

# poslink



## Calling for Action!

The Newsletter of  
People Living with  
HIV/AIDS Victoria Inc

Information, Education  
& Representation

Issue 46 August 2009  
ISSN 1448-7764

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# Note from the President

Paul Kidd

The decision to start HIV treatments is rarely easy – for many people it is the most difficult decision we will ever have to take in living with HIV. Despite all the advances of recent years in improving the effectiveness and tolerability of HIV treatments, the prospect of lifelong treatments, with the possibility of serious or unpleasant long- and short-term side effects, is a daunting one.

It's understandable that many people with HIV want to delay this decision as long as possible. Taking treatments provides a daily reminder of the reality of dealing with HIV and the prospect of illness in the future. Once you start treatments, you're expected to stay on them for good. And if you are unable to take them with the precision demanded by your doctors, you run the risk of developing resistance.

But despite these issues, in my experience most people with HIV are prepared to take the plunge when the time is right – the problem is in knowing when that time has come.

The debate about the best time to start HIV treatments is almost as old as the treatments themselves and the so-called 'pendulum' of scientific opinion has swung backwards and forwards in the interim. From the early days when 'hit hard, hit early' was the slogan, to the 'delay treatment to avoid long-term toxicities' period, to the present day, when most experts agree that 'somewhere in-between' – perhaps around the 350 CD4 count – is the sweet spot.

But despite all the clinical experience and findings from clinical studies (each of which seems to contradict the one

before) there's still no consensus about when is the best time to start treatments. And some experts are now arguing that there could be benefits in starting earlier – maybe at the 500 mark or at the point of diagnosis no matter what the CD4 count.

All of this confusion certainly does not help people with HIV make that critical and difficult decision. We need a definitive, scientifically verified answer which will make it possible for us to plan, prepare and take the plunge when the time comes.

The good news is that that answer is coming. A major international clinical trial called START (Strategic Timing of AntiRetroviral Treatment) will try to determine, once and for all, whether starting treatment at 350 or 500 CD4 cells is best. The START trial will involve 900 people with HIV who have not yet started treatment, in several countries including Australia, who will be randomly assigned to start treatment at one of these two CD4 counts, and will be followed for five years.

This is a potentially groundbreaking piece of research which will do much to inform our understanding of HIV and will provide much-needed information for positive people. While the decision to start treatment is, and should always remain, a personal one, the findings of the START trial will at last provide solid information to assist in making that decision.

The START trial is enrolling now at several clinics around Melbourne. You can read more about the trial at [www.napwa.org.au](http://www.napwa.org.au), or ask your doctor.

## Calling for Action - Cover Picture

Protesters rally outside the 5th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention in Cape Town, South Africa. Organised by the Treatment Action Campaign (TAC), they were calling for an increase in resources for HIV treatment and prevention in Africa. Source - International AIDS Society.

See Page 9 for a report on the latest findings presented at the conference on Anal Cancer.

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# Swiss Supreme Court Overturns HIV+ Man's Conviction for Unprotected Sex

Tim McElreavy

The Federal Supreme Court of Switzerland has upheld the decision of a lower court to overturn the conviction of an HIV-positive man for having unprotected sex with two former girlfriends. Initially condemned to 18 months in prison, the 30-year-old man from Geneva appealed the conviction based on the controversial defense that his undetectable viral load did not constitute a risk of transmitting HIV even during unprotected sex. Article 231 of the Swiss Penal Code makes it a crime to knowingly propagate an infectious disease, which is punishable by one month to five years in prison.

However, a 2008 statement by the Swiss Federal Commission for HIV/AIDS published in the Bulletin of Swiss Medicine (Bulletin des médecins suisses) resolved that "After review of the medical literature and extensive discussion, an HIV-infected person on antiretroviral therapy with completely suppressed viremia ('effective ART') is not sexually infectious, i.e. cannot transmit HIV through sexual contact."

This position has widespread implications for both the Swiss medical establishment and the Swiss legal system. The authors of the statement pointedly addressed the legal ramifications by stating: "The Commission thinks that unprotected sex between a positive person on antiretroviral treatment and without a sexually transmitted infection (STI), and an HIV-negative person, does not comply with the criteria for an 'attempt at propagation of a dangerous disease' according to section 231 of the Swiss penal code nor for 'an attempt to engender grievous bodily harm' according to section 122, 123 or 125."

Based on a number of international studies on HIV transmission, the commission members specified that transmission cannot occur if the HIV-positive individual has an undetectable viral load of <40 copies/ml blood and adheres to a medically approved treatment regimen.



In the first test of this position within the Swiss legal system, the HIV-positive defendant was found to meet both these criteria. Furthermore, neither of the women with whom the defendant had sex has contracted HIV. Defense lawyer Yves Bertossa argued, "On ne condamne pas les gens pour des risques hypothétiques." ["We do not condemn people for hypothetical risks."] The court's decision will have far-reaching implications within the international HIV/AIDS community.

Several HIV/AIDS advocacy groups as well as scientists from around the

world have expressed both skepticism and consternation over the controversial position. "Not only is the Swiss proposal dangerous, it's misleading and it is not considering the implications of the biological facts involved with HIV transmission," said

Dr. Jay Levy, director of the Laboratory for Tumor and AIDS Virus Research at the University of California in San Francisco. For example, most of the studies cited by the Swiss experts followed heterosexuals having unprotected vaginal sex and did not include homosexual men having unprotected anal sex. Unprotected vaginal sex with an HIV-positive individual with an undetectable viral load carries less of a risk of HIV transmission than unprotected anal sex.

Furthermore, the United States Centers for Disease Control maintain that there remains a risk of infection even from individuals with an undetectable viral load. The CDC recommends using condoms and other safer sex practices to reduce the risk of transmission.

[www.carnalnation.com](http://www.carnalnation.com)



# My Story

by ANON

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It all started in 1981 I think, with an advertisement in the Melbourne gay magazine *Outrage* – a meeting to discuss important gay-health issues to be held at Melbourne University Dental School in Carlton. The location seemed very serious and it was. Many hundreds, mostly gay men, turned up and we were told in hushed tones that a new plague of a sexually transmitted disease from the US, nearly exclusively attacking gay men, was arriving in Australia, and it was fatal. This was a virus which had no cure, no vaccine. But the speakers went on to say that only about ten per cent of people infected would not die. Wow, I thought, at least I'll be in that ten per cent! Twenty-eight years later, I am still here and carrying this virus called HIV, now labeled a chronic disease. How happy am I to be alive!

A revisit to the sixties in Sydney...for a young country boy not too sure of his sexual orientation, life in Sydney was quite exciting, but still not the gay mecca it is today. There were probably only two openly gay bars, the Purple Onion, later to become Kens at Kensington, and the mysterious Chez Ivy at Bondi Junction, a favourite haunt of mine. Seeing Dusty Springfield through the smoky haze of a late night bar was something to make a young man dream of other lands and adventure. Cruising hungrily the public toilets at Town Hall Station or St James, or doing the beat at Rushcutters Bay, this was my life in Sydney in the mid-sixties. But it was not long before I escaped the shores of Australia and discovered life elsewhere. Having missed the first draft for National Service, many of whom selected were sent to Vietnam, my war experience was vicarious - having sex with some of the American servicemen on R and R in Sydney. It was through one of these contacts I was given a list of addresses of gay men all through the USA, something I never thought I would use, but I did.



After driving taxis in Sydney for a while, through a contact I made I managed to secure a work-away passage on a German freighter going to Los Angeles. So in 1968, not long after the death of my father freed me from any responsibility of having a career, I was able to quit Australia. This was the beginning of a seductive five year journey which just grew from meeting people, being friendly, and from accepting opportunities when they presented themselves.

I spent six months in the USA, where at one stage, broke and without a visa in NYC, I had to resort to the oldest profession to earn enough dollars for a ship's passage to France. Like many young travelers, especially Australians, I took risks and was unaware of taking them. In Morocco I bought a kilo of the best hashish to help a fellow traveler out of a money problem, and subsequently travelled back to Paris where it was a welcome source of money for the few months I had before getting some work.

My sexuality had up till now been totally open. The French certainly helped me in this regard as they are not like the Anglo-Celtic race with whom I had grown up. I embraced my new life with abandon: I just loved everyone.

I obviously preferred men, but I didn't realize I was creating a habit that might land me in a lot of potential trouble in the years to come. I became literally addicted to sex with men, at age twenty five, and it lasted for the next twenty years. So this is the background I came from, when on that fateful day in 1981 the arrival of AIDS, then called GRID, gay related immune deficiency, was announced in Melbourne.

As sexual freedom was so rampant in seventies, some conservatives considered the arrival of AIDS a retribution for the perceived excesses of the gay population. But through the excellent and immediate intervention of the Federal Health Minister, Neil Blewett, later to come out as gay, a big budget was committed to the fight, including the "Grim Reaper" TV campaign, which virtually threw the whole of Australia into red-alert. In Melbourne the Victorian AIDS Council was quickly established and much important groundwork was done. We had training to become AIDS Mates, helping those who had become very ill not to feel abandoned. But die they did; first a few, then dozens, and eventually up to hundreds. The eighties were a wake-up call that many of us were slow to heed. It was a battle-zone, but safe-sex was still new and we didn't want to know too much about it. My life

was in turmoil as I thought at that stage I wanted to get married, and to a woman! Perhaps I wanted to get away from it all, but ironically it was this decision which resulted in my positive conversion in 1983.

One night after a big fight with my girlfriend and feeling like shit, I went out to the sex bars and completely trashed myself. Any drugs that were available I took, and in particular I had very unsafe sex which landed me a week later with flu symptoms, the evidence of sero-conversion. But as usual I went into total denial, got better immediately, and 'forgot' what I had done. A few months later I decided to leave Melbourne to go back to interstate where my mother was getting older I needed to be nearer to her.

The next fifteen years I really spent in denial, and was terrified of the drugs being given. However in the nineties things changed when AZT was virtually banished and the new tri-therapy arrived. But it was not till 2006 when finally my weight had suddenly dropped 10 kilos and I saw PCP on the horizon that I asked my doctor for the new medications. I responded well, got my weight back and was then thrown into the Health system where I had excellent support from the local country Positive Support Network. It was good to see others like me, and many in worse condition, who were living well and optimistically. After three years my Mum finally decided to quit the realm I was given the green light to return to Melbourne. Like all other positive people, I have experienced the negative health aspects of being positive. I now literally know what 'shitting yourself' means, and my bowels have never returned to their original habits. But I am leaning to be careful about all health issues, diet being a big one, along with regular exercise and a having good mind space. Daily contemplation gives me a good preparation for the rest of the day.

The years I experienced in the early eighties were times when the seeds of a great community organisation were to grow. The Positive Living Centre in Prahran gives fantastic support to its clients and this may sound crazy, but sometimes I think I was lucky to be given the virus, if only because it makes me constantly vigilant. Being on medication for the rest of one's life is not what I had planned to do, but I can live with that. After all, I am still alive and have lots more to do.

So now, as an aging positive man, what IS there to do? They say sixty is the new fifty, but even that doesn't matter. No longer does one walk down Chapel Street and exchange meaningful glances - no, these days are well and truly over. My raging 'fire-down-under' is more like embers I am happy to say, but there are different things to do with embers. Relationships are now built on warm friendships, with both sexes. These are much more enduring than the one-night-stands which we had to have, sometimes seven nights a week! Thank God they're over. That doesn't mean I've lost all desire. On the contrary, I appreciate people more, take time to get to know them, and subsequently have richer relationships. The saunas are always there - good for eye-candy and very relaxing, but even they do not draw me as before.

Everyone is younger, but with age does come a little wisdom, and there are times when you can tell stories of the good old seventies to some younger ones, still doing all that we did then, but with different drugs, and let them know that it doesn't last, and that drugs aren't the answer. But we all have to go through these experiences, and you can smile and say, 'enjoy yourself!' Discrimination still exists but less now, I think. I remember getting bashed at Rushcutters Bay one night; these days it's more likely to meet for a drug deal! In the 70s in London, 'cottaging' resulted often in ending up in the Bow Street Court for 'Indecent Exposure', (in my case not once, but twice!). At least I am in exalted company here as in 1953 famed actor Sir John Gielgud's similar conviction made cottaging a cause célèbre.

On reflection, there have been milestones in my life, and some I was unaware of. - like dancing disco-beat at a hot Afro-American bar in the Village in NYC in 1969, while not far away history was happening at Julius's bar; the Stonewall gay revolution was at my feet and I didn't know it! But a few weeks earlier joining the mile long queue of sobbing mourners to pass the coffin of Judy Garland I do remember. In 1978, nine years later, I was to take part in Sydney's gay history, the gay protest march which resulted in the establishment of Mardi Gras. That was a day and night to remember with relish.

The tapestry of gay culture is rich and colorful, and for most of us it was better to be 'out' than 'in' as there was much to savour. What will the next chapter hold? As an experienced carer for older people I think I know what this will entail, and it is something which I know we'll be ready for. Gay people are naturals in the Arts and in the Care professions, and when the inevitable happens, as we are all getting older with HIV, we need to have a say in our futures. That's why being gay, although a private thing, is intrinsically political: Gay Rights, in all areas, are essential, and we must continue to work towards total equality.

So we have come some way, and the arrival of AIDS has brought in its horrific wake a huge development of a gay community which did not exist before. In my life I have no regrets although I have done some crazy things. I hope I've learned some good lessons from my experiences which will help me create the next stage of my life, just as exciting, but hopefully a little less dangerous and self-centred than in my youth.





## Annual General Meeting

Sunday 18 October 2009 at 12pm  
Positive Living Centre  
51 Commercial Road Prahran

Join us for an annual review of the activities of People Living with HIV/AIDS Victoria, election of board members, presentation of Annual Awards and acceptance of reports and financial statements.

All members and supporters of the organisation are encouraged to attend.

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### Call for Board Members

People Living With HIV/AIDS Victoria is seeking HIV-positive people who are enthusiastic and visionary team players to nominate for election to its Board of Directors.

As a Board member, you will have the opportunity to influence the strategic direction of the organisation and contribute to the organisation's work representing positive people in Victoria. Board members are supported through mentoring and provided with training as needed. We are seeking people from all sectors of the HIV community who can bring their own experience and passion to the work of the organisation and effectively represent the diversity of our membership.

**Nominations must be received by  
5pm on Friday 9 October 2009.**

**An election will take place at our Annual General Meeting, Sunday 18 October 2009**

Nomination forms are available from  
PLWHA Victoria, 6 Claremont Street, South Yarra VIC 3141 or by calling BH (03) 9865 6772

# Australian survey to shed light on treating herpes "Down Under"

Australian Herpes Management Forum

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Australians living with the nation's second most common sexually transmitted infection (STI) are being urged to convey their experience and challenges by completing an online study.

The Australian Herpes Management Forum (AHMF) is calling for people who have been diagnosed with and treated for genital herpes to participate in the Genital Herpes Patient Perspectives Survey of herpes management and treatment practices. The survey, located at [www.ahmf.com.au/herpes-treatment-survey](http://www.ahmf.com.au/herpes-treatment-survey), will provide an up-to-date snapshot of the views of Australians living with genital herpes.

According to leading infectious disease expert, Professor Tony Cunningham, Director of the Westmead Millennium Institute and Research Centre, Westmead Hospital, Sydney, the online survey has been designed to improve clinical understanding of patient experiences and thoughts on the most effective treatments available for genital herpes.

"Gathering Australian-specific information about current experiences with treatment will allow the healthcare community to respond directly to the needs and concerns of people living with genital herpes.

"It is important that people with genital herpes understand the treatment options available and can evaluate which option is best for them, particularly given that 12 per cent of Australians over the age of 25 are carrying the virus," said Prof Cunningham.

All survey respondents will be canvassed on their diagnosis and treatment experience. In particular, they will be asked for their thoughts on episodic treatment [treating the genital herpes outbreaks as they occur] and suppressive treatment [taking daily medication to reduce the chance of an outbreak occurring]. The information provided by all survey respondents will remain strictly anonymous.

One-in-eight Australians has genital herpes. Evidence suggests that the

incidence of genital herpes in Australia is increasing, particularly among Gen Y. An Australian online survey, conducted in 2006-2007 that assessed a person's risk of contracting genital herpes, revealed that 51 per cent of survey participants were at "medium" risk of contracting the genital herpes virus, while 34 per cent were at "high" risk.

Given that genital herpes is generally transmitted through skin-to-skin contact, most commonly through sexual contact, the virus can spread easily from person-to-person. While some people with genital herpes have no noticeable symptoms, others can experience their first outbreak 2 to 20 days after coming into contact with the virus.

"Most of the time, the genital herpes virus lies inactive and often without symptoms. When re-activated, the virus travels down the nerve paths to the surface of the skin, causing an outbreak," said Prof Cunningham.

"Even after the first outbreak of genital herpes, the virus stays in the body for life.

"It is possible to pass on the virus, with or without symptoms," Prof Cunningham said.

"While there is currently no cure for genital herpes, providing effective, patient-friendly management and treatment options is essential to supporting those living with the virus."

To participate in the Genital Herpes Patient Perspectives Survey, go to

**[www.ahmf.com.au/herpes-treatment-survey](http://www.ahmf.com.au/herpes-treatment-survey)**.

**For more information, or to coordinate an interview with Prof Tony Cunningham, please contact Kirsten Bruce or Michaela Patton from VIVA! Communications on 02 9884 9011 or 0401 717 566 / 0423 877 748.**

# Randomized Controlled Trial Shows Circumcision Does Not Prevent Male-To-Female HIV Transmission

Global Health Council

Male circumcision does not prevent the transmission of HIV from men to their female partners, according to a Lancet study conducted in Uganda, Bloomberg reports.

"Male circumcision unleashed a wave of optimism among AIDS campaigners three years ago when trials in Kenya, Uganda and South Africa found foreskin removal more than halved men's risk of infection by the human immunodeficiency virus (HIV)" from a female partner, the AFP/Google.com writes. "Last year, longer-term analysis of one of the trials found the benefit to be even greater than thought, with a risk reduction of 65 percent." However, researchers questioned "whether male circumcision could also reduce the risk for women who have intercourse with an HIV-infected man. The answer, according to a randomised trial carried out in Uganda, is a clear 'No'".

The researchers recruited 922 uncircumcised HIV-infected men between the ages of 15 and 49 for the study, who were then divided into two groups – those who were "immediately circumcised" and those for whom the procedure was "delayed for two years," Reuters reports.

The researchers also observed nearly 170 uninfected female partners of the men participating in the study, following up with them at six, 12, and 24 months, according to the BBC. The study was "ended early because of what the researchers called the 'futility' of carrying on, and the second group were not circumcised," the BBC writes, adding "only 92 couples in the immediate circumcision group and 67 in the control group were included in the final analysis". The analysis found that "18 percent of the female partners of the circumcised men became infected with the virus compared with 12 percent of the partners of men who hadn't undergone the procedure," Bloomberg writes.

All participants were told "adherence to safe sexual practices was imperative," according to the Lancet study. Despite studies that "suggested circumcision ... can lower the rate of male-to-female virus transmission from HIV-positive men" the researchers concluded, "circumcision of HIV-infected men didn't reduce HIV transmission to female partners over 24 months; longer-term effects could not be assessed." The study was funded by the Bill & Melinda Gates Foundation and received support from NIH and the Fogarty International Center.

Lead author Maria Wawer, from the Bloomberg School of Public Health, "said it was not sensible to recommend men with HIV should not be circumcised, or that there should be any down-scaling of circumcision programmes, because of the overall benefits to both uninfected men and to women," and the risk of stigmatizing men living with HIV, according to BBC. Bloomberg writes: The WHO "says that HIV-infected men shouldn't be denied circumcision if requested, as long as there are no medical reasons to avoid it". According to VOA News, "researchers say the longer term benefits of male circumcision to women still need to be further studied".

"The findings suggest that strict adherence to sexual abstinence during wound healing and consistent condom use thereafter must be strongly promoted when HIV-infected men receive circumcision," the authors write in the Lancet study, adding "that "circumcising infants and young boys before their sexual debut would mitigate the challenge of male circumcision in HIV-infected men".

A related Lancet comment says, "Involvement of women in decision making about circumcision offers an opportunity for enhanced messaging about the risks and benefits of circumcision, for men and for women, and for targeted risk-reduction

counselling for HIV-serodiscordant couples".

Ugandan Government To Run One-Year Female Condom Campaign

A separate Lancet world report examines the recent announcement by the Ugandan government to "reintroduce the female condom as part of a 1-year pilot programme to give women more options for protected sex and to help the country reverse a recent rise in HIV/AIDS incidence." The campaign aims to distribute 100,000 female condoms and educate the population about how to use the condoms.

The journal writes: "The move to bring back the female condom is part of Uganda's struggle to regain the success in the fight against HIV/AIDS in the 1990s. After slashing its HIV/AIDS rate from more than 20 percent to about 6 percent, Uganda saw a leveling off of HIV/AIDS cases and then a slight rise since 2000," which the government "blames that rise on a shift away from emphasizing condom use in Uganda".

<http://globalhealth.kff.org/Daily-Reports/2009/July/17/GH-071709-HIV-Circumcision.aspx>



# Negotiating Work Hours - Your Rights

Maurice Blackburn Lawyers

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One of the biggest legal issues for people with a disability who are in the workforce is whether they have the right to reduce their hours of work.

Many have great difficulty maintaining full time work and would benefit by a reduction in working hours either by working alternate days or reduced hours.

The transition from full time to part time work may be relatively smooth with the cooperation of treating doctors and a supportive employer. However, this is not always the case.

Some employers are unable or unwilling to accommodate people with a disability with requests to reduce their work hours, sometimes with the result that workers have to leave their job.

The question that is often asked is whether an employer can be forced to agree to a worker reducing their hours to part time because of a disability.

Until recently the answer was 'no'. However, several Court decisions might mean that workers with disabilities are able to reduce their work hours in some circumstances.

Generally speaking, under anti-discrimination laws, it is unlawful for employers to discriminate against workers because of disabilities. It is also unlawful for employers to indirectly discriminate against people with disabilities by having in place a policy or practice that affects people with disabilities more than other people. However employers will usually be excused if their conduct was reasonable.

Over the years the Courts have interpreted the anti-discrimination laws and have limited them to discrimination against workers in the jobs they were employed to do. This meant that an employer could not be forced to offer a disabled employee different work or reduced hours because that would be a different contract of employment.

Whilst your employer might have had to modify your workplace to accommodate your disability (e.g. provide you with a fan or wheelchair access), they did not have to offer you part time work.

However, recent decisions made by the Federal Magistrates' Court might change this. The Court decided that it was unlawful indirect discrimination against women to refuse to allow them to return part-time from maternity leave. The women in the Court cases were awarded compensation against their employers under the Sex Discrimination Act because their employers had no reasonable excuse not to offer part time work.

For the same reasons, the Disability Discrimination Act and the Equal Opportunity Act (Vic) might protect people with disabilities being discriminated against by their employers refusing reasonable requests to work part time.

Many employers think that anti-discrimination laws are more powerful

than they actually are, which can help you in negotiating a reduction in your work hours. However, keep in mind that anti-discrimination cases do not usually result in your work being changed. Most cases are settled for compensation, sometimes with the worker resigning from their place of employment.

It is also very important to consider whether going part time will have any effect on your superannuation and insurance rights.

Most workers are covered for disability benefits in their employment superannuation and many also have income protection. Sometimes those benefits can be reduced or even lost if you reduce your work below a minimum number of hours per week.

Before you decide to go part time, or stop work altogether it is important that you get advice about your rights. Maurice Blackburn have set up a free advice service for people with disabilities. If you would like to talk to someone about your situation please call 1800 810 812.



# Anal Cancer in Men with HIV much more common in Post-HAART Era: could an HPV vaccination help?

## AIDSMAP

The annual incidence of anal cancer amongst people with HIV has continued to increase in recent years and now stands at 128 cases per 100,000 or one case in 784 people, the 5th International AIDS Society Conference was told on Wednesday by Nancy Crum-Cianflone of the US Infectious Disease Clinical Research Program. This is nearly 100 times the rate in the general population (1.4 per 100,000).

In a separate presentation, Stephen Berman of the Veterans Administration Healthcare System told the conference that findings from a study of HIV/HPV co-infected army veterans implied that up to 89% of men with HIV could potentially derive at least some benefit from one of the currently-licensed HPV vaccines and 53% substantial benefit, providing that HIV infection did not compromise the normal immune response to the vaccine.

In the first study, researchers investigated the incidence of anal cancer in HIV-positive individuals between 1985 and 2008. The figures were obtained from the U.S. Military Natural History Study, a cohort study which followed participants from 1985 till 2008.

A total of 4,901 HIV-infected participants, 55% with documented seroconversion dates, contributed 40,951 person years of follow-up. Researchers investigated the association between CD4 cell count, use of antiretroviral therapy, AIDS-defining illnesses and sexually transmitted infections, and the risk of developing anal cancer.

Anal cancer was diagnosed in 20 patients, all men and 55% Caucasian. At cancer diagnosis the patients' median age was 42 years, with 40% of cases in men below 40.

The rate of cancer was five times higher in the post-HAART era than in the pre-HAART era with an annual incidence of 11 per 100,000 before 1996 and 55 per 100,000 from 1996-2008.



The incidence increased during the HAART era from 13.4 per 100,000 between 1996 and 2000 to 51 per 100,000 between 2001 and 2005 and 128 per 100,000 in 2006 to 2008.

The incidence of anal cancer was also considerably higher in people with longer duration of HIV infection. Up to 10 years post-infection the rate was 28 per 100,000, from 10-15 years it was 63

per 100,000 and in patients diagnosed for more than 15 years it was 348 per 100,000 - one case per 288 patients per year.

In multivariate analysis only AIDS diagnosis and nadir CD4 count were associated with anal cancer, with having had an AIDS-defining illness raising the risk 3.4 times and the risk decreasing by 15% for every 50 cells/mm<sup>3</sup> higher CD4

nadir. Gonorrhoea was also marginally associated with anal cancer with a hazard ratio of 2.33 ( $p=0.08$ ). Being on HAART was not protective against the development of the condition ( $p = 0.19$ ).

Could the HPV vaccine help?

In another study of patients in members of former members of the armed forces, Dr Stephen Berman investigated infection with human papilloma virus (HPV) and its subtypes in 62 HIV-positive men, 90% of them gay and 90% on HAART with undetectable HIV.

"Little or no data has been published on the ability of HIV positive individuals to respond to [the quadrivalent HPV vaccine] Gardasil," he commented. "Can they make an appropriate serological response, and which subgroups will not benefit?"

The study therefore took serological tests of study participants to see if they had antibodies to HPV types 16 and 18. These, the two most common 'high risk' varieties of HPV, cause 70% of cases of anal and cervical cancer, and the available HPV vaccines Gardasil and Cervarix produce a high level of protection against these strains for individuals who are not already infected with them. In addition Gardasil protects against infection with HPV types 6 and 11, which cause 95% of non-cancerous warts.

The patients also had an anal smear for precancerous cells and an anal screen for HPV DNA, which indicates actively reproducing virus. The patients were then given an initial dose of Gardasil.

The second and third doses of Gardasil were given at month two and month six, and tests taken again at month seven for antibodies to HPV, HPV DNA and precancerous cells.

Results showed that 34% of the men in the study had antibodies to HPV-16, 6.4% to HPV-18 and 3.2% to both. The majority of individuals (56.5%) therefore did not have antibodies to the two strains of HPV with the highest risk of anal and genital cancers.

Sixty-three per cent of men had HPV DNA (of any high-risk type) detectable in anal samples, and 22.6% of men had HPV DNA from types 16, 18 or both. This means that 40% of men had active infections with other high-risk types of HPV (although types other than 16 and 18 are associated with much slower progression to cancer).

Berman commented that the men with detectable DNA could either be men with relatively recent infection and a normal antibody response or men with prolonged infection and a delayed or non-existent antibody response. The latter are at most risk of developing cancer. In HIV negative people antibodies to the infecting subtype of HPV develop within 6-9 months of infection and then clear the infection from the body. This process is delayed and attenuated in people with HIV, which is the probable cause of the higher rates of anal cancer seen.

Twelve individuals had abnormal anal cells, six of whom had squamous intraepithelial lesions, or precancerous cells. Of the twelve, ten had detectable HPV DNA, three of whom had HPV-16, three were co-infected with HPV-16 and HPV-18, and four had types other than 16 or 18.

Of the 25 individuals with antibodies to HPV-16, ten (40%) had detectable DNA from this strain detected in samples, in addition to three of the individuals who did not have antibodies to HPV-16, and two men without antibodies to HPV-18 had detectable DNA from this strain. Altogether 11% of patients had both antibodies to HPV16 or 18 and evidence of the genetic material of these strains, indicating a complete or ineffective antibody response.

In answer to a question, Berman commented that it was possible that giving such men the HPV vaccine might stimulate a much stronger response which might result in clearance of infection "but Merck (Gardasil's manufacturers) have absolutely no data on the efficacy of giving their vaccine to people with an existing infection."

Altogether, 53% of men had evidence of neither exposure nor infection with HPV-16 or HPV-18 and were therefore likely to derive substantial benefit from Gardasil as long as HIV infection does not impair the immune response, while another 35% had one of the strains and would therefore benefit at least from vaccination against the other one.

Becker commented that the proportion of men with antibodies to HPV16 was higher than reported previously. However since 40% of men had indications of active infections with subtypes other than HPV-16 or 18, second-generation polyvalent vaccines should be developed.

[www.aidsmap.com](http://www.aidsmap.com)



## Participants wanted

Can you spare half an hour to complete a survey about living with HIV/AIDS, your social supports, your experiences of unsupportive social interactions and your wellbeing? If you live with a pet, or have lived with one in the last five years, are you willing to answer some extra questions about your pet?

Participants are wanted for a study into the relationship between social support (including pets), unsupportive social interactions and personal wellbeing amongst people living with HIV/AIDS. I am looking for both pet owners and non-pet owners aged 18 years and over, who have been diagnosed with HIV/AIDS and are willing to spend approximately 30 minutes completing an anonymous questionnaire.

For more information contact

Vicki Hutton:

Tel:

03 9903 2378; mobile 0434 939974

Email:

[vehut1@student.monash.edu.au](mailto:vehut1@student.monash.edu.au)

Department of Behavioural Studies  
Monash University

Alternatively, you can access the questionnaire direct at:

[www.surveymonkey.com/](http://www.surveymonkey.com/)

[s.aspx?sm=clcf17znbXxmCW\\_2foXYRpVQ\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=clcf17znbXxmCW_2foXYRpVQ_3d_3d)

VAC/GMHC Research and Ethics Review Committee (a joint committee with PLWHA Victoria)

No.RPEC04/09



# The Tingling in My Heart

Laird Peterson

## Little did I know I had a cardiac condition.

I never thought that after living with HIV for more than 20 years that I would have to worry about Coronary Artery Disease (CAD).

But there I was, in March of 2004, thinking that I had dodged the HIV bullet after many combinations of therapy, my T-cells stable and viral load undetectable, working at a job I loved, in a long-term relationship of 10 years and pretty happy with my life.

Then one Sunday, I noticed what I thought to be a re-occurrence of peripheral neuropathy (PN), only this time it was affecting my hands and arms. I thought to myself, "You beat it in your legs, so you can do so in your arms."

Except there was a difference this time. It was not constant, and I was feeling the tingling and numbness more in my left arm than the right arm.

Now, I had been through enough health crises over the last 22 years that I pretty much knew, or I thought I did, how to handle most anything that came my way. In 1998 I was reduced to using a cane or wheelchair for months due to the PN in my legs, had been through numerous other neurological episodes, a scare with a lump on my breast, asthma, COPD [Chronic Obstructive Pulmonary Disease, often referred to as emphysema] -- the list could go on forever.

Yet, I was feeling good except for the tingling. After three days of hounding by my partner, I called my doctor's office to get an appointment, described the symptoms to the receptionist, and all of a sudden one of the other docs in the office was on the phone, asking all sorts of questions that I don't even remember now. He wanted me to go right to the emergency room. I assured him that this was not urgent, as it had been going on for so many days, so reluctantly, I was given an appointment for later that afternoon.

After the conversation with the doc, I was a bit worried about what was happening, but continued with my work and left the office a little early to make the appointment.

After my doc examined me and determined that my pulse was normal and blood pressure was good, he decided to do an EKG, which also was normal. After a few minutes, he reappeared with a nitroglycerin tablet, and asked me to put it under my tongue and let it dissolve, and told me to relax and lay down for about five minutes.

When he came back into the room, I was amazed that I felt much better, the tingling was gone, and I felt as though I had regained my usual energy level. The doctor was not as happy as I was. He told me that I needed to go to the emergency room for further blood work and a few tests, and even gave me cab fare, so I wouldn't waste time looking for an ATM to get some cash.

Not thinking this could really be a heart attack, as I had seen plenty of them on TV and knew the tell-tale signs (crushing chest pain, collapse, etc.), I had the cab drop me off in front of the hospital instead of at the emergency room, so I could have a cigarette and call my partner. When I reached him he was

about an hour away, coming home from work, so I suggested that by the time he could get to the hospital, I would be finished, and we could go out for drinks and dinner. Call me a denialist!

By the time he arrived, I had been poked and prodded by so many people I was losing count, but it was clear that we wouldn't be going out for dinner.

Within a couple of hours, I was wheeled into a catheterization laboratory, and when all was said and done, we were told that I had 100% blockage in one vein, 80% in two, and 60% in two others, in addition to 80% in a vein in my leg, and would be undergoing quintuple bypass surgery the next morning.

I must say that I am a little foggy about the next two days, but was walking and visiting with family and friends 24 hours after surgery, which was a great relief. The cardiac surgeon told us that I was his third HIV-positive case in as many months.

We were home in less than a week, but I almost had a relapse after opening the mail and seeing the hospital bill ... over \$300,000 for a five-day hospitalization, not including doctors' fees! Since I had three unrelated surgeries earlier in the year, my only out-of-pocket costs were prescription co-pays. Thank God!

The recovery was pretty easy for me, though I was extremely weak. I walked a lot to build up strength and then began a cardiac rehabilitation program at the hospital, which I must say, was geared for 70-80 year old patients, not 46-year-old ones, but I kept pushing the limits and was back doing work via e-mail in a week and back at the office in a month.

Fortunately, six months later I was able to have a stent placed in my leg to correct the other blockage, which was by now blocked 100%.

I spent a great deal of time doing my own research, to understand if this was a trend with long-term HIVers, or just the luck of the draw genetically and have



yet to come to any conclusions, though surely my smoking didn't help.

I am heartened, nonetheless, to see that there are many studies, such as the MACS study, looking at the issue of increased lipids as a result of HIV protease inhibitor drugs and the effect they have on hardening of the arteries, and a possible increase in incidence of heart attacks among people who are on HAART (highly active antiretroviral therapy). Researchers are also looking at what effect HIV has on hardening of the arteries. Many healthcare providers prescribe statin drugs to reduce your cholesterol levels.

Since many protease inhibitors raise lipid levels, it is critically important that HIV-positive individuals who are on HAART raise this issue with their providers. Regular monitoring of cholesterol is key to assessing cardiovascular risk factors for developing coronary artery calcification, so that you and your provider can take steps to reduce the risk of arteriosclerosis (hardening of the arteries) and reduce your risk of heart attacks. My cholesterol was very low prior to taking Kaletra and has been controlled by Lipitor since 2001. It is now 171, and the LDL (bad cholesterol) level is 92, so it's pretty good. Monitor your triglycerides as well.



If you smoke cigarettes, you should begin the sometimes long process of quitting!

Also, as HIV is now thought by many to be a chronic disease, we need to think about how our bodies are changing, and yes, aging. Cardiac artery disease and heart attacks are more common than we would like to think in people over 40, and the relationship of HIV infection and HAART therapy and hardening of the arteries has not been fully determined yet because longer-term studies need to be done.

Following are a few of the diagnostic tools that your healthcare provider may use:

- Regular cholesterol screenings
- Blood level of C-reactive

proteins, which measures the level of general inflammation, may correlate with the risk of heart attacks

- Ultrasound imaging of the carotid artery
- Electron beam computed tomography (EBCT), which you should discuss with your healthcare provider.

The significance of findings from ultrasounds, heart scans, and EBCTs should be discussed and evaluated by a cardiologist.

We have lost too many of our friends and colleagues to HIV and AIDS over the last 25 years, so we need to be vigilant about watching out for other health issues that have also taken the lives of many of our friends too early.

All too often when our bodies are reacting to changes, we only think of HIV-related issues, and look at all the side effects and adverse reactions to the drugs we take. Sometimes, we need to look beyond those easy solutions and take a more aggressive approach, and ask our healthcare providers for more diagnostic tests. You should also demand that your provider provide a comprehensive set of tests to determine your baseline, and then monitor progression to avoid unnecessary health crises in the future.

## Health Promotion Officer

### COMMUNICATIONS AND RESOURCES



### FULL-TIME 12 MONTHS FIXED TERM APPOINTMENT

### (38HRS/WEEK) – BASED IN MELBOURNE

People Living with HIV/AIDS Victoria is seeking an experienced and motivated person to join our team as a Health Promotion Officer to develop and coordinate communications and resources.

The successful applicant will have an understanding of and commitment to effectively communicating health promotion information to people with HIV. The successful individual will also coordinate the development of the organisational communication objectives through print and various electronic media. Relevant qualifications and/or demonstrated experience are desirable.

A position description is available on request by contacting the Administrator at PLWHA Victoria on 03 9865 6772 or by e-mailing [info@plwhavictoria.org.au](mailto:info@plwhavictoria.org.au).

**PLWHA Victoria is an equal opportunity employer and offers a smoke-free workplace. People living with HIV/AIDS are particularly encouraged to apply. Applications close 5pm Monday 21 September 2009.**



In the month of July we have seen our new CEO Kerrilie Rice join our organisation. Kerrilie's background is primarily in women's issues: working in academia, in the community sector as well as in women's affairs within the state government. She has also done short stints for not-for-profit organisations focused on disability, education and ageing. Kerrilie has hit the ground running and has already achieved an amazing amount of work in meeting with our strategic partners and supporters.

Positive Women Victoria would like to thank Dawn Wilcock for her commitment and hard work in her time with the organisation as Executive Officer and Kellie Madge for her time as Acting Executive Officer. Kellie has been retained with Positive Women Victoria in an administrative/projects capacity.

It is great to see at least six Victorian HIV-positive women presenting at the Asia Pacific Congress in Bali - go positive women! Michelle our Peer Support Coordinator and one of our members will be attending on our behalf, to represent Positive Women Victoria and HIV-positive women in general. We look forward to their reports at our August member lunch.

With the AGM coming up in October it is time for HIV-positive women to think about if you are interested in joining the board and for our supporters, to come along and see where we are at and where we are going. Our AGM will be held at the Queen Victoria Womens Centre in Melbourne on Thursday 29th October. Keynote speakers will include positive women who are working on a number of amazing projects. We hope to see you there!

Once again our peer support dinner was a great success and a good opportunity to catch up with fellow HIV-positive women. Kerrilie came to introduce herself and talk about the priorities for the organisation in the short and long term. Attendees enjoyed

Middle Eastern food and a great night of peer support!

Our first Positive Steps program is coming to an end, participants have said that they enjoyed the 6 week structured peer support sessions so much that they plan on meeting again for 4 sessions in a month's time. The group members have become very close and hope to maintain regular contact in the future. All the participants have been committed and are finding the group really worthwhile. The stories and experiences we have shared over the past few weeks have been inspiring and strengthening. Due to the overwhelming success of this program, we are keen to run Positive Steps again, co-facilitated by our own Support Coordinator Michelle Wesley and Trish Thompson, an accredited counsellor from the Victorian AIDS Council.

Positive Women Victoria's peer support events give the opportunity for positive women to come together to talk about living with HIV and to ease the social isolation and discrimination that comes with being a woman living with HIV. In addition to facilitating peer support, Positive Women Victoria works in other areas around discrimination and women. More recently, we endorsed the NGO report to the United Nations on Australia's work to eliminate all forms of discrimination against women.

Discrimination happens when you are treated differently or less favourably than everybody else because of an attribute you have such as the colour of your skin, religion, gender, disability or HIV. Many HIV positive women have, sadly, been subject to extreme discrimination, most particularly around the stereotype that an HIV-positive woman must be a "slut" or a "junkie".

Fear of discrimination and stigma, compounded by a lack of HIV awareness amongst heterosexuals, can cause HIV-positive women to be secretive about their HIV status, particularly around

relationships. This has been something the staff of Positive Women Victoria have talked about with many members. It seems to be that there is no real hard and fast rule about if, when or how to disclose. It seems to be different for everyone! Some women feel more comfortable being upfront while others prefer to build trust in the relationship first.

A few common themes do emerge, one being that HIV-positive women like to talk with other HIV-positive women about disclosure to sexual partners. This is a very important part of peer support, this sharing of stories and information which can help inform a positive woman's decisions around the if, when and how to disclose. Positive Women Victoria facilitates this connecting via peer support events and programs. The other theme that emerges, is that positive women like to have information that is relevant for the person they are disclosing to and to be aware of what support services this person can access. Positive Women Victoria can provide this information in person or by post and we are available to talk with women and partners. So, if you would like to talk about stigma, discrimination or disclosure with other positive women, please contact us!

**See the following page for Positive Women and Straight Arrows Diaries.**



# Diaries



## SEPTEMBER

Thu 10 - Drop-In  
 Tue 15 - Members Activity  
 Thu 24 - Drop-In

## OCTOBER

Thu 8 - Drop-In  
 Sun 18 - Family Event  
 Thu 22 - Drop-In  
 Tue 27 - Education Session

## NOVEMBER

Thu 5 - Drop-In  
 Fri 13 - Members Lunch  
 Tue 17 - Members Activity,  
 Thu 19 - Drop-In

## DECEMBER

Thu 3 - Drop-In  
 Fri 11 - Xmas Dinner



## SEPTEMBER

Thu 24 - Dinner

## OCTOBER

Wed 21 - Women's Swim & Lunch

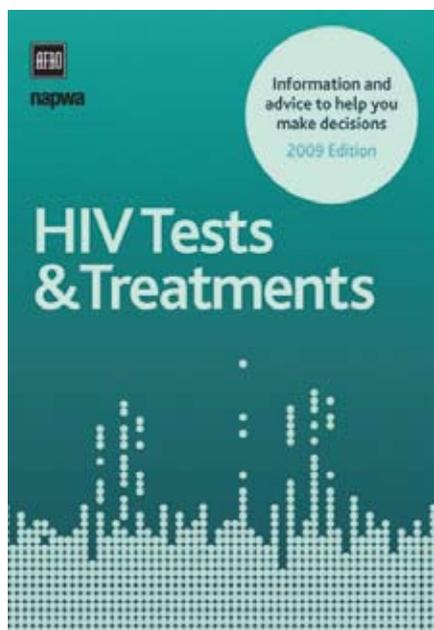
## NOVEMBER

Date to be confirmed - Retreat for heterosexual men and women

## DECEMBER

Fri 11th - Xmas Party

# WHAT'S NEW?



**HIV Tests and Treatments 2009**, describes the currently available antiviral drugs for the treatment and management of HIV infection. It also describes some common tests used to monitor the health of people with HIV, and how these tests can be used to help you look after your health, or make decisions about starting, stopping or changing antiviral treatments.

**REAL TIME:** The truth about fucking without condoms

**REAL TIME** is designed to assist Gay and Bisexual men in resolving conflicts between the perceived benefits and costs of unsafe sex. The workbook style of the booklet will enable you to reflect on past and present actions, and help identify and reduce patterns of behaviour that cause anxiety or stress.



## Prahran Market Clinic has moved!



**Prahran Market Clinic (PMC)** has moved to new premises.

You can now find us at Prahran Central Mezzanine Level Corner Chapel & Commercial Roads Prahran 3181 Phone 9514 0888

Contact PLWHA Victoria on 03 9865 6772 for your copy today

# News briefs



## NAPWA has a new website!

The National Association of People Living With AIDS (NAPWA) has a new website which integrates content from the NAPWA and Treataware websites in an improved, easy-to-use format. As well as the HIV Clinical Trial database, it also incorporates new databases of HIV treatments and HIV service providers.

[www.napwa.org.au](http://www.napwa.org.au).

## Menopause May Occur Earlier in HIV-Positive Women

HIV-positive women may experience menopause at a younger age than their HIV-negative counterparts, according to a study presented at the Fifth International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention in Cape Town.

Due to the success of antiretroviral (ARV) therapy, the life spans of people with HIV have significantly increased. This means that a much larger number than ever before are living well into their 50s and 60s. At this age, most HIV-negative women enter menopause. Because researchers have demonstrated that HIV can accelerate aging in a number of different ways, there have been concerns that HIV-positive women may enter menopause at a younger age than HIV-negative women. This has never been proved conclusively,

however.

To determine whether HIV affects menopause, Myriam Pommerol, MD, from the Centre Hospitalier Universitaire (CHU) de Bordeaux, in France, and her colleagues conducted surveys of 404 HIV-positive women seen at their hospital. The women ranged in age from 19 to 79. Seventeen percent had already gone through menopause. A significant number were going through menopause naturally, (as opposed to surgically by hysterectomy). Menopause was occurring in up to 72 percent of women ages 50 and older, 21 percent of women ages 45 to 49, 3.5 percent in women ages 40 to 44 and in less than 1 percent in women younger than 40.

During 8.8 years of follow-up, 41 women entered menopause. Their average age at the start of menopause was 46. This is younger than what occurs in the general population. Factors associated with early menopause included African descent, a history of injection drug use and CD4 counts below 200.

The authors conclude that although their study was not rigidly controlled—they did not compare the women in their study to a similar group of HIV-negative women, and they relied on surveys rather than clinical examination—it does suggest that HIV-positive women may enter menopause earlier than HIV-negative women.

[www.AIDSmeds.com](http://www.AIDSmeds.com)

## Once- vs. Twice-Daily Kaletra for Treatment Veterans

Once-daily Kaletra (lopinavir/ritonavir) dosing may be an option for treatment-experienced people living with HIV, according to study results presented July 21 at the Fifth International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention in Cape Town.

Caution may be necessary, however, for individuals with more than three key mutations in their HIV's protease gene, because once-daily dosing might not be potent enough to keep viral load undetectable.

In the United States, Kaletra has been approved by the U.S. Food and Drug Administration (FDA) for use once or twice daily in people starting HIV treatment for the first time, with a total daily dose of 800 mg lopinavir and 200 mg ritonavir using either schedule. Data reported in February 2008 at the 15th Conference on Retroviruses and Opportunistic Infections helped confirm that once- and twice-daily doses of Kaletra tablets have similar tolerability and comparable efficacy in first-time treatment takers.

Twice-daily Kaletra is approved by the FDA—and is the only recommended dosing option—for treatment-experienced patients. However, there has been an interest in exploring the possibility of once-daily dosing for antiretrovirals (ARVs) that currently must be taken twice-a-day by treatment-experienced individuals, many of whom suffer from adherence struggles that might be easily remedied with a simplified dosing schedule.

To better understand the safety and efficacy of once- and twice-daily dosing of the Kaletra tablets in treatment-experienced individuals, Abbott funded an international clinical trial involving 599 HIV-positive patients who had been on ARVs in the past (not Kaletra) and had pre-study viral loads of at least 1,000 copies. For 48 weeks, 300 people took four Kaletra tablets plus at least two nucleoside reverse transcriptase inhibitors (NRTIs) once a day, whereas 299 took two Kaletra tablets plus at least two NRTIs twice a day.

According to Sharlaa Badal-Faesen, MD, of the University of Witwatersrand in Johannesburg, slightly less than half

of the study volunteers had been on at least one protease inhibitor in the past.

About 55 percent of those in the once-daily Kaletra group and 51 percent in the twice-daily Kaletra group had viral loads below 50 copies after 48 weeks. As this difference was so slight, the once-daily results were said to be “non-inferior” to the twice-daily findings—meaning there was comparable efficacy between the two groups.

It’s important to note, though, that those who entered the study with HIV containing at least three key resistance mutations associated with the earlier use of protease inhibitors were much less likely keep viral loads undetectable for 48 weeks in the once-daily group compared with the twice-daily group: 30.8 percent versus 57.1 percent, respectively. Among those with HIV harboring fewer than three protease inhibitor mutations, no significant differences in effectiveness were reported.

CD4 cells increased equally in both treatment groups—about 130 cells after 48 weeks of treatment.

As for side effects, diarrhea was not less common in the once-daily Kaletra group than in the twice-daily Kaletra group. However, nausea occurred in 2.7 percent of those in the once-daily Kaletra group compared with 7.4 percent of those in the twice-daily group—a statistically significant difference.

It is unclear if these encouraging data will be enough to support the FDA approval of once-daily Kaletra for treatment-experienced people living with HIV.

[www.AIDSmeds.com](http://www.AIDSmeds.com)

## Abacavir as potent as tenofovir for patients starting HIV treatment with a high viral load

Regardless of baseline viral load, an HIV treatment combination that includes abacavir (Ziagen, also in the combination pill Kivexa) is just as effective at suppressing viral load in the early weeks of HIV treatment as a regimen that includes tenofovir (Viread, also in the combination pills Truvada and Atripla), UK investigators report in the September 1st edition of the *Journal of Infectious Diseases*.

The researchers found that falls in viral load in the first eight weeks of HIV treatment were comparable between patients taking the two drugs, and that after between six and twelve months of therapy equal proportions of patients

taking abacavir and tenofovir had experienced virological failure.

British HIV treatment guidelines caution against the use of abacavir for individuals starting HIV treatment for the first time who have a baseline viral load above 100,000 copies/ml. This recommendation is based upon results from the ACTG 5202 study that showed that patients taking abacavir-containing regimens with a baseline viral load above 100,000 copies/ml had a greater risk of virological failure than individuals taking tenofovir with a similar viral load.

Investigators from the UK Collaborative HIV Cohort Study wished to see if the results of this study were replicated in their large cohort of patients initiating HIV treatment that included either abacavir or tenofovir. The patients took one of these drugs in combination with either 3TC (lamivudine, Epivir, combined with abacavir in Kivexa, or FTC (emtricitabine, Emtriva, combined with tenofovir in Truvada and tenofovir and efavirenz in Atripla, which were taken with either a non-nucleoside reverse transcriptase inhibitor (NNRTI) or a protease inhibitor.



The researchers conclude, “our findings indicate that patients with high pre-HAART viral loads who initiate HAART with abacavir have short-term viral load reductions comparable to those who initiate HAART with tenofovir, and this should be taken into consideration when deciding which nucleoside should be used as part of a patient’s initial HAART regimen.”

[www.aidsmap.org](http://www.aidsmap.org)

## Scientists learn why even treated genital herpes sores boost the risk of HIV infection

New research helps explain why infection with herpes simplex virus-2 (HSV-2), which causes genital herpes, increases the risk for HIV infection even after successful treatment heals the genital skin sores and breaks that often result from HSV-2.

Scientists have uncovered details of an immune-cell environment conducive

to HIV infection that persists at the location of HSV-2 genital skin lesions long after they have been treated with oral doses of the drug acyclovir and have healed and the skin appears normal. These findings are published in the advance online edition of *Nature Medicine* on August 2nd.

“The findings of this study mark an important step toward understanding why HSV-2 infection increases the risk of acquiring HIV and why aciclovir treatment does not reduce that risk,” said NIAID Director Dr Anthony Fauci.

“Understanding that even treated HSV-2 infections provide a cellular environment conducive to HIV infection suggests new directions for HIV prevention research, including more powerful anti-HSV therapies and ideally an HSV-2 vaccine.”

One of the most common sexually transmitted infections worldwide, HSV-2 is associated with a two- to three-fold increased risk for HIV infection.

Some HSV-2-infected people have recurring sores and breaks in genital skin, and it has been hypothesized that these lesions account for the higher risk of HIV acquisition. However, recent clinical trials, including an NIAID-funded study completed last year, demonstrated that successful treatment of such genital herpes lesions with the drug aciclovir does not reduce the risk of HIV infection posed by HSV-2. The current study sought to understand why this is so and to test an alternative theory.

Previous research has demonstrated that immune cells involved in the body’s response to infection remain at the site of genital herpes lesions even after they have healed.

The scientists conducting the current study made several important findings about the nature of these immune cells. First, they found that CD4 T cells—the cells that HIV primarily infects—populate tissue at the sites of healed genital HSV-2 lesions at concentrations two to 37 times greater than in unaffected genital skin. Treatment with aciclovir did not reduce this long-lasting, high concentration of HSV-2-specific CD4 T cells at the sites of healed herpes lesions.

The investigators conclude that reducing the HSV-2-associated risk of HIV infection will require diminishing or eliminating the long-lived immune-cell environment created by HSV-2 infection in the genital tract, ideally through an HSV vaccine.

[www.aidsmap.org](http://www.aidsmap.org)

# Hampstead Dental

We are a new dental clinic based near Highpoint , gay owned and operated.

We have a caring and understanding dentist with GLBT clientele. We also look after patients covered by the Medicare EPC scheme.

We also have a dental therapist who works with us one day a week looking specifically after the requirements of children.

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VIC 3012

Phone: (03) 9318 5599

Email: info@hampsteaddental.com.au

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32 BW Negative

**PARTNERS WORKSHOP**

A facilitated workshop for HIV negative men in a relationship with HIV positive men. Meet men in similar situations, find out how others manage HIV within their relationships and have the opportunity to ask health experts questions.

To be held over two consecutive Saturdays in October 2009.

To register your interest please contact Trish Thompson on 9865 6700.

A joint initiative of People Living With HIV/AIDS Victoria and the Victorian AIDS Council /Gay Mens Health Centre.

32 32A



## Positive Personals

We will accept advertisements under 50 words for dating or friendships under the following categories:

- Men seeking men
- Women seeking men
- Women seeking women
- Men seeking women

*Personals (Dating or Friendship):*

Please keep your advertisements under 50 words. Be clear about who you are and what you are looking for. Be honest to avoid disappointment for you and your correspondent. It is up to you if you want to include the suburb or regional area you live in. Advertisements and replies must be sent by mail only – please do not phone the office about this service.

Write your response letter and seal it in an enveloped with a 50 cent stamp on it. Write the reply number of the advertisement on the outside of the envelope in pencil. Place this envelope in a separate envelope and send it to: Personals, PLWHA Victoria, 6 Claremont St, South Yarra, Vic 3141.

Personal details given to PLWHA Victoria (such as return addresses) will be kept strictly confidential and will only be seen by one staff member working on the magazine at any time. Send your advertisement to Personals, PLWHA Victoria, 6 Claremont St, South Yarra VIC 3141.

### Men Seeking Men

I'm Masculine. A long term. Aus guy. 46 year old. I stay pretty active and am fit. I like the outdoors, sport, music, quiet nights in. Seeking masculine blokes with similar interests. Reply Number #0001 or call 0432 698675

### Men Seeking Women

HIV positive heterosexual male, youthful 40's, seeks female companionship. To be there for each other, share interests and find happiness. I am always looking for new, interesting and worthwhile things to engage in or just attend. I'm friendly, I maintain good health, 6 ft tall and Caucasian. I live in inner Melbourne - though I can travel. Reply Number #0002

I am 40, employed part-time and have a 5 year old son. I would like to write at first and then start meeting. I'm looking for a long term commitment. My interests are outdoor activities, films and reading. Reply Number #0003



### Women Seeking Men

I am 52 years of age. I was diagnosed HIV positive in 2008 at ST Vincent hospital in Melbourne when I was visiting my daughter. I seek male companionship. To be there for each other, share interests and find happiness. I am always looking for new, interesting and worthwhile things to engage in or attend. My diagnosis was a shock to me as I did not have a partner since 1999 when he passed away in an accident. I am an African mosotho woman and I live in Lesotho, South Africa. I am friendly and maintain good health. I feel quite isolated so please reply even if only for correspondence. Reply Number #0006

### Accommodation

Aus guy. I'm fit, honest, etc. 46 year old. Would like to hear from other masculine poz blokes interested in sharing/setting up house. Reply Number #0004 or call 0432 698675

Live in Carer – Caretaker Driver  
Are you in need of help around the home, need someone to drive you to your doctor's, shopping, outings, events, etc? I'm a single young man currently working for ST Vincent hospital. I have health Services papers and Tradesman papers including full Victorian drivers license. The only cost is a place to call home (rent free). Reply Number #0005

DiversityLink



DiversityLink is an e-mail list for and about people living with HIV/AIDS

from culturally and linguistically diverse (CALD) backgrounds run by the

Multicultural HIV/AIDS and Hepatitis C Service in NSW

This group is open to anyone interested in the HIV/AIDS field,

including people living with HIV/AIDS, health, youth and community workers.

To join send an email to: [info@multiculturalhivhepc.net.au](mailto:info@multiculturalhivhepc.net.au) and for more information, call (02) 9515 5030 or visit [www.multiculturalhivhepc.net.au](http://www.multiculturalhivhepc.net.au).



Services, Support and Advocacy for Heterosexual People Living With HIV

Fairfield House  
The Alfred Hospital  
Moubray Street Entrance  
Prahran VIC 3181

Tel (03) 9276 3792

Email

[information@](mailto:information@straightarrows.org.au)

[straightarrows.org.au](http://straightarrows.org.au)

[www.straightarrows.org.au](http://www.straightarrows.org.au)



## Acknowledgement

PLWHA Victoria would like to thank our sponsors for providing unrestricted educational grants to fund *Poslink* and Treatment Interactive Events.



## Free Wills

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

For further information, please call PLWHA Victoria on 9865 6772, and we will arrange for De to get in touch with you.

The service covers up to six beneficiaries and has no provision for setting up trusts, fund management or the like.

## Membership application

All details provided will be treated as strictly confidential.

*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 understand I can obtain copies of the Rules of the organisation from the PLWHA Victoria office.*

Please  Full Membership  
tick 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.

Name

Signed

Address

Postcode

Telephone

Email (required)

Please fax or post your membership application to:

I do not wish to be contacted by postal mail.

PLWHA Victoria  
6 Claremont Street  
South Yarra VIC 3141  
Tel 03 9865 6772  
Fax 03 9804 7978



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