

APRIL, 2007

CHOICES



THE HAWAII ISLAND HIV/AIDS NEWSLETTER

RYAN WHITE

April 1, 2007-March 31, 2008

Our Ryan White year commences on April 1, 2007. As in past years, each client must qualify for Ryan White funds. You must provide current financial information to your Care Team as well as completing various forms. Your financial information must be in our office no later than May 1, 2007 in order for you to continue receiving Ryan White funds. Please provide your tax return for 2006 or in the alternative a copy of the past 3 months of your checking and/or savings account.

A Ryan White meeting to discuss the current funding, limitations on types of services, and anticipated changes will be held as follows:

HILO: Tuesday, April 17, 2007 at 1:00 p.m. at the Hilo Office

KONA: Thursday, April 19, 2007 at 1:00 p.m. at the Kona Office

If you have any questions prior to those dates, please feel free to contact me. I look forward to seeing all of you in either the Hilo or Kona offices.

Georgie Kennedy
Executive Director

Discussion/Support Group

The HIHAF Support/ Discussion group will be meeting at the HIHAF office on the third Thursday of the month, April 19th and May 17th, at 4:30 PM. Snacks are provided and all clients are welcome to attend. Call 982-8800 for more information.

Facilitated by Laura Acevado.
Hosted by Jeff Seyfried.

Free and Anonymous HIV Testing Locations and Dates

Free and anonymous HIV testing and counseling is available to the public on a regular, on-going basis. The testing is confidential and totally needle free.

Hilo/Kea'au

Hawaii Island HIV/AIDS Foundation
Shipman Business Park
16-204 Melekahiwa Place, Suite 1
Monday-Thursday, 9:00am-3:00pm

Pahoa

Pahoa Family Health Center, Pahoa Village
Every second and fourth Tuesday of the month 9:00am-12:00pm

Kona/West Side

Hawaii Island HIV/AIDS
Foundation – Kona Office
75-240 Nani Kailua Drive, Suite 5
In the Pines Plaza , Kailua-Kona
Every Tuesday, Wednesday, and Thursday, 9:00am-4:00pm

West Hawaii Community Health Clinic
Every Friday from 1:00pm-3:00pm

Ka'u Family Health Center, Na'alehu

First Wednesday of the month, 9:00am-12:00pm *

*** THIS REPRESENTS A CHANGE IN THE PREVIOUS SCHEDULE**

Hawai'i Island HIV/AIDS Foundation

CHOICES

is a publication of the
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Daron Scarborough/Prevention Coordinator
Bob Kraus/Administrative Assistant

Staff Kona

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Mission Statement

The Hawaii Island HIV/AIDS Foundation is a non-profit organization dedicated to assisting those affected by HIV/AIDS to maximize their quality of life, and to ending the spread of HIV. We also utilize the lessons learned in the HIV epidemic to care and advocate for others in the fight against related diseases.

Vision

To build a healthier, stronger, and more sustainable community that supports all its members with a focus on HIV issues.

Core Values

Responsiveness: To people with HIV/AIDS and their families and to the prevention education needs of the community.

Accountability: To our consumers, funding sources, and the community at large.

Integrity: To provide services to the entire community in a humane, loving, non-judgmental manner.

Diversity: To embrace the philosophy of "inclusiveness".

Collaboration: To establish and maintain partnerships within the community that maximizes resources and decreases duplication of services.

Leadership: To set the highest standards for responsibility to our mission, vision and values, and be recognized as a positive, inspirational role model in our community.

Advocacy: A collective public voice to speak on behalf of those affected by HIV/AIDS.

Editorial Policy

The articles contained in this publication are meant to inform and entertain only. They do not constitute an endorsement. The publication of any name or image does not necessarily imply anything about that persons condition, health or sexual orientation. The opinions expressed are those of individual authors and do not necessarily represent official positions of HIHAF or any other organization mentioned herein.

Contributions of articles and other materials for publication are encouraged and welcomed.

2 NEW CLASSES OF HIV DRUGS BLOCK VIRUS FROM REPLICATING

by Jia Rui Chong
Los Angeles Times

LOS ANGELES - In what some are hailing as the most important development in HIV therapy in a decade, two new classes of drugs have been found to block virus replication in patients who have become resistant to existing drugs, researchers said yesterday.

The two new classes, called integrase inhibitors and CCR5 inhibitors, doubled the number of patients in a group of studies whose infections could be brought under control, researchers said at the Conference on Retroviruses and Opportunistic Infections at the Los Angeles Convention Center.

This is “a pivotal moment” for patients who have become resistant to most AIDS drug said Dr. Eric Daar of Harbor UCLA Medical Center. Daar, who was not involved in the research, estimated that about 20 % of his patients are resistant to the existing classes of drugs.

Given the serious problems in treating drug resistant patients, Daar said the findings “brings the opportunity for a new life.”

Closest to federal approval is maraviroc, developed by drug maker Pfizer Inc. The drug binds to a receptor on the surface of human cells, known as CCR5, preventing HIV from locking on and entering the cells.

Maraviroc represents the first class of HIV drugs that targets the human immune system rather than the virus itself.

Dr. Howard Meyer of Pfizer reported on studies of maraviroc in 1,049 patients in 13 countries: 840 received the experimental drug in combination with their regular drug regimen, while the rest received a placebo and their regular drugs.

About 44 percent of the patients receiving maraviroc saw their blood HIV concentrations fall to undetectable levels after 24 weeks of therapy, Meyer said, compared with 23 per cent of those receiving a placebo. Experts believe the drug could be approved by the food and Drug Administration by the end of the year.

The second new drug is Merck & Co's raltegravir, formerly known as MK-0158. It blocks an HIV enzyme called integrase, one of three enzymes used by the virus to copy itself in the human immune system.

Dr. David Cooper from the University of New South Wales in Australia and Dr. Roy Steigbigel from State University of New York and Stony Brook reported in two studies involving 699 patients, two-thirds of whom received raltegravir in addition to their HIV drugs. Both studies were funded by Merck.

About 62 per cent of the patients receiving raltegravir saw the HIV in their blood fall to undetectable levels after 16 weeks, compared with 35 percent of those receiving the standard drugs alone, the researchers said.

The drug, which has been fast-tracked by the FDA, was well tolerated by patients.

CHLAMYDIA

Chlamydia is a sexually transmitted infection. In recent years the number of people infected has risen. If left untreated, the infection can cause infertility in women, and increase the likelihood of passing on HIV. Although anybody who is sexually active can get chlamydia, some groups, most notably young women or gay men, are more likely to be infected.

Transmission

Chlamydia is caused by bacteria called *Chlamydia trachomatis*. It can be transmitted during anal, oral and vaginal sex if no condom is used, and can affect the anus, penis, cervix, throat and eyes.

Untreated chlamydia may make a person with HIV more infectious as chlamydia can cause breaks in the mucous membranes (the barriers) of affected areas, and increases the number of HIV-infected cells in those areas. Having chlamydia can also make it more likely that an HIV-negative person will be infected with HIV if they are exposed to the virus.

Chlamydia can also be passed on from mother to child during child birth and can affect the baby's eyes, and cause pneumonia.

Prevention

Using a condom for anal, oral or vaginal sex is an effective way of avoiding infection with chlamydia or passing the infection on to somebody else. People who are sexually active are advised to have regular sexual health check-ups, where they will be tested for chlamydia and other sexually transmitted infections.

Symptoms

Symptoms of chlamydia normally occur one to three weeks after infection. However, many people who have chlamydia are unaware that they have the infection. It is thought that as many as 75 per cent of women with chlamydia, and 50 per cent of men with chlamydia have no symptoms.

Where symptoms do occur, in men it usually consists of a milky discharge from the penis, particularly in the morning, and a burning sensation when urinating. Chlamydia can also cause the testicles to swell. If a person has been infected anally, there may be soreness around the anus and a discharge.

Women with chlamydia may notice a milky discharge from the vagina and/or lower abdominal or back pain, or pain when having sex. There may also be vaginal bleeding during sex and bleeding between periods.

If chlamydia is left untreated it can lead to pelvic inflammatory disease (PID) in women, which can cause ectopic pregnancy, infertility, and even death in extreme cases. Men are less likely to develop serious complications, though untreated chlamydia may cause infertility. Both men and women may develop arthritis as a consequence of untreated chlamydia.

Treatment

Chlamydia is treated with antibiotics. Normally this consists of a seven day course of doxycycline, or a single dose of azithromycin. It is important to take all your tablets to ensure that the infection is eradicated from your body. Symptoms may persist for a few days after taking azithromycin as the antibiotic takes time to work.

When chlamydia is diagnosed you may be given the opportunity to see a Health Adviser. Health Advisers can give you information about safer sex and how to protect your own and other people's sexual health. They may also ask you to help them, where possible or practicable, to contact your sexual partners so they can be tested and treated too. In turn, this is intended to prevent you from becoming re-infected through continuing to have sex with someone who is them self infected.

STIs and DRUG RESISTANT HIV TRANSMISSION

A study of people newly diagnosed with HIV in the United Kingdom has found that sexually transmitted infections (STIs) are strongly associated with the transmission of antiretroviral-resistant HIV.

Researchers from two UK hospitals and the Health Protection Agency (HPA) have investigated the connection between two phenomena: sexually transmitted infections (STIs) as a factor in HIV transmission, and the transmission of drug-resistant HIV. STIs in either or both sexual partners make HIV transmission more likely – probably due to a combination of factors, including increased HIV shedding and greater susceptibility of sexual mucous membranes.

The transmission of antiretroviral drug-resistant HIV is also well documented: studies have shown that it occurs frequently in the UK (prevalence was at its highest – 16% – in 2002, and remains at 9% as of 2004).

This study, presented last week at the Fourteenth Conference on Retroviruses and Opportunistic Infections in Los Angeles, looked at 185 cases of primary HIV infection (infections acquired during the preceding six months), culled from 604 new HIV diagnoses made between 2000 and 2005. These cases were nearly all in white gay and bisexual men: of the 185, 175 (95%) were white, 174 (94%) were male and 169 (96% of the males) were men who have sex with men (MSM). The median age was 34 years.

Genotypic resistance testing was performed on blood samples from all individuals; 28 (15%) were found to have resistance mutations based on IAS 2005 definitions – a figure comparable to similar UK studies. A variety of resistance patterns were identified, predominantly NRTI or NNRTI resistance (61% and 43% respectively); PI and multi-class resistance were found in two cases (7%) each.

One hundred and twenty-four (67%) of the participants were screened for STIs at HIV diagnosis or within the preceding three months; there was essentially no difference in screening frequency between the groups with and without transmitted drug resistance (TDR).

One or more STIs were identified in 56 (45%) of the 124. However, STIs were more than twice as prevalent in the TDR group as in the group without TDR (68% vs. 31%, $p=.03$). The most frequent STIs identified were non-specific urethritis (22%), gonorrhoea (17%), and Chlamydia trachomatis (10%); syphilis, genital herpes and trichomoniasis were found in 2% or fewer, and multiple STIs were diagnosed in 5%.

Grilled Lemon Chicken



INGREDIENTS

- 1/3 cup lemon juice
 - 1/4 cup olive oil
 - 1 tablespoon Dijon mustard
 - 2 large cloves garlic, finely chopped
 - 2 tablespoons finely chopped red bell pepper
 - 1/2 teaspoon salt
 - 1/4 teaspoon ground black pepper
- 4 skinless, boneless chicken breast halves

DIRECTIONS

1. In a bowl, mix the lemon juice, olive oil, Dijon mustard, garlic, red bell pepper, salt, and pepper. Set aside 1/4 cup of the mixture to use for basting. Place chicken in the bowl, and marinate at least 20 minutes in the refrigerator.
2. Preheat grill for high heat.
3. Lightly oil grill grate. Drain and discard marinade from the bowl, and place chicken on the grill. Cook 6 to 8 minutes on each side, until juices run clear, basting occasionally with the reserved marinade



EARLY SYPHILIS INFECTION LOWERS CD4 COUNT AND RAISES VIRAL LOAD IN HIV-POSITIVE PATIENTS

Carolyn Partrick, Sunday, March 18, 2007

A study has found that syphilis infection in HIV-positive patients is associated with increases in viral load and decreases in CD4 cell count. The Spanish study, published in the March 1st issue of the Journal of Acquired Immune Deficiency Syndromes, is the largest of the three and, its authors believe, the first to have analyzed the factors associated with changes in viral load and CD4 cell count during syphilis infection.

The investigators found that syphilis infection was associated with CD4 count decreases and viral load increases in almost one third of the patients studied. Their results showed that the only factor associated with an increase in HIV viral load was not being on antiretroviral therapy (ART), while the only factor associated with a fall in CD4 cell count of more than 100 cells/mm³ was the patient's pre-syphilis CD4 cell count (patients who had higher pre-syphilis CD4 counts experienced greater falls).

The study's authors highlight one other finding from their study: more than two thirds of the syphilis cases were diagnosed in patients who had previously been diagnosed HIV-positive. This, they say, "highlights the risky behavior of our patients" and their "weak preventive strategies". They call for public health efforts to prevent new syphilis infections and to identify and treat infected patients as soon as possible, in order to reduce the spread of both syphilis and HIV.

The study was a retrospective one, using data from twelve Spanish hospitals. Researchers identified all the HIV-positive patients who had been diagnosed with early (less than two years) syphilis infection between January 2004 and December 2005. Patients who began or changed HIV treatments during the analysis period were excluded.

One hundred and eighteen patients were analyzed. Of these, 95.8% were men, 83.9% were gay, 50.8% were on ART at the time their syphilis was diagnosed, and 32.2 % had received their HIV and syphilis diagnoses at the same time. Mean patient age was 38.2 years.

The investigators compared the patients' plasma viral load measurements and CD4 cell counts at three points during the analysis period: 3-9 months before the diagnosis of syphilis, during the infection (between twelve and two weeks before the syphilis diagnosis), and three to nine months after diagnosis and treatment. For all the patients, treatment consisted of standard doses of benzathine penicillin.

Viral load and CD4 cell measurements "before" and "during" syphilis were available for 76 participants. Thirty-two of these had detectable viral loads before their syphilis diagnosis, ten (33.3%) of whom demonstrated viral load increases during the infection. The other forty-four patients had a fully suppressed viral load before their syphilis diagnosis, and eleven (25%) of them demonstrated a detectable viral load during their infection. Even so, the only factor associated with an increase in viral load was not being on ART.

The 76 patients with "before-to-during" data also showed significant decreases in CD4 cell counts during syphilis infection (590 vs. 496 cells/mm³; P = 0.0001), and the 94 who had "during-to-after" data showed significant increases in CD4 count after their syphilis was treated (509 vs. 597 cells/mm³; P = 0.0001).

The authors note that though it has previously been thought that increases in viral load occur mainly among patients with secondary syphilis infection, "our study [found] no difference in the virologic change depending on the stage of the syphilis". They also note that, in line with several other studies of coinfection in HIV-positive patients, they found no reduction in viral load after the syphilis was treated. These findings are thought to be the result of persisting immune activation.

HIV/AIDS SURVEILLANCE SEMI-ANNUAL REPORT

Hawai`i Department of Health Cases to December 31, 2006

AIDS Data: As of December 31, 2006, a cumulative total of 2,920 AIDS cases have been reported in Hawai`i. Of these, 1,719 (58.9%) are known dead. There were 88 cases reported during 2006 (one-year period), which yields an annual AIDS report rate of 6.8 per 100,000 population. Of the 88 AIDS cases, there were 78 (88.6%) males and 10 (11.4%) females. Honolulu County reported 65 (73.9%) cases; Maui County 10 (11.4%) cases; Hawai`i County 10 (11.4%) cases; and Kaua`i County 3 (3.4%) cases. AIDS data is detailed on pages 2-4.

HIV Data: Hawai`i is in the process of changing the reporting system from coded to named HIV reporting. At this time, Hawai`i HIV data based on code reporting are not available. It is recommended that all providers continue to report HIV cases with UTCs and keep the linkage of UTCs and names in their offices for follow up of missing information on case report forms and for future code to name conversion.

AIDS Mortality in Hawai`i, 1983—2005: There have been 1,708 AIDS-related deaths among Hawai`i diagnosed AIDS as of the end of 2005. This accounts for more than half (59%) of Hawai`i's diagnosed AIDS cases. AIDS mortality in Hawai`i reached its second highest level in 1995, then declined from 1996 and has stabilizing since 1998. In general, deaths among people with AIDS is around 40 cases per year since 1998. The reduction of mortality is related to the highly active antiretroviral therapy (HAART), which was introduced in 1996. It has reduced HIV progression to AIDS and decreased AIDS-related deaths. This results in people who have HIV/AIDS living longer. Table 1 shows the selected characteristics of AIDS death for the time periods pre-1996 and 1996-2005. In comparing the two time periods, data indicates a higher percentage AIDS mortality in the latter period for females (3.9% vs. 9.8%), Hawai`ians/ Pacific Islanders (11.3% vs. 16.6%), Asians (14.3% vs 18.9%) and Hispanics (3.9% vs. 5.3%). More people who were dying from AIDS were doing so at an older age (aged 40 and above) in the 1996-2005 period as compared with AIDS death in the earlier period. The average of length of time from initial AIDS diagnosis to death was 11.7 months pre-1996 and 41.4 months in the 1996-2005 time period. Most AIDS death were in Honolulu County (75.9%), followed by Hawai`i (11.8%), Maui (8.3%) and Kauai (4.0%) County.