

# poslink

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# WHAT DOES TREATMENT MEAN FOR YOU?

by Craig Burnett



*I was diagnosed with HIV in 2008 when I was only 20 years old. This was before treatment as prevention had been discovered and in an environment where people relied heavily on condoms to prevent transmitting HIV.*

By the time of my diagnosis I had been living with HIV for some time. I had a fairly high viral load and my CD4 count was low. The doctors took six months of observations on my health to see my trajectory. After six months they recommended I go on treatment. This is a pretty standard level of care for someone newly diagnosed with HIV. At the time, I didn't really understand what treatment meant for me; it was just two pills once a day. I took my medication because my doctors said it was the right thing to do. I very much relied on my doctors taking care of my health after my diagnosis. It was shocking to me to have been diagnosed with HIV. I hadn't engaged in any risky behaviour and my shock was compounded by the stigma I had for people living with HIV. It was an incredibly turbulent time for me and I was not able to properly take care of myself completely.

As such, I did what my doctors said was best for me medically. I didn't consider whether or not I was ready to start treatment. Would I be able to handle the side effects? How would it impact my lifestyle and my livelihood? Was I able to properly adhere to my regime? Thankfully, everything worked out with help and support from my friends, but I was too overwhelmed to fully comprehend what treatment would mean for me.

At first, it was a daily reminder of a part of my life I didn't like. I still took my medication every day, but it was a struggle; I considered it a chore. One day, I mentioned this to a friend and they corrected my thought: it wasn't a daily reminder of a bad thing, it was a daily way of looking after myself. After this shift in thinking, I became more health focused. I joined a rugby team and started going to the gym. I realised my health and my life are my responsibility.

It was around this time I started to become comfortable with disclosing my HIV status. This coincided with my doctors starting to mention that being on treatment made it unlikely for me to transmit HIV through sex, even without a condom. This was excellent news. When I was diagnosed I didn't have sex for three months out of fear of transmitting the virus. However, there were only preliminary studies and only doctors knew about them. There was a lot of stigma I still faced. A lot of people who found out I was living with HIV would not have sex with me, even with a condom on. They also flat out refused to believe any of the studies I quoted and would retort with saying I was just lying so I could sleep with them. As much as the science behind treatment as prevention was developing, the social understanding of living with

HIV was very far behind. This put a strain on my relationships and I found it hard to have a partner for more than a few months.

When I finally had my first long term relationship, treatment as prevention was starting to be talked about in the community. I saw it as a way for me to protect my partner and my partner felt the same way. Although I no longer have a partner, I still see my treatment as me protecting my sexual partners and my community as a whole. My doctors were very clear about what treatment meant for me physically, but nobody ever told me what treatment would mean for me emotionally. There is a big push for people living with HIV to start treatment as early as possible because of the health benefits. However, treatment can be ineffective if the person is not in the right frame of mind.

*We, as a community, should be aiming to support people living with HIV as best we can so they are also emotionally ready to start treatment as early as possible.*

There are many reasons for someone living with HIV to take treatment; health, to take care of themselves, protect loved ones and to reduce HIV transmissions. It is important for people living with HIV to go on treatment for the reason which is right for them. We should not force people to go on treatment just to reduce HIV transmissions; we should aim to get people living with HIV in a position where they are comfortable with treatment, where applicable. There is still a lot of stigma that casts people living with HIV as irresponsible. I feel having a community of people living with HIV who are healthy—both emotionally and physically—will help to debunk that myth.

# GONORRHOEA: A NEW LOOK AT AN OLD DISEASE

by Dr Eric P.F. Chow and Professor Christopher K Fairley

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Gonorrhoea is one of the most common sexually transmitted infections (STIs) among gay and bisexual men in Australia. Rates are higher in younger men and while the number of cases in Australia has increased quite dramatically in recent years, condom use has only fallen slightly. The reason for these changes is not at all clear.

Gonorrhoea can infect three sites in men: the throat, urethra and anus. Data from the Melbourne Sexual Health Centre (MSHC) indicates that the throat (8.3%) is mostly commonly infected followed by the anus (8.0%), and urethra (2.0%). Symptoms are common in men with urethral gonorrhoea, which include urethral discharge and a burning sensation while urinating. However, infections in the throat or anus do not usually cause symptoms.

Most men think gonorrhoea is mainly transmitted via condomless penile-anal sex, but research at MSHC is challenging this belief.

**Many people are unaware that saliva can carry gonorrhoea, and that you may contract it through kissing, oral sex and rimming—probably through exposure to saliva.**

We are not exactly sure how common these other routes of transmission are, but we are working hard to provide estimates so that men know how to prevent transmission.

Using a partner's saliva as lube is a common activity in gay and bisexual men—reported by about 70% of sexually active men who have sex with men in Melbourne. Many men are surprised when they get rectal gonorrhoea, particularly those who always used a condom during anal sex. But assume a guy who is a top unknowingly carries gonorrhoea in his saliva. If he uses saliva as lube, it is possible to transmit gonorrhoea through penile-anal sex to the bottom partner, even if a condom is used.

Kissing is another common activity among gay and bisexual men, particularly at gay bars and dance parties. Because saliva can carry gonorrhoea, it is possible that men can get gonorrhoea via kissing. However, it is very difficult to answer whether it is 'safe' to kiss. Most sexually active men would kiss and have sex with their partners so we do not know whether they get the infection from kissing only, or from sex. We need to understand more about the way, duration and position people kiss in order to answer this question.

## **So, what can be done about preventing gonorrhoea and other STIs?**

Firstly, because it is impossible to know if you have throat or rectal gonorrhoea, men should get tested frequently and make sure the tests include both chlamydia and syphilis. At MSHC, we offer 15-minute appointment slots at our 'Test-And-Go' (TAG) clinic for HIV/STI testing so it is quick and easy. Make sure you call and ask about this before going.

Secondly, it is probably best to stick to lube and avoid using saliva. Condoms protect well against most STIs and the use of saliva as lube for anal sex compromises this risk reduction strategy.

Prevention is better than cure but if you are unlucky enough to catch gonorrhoea, treatment is as simple as a course of antibiotics. Although effective, overuse of antibiotics can lead to resistance, so the less we rely on it the better.

We have some preliminary findings on alternative ways to prevent gonorrhoea, including antiseptic mouthwash, but there is still a long way to go. We need to know which mouthwash works and which do not, and how and when to use them so they are most effective. MSHC is now conducting a large clinical trial to evaluate whether daily use of mouthwash can prevent getting throat gonorrhoea. If this works, it will be a cheap, easy to use, and easy to access intervention to prevent throat gonorrhoea without the use of antibiotics and condoms. It is too early to make any recommendations and more research is required.



# WHAT YOU NEED TO KNOW: HPV-RELATED CANCER

By Joël Murray and Timothy Krulic



**Anal cancer is now the most common cancer for people living with HIV.<sup>1</sup> We also have a substantially higher risk of developing many other cancers caused by the Human Papillomavirus (HPV)—so what can we do to protect ourselves?**

This article will explore the risk of HPV related cancer in women, men and non-binary people living with HIV, as well as discuss some of the important changes to screening and vaccination programs in Victoria.

## WHAT IS HPV?

HPV is a common sexually transmitted infection in Australia. Transmission is through skin to skin contact and not all strains are sexually transmissible. There is no cure for HPV, and while most HPV infections and symptoms clear on their own, it is related to the development of cancer in the cervix, anus, throat, penis, vulva and/or tonsils. There are over 100 different types of HPV, however, the majority of health complications are linked to only a few key strains. Genital warts are mainly associated with HPV types 6 and 11 (causing more than 90 % of warts)<sup>2</sup> while 16 and 18 are associated with approximately 80% of cervical cancer and 90% of HPV-related cancers in men (cis and trans).<sup>3</sup>

## HPV-RELATED CANCER AND HIV

People living with HIV can sometimes have compromised immune systems, reducing the body's ability to fight viral infections that may lead to cancer. Globally, HPV accounts for approximately 5.2 % of cancer<sup>4</sup>, yet its burden is significantly higher among people living with HIV.

The overall rates of anal cancer in people living with HIV are 30 times greater than in the general population.<sup>5</sup> In fact, anal cancer is the most common cancer occurring among people living with HIV. Due to higher anal HPV exposure, incidences of anal cancer are up to 100 times higher among gay, bisexual and other men who have sex with men (cis and trans) living with HIV.<sup>6</sup> While a new study examining anal and cervical HPV in Canadian women showed that the risk for anal cancer was up to 24 times higher for women living with HIV than those who were not.<sup>7</sup>

HPV-related cervical cancer is the 13th most frequent cancer among Australian women.<sup>8</sup> In 2012, there were approximately 800 diagnoses of cervical cancer, one third of which were terminal. It is estimated that 8.5% of women in Australia have HPV16 and/or HPV18. Women and trans men living with HIV with compromised immune systems may have higher prevalence as suggested by a study in the US which showed that the likelihood of HPV infection increases with a CD4 t-cell count of less than 500.<sup>9</sup>

Despite facing much greater risk to HPV-related cancers, not all people living with HIV have equal access to the HPV vaccine (Gardasil). Best practice screening for anal cancer is also infrequently performed among men, women and non-binary people living with HIV. However, a catch up vaccination program in Victoria will increase coverage for men who have sex with men while important changes are happening to how we screen for cervical cancer.

## HOW CAN I PROTECT MYSELF?

**Talk to your doctor about the HPV Vaccine.** Gardasil protects against HPV types 6, 11, 16 and 18. Even if you have already been exposed to one or more HPV types you can still get protection from other HPV types in the vaccine. A new vaccine that protects against nine HPV types will be available in Australia next year.<sup>10</sup>

The Victorian government recently extended the vaccination scheme to gay men and men who have sex with men aged under 26 who can now access Gardasil for free through general practices and a number of sexual health clinics. If you were not covered in earlier subsidised programs for women and trans men, and boys and girls aged 12-13 years old in schools, the cost of the vaccine is around \$150 per dose, with three doses required over six months.

**Screen for cervical cancer.** For women and trans men aged 18-69, screening for abnormal cells (which lead to cancer) and early cancer in the cervix has been done by a Pap test (or Pap smear) on a biennial basis (every two years). However, changes in screening methods—called the Cervical Screening Test which came into effect on 1 December 2017—have dramatically improved the early detection of precancerous cells and invasive cancers by looking for HPV in the cells. The new screening is undertaken in a similar way to a Pap test but is only required once every five years. The age for first screening will be raised from 18 to 25 due to the coverage of the HPV vaccine.

**Screen for anal cancer.** The most effective and widely available screening method for anal cancer is a digital anal rectal examination (DARE) which can be performed by your GP or HIV-specialist. A DARE involves the practitioner inserting a gloved and lubed finger up your bum to feel for lumps and/or cancer. While this is a fairly simple and painless test, it is infrequently performed. We therefore encourage all people living with HIV over the age of 35 to raise this with your GP or specialist at your next HIV management appointment. A DARE should be performed on an annual basis.

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