact sheets about topics such as adherence, resistance, pregnancy and childbirth and

lots more. Information on this site is graded according by knowledge level, from 'beginner' to 'expert' and all the information is referenced and regularly reviewed.

Other useful treatments websites include the US-based Project Inform (www.projinf.org), the handy reference site www.aidsmeds.com, with fact sheets on the range of HIV treatments and HIV Insite (hivinsite.ucsf.edu).

POSITIVE STORIES

The web is rich with personal content, and positive people are reasonably well represented. Reading other's personal stories can be a therapy all by itself, as it helps reinforce the truth that we're not alone as positive people. Of course, with all anecdotal information, including blogs and reader-contributed sites, it's you should bear in mind that any medical information needs to be verified via a reputable source before it can be relied on.

The Body (www.thebody.com) is a popular US-based site with lots of information about HIV treatments as well as lifestyle info, much of it drawn from HIV-related publications in the US and elsewhere. But the Body also has an online gallery of HIV-focused artwork and a popular 'ask the experts' forum, as well as bulletin boards

covering a wide range of topics. Much of the content is US-centric, and some of it borders on the peculiar, but this extensive site is well worth a visit.

An Australian based site at www.hivaids.webcentral.com.au has lots of personal stories by people living with and affected by HIV/AIDS from Australia and around the world. The stories cover areas such as getting tested, dealing with a diagnosis, disclosing your HIV status and women living with HIV/AIDS.

The explosion of blogs over the last few years has meant there are quite a few positive bloggers on the net. As is the case for non-HIV-focused blogs, these tend to come and go and the quality of the content is pretty variable. A Google search for 'HIV blog' or 'poz blog' will turn up lots of possibilities.

A couple of bloggers worth checking out, at least as a starting point for explorations (most have links to other HIV-related blogs) are Canadian Brian Finch (www.acidrefluxweb.com), New Yorker Tommy Rico (www.tommyrico.blogspot.com) singer-songwriter Steve Schalchlin (www.bonusroundblog.blogspot.com) 'I Deal with It' (www.idealwithit.com) and 'Too Busy Living Life to be Sick' (toobusylivinglife.blogspot.com). Some of these sites include material that may not be suitable for all readers and/or may not be suitable for viewing at work, so take care.

Another option is to join an online discussion group. OzPoz (www.ozpoz.org) is an Australian email-based group for gay men who are HIV-positive; it's been going for more than ten years and it's an easy way to get in touch with other Australian positive guys, anonymously if you prefer. OzPoz also hosts a NAPWA-auspiced group run by and for HIV-positive women (women@napwa) – details on how to join are on the website.

—Paul Kidd

Note: NAPWA and Positive Living don't endorse any external websites, and while the sites listed in this article are recommended, you should still be careful in appraising any information you find.

Treatment has some effect in highly resistant individual

A French man with resistance to virtually every antiretroviral drug still gained some benefit from antiretroviral therapy, raising his CD4 count and reducing viral load. In a case with striking similarities to the New York 'superbug' case which generated world headlines in early 2005, resistance testing showed the man, who had never taken treatment, was resistant to all available antiretrovirals except 3TC, FTC and T-20. Treatment was started after his CD4 count fell to 184, initially with 3TC, tenofovir and Kaletra, which was later switched to atazanavir. More than four years after seroconversion, the man remains



relatively stable with a CD4 count of over 300 and a viral load about 10,000. —Aidsmap

Treatment combats vitamin deficiency

US researchers have found that micronutrient deficiencies are relatively uncommon in people taking antiretrovirals. Studies before the widespread use of HAART found significantly low levels of some vitamins and minerals in people with HIV, leading some to speculate on a possible link to disease progression. The

researchers looked at levels of vitamin A, vitamin E, zinc and selenium in 288 positive people taking antiretroviral therapy. Except for zinc, the rate of deficiency was less common than among people not on antiretrovirals, and none of the micronutrients had a significant effect on CD4 counts. —Aidsmap

Tipranavir trial halted

A clinical trial of the protease inhibitor tipranavir (Aptivus) in treatment-naïve people has been

halted early, after it became apparent the treatment was inferior to Kaletra, the drug it was being compared with. The BI 11882.33 trial had been planned to go for three years, comparing two different tipranavir doses with Kaletra, however after 60 weeks researchers concluded that the lower dose was inferior to Kaletra, while the higher dose caused more side effects. Tipranavir is approved for use in Australia in people who have failed other treatments.

No benefit in continuing 3TC after rebound

A European study has found no benefit in continuing to take 3TC after experiencing viral load

rebound, contradicting earlier findings which found a beneficial effect. The signature mutation for 3TC resistance, M184V, is thought to reduce viral fitness, leading many physicians to recommend continuing 3TC even after failing treatment, but this is the first randomised trial to look at the issue. The 131 participants, all of whom had experienced viral load rises while on 3TC, were randomised to either continue taking 3TC with their new regimen or switch to a new non-3TC combination. After 48 weeks, there was no significant difference between the groups. Although the study found no benefit in continuing 3TC after failure, the investigators noted that the approach may still have merit in heavily pre-treated people. —Aidsmap