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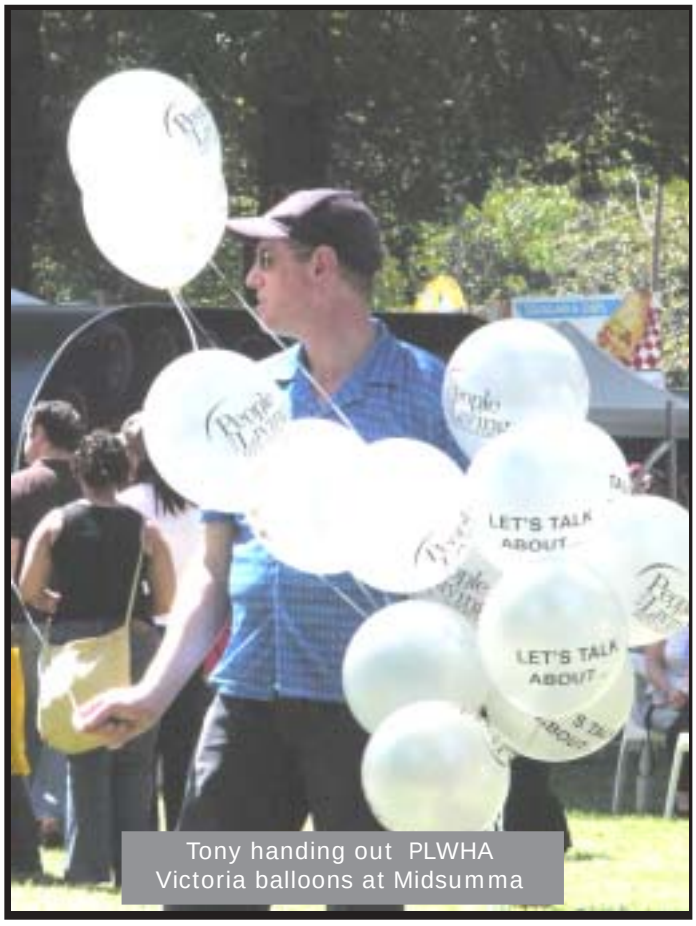
POSLINK

The Newsletter of People Living With HIV/AIDS Victoria



Tony handing out PLWHA Victoria balloons at Midsumma

Issue 27 March / April 2006

Inside this issue:

More on superinfection at major conference

Rumour has it that this year's Conference on Retroviruses and Opportunistic Infections (CROI) held in Denver was overflowing with high quality scientific information (*see In The News*). Among some of the information presented was data from Los Angeles/San Diego and San Francisco that appear to be unlocking some of the mysteries to superinfection and why only some people seem to be vulnerable to infection with a second strain of HIV more so than others. Sometimes a second HIV infection can cause damage to the immune system more quickly.

To date we know that re-infection with HIV, otherwise known as superinfection, can and does occur in some people who have been recently infected and who engage in unprotected sex with other HIV positive people. Thus an immune response to HIV does not protect everyone from re-infection. Now data from CROI indicate that the answer to this mystery may lie within the strength of neutralising antibodies. The immune system produces around 15-20 different types of neutralising antibodies that attach to six different regions on the HIV virus preventing it from attaching to CD4 cells. It was originally thought that these antibodies were very specific to a person's individual virus and that they would not provide protection against other forms of HIV.

The Los Angeles/San Diego data looked at neutralising antibodies in 3 people with superinfection and tested the activity of the antibodies against the activity of antibodies taken

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The Speakers Bureau is sponsored by unrestricted educational grants from:

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Note from the Executive Officer

Sonny Williams

Since the last issue of Poslink, here at PLWHA Victoria we have been focusing on preparing for three important events - Pride March, Midsumma Carnival, and Daylesford ChillOut. Not a simple process when you start to map out who has to do what, when and how; factor in dates for budgeting and reviewing progress; layer onto this working out key messages, themes, a call for volunteers, rostering, numerous phone calls; and then deal with not one but three suppliers unable to follow through with the promotional goods which required an urgent rethink!

This year we decided to build on the World AIDS Day theme of 'Let's talk about it'. Those of you who attended Pride March would have seen the black and white placards which had the PLWHA Victoria logo and 'Lets talk about...' on one side, the reverse with different messages such as *Relationships, Treatments, Sex, Advocacy, Friendship, Treatments* and *Condoms* etc. For Midsumma Carnival we recycled the placards and messages to decorate the tent, including 300 helium filled balloons and 500 condom packs as giveaways, again with the same messages. The response to both events was positive and outstanding. Feedback has been supportive and the idea of building on and carrying a consistent message throughout has been encouraging. Those of you who are maybe going to ChillOut in Daylesford on Sunday 12 March should keep an eye open for our stall which we have in partnership with Country AIDS Network and the ALSO Foundation.

Planet Positive has been moved to a new home in Commercial Road at Heaven's Door. We have the entire place to ourselves so the space is confidential, safe and for those members of the community who cannot navigate stairs, access is directly from the street and into the venue. This was our first Planet Positive for the year which was well attended. It was good to see some new faces turning up and given we were up against another two major community events on the same evening, the numbers were better than expected. Thanks to everyone who volunteered their time and energy to contributing to the success of the events.

Speaking of volunteering, I would like to echo Greg's comments that PLWHA Victoria is only as strong as the contribution that the members put in. As an organisation we are always keen to attract more volunteers to assist at events, functions or contributing to potential programming to donating some spare time to volunteer at the office or with mailouts or safe sex packs. What better way to understand and to get to know an organisation or the people who work in it?

Note from the President

Greg Iverson

Not that it is unusual, but the start of the year has been a very busy time for us at PLWHA Victoria. This time of year sees us involved in the many events that are put on by the gay community as part of the Midsumma festival.

First was the Pride March. Whilst it wasn't the biggest crowd that we have had marching under our banner, our numbers were substantial, and as usual, we received great ovations from the crowds lining the streets. I realise that for a lot of people, marching under the PLWHA banner as an openly positive person can be a bit intimidating, but personally, I find participating in these marches an uplifting experience, thanks to the reaction of the crowd to our group. I would encourage members to consider marching next year; you may be surprised at just how empowering the event can be.

The following weekend was the Midsumma Carnival. Unfortunately, again I am afraid due to ill health, I was unable to attend on the day, but from all reports that I have received back, our stall was well attended and comments have been made directly to me about the success of the day for PLWHA Victoria. A big thank you has to go to our staff and the volunteers who assisted in both of these events.

The next major event that we are attending will be the Chill-Out Festival in Daylesford on the 12th March. If you are around at the festival, make sure you pay a visit to the PLWHA Victoria stall and say 'hi'.

Also, by the time you are reading this, we would have held our annual Planning Day. The focus for the Planning Day this year will be to review the current Strategic Plan that was formulated last year (this plan is intended to run from 2005 – 2007), to see what is still relevant, what we may need to update and also to look at future directions for the organisation. Another issue that will take up some time on the day, will be discussion around the new Funding and Service Agreement (FASA) that we will be negotiating with the Department of Human Services this year.

We will be trying our hardest to increase the funding base for the organisation, though in these times of rationalisation and cut backs in government spending, this task will not be easy. The good news here is that as a community organisation, we have great support for our work within the DHS, and there is recognition that what we do is effective and valued in the community sector.

Another item that I would like to bring to the attention of members is that due to a range of personal reasons (work commitments and health mainly), a few of our Board members have had to resign from their positions. I would like to thank the outgoing members for their contributions to PLWHA Victoria – stepping up to make the commitment to assist the organisation is always valued.

One of these vacant positions has been taken up by a member from the Fresh group from the PLC; it has been a goal of mine to get some younger people involved in PLWHA Victoria in a more active way, so I was very glad when this member joined our board. We still have two vacant positions that we would like to fill, so I would like to put the call out to our members for Expressions of Interest in putting your name forward to fill these roles. No expertise is required – just a commitment to represent your community and contribute to the task of enriching the lives of the positive population of Victoria. If you are interested in applying for one of these positions, then please contact the PLWHA Victoria offices.

Of course, the board is just one way that you can assist PLWHA Victoria – we can always use more volunteers to assist in our events and functions. Please consider it, because (as I have mentioned many times before in these columns) our organisation is only as strong as the contribution that the members put in. We are not a government or private enterprise body, but a collection of everyday positive people, who are trying to maintain the best of possible outcomes for the positive population of our state. Whilst we have a band of dedicated and hard working people, we can always do with more!!

What's Up: News and Information

More on superinfection at major conference - *continued from page 1*

from 11 men recently infected but who had not become superinfected. The antibodies were tested against the host HIV and 2 laboratory strains of HIV. Antibodies from the men with superinfection showed weak to no activity against their own virus and only weak activity to the laboratory virus, while antibodies taken from the control group showed strong activity towards their own virus and the lab virus.

A San Francisco study found similar results when comparing the activity of neutralising antibodies in 4 people with superinfection to the activity against antibodies in 8 couples recently infected with HIV who were not having protected sex but in whom superinfection had not occurred (or had not been detected). Once again the activity of the antibodies was higher in the non-superinfected couples. And to add to the data, the antibodies from the couples not only showed strong activity against their own virus but also to their partner's virus and to 10 HIV samples taken from other people (total strangers). In a third study, investigators looked at the genetic diversity of HIV in white blood cells in two recently infected people and 17 people who'd had HIV for around 10 years. All people were on effective antiviral therapy and were having unprotected sex with their HIV positive partners. They found different types of HIV in the blood cells from the two recently infected people and in 3/17 of the chronically infected people. Interestingly 3/5 HIV strains collected showed resistance mutations to the HIV drugs but treatment failure had not occurred. This led the researchers to believe that localised superinfection appears to be taking place at the point of infection but that an unknown mechanism was preventing the spread of the HIV into other areas of the body, thus preventing systemic superinfection.

Although their data does not conclude that neutralising antibodies may be creating localised pockets of superinfection, it remains a possibility that these antibodies are doing a lot more than we give them credit for. [*Editor's Note: Much of this data makes sense and seems to be filling the gap in our knowledge as to why some people can become superinfected while others don't. The idea of these neutralising antibodies that are displaying activity to a broad range of viruses is good news to vaccine researchers and may help to open the way forward for more effective vaccine development. Unfortunately there is no lab test to see who is vulnerable to superinfection and who isn't. Currently the only sure way to protect yourself from infection with HIV again is to always use condoms. However, most people like to weigh up the risks associated with superinfection along with intimacy values, when deciding whether or not to have unprotected sex with an HIV positive partner.*]

US Gay Games to welcome people with HIV

What's your flavour? Do you like Canada or do you prefer the USA? The battle for best attendance at the Gay Games between Montreal and Chicago is starting to shape up and people with HIV who wish to attend these games have a few things to think about. If you chose Montreal there are no entry restrictions for Canada provided you fly via Europe, Hong Kong or Japan to avoid the draconian and discriminatory policies of the US Government that are in place to prevent people with HIV entering into their country. However, the Chicago Gay Games' organisers are now over the moon that their event has been given 'Designated Event Status' which will allow people with HIV to enter the USA on a single entry B-2 visa. The www.gaygameschicago.org website indicates that people using the 'designated event status' visa are not required to declare their HIV status. [*Editor's note: The US Consulate in Melbourne is quite busy. To get a visa you sometimes need to book weeks in advance over the internet. The standard cost for a visa is usually around $140 and will only be valid during the period of the event for which it is issued.*]

Roche to share technology with least developed nations...free

A number of HIV companies, including Roche, have relinquished patent rights to least developed countries in order for local manufacturers to produce HIV drugs cheaply for the local population. While manufacturers have the capacity to produce first line therapy drugs such as AZT, 3TC and nevirapine, other drugs for second line therapies such as protease inhibitors are more difficult and complex to produce. In order to address the need for least developed countries to be able to produce cheap protease inhibitors, Roche has announced it will share the technology and know-how to manufacturers in these countries for them to produce the Roche drugs saquinavir and nelfinavir with no strings attached. Once this technology has been transferred to these countries they will be in a better position to be able to produce a broad range of protease inhibitors cheaply.

Early Access Program for new drug: Darunavir (TMC114)

The Tibotec protease inhibitor, TMC 114 otherwise known as darunavir, is now available through an early access program. Australia is only one of 11 countries that appears to have access to this important new drug to date. Tibotec is a biotechnology company based in Belgium that was the first company to successfully develop HIV drugs that are able to 'twist' when attaching to HIV enzymes. The twisting motion allows the drug to remain attached to the virus protease enzyme even after resistance has developed. So far darunavir appears to work really well in people with virus that is even resistant to Kaletra. Darunavir works even better when a new drug is added to the equation such a T-20 (*see In The News*). Tibotec is owned by Johnson & Johnson and is being distributed in Australia through Janssen-Cilag, a subsidiary of J&J. Talk to your doctor if you think you would benefit from access to darunavir. Access criteria to the darunavir program are listed below:

- are over 18 years of age
- have limited or no treatment options due to virological failure or intolerance to multiple ARV regimes
- have received treatment from each of the 3 major classes of HIV drugs (NNRTIs, NRTIs), including 2 different PI-based regimens
- have a CD4 cell count of equal or less than 200 cells/mm3
- are not eligible for participation in any other Tibotec-sponsored HIV trial

NB: Some clinics have not been registered for the program yet. There may be a slight delay in accessing this new drug if registration has not been completed by the clinic.

VAC/GMHC Christmas party in February

PLWHA Victoria staff enjoyed good food, good company and lots of fun while attending this year's VAC/GMHC Staff Christmas party in February at the Flagstaff Garden Bowls Club. Suzy Malhotra and Sonny Williams led the PLWHA Victoria team at bowls against the aggressive yet bewilderingly funny VAC/GMHC staff. Thanks to all involved for making the afternoon such a smashing success.

What's Up:
News and Information

Marching With Pride

Over 40 members, family and friends marched with PLWHA Victoria at this year's Pride March on Sunday 5 February. We waved our flags, held our banners high and distributed safe sex packs while walking down Fitzroy Street to loud cheers and applause from everyone present.

Marching under the theme 'Let's talk about it', we held up a number of banners that addressed the issues, services and concerns for people living with HIV/AIDS. The distinctive black and white banners displayed the words, 'Advocacy', 'Information', 'Support, 'Relationships', 'Sex', 'Love', 'Treatments' etc. with the aim of providing an interesting focus for discussion and comment.

The march wrapped up at the Catani Gardens where Tony White, PLWHA Board Member and chef extraordinaire, laid out a fantastic picnic lunch for all our marchers. Thank you to everyone who joined us on this important day, especially to the huge number of new faces who came along to proudly support and walk with us.

What's Up: News and Information

Personal Advertisement

Guy in Ocean Grove looking for people in the area for friendship. Please contact PLWHA Victoria with your details on poslink@plwhavictoria.org.au or 9865 6718.

Planet Positive goes south!

Planet Positive began 2006 with a trek across the river from Collingwood to a new home in South Yarra. On Wednesday 8 February, Heaven's Door on Commercial Road held host to our bi-monthly Planet Positive social evening, and by all accounts was considered a huge success!

The funky and welcoming bar Heaven's Door is fast becoming an institution on the Commercial Road strip and offers a great space for catching up with friends and enjoying a few beers and cocktails. We were fortunate to have the entire space for the night of Planet Positive and the venue provided easy disabled access and a choice of smoking and non-smoking rooms.

The café Heaven@151 catered for the night with spectacular food including tandoori chicken salad on roti bread, asparagus wrapped in beef with wasabi mayonnaise and assorted frittatas. The mini spicy glass noodle boxes went down particularly well!
Our thanks to the fabulous team at Heaven's Door and Heaven @151 for their fantastic hospitality, food and warmth. Kye from Heaven@151 donated a door prize of 2 free flights to anywhere in Australia and moved the winner to tears! Thanks to all the staff and volunteers who made the evening such a success - Brian, Joe, Kye, Pike, Edmond, Jamie, Tyrone, Steve, Colin, Tony and Robert.

Since feedback from those who attended on the night has been very positive, we'll be holding the next event at Heaven's Door (147 Commercial Road) again on **Wednesday 5 April**. Please continue to let us know what you think of events like these, and we'll continue to improve them!

Planet Positive is a free bi-monthly social group for people with HIV/AIDS and their friends. Free first drink and food provided. For more information call Suzy on 03 9865 6756 or email planetpositive@optusnet.com.au.

Suzy and Tony in front of the PLWHA Victoria Stand at Midsumma

Can you spare a day a week to volunteer on an exciting community project?

If so, we are looking for volunteers to help co-ordinate PLWHA Victoria's gardening project, Positive Plots.

Positive Plots is an initiative to give HIV positive people the opportunity to form new social networks and pursue a hobby at no cost in a community garden setting. The garden plot is designed as a pirate ship and is located in St Kilda's famous Veg Out Community Garden. We are looking for volunteers with experience, interest or passion for all things green and who can spare a day a week overseeing the design and maintenance of the plot. Experience of working with volunteers is desirable but not essential, as is an understanding of how HIV can impact on people's health.
For more information contact Suzy on 03 9865 6756 or suzy.malhotra@plwhavictoria.org.au

What's Up:
News and Information

Well, Well, Well and T-Cell merge for Autumn program on JOY 94.9

Due to changes in the Autumn program grid for JOY 94.9 *'Well, Well, Well'* and *'The T-Cell Variety Hour'* will merge into one program under the banner of *'Well, Well, Well'*. The program will be split into two distinct segments to continue providing listeners with current news and information on gay men's health and well being and HIV specific issues for people living with HIV / AIDS. The program will air Thursday evenings from 8pm to 9pm, presented by Tex and Kylie from the Health Promotion Program at the Victorian AIDS Council / Gay Men's Health Centre. We are always looking for new stories and information for the program as well as feedback from listeners. If you would like to hear about a particular service or have a suggestion we'd love to hear from you. Please contact Kylie or Tex at the VAC / GMHC on 9865 6700.

Healthy Living Skills National Pilot Project – A guide to living well

The impact of antiviral therapy on HIV has increased the life expectancy of people living with HIV/AIDS. However, long term use of antiretrovirals has lead to the development of health complications due to side effects from the drugs such as increased risk for diabetes and cardiovascular disease. The Healthy Living Skills Pilot Project developed by PLWHA Victoria (and funded by AFAO and NAPWA) will address these key risk factors by providing you with information, life skills and support to implement lifestyle changes related to diet, exercise and smoking cessation.

A number of workshops (developed with the Alfred Hospital and the Positive Living Centre) and support systems have been developed that will help you make changes in your life in terms of developing healthier living strategies and skills. The workshops will target the following areas:

Smoking cessation
The 'Quit It!' smoking program (developed with Quit Victoria) will provide specific information on increased vascular risk associated with antiviral therapy and the benefits of smoking cessation for improved health. **Program begins – 13 March.**

Exercise
Provides specific information on the benefits of exercise to reduce cardiovascular risk, diabetes and muscle wasting from nucleoside analogues. You will be linked in with exercise routines/classes and access to a gym either via the PLC, the Alfred or via sponsorship from private gyms. You will receive a manual and diary to record your progress and review all information presented including weekly exercise routines. **Workshop begins – April.**

Nutrition
Provides specific information on nutrition, shopping and cooking to manage or reduce risk factors associated with cardiac risks and lipids and dietary factors for diabetes. You will be given a diary to record your progress and observations, as well as a manual to review all the information presented including a weekly shopping list and cookbook section. **Workshop begins – May.**

As well as being able to tap into a number of workshops to learn new skills and information, you will also receive one-on-one support to monitor your success and offer support and encouragement. The ultimate aim of this project is to provide you with the confidence to make positive changes to your life, to learn new skills and also to develop the ability to maintain these changes in the long term.

These workshops will all be taking place within the next 3 months and you can join one or all of these sessions. If you are interested in signing up to this project or finding out more information, please contact Suzy on 03 9865 6576 or email suzy.malhotra@plwhavictoria.org.au.

Positive Living Centre
31 – 51 Commercial Road, Prahran

www.vicaids.asn.au

Community Announcement

Fundraising Event

'Trivia Night' Extravaganza

- The Positive Living Centre and Community Support Program is holding its annual **'Trivia Night Extravaganza'** at the **Caulfield Town Hall** on **Saturday 22nd April** from **7pm.**
- Games commence at **7.30pm Sharp.** The night will be fun filled with **celebrities and other entertainment**.
- The cost is **$15.00 per person**. Group bookings welcome. **Tables of 10 available for $130.00**
- All proceeds will go towards **supporting services for HIV positive people** provided through the **Positive Living Centre** and **Community Support Program**.
- Bring your banquet and drinks and prepare for a fun night! Test your knowledge on a wide range of questions.
- **Tickets available from the PLC on 9863 0444** and must be pre-purchased. Refreshments are included. Donations toward the night are also welcomed.
- The **Positive Living Centre (PLC)** is a vibrant and safe environment for all people living with HIV/AIDS (PLWHA). The PLC's main aim is to enhance the health and well-being of HIV positive people, through the provision of social, emotional, recreational, and skills-based services and activities.
- The **Community Support Program (CSP)** is a volunteer-based Program that offers regional support to people living with HIV/AIDS and consists of a team of skilled Client Support Officers (CSO's) who offer case-work, and utilise the skills of trained volunteers, to provide support in accordance with identified needs.
- We hope the Community will support this night of fun for such a good cause.

We are seeking sponsors to help support the night

Positive Living Centre
51 Commercial Road, Prahran Vic 3181
Phone: (03) 9863 0444 Fax: (03) 9820 3166

PositiveWomen

Supporting Women Living with HIV/AIDS

Farewell Karen

As you all know I am officially taking leave as of the 16th February for six months to take on my new role as 'Mum.' I am very excited and also very ready to start this chapter in my life.

We have Danielle, our new Support/ Community Development Worker, starting on March 6th. I hope everyone in the community will all make her feel welcome and that the positive women will attend the various projects and events that are in the making whilst I am on leave. I see this as a great opportunity for the organisation to have a set of fresh new eyes on the role of Support Worker and approach the job from a completely new angle. Danielle's written a piece for this Poslink to introduce herself; you will of course have plenty of opportunity to meet Danielle in the flesh during her time with the organisation.

I'll pass on a photo of Bubs to Alan to put in the next Poslink. Hopefully I will get a few weeks rest before he/she decides to come but to be honest I'm more intent on meeting this crazy acrobat that has been inhabiting my tummy!

Thanks to everyone for your support and in the immortal words of Johnny Young 'Take care of yourselves, and each other.'

Karen

Welcome to Danielle

Hello everyone.

My name's Danielle and I'm going to be the new Support Worker at Positive Women as of March 6th. Karen (who as I write this is growing still, and getting increasingly closer to her due date), will soon be very busy looking after her new bubba and adjusting to life as mum. So that leaves me excitedly stepping into this role.

I'll tell you a brief bit about myself, but I do hope that over the coming weeks and months, I'll be able to meet you all so we can get to know each other properly!!

I have a background in Counselling Psychology, and have worked in various areas including illness and injury, with adults, children and families. I was first drawn to working in the HIV area around 6 years ago. I was becoming increasingly aware of the need for greater support, advocacy and education in the HIV area. I was a poor uni student, and the only kind of contribution I could give was of my time. So I became a volunteer counsellor with AIDSline. Looking back on my time working at AIDSline, I like to think that I was able to help many people through some tough times. Basically, my role was to be a nonjudgmental, friendly, and caring person at the other end of the phone who could listen, chat, provide information, support and referrals as needed. I hope to fill a similar role here.

Positive Women has so many fabulous, inspiring, and passionate women involved in this organisation, I feel privileged to be a part of it, and I look forward to learning from and working with you all.

I hope that as a Support Worker I'll become a person you can trust, talk to, cry with, laugh with and share with. I ask you to please let me know what it is you want and need from me as a support worker, and what kind of events you are interested in for the coming year. I know Karen has a few things in the works, and I'll certainly ensure we keep having the great events and activities that you've enjoyed in the past.
I will continue to write the Poslink articles for Positive Women to keep you in touch with what's happening at the organisation.

See you in March.
Danielle.

QUIT IT!

A free 4 week course to quit smoking for people with HIV/AIDS

Monday 13 March, 7pm
Positive Living Centre
31 Commercial Road, Prahran

Share your experiences, get one-on-one support/information and find out more about how smoking affects you and HIV

To book a place or for more information call Suzy on 03 9865 6756 or email suzy.malhotra@plwhavictoria.org.au. Anti Cancer Council of Victoria QUIT *FRESH START* course provided by PLWHA Victoria as part of the Healthy Living Skills Pilot Project.

Special Feature

Positive Men **and** Sexual Health

By Garrett Prestage

Reprinted with permission from Talkabout Issue 142

Many HIV-positive men have anal intercourse without condoms, although much of that is with other HIV-positive men. While HIV transmission may not be an issue in those cases, transmission of other sexually transmissible infections (STIs), such as syphilis, is much more likely in these circumstances. But until recently we were uncertain just how much of a problem that was.

The Positive Health study has interviewed several hundred HIV-positive gay men for the past few years. The men are interviewed each year on a broad range of topics. This year we also tested the men for STIs, as was previously done in the Health in Men study of HIV-negative men.

Of the more than 200 men in Sydney who are part of the study, 177 men agreed to be tested. These men were similar to other samples of HIV-positive gay men in Sydney.

About one in ten tested positive for gonorrhoea, mainly in the throat and a similar proportion tested positive for chlamydia, though mainly in the rectum. A quarter of the men had ever had syphilis, while 4% had been diagnosed with syphilis in the previous year. About 1% tested positive at the time of their interview but had not known they had syphilis.

These are frighteningly high rates of infections for these STIs, and in some cases the long-term consequences to one's health can be very damaging, particularly from untreated syphilis.

Only about half reported being tested for STIs in the previous year, including just half of those who tested positive for an infection at the time of their interview. These high rates of recent and current infection, and sporadic testing patterns, indicate a need for much more attention to STI screening, treatment and prevention among HIV-positive men.

There is no reason to assume that the men at greatest risk of these STIs would be any different to those who engage in risk behaviour in general, or, indeed, to the men who have recently seroconverted: Men who regularly participate in gay party scenes and who are 'adventurous' in how they play.

Sex and drugs are played heavy in some gay sex cultures. Some men are fully immersed in those cultures and some just play on the edge of them. But the very nature of playing hard and heavy, and with lots of partners, necessarily means that the risk of infections is high.

On the other hand, these same men are also usually well-informed and have quite detailed understandings of ways they can minimise the risks of infection. For the most part they are not ignorant, nor are they irresponsible, nor are they just drugfucked. They are simply weighing up the risks and making calculated decisions about the relative risk: "If I just do it in this particular way, and with these particular guys, then I'm probably pretty safe."

Usually we think this sort of reasoning is applied to HIV transmission, but I suspect it also applies for STIs as well. The difference, though, is that few men seem to actually understand the real risk to their health that some STIs, particularly syphilis, pose.

Nor is there the same attitude about protecting one's partners that seems to apply in the case of HIV. When it comes to HIV transmission, most positive men appear to use a variety of strategies to lessen the risk of infecting their partners. However, when it comes to STIs, a different attitude prevails: "This isn't a big deal and it's easily treated, so we don't need to worry about it." On one level that is true - but the potential long-term risks for people with a compromised immune system are suffi- ciently serious that it should be a factor in these calculations.

The more fundamental question is: Can we prevent STIs among positive men - and among gay men in general? If, by that, we mean a change in sexual behaviour, I suspect we can only expect to have limited success. To fully prevent STIs like Chlamydia & gonorrhoea & even syphilis, we would need to be promoting condom use for oral sex, and a drastic reduction in partner numbers. This has never happened among gay men - even at the height of HIV transmissions. Some gay men may have had fewer partners - but only for a very brief period. And almost none have ever used condoms for oral sex.

However, we did virtually eradicate syphilis among gay men in Australia, and reduced other STIs to negligible rates. And the only sustained change in behaviour was condom use for fucking, which is the one thing that has changed in recent years to account for why these infections have increased - fewer men are using condoms consistently now than was the case just a few years ago. While pos-pos sex does not transmit HIV, and while neg guys always being the top may, possibly, reduce some of the risk of HIV transmission, neither of these strategies does anything to reduce the transmission of other STIs - and probably actually increases it.

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And we should not pretend this is just a problem for HIV-positive men. In an equivalent study of HIV-negative men - Health in Men (HIM) - about 1% tested positive for undiagnosed syphilis and about 8% had either gonorrhoea or chlamydia. Also in an earlier study of gay men recently diagnosed with syphilis almost half the men were HIV-negative.

While these infections may be more common among positive men, there are probably just as many negative men with STIs as positive men.

It is my belief that we can probably beat syphilis back to a state of virtual nonexistence, and substantially reduce the other STIs as well, at least in the short-term. And I think we can probably keep them relatively under control in the long-term as well. But we have to adopt a short-term and a long-term strategy.

One short-term strategy is to ask men to return to consistent and universal condom use for anal sex with ALL casual partners for a period of time - probably at least six months - regardless of how well you know them. And while it is important to emphasise the health risks posed by syphilis, especially for positive men, I think a major point of this is the protection of the community: We all need to do this, in a concerted and consistent way, for a sufficient time to quickly bring the rate of transmission down - both to protect positive men from serious risks to their health, and because we have a responsibility, as a community, to do it. And this needs to be accompanied by better testing for STIs.

Which brings me to the long-term strategy. While we need to get gay men testing for these STIs, and treating them, in the short-term so we can quickly bring their rates down, we also need to reinstate a culture of testing that will ensure that STIs are more quickly identified and treated in future, so they never approach epidemic levels again.

But there is an obstacle: Most gay men are probably tested for STIs every 1-2 years. We now have guidelines that emphasise testing every twelve months. But the infections occur mainly among highly sexually active men, and the period of infectiousness implies a much shorter turnaround than twelve months. Prior to HIV, most gay men got tested for STIs every six months - we somehow learnt it as part of our initiation into gay life. It seems very odd that we now ask them to test less often than we did back then, even though the risks posed by STIs may be even greater than they were back then. It might be more appropriate to consider more regular testing for these men, such as every three months.

Another obstacle is the one size fits all approach. While the guidelines suggest that those who are more sexually active should test more often, that is offered more as an afterthought, and there are no definitions for 'more sexually active' or 'testing more often'. Knowing that the most sexually active men are actually the driving force of our STI epidemics, it makes sense to focus our primary effort on them, to help them decide precisely how often they should be testing, and why.

The final issue is knowledge. While most gay men know about STIs, they do not necessarily know the important details, like symptoms, routes of transmission, periods of infectiousness, or treatment. Again, I think we did much better at this before HIV. The men who are most at risk of STIs, and especially the positive men, are generally well-educated and have proven themselves capable of evaluating highly complex information about infection and disease. If we ensure that gay men are properly informed about STIs, then they will complement regular focused testing with early recognition and treatment of actual infections. I think these are doable tasks, both as short-term and long-term strategies. The short-term task is definitely a challenge - but it could be achieved in a relatively short time. However, it would be useless if it was not backed up with a clear strategy to ensure that gay men adopt comprehensive and reliable STI testing and treatment in the long-term.

Garrett Prestage is a researcher at the National Centre in Epidemiology and Clinical Research and the opinions expressed here are his personal views.

HIV Consumer Committee
The Alfred

The Statewide HIV Service at The Alfred is establishing a committee with an aim of assisting us to develop ways to gain input and feedback on our service. We are seeking people who are HIV positive and use our service. Verbal expressions of interest are sought by 24th March 2006.

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Treatments Update:

what's new, what's changed

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DHEA for depression

A New York study published in the *American Journal of Psychiatry* has shown that DHEA is effective at treating sub-clinical depression in people with HIV. DHEA (de-hydro-epi-androsterone) is a naturally occurring molecule that the body produces for normal function and production of testosterone. Levels of DHEA can be low in people with HIV or as people get older. 145 people were randomised to receive either 100mg to 400mg DHEA daily or placebo. After 8 weeks, response rates were 56% for the DHEA group versus 36% for the placebo group. Researchers concluded that DHEA was superior to placebo in reducing depressive symptoms. While advocating for more research, the investigators concluded that DHEA may be a viable alternative for the treatment of non-major depression in people with HIV who are unwilling to take antidepressants. [*Editor's note: It would have been helpful if this study had a third arm comparing DHEA to placebo and an antidepressant. This would help to show the differences in efficacy between the DHEA and an antidepressant. DHEA is available on prescription from 'compound' pharmacies in Australia but it is not cheap. It is illegal to import cheap DHEA into Australia through internet purchases unless your doctor fills out a TGA importation certificate for a restricted substance for Customs.*]

Resistance identified for atazanavir

A study in 62 people has identified 8 resistance mutations (changes in the virus) that are associated with reduced efficacy for ritonavir boosted atazanavir. The mutations identified were 10F/I/V, 16E, 33I/F/V, 46I/L, 60E, 84V, 85V and 90M [the number corresponds to the position of the mutation on the protease enzyme and the letter is the symbol for the name of the amino acid]. 100% of people with only one or no mutations showed virologic response to boosted atazanavir, efficacy began to decrease with more than one mutation while only 42% responded with 3 mutations. More than 3 (4 +) of these mutations rendered the drug ineffective. The researchers were quick to point out that atazanavir works well in previously treated people compared with other protease inhibitors.

Prostate cancer may be linked to XMRV virus

Researchers in the USA think they may have discovered the mechanism behind prostate cancer. They noted that there was a high number of men with the cancer who express a specific antiviral gene. After screening for 5000 viruses they found that a virus similar to one that causes leukaemia in mice could be isolated in 45% of the men they were testing. This has lead them to believe that a virus called XMRV may be responsible for causing prostate cancer and could be sexually transmissible. Researchers agreed that more research is required to confirm their findings and that a vaccine may one day be able to prevent prostate cancer.

Key news from the 45th Interscience Conference on Antimicrobial Agents and Chemotherapy

Hepatitis C key reason for liver problems from anti-HIV drugs

Three studies were presented displaying implications of liver toxicity that were related to Hepatitis C (HCV). The first study in 256 people (21% women) with HIV and starting anti-HIV treatments resulted in 4% (10 people) liver toxicity. 30% of participants had HCV. 88% of the patients with liver toxicity had HCV and frequent alcohol use increased the risk of toxicity by 3 fold (300%). In a second study of 226 co-infected people investigators reported that 33% of people with cirrhosis (severe liver disease) displayed more liver toxicity with nevirapine than with Kaletra. A third study indicated that people with HCV genotype 3 were 3 times more likely to experience liver toxicity than people with other HCV genotypes.

TMC 114 + T-20 power on

24 week results from the POWER-2 study were released showing that boosted TMC 114 (darunavir) is superior to other boosted protease inhibitors in a heavily pre-treated population. 225 people were in the boosted darunavir + optimal background therapy (OBT) arm with or without T-20 (Fuzeon) compared with 53 people taking placebo with OBT only. 78 – 83% of people in this study had virus that was resistant to Kaletra. 4% of people in the OBT arm only (without T-20) achieved an undetectable viral load (less than 50 copies/mL). 30% of people in the darunavir + OBT arm had an undetectable viral

load. 64% of people taking darunavir + OBT with T-20 achieved an undetectable viral load. Data showed that people in the darunavir arm experienced more severe side effects than the OBT placebo arm (28% vs 19%). [*Editor's note: Darunavir is now available through a special access scheme via your doctor. It is always a good idea to use at least two or more active drugs (drugs with no viral resistance) when starting a new combination whenever possible to ensure the best chance to be able to control the virus. As this study has shown, in people with few treatment options, using T-20 for the first time with darunavir along with other drugs appears to be very efficacious.*]

New drug lowers blood fats

Ezitimibe, otherwise known as Zetia, is a new drug that prevents cholesterol absorption across the intestines. It improves blood lipid values alone or in combination with lipid lowering agents called statins. In this study investigators tested 10mg/day of ezitimibe with pravastatin in people taking HIV drugs who did not have a good cholesterol lowering response to 20mg/day pravastatin alone. 18 people were enrolled into the study (39% women). Normal total cholesterol was achieved in 53% of participants and triglyceride levels also fell considerably. While emzitimibe is not thought to be associated with drug interactions via the liver, it did cause nevirapine trough levels to fall by an average of 17% and caused an increase in protease inhibitors by 10%.

GSK Protease inhibitor

Brecanavir (640385) is GSK's new protease inhibitor that is meant to have activity against resistant virus. 31 people participated in this study (25 without resistant virus and 6 with virus resistant to protease inhibitors (like Kaletra etc) and nucleoside analogues (like AZT etc). All participants were given ritonavir boosted brecanavir 300mg twice daily along with two nucleosides (excluding abacavir and tenofovir). Preliminary 24 week results showed that brecanavir was associated with a 3.3 log reduction in participants with non-resistant virus while the viral load was reduced by 2.2 log in participants with resistant virus. Two people left the study for reasons unrelated to the study drug, while one person withdrew due to vomiting and nausea and one due to liver toxicity.

Key news from the 13th Conference on Retroviruses and Opportunistic Infections

Data on SMART study presented

In the last issue of Poslink we informed you that the SMART study had been closed early by the Data Safety and Monitoring Board. The SMART study is an international multi-centre trial that had enrolled 5472 people who were randomised to receive either continuous treatment or CD4 guided treatment interruptions, starting HIV drugs at 250 cells and stopping when the count increased to 350 CD3 cells. The trial was originally due to run for over nine years but was stopped early due to significantly more incidences of disease progression in the interruption arm than the continuous treatment arm. Results presented showed the cases of disease progression in the interruption arm were 117 (3.7%) versus 47 (1.5%) cases in the continuous therapy arm. This is equivalent to a 2.5 fold increase increased risk of disease progression in the interruption arm ($p<0.001$….highly statistically significant). Thus it was deemed necessary to stop the study due to the high statistical significance of this difference as the study has already proven that remaining on continuous treatment was less harmful than taking a break and recommend all people be placed back onto continuous therapy.

Investigators also noted that patients were at a higher risk of death in the interruption arm (1.7% versus 0.9%, $p=0.01$) or to have experienced severe disease progression (0.6% versus 0.1%, $p=0.004$).

Even on top of these results, further data revealed an as yet unidentified issue with treatment breaks where people were at a higher risk of serious complications including heart attack, stroke, coronary artery disease requiring surgery and kidney or liver disease (2.1% versus 1.4%, $p=0.04$). It was thought people not taking treatment breaks would be more at risk of these complications due to the toxicity profile of some antiviral treatments. It appears that having a detectable viral load during treatment did not increase the risk of serious complications as opposed to those who had an undetectable viral load. It was stipulated that these serious events may be due to increased levels of inflammation either due to a lower CD4 count in the interruption arm or because of the higher viral load. [*Editor's note: These data are just the first results that will be released from this study. There are more data still to be analysed. A number of people don't believe that the SMART study results will apply to all groups of people as the majority of people involved in the study had been on treatment for an average of 6 years. Thus, the data may not apply to people who are on their first drug regimen who want to take their first treatment break. Also, the CD4 count in this study was relatively low. Some researchers believe there may have been a different outcome if the treatment breaks and re-initiation had been set at higher CD4 counts. One way that I interpret these results is that doctors will now be less comfortable with their patients taking treatment breaks.*]

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

Pioglitazone increases skin fat
French researchers investigated a possible role for the diabetes drug pioglitazone for restoration of skin fat and improvement in blood fats. 130 highly treatment experienced people were randomised to receive pioglitazone or placebo. 28% of the group were still taking d4T, a drug known to cause fat wasting. People not taking d4T showed limb fat increase of 400gm after 48 weeks of treatment. People taking d4T experienced only a 110gm increase in limb fat. There was also an increase of 0.08mmol/L of HDL (good) cholesterol in people on pioglitazone. The researchers concluded that pioglitazone may be an effective treatment for lipoatrophy when not taken with d4T but that more research is required.

Capsaicin patch relieves pain
Up to 30% of people with HIV can be affected by peripheral neuropathy (PN) either caused by HIV or the antiviral 'd' drugs (ddI, d4T, ddC). PN occurs when nerve cells stop functioning properly resulting in pain, burning or tingling in the extremities (hands/feet) which can be severe. A study of a patch containing 8% capsaicin applied to the skin for 30, 60 or 90 minutes versus placebo has shown that the patch was able to reduce the level of pain by 23% in pain scores with the effect lasting from 2 to 12 weeks. Capsaicin is the hot chemical in chilli peppers. A local anaesthetic cream was used prior to the patch application to reduce the burning sensation of the capsaicin. The patients in this study are continuing to be examined to determine the long term effectiveness of the patch.

Another treatment interruption study arm stopped
The CD4 guided treatment interruption arm of the Trivacan study in Africa has been stopped by the Data Safety and Monitoring Board. People in this arm were found to be at a higher risk (2.6 fold) of disease progression and a 2 fold increase risk of death compared to the continuous treatment arm. The Trivacan study consists of 840 participants (77% women) with three arms; continuous treatment, a CD4 guided interruption arm (150 – 350 cells) and a timed interruption arm (2 months on: 2 months off therapy). The timed interruption and the continuous therapy arms of the study are continuing.

Tenofovir and the kidneys
Tenofovir is a nucleotide analogue that is related to other drugs that are known to cause kidney problems, but whether tenofovir causes these problems is still being determined. A number of studies on the affect of tenofovir on the function of the kidneys were presented at the conference. One study with data collated from 10,343 people taking tenofovir showed that kidney problems were only experienced in 1 in 454 people (0.22%). Another study of 11,362 people determined kidney problems as mild (35.1%), moderate (6.4%) and severe (2.6%), with age above 50 years, diabetes and high blood pressure increasing the chance of severe impairment by around 3.5 fold. Other studies also showed a correlation between kidney function and tenofovir but there is a lack of conformity for what constitutes reduced kidney function among the researchers and a failure to control for other drugs that may also cause kidney problems. In general the take home message from the presentations is that severe kidney toxicity associated with tenofovir is low. [*Editor's note: Tenofovir is proving to be a safe drug with minimal problems for most people. Your doctor can easily monitor your kidney function to ensure all is good. Peeing lots and feeling very thirsty is a possible sign of reduced kidney function and should be brought to the attention of your doctor if this occurs.*]

Gilead integrase inhibitor
Gilead have entered the race to market the first integrase inhibitor with a dose ranging study of GS-9137 released at this conference. Integrase inhibitors prevent HIV genetic material inserting into human DNA. GS-9137 interacts with the liver enzyme CYP3A and is expected to have drug interactions with NNRTIs and protease inhibitors. Ritonavir increases levels of GS-9137 by 20-fold. 40 people who were treatment experienced or had never taken treatments were placed onto five different dosage arms and a placebo. Doses were either twice daily at 200mg, 400mg, or 800mg, or once daily at 800mg or 50mg + ritonavir. Viral load results after 10 days were reduced by 1.44, 1.98, 1.78, 0.89 and 2.03 log respectively.

MSD's integrase inhibitor
16-week interim data were released at the conference on the efficacy of the new integrase inhibitor MK-0518 with excellent results. Only 50% of results were available for evaluation from 167 heavily pre-treated people with resistance to three classes of HIV drugs. MK-0518 does not appear to interact with the CYP3A liver enzyme and as such is not expected to have any major drug interactions (still to be confirmed). Participants received optimal background therapy (i.e. whatever drugs might

work) with either placebo, 200mg, 400mg or 600mg MK-0518 twice daily. Viral loads were reduced to under 50 copies in 56-72% in the MK-0518 arms versus 8% in placebo. Side effects were similar between the active drug groups and the placebo group. [*Editor's note: While these results are only preliminary they show great potential for this drug to control viral replication in people who have very few drug options, if any. These results are being touted as the best salvage results to date and it is hoped the good results will continue out to 24 weeks and beyond. MK-0518 should be available via clinical trial in Melbourne soon.*]

Atazanavir/r monotherapy looking good

Simplification from three drugs to just ritonavir boosted atazanavir has been shown to work in 91% of people followed for a median on 194 days. Participants needed to have an undetectable viral load for 48 weeks on two NRTIs (like 3TC) and a PI (like Kaletra) prior to switching their PI to atazanavir/r (300mg/100mg). After 6 weeks people withdrew the NRTIs and remained on atazanavir/r only. 2/36 people had to stop the study prior to single therapy – one withdrew consent and one had a viral rebound. Of the 34 remaining people, 91% continued to achieve undetectable viral loads. Three people (9%) experienced virological failure, two of whom had no measurable atazanavir in their plasma while the third person achieved a sustained undetectable viral load again with boosted atazanavir monotherapy. No PI resistance mutations were detected in any of the three people. [*Editor's note: Monotherapy treatment is starting to look like a possibility, and if proven effective, will reduce the drug burden and toxicity on the body along with reducing the cost of antiviral therapy. Still, more data in large numbers of people is needed before changes to treatment guidelines and standard of practice will be implemented.*]

New atazanavir data in naïve patients

In general atazanavir is taken when boosted with ritonavir (r) following the BMS045 data showing that atazanavir/r appeared to be equivalent to Kaletra. This is how atazanavir (ATV) has been taken in people who had previously used protease inhibitors and those who were on their first protease inhibitor even though there has been no specific data to back up the use of ATV/r in treatment naïve patients. To address this issue 48 week results were released at the conference of 199 people randomised to receive either ATV (400mg) or ATV + ritonavir (300mg/100mg) in combination with other antivirals. The results showed that both arms of the study did well for ATV and ATV/r with 70% and 75% below the limit of detection (< 50 copies) respectively. A similar number of people stopped treatment in each arm however more people stopped due to ritonavir than those not using ritonavir to boost the level of ATV (8% vs 1%). Yellowing of the skin and eyes were more common in the ritonavir boosted arm than the non boosted arm (22% and 23% vs 7% and 13%) respectively along with increases in cholesterol (15% vs 6%). Triglyceride levels fell by 3% in the non boosted arm but increased by 26% in the ritonavir boosted arm. [*Editor's note: This study will continue out to two years which may shed more light on differences in efficacy between the two regimens in the longer term. This data shows that not boosting ATV with ritonavir displays a better toxicity profile and clearly shows the effect of ritonavir on the body, even at only 100mg daily. Most people in Australia will need to continue using ATV boosted with ritonavir as there may be mutations present from previous protease inhibitor use that require higher levels of ATV to treat resistant virus. For those who don't have protease inhibitor mutations, there is the possibility of changing to an unboosted ATV dose (400mg daily) provided tenofovir is not in the combination. Tenofovir reduces ATV levels requiring ritonavir to counteract this effect. A five percentage point difference in efficacy after 12 months may not mean anything now, but this could change out to two years of the study. A wait and see attitude towards these results may be a good idea before deciding whether to change from a boosted to an unboosted regimen*.]

Pfizer CCR5 study glitch

An arm in the Pfizer CCR5 (maraviroc) study has been stopped by the data safety and monitoring board (DSMB). The arm stopped was the once daily treatment naïve arm of AZT + 3TC + maraviroc as it was considered to be inferior to the efavirenz comparator arm. However, the study in general is continuing as a twice-daily maraviroc arm is being permitted to continue by the DSMB. [*Editor's note: As a community we have placed a lot of hope and expectation into the development and success of the CCR5 inhibitors which stop HIV entering into cells. The Schering-Plough CCR5 study has also had an arm stopped following lack of efficacy and the GSK CCR5 drug has been withdrawn following toxicities. My fingers are crossed in hope that this is only a glitch and that maraviroc will still prove to be an effective antiviral agent.*]

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

Hep C protease inhibitor
A phase 1 study of 20 people with Hepatitis C (HCV) genotype 1 (difficult to treat HCV) has shown that the HCV protease inhibitor VX-950 combined with peg-interferon (Pegasys) reduced the HCV viral load to undetectable levels in 50% of people by day 14. VX-950 alone reduced the viral load by 4 log, VX-750 + Pegasys reduced the viral load by 5.5 log and Pegasys alone reduced the viral load by 1 log. A larger phase II trial is now planned to test the new drug in 200 people.

Sexual transmission of Hepatitis C
A UK study of 111 gay men with sexually acquired Hepatitis C (HCV) has identified four key risk factors associated with the sexual transmission of HCV:

- unprotected receptive or insertive anal sex
- receptive and insertive fisting, use of sex toys
- group sex
- under the influence of club drugs during sex

Unprotected anal sex or fisting without gloves all increased the risk of sexually acquiring HCV with group sex greatly increasing the risk. The risk was increased 9 fold (900%) if two of the above practices took place while three or four of these practices increased the risk by 23 fold.

TMC 125 data
Efficacy and resistance data on TMC 125, now known as etravirine, was presented from the TMC125-223 study. etravirine is an NNRTI like nevirapine but has been designed slow the development of resistance (a high genetic barrier) and to work against NNRTI resistant virus. In the 24 week data of the 223 study of 199 people with documented PI and NNRTI resistance, etravirine worked best in people with fewer baseline resistance mutations. In 79 people receiving the 800mg twice daily dose with background HIV drugs the viral load was reduced by 1.82, 1.65, 1.00 and 0.66 log in people with 0, 1, 2 and 3 or more codon mutation points (changes in the viral enzyme) respectively. [*Editor's note: Usually only one mutation is required to lose efficacy of the current NNRTI drugs like nevirapine or efavirenz, thus this new drug is looking very promising.*]

TMC 114 resistance data
The Tibotec protease inhibitor TMC 114 (darunavir) had data presented from the Power 1, 2 and 3 studies. A combined sub-analysis study on the three clinical trials was investigated to determine the resistance mutations required for the drug to stop working. An undetectable viral load was achieved in 1/3 of people with 1-9 baseline resistant mutations. The response rate to the drug dropped off when 10 or more mutations were present. [*Editor's note: 10 or more mutations are a lot more than what is required for other drugs to become ineffective. This drug should display activity in people with multiple resistance patterns to PIs.*]

Treatments Information Service

Do you have any questions about HIV and drug therapies?

Call Alan on 9865 6718

Free Wills

PLWHA Victoria offers members a limited* free will-making service via De Ayers.

For further information, please contact Frank on 9865 6772, and he will arrange for De to get in touch with you.

*Service covers up to six beneficiaries and no provision for setting up trusts, fund management or the like.

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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.

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No appointment necessary. If you wish to be anonymous, you can - we don't ask for your Medicare Card.

Melbourne Sexual Health Centre
580 Swanston Street, Carlton
Telephone: (03) 9347 0244
Opening hours:
Monday - Thursday: 9.00am - 5.00pm
Friday: 1.10pm - 5.00pm

www.mshc.org.au

get wise get screened

If you are a sexually active man who has sex with other men, it is recommended that you be screened for sexually transmissible infections every 3 to 4 months.

Additional clinics specialising in sexual health:
(Medicare card and ID cards are required. Some clinics may charge for services).

The Centre Clinic
Rear 77 Fitzroy Street
St Kilda
Ph: (03) 9525 5866

Carlton Clinic
88 Rathdowne Street
Carlton
Ph: (03) 9347 9422

Prahran Market Clinic
131 Commercial Road
South Yarra
Ph: (03) 9826 4500

Middle Park Clinic
41 Armstrong Street
Middle Park
Ph: (03) 9699 4626