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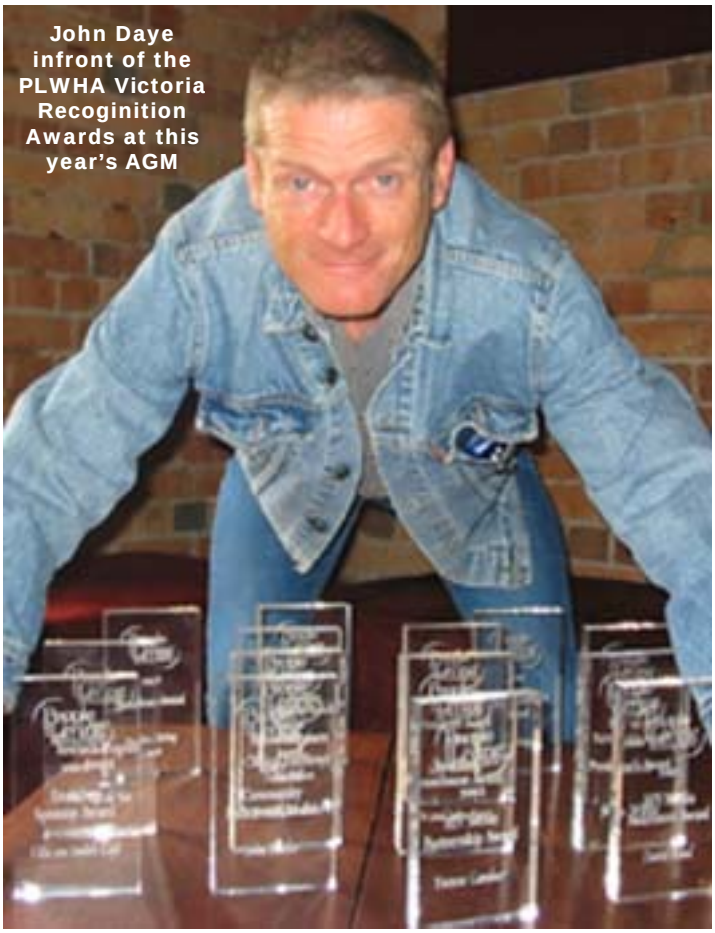
POSLINK

The Newsletter of People Living With HIV/AIDS Victoria



John Daye infront of the PLWHA Victoria Recoginition Awards at this year's AGM

WORLD AIDS DAY STATISTICS, 2003

40 million people with HIV/AIDS
5 million new HIV infections
3 million AIDS deaths

Issue 14 + Dec 2003 / Jan 2004

Inside this issue:

Tasmania leading the way in protecting young people from HIV: Speaking out about being HIV positive

By Max Niggl

In a unique initiative, two HIV positive speakers from PLWHA Victoria's Speakers' Bureau shared their personal experiences of living with HIV at the launch of Tasmania's AIDS Awareness Week in the last week of November. The speakers spoke to more than 400 year 9 students at three secondary high schools. They were also interviewed on ABC radio and three television stations. The launch at Parliament House Hobart took place with our very own Tony King and Deanna Blegg from the Speaker's Bureau, along with the Health Minister, the Police Minister and Martyn Goddard the President of the Tasmania Council on AIDS, Hepatitis and Related Diseases (TasCAHRD).

Tony and Deanna's personal stories about living with HIV challenged traditional stereotypes and the invisibility of the HIV epidemic in Australia. Their

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Note from the Executive Officer

Mark Thompson

I cannot believe that six months has already gone by since I started this job. It has been an extraordinarily enriching positive experience and I firmly believe that I have joined the organisation at a time when new exciting new opportunities and challenges are arising.

While the results of the review of People Living With HIV/AIDS Victoria and the Victorian AIDS Council have not yet been released and it is not appropriate to speculate on its recommendations, I think that there have been tremendous benefits from undertaking this process, even though it has taken up a large part of the organisation's resources.

Many organisations can benefit from an in-depth examination of their practice, and this aspect of the review, resulting in the detailed submission to the review panel, certainly helped focus the priorities for the organisation as we tackle the challenges that HIV/AIDS continues to present.

In addition, the feedback through the public consultations conducted by the review was a valuable opportunity to receive important views about how we are doing our job.

This will also help us to ensure that we attempt to do the best possible job in representing you, our members, and the wider HIV positive community. In the New Year we will be conducting a detailed survey of our members so you will have the opportunity to have your say on what you want from PLWHA Victoria.

Another important influence on our future direction was the NAPWA Conference, held in Cairns in October. While it was a great opportunity to introduce myself to my peers in other organisations, it was also a time to listen and learn from them. I believe this continued development will ensure that PLWHA Victoria will continue to meet the needs of its members and the wider community.

HIV FUTURES 4

Many of you will have completed the HIV Futures surveys in past years conducted by the Australian Research Centre on Sex, Health And Society. These surveys are incredibly important in looking at the HIV epidemic in Australia and help highlight the emerging and current issues affecting HIV positive people. HIV Futures 4 has arrived and we have included it in this posting to members and I encourage you to take the time to complete it. If you did not receive a copy with Poslink and would like to complete the survey, you can download a copy from the Futures website http://www.latrobe.edu.au/hiv-futures or call ARCSHS on 1800 064 398.

Note from the President
John Daye

This is the last edition of Poslink for 2003 and when I look back over the year I am struck by how quickly that time has passed and the breadth of work the organisation has undertaken.

During the year we recruited Mark Thompson to the position of Executive Officer and Alan Strum to the position of Treatments Policy & Education. They have both worked diligently and hard to ensure that the organisation is operating at its best. The improvements to Poslink that Alan has put in place have made this publication particularly significant in the depth of information about treatment. Mark has played a major role in overseeing the review process of PLWHA Victoria and establishing our own independent management of financial affairs that make our organisation more transparent. Max Niggl our Executive Assistant has worked very hard in supporting the work of the organisation and extending general community awareness of HIV/AIDS through the operations and coordination of the Speakers Bureau. Suzy Malhotra was our Projects Officer and did an outstanding job implementing the Connect Project and coordinating several of our popular Treatment Interactive Events.

The strong turnout at our recent Annual General Meeting (AGM) demonstrated ongoing support from positive people for the important work of this organisation. New Board Members elected include Daniel Donnelly, David Staneck and Greg Iverson and I welcome them to their new role. I want to thank outgoing Board Members including Alby Clarke, Greg Horn and John Willis for their work and commitment to the organisation whilst on the board. At our AGM members voted to change the constitution to allow for greater democratic processes in filling casual vacancies of the board and improved processes to appoint office-bearers. We were delighted that Jo Watson (Executive Officer of the National Association of People Living with HIV/AIDS), who travelled down from Sydney could attend the occasion.

In October two major conferences occurred in Australia. The conferences were back to back and held in Cairns Queensland. The first of these was the Australasian Society of HIV Medicine (ASHM). This was followed by the 9th National Conference of People Living with HIV/AIDS (NAPWA). The theme for this year's ASHM conference was 'Global Crisis – Local Action'. The one thing that marked this ASHM conference as being different from previous ones was the strong international focus particular of our neighbours in the Asian-Pacific region. Focus on the continuing rise of HIV infections both in Australia and also in countries like Papua New Guinea and Indonesia was a hot topic of discussion at ASHM.

The Art of Living was the theme for the NAPWA Conference. The program for the conference was rich with many cultural aspects related to living with HIV. The NAPWA Conference also had unprecedented focus on international issues. The Collaboration for Health in Papua New Guinea (PNG) Project was one of the most innovative projects in which NAPWA has ever been involved. This project saw a delegation of people from PNG including HIV positive people, carers and clinicians come to both the ASHM and NAPWA conferences to learn new ways to improve the health and well being of HIV positive Papua New Guineans. Both Max Niggl and Andrew Timmins from PLWHA Victoria were positive guides and hosts to some delegates and did an outstanding job in making the Papua New Guineans feel welcome.

While the conferences were taking place news was coming out of Canberra about the Pharmaceutical Benefits Scheme (PBS) being subject to discussion in our Free-Trade Agreement (FTA) with the United States. There was still some fear in some quarters about the costs of medicines still being an issue of discussion in the FTA. The Federal Government is on public record saying that the cost of medicines as discussed within the FTA is no longer under threat. The fact that PBS is still subject to FTA discussions is of concern. As Poslink goes to press those negotiations are still unresolved and we will be keeping a close eye on developments.

World AIDS Day has come and the theme for this year's campaign was focused on stigma, discrimination and community attitudes towards HIV/AIDS. Despite being twenty years into the HIV epidemic, discrimination and stigma are still a major concern for many HIV positive people. Issues related to housing, employment, healthcare and relationships continue to be difficult for significant numbers of positive people.

In conclusion, I wish everyone a safe and enjoyable time over the Christmas and New Year period. Take care and have fun!

Tasmania leading the way in protecting young people from HIV: Speaking out about being HIV positive

(Continued from page 1)

stories encouraged young people to think about protecting themselves from HIV both at home and when travelling. In a broader context, media interviews encouraged the Tasmanian community to develop an understanding of the hurtful and negative ramifications of discrimination and stigma. We also challenged them to be more open about knowing and supporting people affected by HIV/AIDS.

I was touched and overwhelmed by the immediate and immense media response to our presence. All of the politicians, interviewers and students were responsive and open to asking personal questions. They were so incredibly thirsty for first-hand knowledge and experience about being gay or straight and having HIV and AIDS. They asked questions about relationships and showed particular interest in Deanna's scenario about being HIV positive, courageously rebuilding her health, finding a new partner and having children. There were audible gasps in response to Tony's story and astonishment at the discrimination and ultimate dismissal for being HIV positive from two employers. An enormous range of emotions and responses emanated from the audiences.

Top: Deanna and Tony at ABC Radio.

Middle: Deanna being interviewed for TV.

Below: Murray, Marie, Jude, Tony, Deanna and Max at TasCAHRD celebrating Marie's birthday after the AIDS Awareness Week launch.

This was an incredible journey for everyone involved. As Tony said, 'I am still bewildered at my own personal growth and development from this experience. The sincere warm welcome and genuine interest students and teachers expressed in myself and HIV stole my heart.'

During our visit to Tasmania I provided support for our speakers and liaised

with Marie Frodsham from TasCAHRD to assist her in the process of recruitment and public speaking training for the establishment and development of their own HIV Positive Speaker's Bureau.

The uniqueness of the situation and the excitement of responses shown to us whilst in Tasmania resulted in incredible bonds of trust, honesty and open communication forming amongst us. These bonds showed that social and peer support is an imperative part of the Speakers Bureau in overcoming aspects of social isolation. I believe that the outcomes from this pilot project will have enormous benefits for both PLWHA Victoria's Speakers' Bureau and TasCAHRD.

I feel we were more than successful in achieving our goal of communicating awareness around HIV and AIDS and safer sex. Every person, no matter what his or her background may be, is entitled to a quality of life safe from discrimination.

The vision, leadership and financial support from Murray Altham of Merck Sharp and Dohme enabled this project to achieve this incredibly rewarding result. Murray helped make all our dreams come true!

If you are interested in the Speaker's Bureau Program please contact Max Niggl on (03) 9865 6771 or max.niggl@plwhavictoria.org.au

Community Letters: The Scratching Post

The Scatching Post is your connection to the community. You can write to us to share information or voice your opinion or concerns on issues that affect the HIV community.
scratch@plwhavictoria.org.au

Hi,

Firstly, thank you to everyone who attended Planet Positive last Wednesday night [October 16] at Rush Bar! Both David and I were once again rapt with the response of all those that attended. By all accounts, everyone had a great night socialising, enjoying a drink and hopefully meeting new people.

Personally, I was incredibly touched by those who came to Planet Positive for the first time as Positive People. It has been part of my vision with Planet Positive to have a space where people can feel comfortable and supported in the knowledge that they are with other people who stories and personal experience of living with HIV can reflect their own.

For those of you that could not attend the evening, we enjoyed a drink or 5 in what was essentially our own bar! We had several different spaces including a main bar, pool tables, lounge area and dance floor with (and I have to say a somewhat Spunky) live DJ...not to mention the fabulous Ms Kaye Sera who provided great entertainment and the odd spot prize! I'm just curious to know if the tissues or the Doll are getting most use! I have to say a big public thank you to the staff at Rush for assisting us in the night!

I would appreciate your feedback, comments and suggestions for future events.

Thanks for now
Daniel

PS ... Please note our new email address! planetpositive@optusnet.com.au. The Bigpond address may still work...depending on Telstra of course!

Shared Stories

Email your stories to
stories@plwhavictoria.org.au

HIV & Libido

The very day after my diagnosis I received an acceptance letter from abroad to study a semester at San Francisco State University. I drank away the shock and quickly tried to get my shit together so I could find the money for the airfare. After a debilitating seroconversion illness, a week of post diagnosis panic attacks and a nasty separation from an even nastier boyfriend, I finally made it to orientation week. I didn't really consider the impact the diagnosis would have on my sex life at the time because I was too busy trying to stay composed and finalise affairs in Sydney. In San Francisco, I discovered a queer culture that is comparatively uninhibited when it comes to mating and also has a far higher percentage of HIV positive locals. However, I do recall my first night out in the leather district at a bar known as 'The Hole In The Wall' where I was approached by two college boys in their early twenties. They offered me a drink and gravely warned me to be cautious in that particular bar because at least 90% of the clients were definitely positive. Their ignorance certainly didn't represent the views of most people I met in the city. However, my big night out on the town suddenly nose-dived into a sad and cynical evening between the sheets, by myself.

I was definitely acquainted with a high-risk environment in Sydney. However, I never really explored my sexuality to its' full potential. I was always too shy, inhibited and insecure to go out and really get into it and sex was never really a huge equation in my social agenda. Most of the guys I ended up with were usually early morning frolics after a night on the turps. Generally I had nothing in common with any of these guys and the sex was always pretty hollow and boring. I never did anything risky, however, until I found myself living with another local boy. Transmission rates in Sydney were on the rise and there were several warnings about infections occurring in new relationships. However, I guess I just slipped into a false sense of security and thought that I was no longer in danger. Even then, the sex wasn't that great and definitely not that frequent (it never is with a compulsive stoner).

So I was never all that comfortable with sex in the first place and a lot of the experience I had prior to becoming positive was rather shoddy and hard to remember. In San Francisco, fortunately my timid ways were no barrier. As you may have noticed, Americans are rather intrusive, arrogant, but also friendly and inquisitive. Therefore it was difficult to stay alone for long, especially as a foreigner in one of those bawdy back rooms. Somehow I managed to forget about my new status and live it up, although I only engaged in risk free activities with a moderate number of partners (That was rather well behaved considering I worked in a sex club for six months as well.)

Most of the time HIV was never discussed although in San Francisco the numbers are virtually even either side, so you had just as much a chance as meeting another positive guy upon disclosure. I found myself getting into it like I never did back home and that was surprising to me after being newly diagnosed. After over staying my visa for a month, I finally accepted the reality of having to return home and my…how the situation has changed. A year and a half later and I'm just as celibate as any monk and I never really meant for it to happen, it just did. I guess I'm a little more reserved here because the culture is certainly more inhibited. There isn't as much overt sex taking place in bars and people are nowhere near as forward as they were in San Fran. Which leaves a shy boy like me shuddering in

Shared Stories

Email your stories to
stories@plwhavictoria.org.au

the corner of The Laird trying to trip someone up accidentally as they pass by.

I guess I noticed my discomfort as soon as the opportunities popped up when I relocated to Melbourne and started checking out the bars. I found myself getting tongue tied and anxious and weeping and stuttering. I wanted to disclose but I was too overwrought to spit it out, so I usually feigned ignorance and buried my face in my beer. Once or twice I went through with it but then I experienced hassles with performance anxiety. I decided to try another approach. After getting to know a potential mate over dinner, I finally let him in on the secret before he popped the question. He ran to the bathroom in tears but at least we remained friends. Another local guy was downright pissed when I told him and now he passes me by with his head down whenever we bump into each other at the supermarket. In the end, I decided to check out of the situation altogether and now I find myself doing meditation and yoga whenever the urge is consuming me. Not that I recommend that course of action but it's just the way it is for me right now.

It's not all about HIV though. Fear of disclosure is certainly a big issue but so is the fact that I'm not who I used to be and my lifestyle has changed quite dramatically. Taking care of my health means that I tend to spend a lot more time at the juice bars and the gym instead of nightclubs and dance parties. And, strangely enough, I'm actually encouraged by many of the physical, emotional and spiritual benefits that flow from a healthy lifestyle. However, this does mean that opportunities for sex are more limited than before, when I was cruising the bars every weekend. Also, I guess I'm a little intimidated by sex clubs although I really need more than a quick blowjob in a dark cubicle these days. HIV has made me question the way I was living and that includes who I was fooling around with and what I was getting out of it. These days I'm looking for quality rather than quantity and I'm not as easily satisfied as I used to be.

So I suppose HIV has definitely had a profound impact on my life, including my sexuality. However, it's not all for the worse. While I'm fast getting over my vow of chastity, I'm sharing a lot more genuine intimacy with friends and strangers and that's something that was sadly lacking before. Although I'm not really getting down and dirty right now, I'm not waking up with head pounding hangovers beside people I have nothing in common with nor desire to be with. No doubt, HIV has interrupted my sex life, but it's also made me take a good look at what healthy, satisfying sex is really about. Before HIV I didn't even think it was an issue, or a possibility.

Name and address withheld.

More Positive Steps

By Karen Allen

Positive Women held this year's Positive Steps to celebrate World AIDS Day at O'Donnell Gardens in St. Kilda next to Luna Park on a blustery Sunday morning with rain, thunder and lightning. With luck on our side the weather cleared up in time for the actors to come on stage. The theme for this year's Positive Steps was 'HIV/AIDS...A Public Conversation'.

Positive Steps was created three years ago to help raise awareness about how women can protect themselves from HIV to prevent further infections occurring. This year was a coming together of the ideas and aspirations that positive women are portraying through Positive Steps. With the help of Graham Pitts, playwright, four women's stories were adapted into a theatre piece. It was called Promenade Theatre as the actors literally promenaded around the garden taking the audience with them. At least 200 people attended the event and all agreed it was a moving and uplifting experience. We would like to thank Debra Byrne, Jacinta Stapleton (Stingers), Janet Andrewartha (Neighbours) and Annie Phelan, actor and patron saint of Positive Women, for their time and brilliant performance displayed. Jane Bayly (Crying in Public Places) and partner, Pete, provided beautiful music to help the day along.



John Daye (left) talking at the PLC World AIDS Day event 2003. Approximately 120 people attended for dinner and the remembrance ceremony. Suzanne Lau-Gooey and Michael Rogerson (pictured above) also spoke to the audience on the diverse issues facing our HIV/AIDS communities.

World AIDS Day Talk at the Positive Living Centre Focusing on Stigma & Discrimination

By John Daye

This is a day to reflect on the challenges associated with HIV/AIDS in Australia and indeed, around the globe. It's an opportunity for us to take a deep breath, take stock and decide whether we've done enough, whether we're going in the right direction and where our efforts need to be strengthened.

The challenges around us are great. The world has become a much meaner place to live. It's a cruel irony that our parents put in place universal health care and access to pharmaceuticals in times that weren't as prosperous as today and the Federal Government has systematically tried to erode these essential services by creating division between those that pay and those that don't. Current proposals around Medicare further entrench a class of working poor.

We also need to see some leadership from the opposition challenging this nonsense with a vision that there are real alternatives. Australian society has become meaner in many ways we no longer talk about multiculturalism or indigenous issues and reconciliation have been sidelined. People are expected to work harder and longer for less. There is a notion that paid work is the only way you can properly participate in our community and volunteering is not seen as valuable. Proposed changes of tax laws by Peter Costello in relation to charitable organisations reinforce this belief. This is the backdrop against which we manage HIV/AIDS today. We need to challenge those Government policies that breakdown the supports that underpin our well-being and ensure quality of life.

The theme of this year's World AIDS Day is ***focusing on stigma and discrimination***. Focusing on improving awareness of HIV-related stigma and discrimination is about building a better place to live in for our future.

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WORLD AIDS DAY

Stigma and discrimination are major factors that create a climate of fear, cause isolation, break down relationships, feed insecurity, promote ignorance and fuel increased HIV infections.

United Nations AIDS Programs are targeting HIV-related stigma and discrimination in a two-year initiative to reduce the harmful effects faced by HIV positive people.

Recent research in Australia reported that more than one in three people with HIV had experienced less favourable health treatment because of their HIV, and more than 50% said their HIV status had been disclosed without their permission.

Discrimination against positive people is rife. The issue of discrimination and harassment against positive people in public housing is a matter of great concern to PLWHA Victoria. Individuals have been verbally abused, threatened with physical violence and made to feel extremely vulnerable simply because details of their status have become known.

Poverty, discrimination and breaking people's confidentiality and trust; these are real issues facing positive people in Australia and need to be tackled comprehensively.

Australia is held up as one of the most successful nations in dealing with HIV/AIDS in the world. This week new international figures showed that we rank at the top of the world in controlling HIV/AIDS.

This good news should to be tempered by the knowledge that HIV infections are on the increase in every state and territory of Australia and have nearly doubled within the indigenous community over the past year.

We are in a strategic position to reduce HIV infections further but recent deprioritisation of HIV/AIDS by the Federal Government will have serious ramifications. The review of the Australian National HIV/AIDS Strategy has called on the Government to provide leadership.

All Governments have seen overseas the danger in relaxing our approach to HIV/AIDS; it will be instructive several years hence to remind them that their failure to act has directly led to increased infection rates. Though I hope on this point I am wrong.

The success of the Australian response relies on the efforts and commitment of many people but fundamental to all spheres of activity in dealing with HIV/AIDS is direct partnership with HIV positive people themselves in coming up with solutions to address issues about HIV.

Lessons learnt from the past have shown how effective this partnership can be. We must not let the partnership approach between positive people, service providers, clinicians, scientists, researchers and educators be dismantled by either Government or any one else. We all need to collaborate if we're going to wrestle with the problem of increased HIV infections.

In comparative terms Australia is doing very well internationally but I would caution strongly against relaxing our efforts. In the blink of an eye the direction of the epidemic could change.

To our immediate north in Papua New Guinea HIV infections are raging out of control and AIDS is the highest cause of death in all people

under 35 years of age. A humanitarian disaster is unfolding. This is 60 kilometres off the Australian mainland. The major opportunistic infection killing these people is the preventable disease, tuberculosis.

Unlike Australia, HIV infection in Papua New Guinea is primarily through heterosexual contact. The contact and activity between Papua New Guinea and Australia is intense and so are the risks. Australia should be very worried about the dramatic increase of HIV/AIDS in the region, especially Papua New Guinea.

Just over a week ago the Federal Minister for Health Tony Abbott spoke about his perceptions of HIV and Hepatitis C rising infection rates on Sunday's *Meet the Press* program. His response to questions about both viruses was "just say no to drugs" (a quote from Nancy Reagan).

In essence he said that his Government would maintain existing support for fighting HIV and Hepatitis C with a dose of self-responsibility thrown in to manage the existing situation. If only this were so simple.

He failed to understand that taking responsibility for behaviour and making choices can only take place if people believe they have choices.

His comments did not take account of the social dimensions people live in or sound health promotion principles. I do hope he gets better advice from his advisors than this in the future his comments show a lack of understanding.

Blaming people will not engage them in prevention efforts. Maintaining a political bipartisan relationship with all political parties is crucial to the Australian response in tackling HIV, stepping away from responsibility to deal with the real issues confronting HIV positive people undermines it.

On a more personal note, no matter how many changes that have occurred I am still struck by the continuing impact of HIV/AIDS. This year we lost two very important Australian leaders and activists, Phillip Medcalf and Sonja Ristov, and I have to say the grief and loss never gets any easier.

One of the things that HIV has taught me is that it is important to give back some of what I have enjoyed to others. That's been the main reason I'm in the shoes of the President of People Living with HIV/AIDS Victoria.

If I'm lucky enough to survive this long, I want to give something back to the community who needs my support and has given so much since I needed help.

Finding your own way to give something back to the community is an immensely rewarding experience. There is still so much work to be done. We have achieved so much and when we work together we have incredible capacity to change the things that improve the quality of life for positive people.

Thank you for all the parts you have played in making it an easier world to live in.

We are very fortunate to have the range of services that exist here in Victoria but they only exist through the hard work of many dedicated individuals. From the positive community I want to thank everyone who has stood up and counted when we needed you

Thank you

9th National Association of People Living with HIV/AIDS Biennial Conference (NAPWA)

In late October of this year NAPWA held its 9th biennial conference in Cairns. The following articles are impressions of the conference from some Victorians who attended.

David Menadue
Vice President
PLWHA Victoria

My impressions of the NAPWA Conference are wrapped up in the memory of all the frantic conference preparations which I was involved in as President – it is only after I reflect a few weeks later that I can appreciate what I think we achieved with this year's event. I think, contrary to some (largely Southerner's) misgivings, Cairns proved to be a great venue for the conference for reasons beyond the tropical location. The lack of distractions (like Oxford Street, Sydney) meant that people spent a lot of time focused on the conference – and a special bond seemed to develop amongst a lot of the delegates.

I have read the feedback forms and there was an overwhelming response that the conference was either 'Excellent' or 'Good'. People loved the opening ceremony with Justice Marcus Einfield's passionate speech on human rights and Frika's heartfelt story about being HIV positive in Indonesia. The Papua New Guinea delegation was welcomed by all, and the awareness which they raised about the epidemic to our near north helped people focus on the very real needs of positive people in our region as well.

My favourite session was the gay men's satellite that had participants enthusiastically debating a broad range of topics including gay men and ageing, identity, recreational drug use, among others. The most useful for me was the session on Positive Living Centres that gave a multi-state focus on the difference models of service provision and what they offer – and I gather Centre Coordinators are going to continue to get together and swap ideas after this initial meeting. There are a range of conference resolutions, some of which involve lobbying for changes in government policy, which NAPWA will be pursuing as a result of this very productive conference.

Brett Hayhoe
Secretary
PLWHA Victoria

As a NAPWA conference virgin, I didn't know what to expect and just as well as it exceeded anything I could have thought.

Socially it was stimulating and exciting. I met some really lovely people and have probably forged some long-term friendships.

I found the conference content to be educational and informative. I wasn't quite sure what NAPWA did before I attended but I certainly do now....with a greater admiration for all involved and a yearning to be a real part of it myself as well.

Content - wise, I learnt a great deal - knowledge that I can now take into my work/ social life and go forward with a greater knowledge of all aspects of HIV/AIDS and the portion of our community who live with it on a daily basis - which of course includes me.

My congratulations go to the Board and organisers and I will certainly be attending the next one should the opportunity present itself.

9th National Association of People Living with HIV/AIDS Biennial Conference (NAPWA)

Guy Kharn
Director
PLWHA Victoria

It was bloody fantastic!!!
What, when & why…the NAPWA conference in Cairns

It was held in the Hilton. All the staff and volunteers did a fantastic job organising everything. It was my first HIV/AIDS conference and I have to say it was the best thing for me as I made important and useful contacts for my work on the Board of PLWHA Victoria. It has enabled me to work out what's happening and who is doing what and how they are doing it. Everybody was enthusiastic about what they are doing in their state, and were eager to share the information so we can all come back to our respective states with the ideas knowing how to uphold and hopefully improve our situations.

I attended many workshops and they were all rewarding. I personally got extremely excited and enthusiastic about one of the workshops that was about the ideas positive people have about HIV/AIDS & safe sex campaigns. For example PLWHA NSW has taken the initiative to produce a safe sex campaign from a positive point of view. I am encouraged and applaud this train of thought as I feel that we as HIV positive people can contribute tremendously to prevent the spread of HIV.

Collaboration for Health in Papua New Guinea Project: Report back from Andrew Timmins (Host of PNG Delegates)

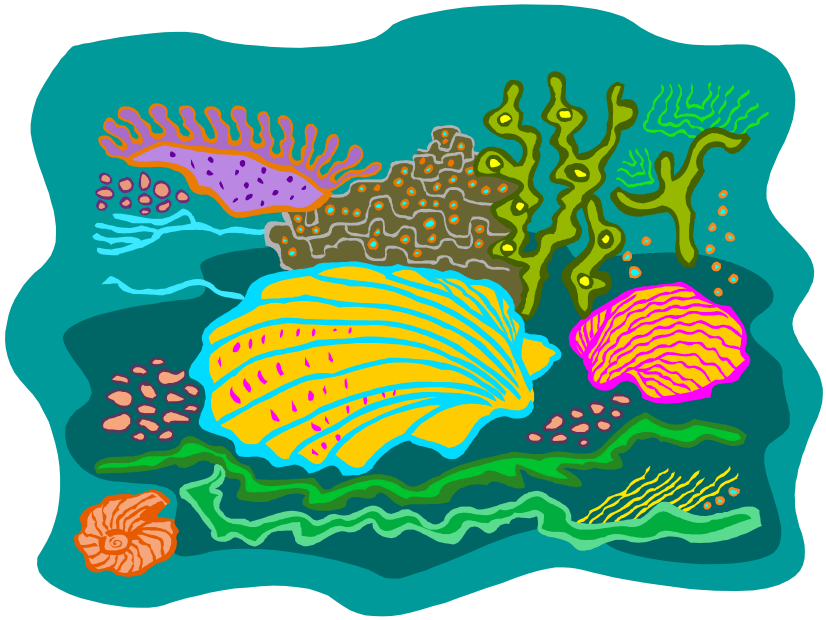
For some time I have been personally concerned about reports I'd read in the media about high levels of HIV in PNG and poor access to healthcare. I have a particular interest in PNG because I had spent a good portion of my childhood there.

Earlier this year I heard of an innovative project that was being organised to coincide with the 9th NAPWA Biennial Conference in Cairns this year and I registered my interest in supporting PNG delegates in whatever way possible.

I was invited to participate in a facilitated study and reflection tour of 12 people who were directly involved in providing care & support to people with HIV/AIDS in PNG.

Being involved in this project was at once a very uplifting and yet also a confronting experience. The PNG delegates were people of great personal strength who had to deal with the situation of either having HIV or of having to provide services to people with HIV with very limited or in a lot of cases no resources. In many places people don't have access to the sort of

(Continued page 14)



9th National Association of People Living with HIV/AIDS Biennial Conference (NAPWA)

(Continued from page 13)

basic services we take for granted like indoor plumbing or a regular electricity supply. The huge challenges that these workers face in trying to provide services is truly astounding and inspiring.

The PNG Government does not provide effective services to people with HIV/AIDS. In fact medications such as antiretroviral drugs and treatments for opportunistic infections are not supplied by the Government. Faith-based organisations form the basis of what services exist. To give you some idea of what can be involved, picture a nun travelling on foot for several days through the highlands of PNG to deliver test results to isolated individuals. They also provide what prevention education is available.

In PNG there is immense stigma and discrimination against people with HIV/AIDS. Outside of the church it's very hard to find people who are prepared to openly support people with HIV/AIDS. This fear is also prevalent amongst many health-care workers at all levels where horrific stories of discrimination are commonplace, including refusal of treatment at medical facilities.

There are high levels of ignorance about how to prevent the spread of HIV. The project that brought delegates from PNG to the conference set out to help these workers better understand the health and social benefits that can be achieved through improved prevention and the use of daycare and drop-in centres.

The project was lead by Elizabeth Reid from the United Nations and it was a big learning experience for me and also allowed me to reconnect with the place where I grew up.

As an attendee at the "Art of Living" conference I thought the highlight for me was the impassioned opening speech made by Justice Marcus Einfeld who spoke with great conviction about social justice issues in our country.

The cultural program was a brilliant little addition to the conference with the singing and the book readings being a very enjoyable experience. Of course I must also mention the truly inspiring speech by Margaret and Dora (two delegates from PNG.), who at the farewell ceremony brought the conference to a standing ovation with a stirring heartfelt plea for their people to rise to the challenge of HIV. Their speech was truly affecting and brought tears to my eyes.

LET YOUR VOICE BE HEARD

Become involved, email us for:

Ask Dr Nick
Dr Nick Medland will answer questions about your health. Please send your questions to doctor@plwhavictoria.org.au

The Scratching Post
This will be a page dedicated to what you have to say about anything you consider to be important. Pretty much anything goes on this page. However, inclusion of material is subject to editorial discretion and is not automatic. Please write a maximum of 200 words. To have your say email scratch@plwhavictoria.org.au

Personal stories
One of the best ways for people to learn about dealing with HIV is to listen to other people's stories. PLWHA Victoria will pay $50 for each story that is published in *Poslink*. Please be aware that not all stories will be published and therefore payment for a story is not guaranteed. Payment for stories can only be provided while funding is available. Funding is currently available for the next 2 issues of *Poslink*. Please write a maximum of 1000 words. Email your stories to stories@plwhavictoria.org.au

Future direction
We need to know what you would like us to write about. Examples of articles you may like us to write about could include topics that cover counselling issues, treatment issues or specific drug therapies, side effects, complementary therapies (please be specific), diet or political issues etc. Email your requests to ideas@plwhavictoria.org.au

Advocacy
Have you experienced problems with discrimination or access to health services? Call PLWHA Victoria on 03 9865 6772 and tell us what the problem is. We'll then assess if there is something we can do to fix the problem.

Annual General Meeting

New Board elected at PLWHA Victoria

By Mark Thompson

Three new Board members were elected at PLWHA Victoria's Annual General Meeting on Sunday 16 November 2003.

Longstanding President, John Daye, was elected unopposed as President as was David Menadue as Vice-President.

Kevin Guiney was elected Treasurer, a role he filled in 2002, and Brett Hayhoe was elected Secretary, a position he has held since July 2003.

The election of ordinary members of the Board was hotly contested, with nine people standing for six positions. The result was that Daniel Donnelly, Pat Garner, Brett Hayhoe, Greg Iverson, Guy Kharn, Kirk Peterson and David Staneck were elected.

Mr Donnelly, Mr Iverson and Mr Staneck are new to the Board, while Mr Kharn has been elected after being co-opted to the Board in July 2003.

PLWHA Victoria would like to express its thanks to the outgoing board members; Jon Willis did not renominate and is now the President of the Victoria AIDS Council, and Gregory Horn and Allan (Alby) Clark who were not re-elected. Their hard work and dedication to the organisation and to improving conditions of HIV positive people in Victoria are much appreciated.

PLWHA Victoria President John Daye with Tony Lupton MP Member for Prahran at this year's AGM

Recognition Awards

PLWHA Victoria also presented 14 awards at the AGM that recognise contributions to people in all sectors, from volunteering to research. The Annual Awards are a way of highlighting the enormous amount of work, paid and unpaid, that continues to be needed for HIV positive people and to recognise the people and organisations whose efforts in their particular area have been exemplary.

The awards were presented to the following people and organisations:

Award	Recipient
President's Award	Suzy Malhotra Positive Living Centre Pantry
HIV Sector Partnership Award	Yvonne Gardner Brian Price
Clinical Excellence Award	Peter Hayes Dr Nick Medland
HIV Media Awareness Award	David Rood
Research Progress Award	Paul Van de Ven
Volunteer Commitment Award	De and John Ayers
Community Endeavour Award	John Fowler
Enabling Sponsor Award	DT's Hotel Vibe on Smith Café
Special Acknowledgement Award	Jo Watson Susan Paxton

Treatments Update: what's new, what's changed

Alan Strum
PLWHA Victoria
Treatments Policy
andEducation
Co-ordinator

The 15th Annual Conference of the Australasian Society for HIV Medicine: The 15th ASHM Conference, 'Global Crisis: Local Action', was held in late October in Cairns. Alan Strum reports back on a few of the more interesting presentations that will have a direct impact on our members and the HIV community.

Lipoatrophy treatment fails

Sean Emery presented the Australian 'Rosiglitazone for Lipoatrophy' study results in Cairns. Rosiglitazone is a drug normally used for the treatment of Type 2 diabetes. The decision to investigate the use of rosilitazone as a potential treatment for lipoatrophy was based on research that showed this type of drug had been useful at increasing peripheral fat and decreasing visceral (tummy) fat in people with congenital lipoatrophy. The study was run over 48 weeks and recruited 108 patients. The results showed that rosiglitazone did not increase peripheral fat tissue nor did it reduce visceral fat from the tummy. [*Editor's note: There was a lot of hope placed on this study to ascertain whether rosiglitazone would be an effective treatment for lipoatrophy. I have to admit these results are very disappointing. The National Centre in HIV Epidemiology and Clinical Research, the study participants and the sponsoring companies Bristol-Myers Squibb and GlaxoSmithKline should be commended for pursuing this research in an effort to find solutions for our community members affected by lipoatrophy. On the upside we can use this information to reinforce our message to the government that NewFill® should be funded as a cosmetic treatment for lipoatrophy.*]

Preliminary results from the Alfred lipoatrophy trial

Dr Anne Mijch presented preliminary results on the benefits of NewFill® (polylactic acid) injections in 6/27 people enrolled in a clinical study at the Alfred Hospital. Apart from increasing the volume of the face with the polylactic acid where fat is missing it is thought that the active substance also causes an increase in collagenous fibres that remain even after the polylactic acid has been resorbed. The main aims of the study are to assess polylactic acid durability, effectiveness, safety, tolerability and the effect on quality of life. The study will also develop a grading system that will identify the severity of facial lipoatrophy and quantify potential improvements from treatment. Patients were given 4 – 10 injections in each cheek at day 0, day 42 and day 84. Firm massage pressure was applied for two days immediately following the injections to assist the distribution of the polylactic acid around the injection sites. Results in 6 people to date have shown that the treatment is well tolerated, that it is possible to quantify changes in the volume of the face where the polylactic acid was injected (see pictures 1 and 2 at bottom of page 17) and that distress experienced by people due to facial lipoatrophy was significantly reduced with improvements in facial volume. This study is ongoing.

Meet the Experts

Some of the more enlightening and controversial information discussed at ASHM occurred in the 'Meet the Experts' session. In this session Marty Markowitz from the Aaron Diamond Institute in New York and Alan Landay from St. Luke's Medical Centre in Chicago shared their experiences and ideas about cutting-edge treatment issues. The following is a summary of Alans Strum's impressions of their ideas and ensuing group discussions based on questions from the audience. Please note these are not direct quotes nor is the information discussed neccessarily endorsed by the writer or PLWHA Victoria.

Barebacking

What do you discuss with your patients about barebacking?

Response and discussion

Barebacking leaves people prone to super-infection with drug-resistant HIV viruses and other sexually transmissible diseases. There is sufficient data to show that being infected with HIV does not mean that people are protected from other HIV strains. To avoid catching a drug resistant strain of HIV it is best for people with HIV to engage only in safe sexual practices. They need to be given this type of information in order for them to make informed decisions.

Trizivir

How should Trizivir be used after the ACTG 5095 study results that showed it did not do as well as the comparator arms containing efavirenz?

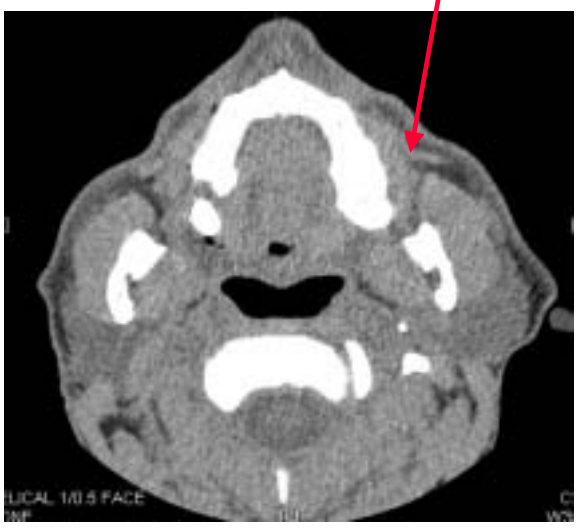
Response and discussion

The efavirenz arms in this study did extraordinarily well and Trizivir did not do

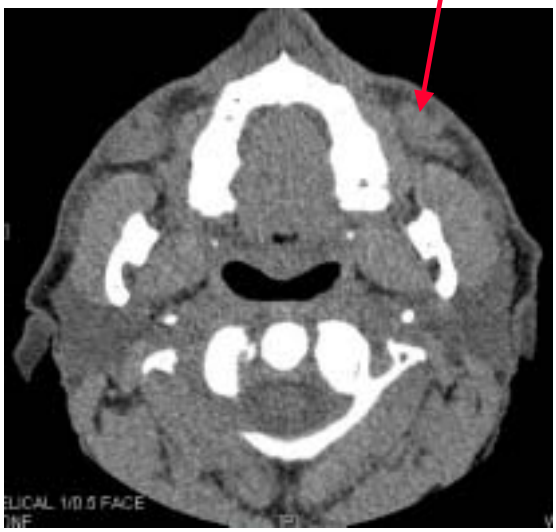
Pictures 1 and 2

CT scans through the head showing volume of the cheeks before after NewFill treatment

Before NewFill cheeks are shallow



After NewFill cheeks are filled out



too badly. However there is mounting evidence that triple nucleoside therapies in general do not appear to be doing well. Trizivir should not be used alone for initiating therapy unless there is a specific need for simplified therapy. It should not be used at all in people with viral loads above 100,000. If a person has started Trizivir and their viral load has remained undetectable out to around 1½ to 2 years, then they have successfully reduced the viral burden in their body and it should be okay for them to continue on it. For those who have not been on Trizivir for long, adding in a fourth drug is important to ensure they remain at undetectable levels and don't develop resistance to their drugs. Tenofovir is a good fourth drug to use with Trizivir because its AZT component helps to protect against the development of resistance to tenofovir. [*Editor's note: All 4 nukes in this combination are able to affect the health of mitochondria (energy factories) inside cells that has been shown to be associated with fat cell death and lipoatrophy. While most of these drugs individually appear to affect mitochondria only mildly, they could have an additive effect. Personally, I would like to see safety results from a long-term clinical trial (i.e. >2 years) on the use of this combination before seeing it used in the greater community at large.*]

Atazanavir

Atazanavir is about to become available in Australia. Given the BMS 045 data has shown that atazanavir boosted with ritonavir is equal in efficacy to Kaletra in PI experienced patients, how would you recommend atazanavir be used in PI naïve patients?

Response and discussion

Given that Kaletra is considered to be the benchmark of efficacy (i.e.

Treatments Update: what's new, what's changed

Alan having fun with 'Jeannie' outside of the Gilead Sciences stand at ASHM (secretly I was hoping that a youngish Major Nelson was hiding somewhere behind their display)

it works really well) it will be important to prescribe atazanavir boosted with ritonavir for PI experienced and PI naïve patients. Using boosted atazanavir will reduce the possibility of resistance developing. It might be that people will experience more side-effects by using the ritonavir with the atazanavir but at least the side effects can be managed or the ritonavir can be stopped. Resistance is something someone has to carry with them for life if drugs are not used properly. Following the BMS 045 data Bristol-Myers Squibb will probably need to do a study in PI naïve patients showing that unboosted atazanavir is as effective as boosted atazanavir before atazanavir should be prescribed as a single PI.

PEP

What combination of drugs should be used for post exposure prophylaxis?

Response and discussion

Tenofovir should be part of PEP combinations because of a study showing that it was able to prevent infection in 5 out of 5 monkeys that were inoculated with virus. Tenofovir + 3TC + efavirenz was the panel's preferred PEP combination.

Low CD4 Counts

What do you do with patients who have an undetectable viral load but whose CD4 count remains low (below 200)?

Response and discussion

New CD4 cells require an active thymus gland to increase in numbers. The thymus gland usually shrinks and becomes less active as we get older. Human Growth Hormone has been shown to stimulate growth and activation of the thymus gland. Using Human Growth Hormone should help patients increase their pool of CD4 cells. [*Editor's Note: Human Growth Hormone is not easily available in Australia*.]

Slow response to therapy

A patient started a combination therapy that includes a double protease inhibitor - Kaletra with Indinavir. They have not yet achieved an undetectable viral load but have had a –1.8 log reduction by week 12. Is this combination good enough for this patient to achieve an undetectable viral load or does he need to change therapy?

Response and discussion

As long as the viral load is still going down it's okay. If they don't reach an undetectable viral load by week 16 then add another drug to their combination. The panel was of the opinion that indinavir was not the best choice of drug due to its side effects. They recommended combining Kaletra with amprenavir instead. It was considered that Kaletra combined with amprenavir is controversial due to an identified drug interaction but in the panellists' experience this combination appears to work.

In the news

By Alan Strum

NewFill® continues to work out to 2 years

NewFill® (polylactic acid) has been used in cosmetic surgery since the mid 1990s. More recently it has started to be used by people with HIV to reverse the effects of lipoatrophy on the face caused by a loss of fat tissue as a side effect from some anti-HIV drugs. However, there has been some debate as to how long the effect of NewFill® lasts versus the cost of the treatment. A French study of 50 people has now shown that the effect of NewFill® lasts out to two years. The median increase in skin thickness at 2 years was 6.8mm. [*Editor's note: This is good news as there were concerns that NewFill® would only work for a short period of time.*]

Risk of heart disease increases on HAART

A study published in the New England Journal of Medicine from the Data Collection of Adverse Events of Anti-HIV Drugs (DAD) Study Group indicates there is a 26% increased risk of heart attacks for every year of exposure to anti-HIV drugs over a 4 – 6 year period. In an editorial in the same issue, the DAD investigators emphasised that there was a high number of cardiovascular risk factors in this patient group and advise that stopping smoking and dietary changes along with the use of statins for lowering cholesterol are logical steps to take in order to reduce the risk of people developing coronary heart disease.

WHO fixed dose guidelines

The World Health Organisation has released draft guidelines on the use of anti-HIV drugs in resource poor settings. They have advised fixed dose combination tablets be used consisting of AZT+3TC or d4T+3TC with efavirenz or nevirapine as a first line treatment. This recommendation provides direction for generic manufacturers to scale up production of the combination tablets for greatly reduced prices. The Clinton Foundation has been able to secure a price for a combination tablet of d4T+3TC+nevirapine at $186 AUD per year for 13 locations throughout Africa and the Caribbean. [*Editor's note: The price for this type of drug combination in Australia starts at $10,200 per year. The introduction of generic manufacturing of anti-HIV drugs is going to allow for large numbers of people to be treated throughout the developing world. In Australia and the rest of the world we are going to miss out on simple combination tablets due to industrial rivalry between pharmaceutical companies.*]

India meets with local generic manufacturers

The Indian government has announced plans to provide free antiviral therapy through government hospitals to people with HIV beginning in April 2004. They expect around 100,000 people will commence therapy within the first year of the program commencing. The cost for triple combination therapy in India is currently $396 US per person per year. The Indian government has recently met with local generic drug manufacturers and believe they will be able to have this price reduced to approximately $140 US per patient per year. The official estimate of the PLWHA population in India is 3.8 – 4.2 million. Unofficial estimates are 10 million. New legislation is currently being drafted to ensure doctors are not able to refuse treatment to people with HIV and will ban discrimination against

children with HIV. The government is also introducing new harsh penalties for people selling fake HIV drugs or making false claims for untested treatments.

South Africa follows through on promise – miracles do happen!

On November 20 the HIV community in South Africa had good cause to celebrate as the government released information on a comprehensive plan to deliver HIV care and treatment for five million HIV positive people. The government has set aside 12 billion Rand to meet the costs of the program that will take 5 years to implement. A significant expense for the program will be the recruitment and training of doctors, nurses, pharmacists, laboratory technicians, counsellors and other heathcare workers who will be placed at specific 'service points'. The first of these service points are to be set up within the first year and will be located in each health district of which there are around 12 health districts per province. This will provide treatment to 50,000 people. The next goal of the program is to set up service points in every municipality in order for all HIV positive people in South Africa to be able to access HIV healthcare and treatment.

Atazanavir resistance

Data presented at the 9th European AIDS Conference in Warsaw from the BMS 045 study looking at boosted atazanvir has shown that resistance to atazanavir appears to occur when 4 or more mutations appear on the HIV protease enzyme.

Barebacking leading to Hepatitis C co-infection

At the 9th European AIDS Conference in Warsaw Dr Brian Gazzard from the Chelsea & Westminster Hospital reported that barebacking is leading to HIV positive people becoming infected with Hepatitis C (HCV) in London. The hospital has had 44 acute HCV co-infections in the last 21 months with more cases being reported from other clinics around London. [*Editor's note: Some people would like to believe that unprotected sexual intercourse among HIV positive sero-concordant partners is okay. Information is available that indicates different strains of HIV and drug-resistant HIV can be transmitted through unsafe sexual practices. HIV/HCV co-infection results in a higher HCV viral load that appears to make the Hepatitis C virus more transmissible. In Dr Gazzard's cohort of patients in London it is still unclear whether transmission is occurring from people who are acutely or chronically infected with HCV. 15% of the Australian HIV population is co-infected with HCV. It may be time for people to re-educate themselves around the risks associated with unprotected sex with HIV positive sexual partners.*]

Nevirapine vs efavirenz drug levels

A sub study of the NARVAL-ANSR 088 study was presented at the 9th European AIDS Conference in Warsaw looking at the drug levels of nevirapine or efavirenz in 357 patients. 91% of patients had adequate drug levels of efavirenz while only 57% had adequate levels of nevirapine. In a separate poster presentation, data from the Liverpool Therapeutic Drug Monitoring Service showed that 30% – 32% of people taking nevirapine or efavirenz displayed drug

levels that were below the minimum levels required to inhibit the virus. [*Editor's note: These data indicate that therapeutic drug monitoring may be beneficial for people taking NNRTIs.*]

Tenofovir and ritonavir interaction

Researchers in France have identified another case of Fanconi's syndrome in a patient taking tenofovir with Kaletra (lopinavir/ritonavir), ddI and 3TC. The patient had shown a five-week history of fatigue, dehydration, weight loss, painful neuropathy in the lower limbs, increased urination, excessive thirst, raised blood pressure and an elevated heart rate. Therapeutic drug monitoring showed that tenofovir and ddI levels were 4 times greater than normal. The researchers put forward the idea that ritonavir can block elimination of tenofovir in the kidneys resulting in an increase in tenofovir leading to kidney toxicity. They recommend that people taking tenofovir with protease inhibitors should be monitored for kidney toxicity. [*Editor's note: Ritonavir was shown in a recent study to increase levels of tenofovir by 30% that is thought not to be clinically relevant except in people with a low body weight. This new case of Fanconi's syndrome is a reminder of the importance to monitor kidney function for people taking tenofovir*.]

HIV resistance in France

A study has been published in *AIDS* of resistance surveillance in 2248 people with HIV across two major treatment centres in Marseille between 1997 and 2002. In 1997 3.6% of people displayed resistance to the three major classes of anti-HIV drugs which increased to 25% in 2002. 78% had resistance to at least one NRTI, 47% had resistance to at least one protease inhibitor while 39% had resistance to NNRTIs.

Europe issues another warning against triple nukes

In July this year the European Medicines Agency put out a warning advising doctors not to start patients on tenofovir + abacavir + 3TC following results from a clinical trial where nearly half of the patients taking the combination failed to respond to therapy. In October a warning was issued again, this time advising doctors against the use of tenofovir + ddI + 3TC following a 91% virological failure rate from a recent study.

Fosamprenavir approved in the US

A new HIV protease inhibitor called fosamprenavir (Lexiva™ has been approved in the USA. Fosamprenavir is the pro-drug of amprenavir, which means that it breaks down into amprenavir once it is in the body. Amprenavir is currently 6 capsules taken twice a day. Fosamprenavir is only 2 tablets taken twice a day, or it can be boosted with ritonavir for once daily or twice daily routines. It can be taken without regard to food.

Study shows women produce more active AZT and 3TC than men

A study from the University of Colorado of 33 people with HIV has shown that more AZT and 3TC becomes active inside the cells of women than in the cells of men. Compounds like AZT and 3TC are phosphorylated (chemically changed) into their active forms inside cells before they can inhibit HIV. Women ended up with 2.3 times more active AZT and 1.6 times more active 3TC. In addition, it took only half the time for the viral load

women to become undetectable than men. [*Editor's note: Women have experienced more side-effects than men from HAART for too long. This data finally explains why many women had to reduce their AZT doses to levels below those that are recommended from data collected from clinical trials that were done mostly in men.*]

Australian company using new technology to prevent HIV transmission

Starpharma, an Australian biotech company, is developing a new compound that can be used as a topical microbicide to prevent transmission of HIV. The new topical microbicide is called Vivagel™and can be applied to the vagina or the rectum prior to intercourse. Vivagel™contains a molecule called SPL7013. SPL7013 was created by using nanotechnology and attaches to the gp120 surface protein of HIV rendering it non-infectious. A recent study has shown that Vivagel™was 100% effective in preventing infection from occurring in monkeys. Vivagel™does not only appear to work against HIV, but test tubes studies have shown that it can work against genital herpes, Chlamydia, hepatitis B and genital warts. The FDA has given the go ahead for Vivagel™to be tested in humans in the USA. [*Editor's note: Given that HIV vaccines are proving to be elusive, this is one of the most exciting developments that I have come across in many years. Should this microbicide prove to be effective it will provide a major step forward in preventing HIV transmissions worldwide. This is a real case of 'watch this space'. For further information visit* www.starpharma.com]

Syphilis highest in San Francisco

Thinking of travelling to San Francisco? The US Centre for Disease Control (CDC) has identified that San Francisco has the country's highest rate of syphilis at 40.6 cases per 100,000 people. The US national average is 2.4 cases per 100,000. Gay and bisexual men apparently drove the infections. A study in New York has reported that men with syphilis were more likely to have unprotected anal sex, attend private sex parties and use methamphetamine and Viagra or other drugs before having sex. According to the AIDS Project Los Angeles, men meeting for sex over the Internet is becoming problematic in terms of syphilis transmissions.

Tenofovir: advancing HIV drug therapy

By Alan Strum

Introduction

Tenofovir (TDF), also known as Viread, is a nucleotide analogue used to inhibit HIV. This drug is very potent and is convenient to take with only one tablet taken once a day with food. It also has an excellent resistance profile and is well tolerated with minimal side effects. TDF has provided excellent results in clinical trials in people who were either treatment naïve or treatment experienced.

How it works

As a nucleotide analogue, TDF acts against HIV by pretending to be a DNA building block. The HIV reverse transcriptase enzyme picks up DNA building blocks when it is producing viral DNA for insertion into human DNA. When the enzyme picks up TDF its replication cycle becomes blocked and it can't produce the viral DNA. In this regard TDF works similarly to drugs like AZT (nucleoside analogues) except that it is already in its active form.

Drugs like AZT need cells to chemically change them before they become active. Some cells aren't able to chemically change all of the nucleoside type drugs into their active forms. This means that TDF may be able to block HIV in a larger range of different cell types.

Side-effects

Some side effects that have been reported from clinical trials in people taking a combination of drugs with TDF include headaches, nausea, vomiting, diarrhoea and flatulence. These side-effects are not considered to be common or severe.

Other nucleotide analogues similar to TDF have been

Table 1. Drugs that can cause kidney toxicity

Aminoglycoside antibiotics	amikacin gentamicin paromycin streptomycin tobramycin
Other antibiotics	bactrim
Antifungals	amphotericin B
Antivirals	acyclovir adefovir cidofovir foscarnet indinavir valacyclovir
Antiparasite drugs	IV pentamidine
NSAIDS	paracetamol ibuprofen indomethacin naproxen

associated with kidney toxicity. Clinical trials of TDF have shown that it is safe and does not affect the kidneys like the other drugs of this class. However, since its release into the general population, some mild kidney toxicity has been reported. One study in Canada showed mild kidney toxicity in 7% of 322 people treated with TDF, with only 1% needing to stop the drug. The toxicity mimics a disorder called Fanconi's syndrome. Fanconi's syndrome is where the kidneys become 'leaky'. This may be related to TDF interfering with mitochondria (energy factories) inside cells of the kidneys resulting in the filtering process being altered. Symptoms of leaky kidneys are associated with extreme thirst (dehydration), frequent urination, confusion or muscle weakness. It would appear the chances of developing kidney toxicity from TDF might depend on prior or current usage of other drugs that can also cause kidney toxicity (see table 1). Because of the possibility of developing kidney toxicity while on TDF it is important that kidney function tests be done as part of routine monitoring. This is especially important for people taking Kaletra as this drug increases TDF by 30%.

Leaky kidneys can result in a loss of bone mass as essential elements escape from the body. This has not been identified with TDF. People should seek medical advice if they experience bone pain.

In general the side-effect profile of TDF is considered to be very good. TDF is less of a mitochondrial toxin than ddC, ddI, d4T and AZT. As such it is hoped that TDF will not interfere with fat metabolic processes to the same extent as these drugs. In

a study of TDF versus d4T, TDF had a more favourable blood lipid profile and people had less lipoatrophy. Thus TDF joins 3TC and abacavir as drugs that are gentler on the body with regards to body fat changes associated with lipodystrophy and lipoatrophy.

Drug interactions
A number of drug interactions have been identified between TDF and other HIV drugs (see table 2). Taking TDF with other drugs that cause kidney toxicity should be avoided. Where taking such drugs cannot be avoided it is recommended that kidney function be monitored regularly and at least monthly.

Cidofovir, gancilovir, valganciclovir and TDF are eliminated through the kidneys along the same pathway that could result in drug interactions occurring.

TDF does not appear to interact with methadone.

There are concerns there may be a drug interaction between TDF and abacavir following poor results from this combination in triple nuke clinical trials. Current data shows normal levels of both drugs are reached in the blood when used together. Gilead Sciences and GlaxoSmithKline are currently investigating this combination to see whether there might be a drug interaction inside of the cells where the drugs are meant to be working in their active form against the virus.

TDF in triple nuke combinations
Of late triple nuke combinations have performed poorly in a number of clinical trials with up to 91% of participants experiencing virologic failure. It is unknown why these combinations performed so poorly. The US antiviral drug guidelines recommends against the use of TDF with either ddI + 3TC or abacavir + 3TC in triple nuke combinations.

Women and tenofovir
Women experience less diarrhoea than men. No differences in pharmacodynamic parameters have been detected between men and women.

Table 2. Known drug interactions with tenofovir.

Atazanavir (ATV, Reyetaz)	↓ ATV	Reduce ATV to 300mg and boost with 100mg ritonavir
Didanosine (ddI, Videx-EC)	↑ ddI	Reduce ddI to 250mg. Allows for ddI to be taken with food
Kaletra (lopinavir/ritonavir)	↑ TDF	Monitor kidney function

Tenofovir and renal insufficiency
Tenofovir is mostly eliminated from the body by the kidneys. People who have reduced kidney function may need to take tenofovir less frequently and should discuss dosing requirements with their healthcare provider.

Resistance profile
Resistance can occur to drugs when parts of the enzyme change slightly that drugs attach to. These mutations are changes in the sequence of amino acids in the enzyme at specific codon locations. When these mutations occur drugs can no longer attach as easily to the enzyme anymore and become less effective.

Reduced efficacy of TDF has been associated with changes at codon 65, with 69 insertions or when 3 or more thymidine analogue mutations (41, 67, 70, 210, 215 and 219) occur that include changes at codon 41 and 210. In general, these types of mutations occur infrequently which means that TDF will work in most people.

If the mutation at codon 65 does occur there is evidence to show that TDF may still be able to slow down the replicative capacity of the virus (viral fitness).

Tenofovir and Hepatitis B
A number of studies have shown that TDF is active against hepatitis B (HBV) including those who have HBV resistance to 3TC. Suddenly stopping TDF could result in a sudden increase in HBV viral load that could be dangerous. People should consult their doctor regarding TDF and HBV.

Conclusion
TDF is a good drug to use that is easy to take, is well tolerated and has a good resistance profile. It works well in both people starting treatment for the first time, people changing treatment or in people who need to intensify their treatment. There are some drug interactions of which people need to be aware. In Australia tenofovir has been listed on the PBS for use in people who have taken HIV drugs previously. With this in mind it might not be possible to access this drug for those who are starting treatment for the first time.

Acknowledgement

PLWHA Victoria would like to thank Bristol-Myers Squibb and Abbott Virology for providing unrestricted educational grants to fund this issue of Poslink.

Membership application

All details contained herein will be treated strictly confidentially.

I wish to become a member of People Living With HIV/AIDS Victoria and to receive all privileges of said membership. I agree to abide by the Rules* of the organisation at all times. I give permission to receive information from PLWHA Victoria.

Please tick ☐ **Full Membership**: I am HIV positive and am able to provide verification of this if required.

☐ **Associate Membership**: I do not wish to disclose my HIV status, I am HIV negative or I do not know my HIV status.

Signed Name

Address Postcode

Telephone (optional) E-mail address (optional)

Please fax or post your membership application to:

PLWHA Victoria
6 Claremont Street
South Yarra VIC 3142
Tel: 03 9865 6772
Fax: 03 9804 7978

*Copies of the Rules of the organisation are available from the PLWHA Victoria office.

advocacy · advice · representation · information · support