

inside
▷▷▷

05 ▷ POLICE COMPLAINT

BCPWA's complaint against the Vancouver Police Department for disclosing a man's HIV status.

06 ▷ E-HEALTH

The government's new digital medical record-keeping system could threaten your privacy.

08 ▷ HIV AND AGING

A Positive Gathering workshop explored the issues around aging with HIV.

12 ▷ MEDICINAL MARIJUANA

The unsettling findings of the Canadian AIDS Society's report on the medicinal use of marijuana.

14 ▷ BC HEALTH MINISTRY'S PRIORITIES FOR ACTION

The 2005 Annual Progress Report reveals how the government is failing to meet targets.

16 ▷ PREVENTION

How do you decide if, how, and when to disclose your HIV status?

40 ▷ LAST BLAST

Weathering a mid-life crisis.

features
▶

09 ▶ CIRCUMCISION

Is male circumcision effective as an HIV prevention strategy? It depends on how you, uh, slice the matter.

20 ▶ HEART ATTACKS & HEART HEALTH

- ▷ Some tips on how to survive a heart attack.
- ▷ Understanding cholesterol and triglycerides.
- ▷ Eating well for a healthy heart.

treatment
information
▷▷▷

17 ▷ OPPORTUNISTIC INFECTIONS

- ▶ Community-acquired MRSA is not as rampant as news reports suggest.
- ▶ If you have persistent GI problems, it could be *Helicobacter cinaedi*.

26 ▷ SIDE EFFECTS

How one PWA got the province to pay for surgery to remove his buffalo hump.

28 ▷ COMPLEMENTARY THERAPIES

Integral spirituality embraces a broad range of mind states and spiritual practices.

30 ▷ STRAIGHT FROM THE SOURCE

New lab test available for abacavir hypersensitivity.

31 ▷ LET'S GET CLINICAL

The latest trials at the Canadian HIV Trials Network.

33 ▷ CMV TREATMENT

There may be new options on the horizon for this virus.

34 ▷ ANTIRETROVIRALS

- ▶ A report on the latest antiretroviral update from the BC Centre for Excellence.
- ▶ Kaletra is now in a more convenient tablet form.

living is published by the British Columbia Persons With AIDS Society. This publication may report on experimental and alternative therapies, but the Society does not recommend any particular therapy. Opinions expressed are those of the individual authors and not necessarily those of the Society.



**British Columbia
Persons With AIDS Society**

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think ⊕

opinion & editorial . . .

Canada's election puzzle

by R. Paul Kerston

It's like putting together a jigsaw puzzle: take three batches of single-coloured pieces (actually four colours, but only in one province) with highly irregular shapes, and you must somehow make sense of it all.

Welcome to our impending 2007 federal election.

The colours—blue, red, and orange—are the primary political parties, and those irregular shapes represent how the parties deal with issues. We have a lot at stake here: timely and fair healthcare access, women's issues (including those highlighted at International AIDS Conference in Toronto last summer), medicinal marijuana, safe injection sites, and affordable housing for everyone. Even the dreaded "C" word—the constitution—is back again, with questions from Senate reform to nationhood. And yes, there's the environment. We get it, but do the politicians?

As voters we must decide!

This new Conservative government rewarded its supporters by reopening the debate on marriage. That debate closed really fast. The Tories' 2006 campaign document, *Stand Up For Canada*, made it clear that one of their core values is family, but their definition rubs many the wrong way. And if their long-unkept promise on health care wait times is any indication, we should probably worry about family values rearing its head again despite assurances to the contrary. Speaking of healthcare, it's interesting that out of the five non-alphabetically-listed issues on their website, health care is dead last. And even though Stephen Harper didn't endear himself to many by boycotting the Toronto AIDS conference, voters can have short memories.

Liberals have a new and largely unknown leader. The party whom voters have most often rewarded must prove itself again. Still, only days into his job, Stéphane Dion permitted his party to have a free vote on the marriage motion. We expect his famous dog, Kyoto, to make dealing with the environment a sooner-than-later reality. Dion is an alternative, but must prove what kind of alternative.

Jack Layton's NDP party is at the forefront of every issue. The question remains: Can the NDP turn their criticisms into votes? We know they support healthcare reform, and the necessity to fight AIDS, especially in the context of women. Traditionally, they also have a greater number of women candidates. But, can they do it all?

Our nation is suffering a lack of affordable housing and the 2010 Olympics in Vancouver is forcing a housing crunch locally. City government is pressuring other levels of government for help, yet there are continued reports of single-room hotel closures and conversions being allowed. Our seniors, women, and all members living with disabilities have a keen interest in this issue. The federal government used to have more say in housing.

How voters deal with these issues will determine what our puzzle looks like when it's completed. So please make an informed vote—for us all. ⊕



R. Paul Kerston is a researcher with BCPWA's Treatment Information Program.



REALITYBITES

News from home & around the world

Vancouver syphilis rates climbing

The syphilis rate continues to climb within Vancouver's community of men who have sex with men (MSM), with almost one diagnosed case per day in early 2007. The BC Centre for Disease Control reports 158 syphilis cases within this community in 2006 and 120 cases in 2005.

More than 50 percent of the newly-diagnosed syphilis cases from the MSM community in 2006 were HIV-positive. Untreated syphilis increases the transmission risk of HIV and can cause complications in those who are HIV-positive. Syphilis can be transmitted through oral or anal sex. Condoms reduce the risk of infection but don't offer complete protection. Many people diagnosed with syphilis don't recall having symptoms.

Ask your family doctor for a syphilis test. Syphilis is curable with antibiotics. For more information, visit stdresource.com. Bute Street Clinic at 1170 Bute Street and the STI Clinic at 655 West 12th Avenue offer free confidential testing.

Glenn Doupe, BC Centre for Disease Control

Long-term CD4 response to antiretrovirals

Recently published data looking at CD4 response to long-term antiretroviral treatment shows that starting antiretrovirals earlier is associated with improved long-term median CD4 cell counts.

In a cohort of 655 HIV-positive patients studied over a six-year period, those who started antiretrovirals when their baseline CD4 counts were higher than 350 were more likely to achieve "normal" CD4 counts (750 or higher) than those who had lower CD4 counts when starting therapy. All patients had

fully suppressed virus during the six-year period and, after four years of therapy, everyone in the study experienced a plateau in CD4 cell increase.

Current guidelines suggest that people don't need therapy as long as they're healthy and their CD4 count is above 200. These findings suggest that starting therapy at an earlier stage might be beneficial, although the clinical significance of this is uncertain.

Rob Gair

Source: Medscape

Revamped HIV clinic sees health improvements

Reductions in acute emergency department visits, a drop in the rate of hospitalization, and improved health outcomes for HIV-positive patients are being attributed to recent revamp of the John Ruedy Immunodeficiency Clinic (IDC) at the BC Centre for Excellence in HIV/AIDS. The clinic also continues to see significant increases in patient numbers.

The expanded IDC offers consulting expertise in psychiatry, diet/nutrition, addiction, hepatitis C co-infection, neurology, internal medicine, and anal dysplasia. The additional services complement current consulting expertise in HIV therapy, dermatology, infectious diseases, and metabolic disorders. In the future, the clinic will also offer palliative and respite care, pain management, and alcohol/drug counselling.

The IDC serves HIV patients in need of family physicians; active drug users who live outside the Downtown Eastside; and those recently discharged from St. Paul's AIDS ward without access to follow-up from a primary-care physician. The IDC also cares for patients who would normally have accessed St. Paul's emergency room.

HIV vaccine trial in South Africa

The first large-scale trial of a potential HIV vaccine has started in South Africa. Merck & Co. is providing the vaccine for the study, which is expected to take four years.

Since the vaccine contains three HIV genes rather than the whole virus, volunteers will not be able to become infected from the vaccine, scientists say.

Researchers in South Africa and the US are running the trial, which is designed to show if the vaccine helps protect heterosexual people against the C strain of the virus, the most prevalent type in South Africa. The study is a "test of concept" trial that will help researchers determine if the vaccine prevents HIV infections, and results in lower HIV levels in those who become infected after vaccination, or both.

Source: CBC News

Microbicide gel trial halted

Researchers have halted studies of a vaginal microbicide after results suggested the gel might raise rather than lower the risk of HIV infection. Doctors had hoped that the microbicide would prevent HIV infection. The results are "a disappointing and unexpected setback" to efforts to get a simple tool for women to help lower their risk of getting HIV from sex, the World Health Organization said in a statement.

The studies were testing Ushercell, a gel containing cellulose sulfate, a cotton-based compound developed by Polydex Pharmaceuticals in Toronto.

The large, final-stage experiments were in parts of Africa and India. More than half of all new infections with HIV in Africa involve women and girls, and scientists have long sought a method women could use—even without their



REALITYBITES

News from home & around the world

partners' knowledge—to reduce risk, because many men refuse to use condoms.

Source: Associated Press

Selenium linked to lower HIV viral load

A recently published study showed lower viral loads and improved CD4 counts in patients who took selenium supplements.

In a double-blind study, 260 people with HIV were randomized to receive either placebo or 200 mcg/day of selenium. After nine months, those who were getting placebo had viral load increases and lower CD4 counts, whereas those who adhered to their selenium treatment showed no change in HIV viral load and improved CD4 counts. There were no observed side effects from the selenium. About 75 percent of study subjects were also receiving antiretrovirals.

Researchers used special selenium-enriched yeast capsules because they're better absorbed than other forms of selenium. A similar product (Seleno Excell from Natural Factors) is available at local health stores.

Rob Gair

Source: Archives of Internal Medicine

Danish study explores life expectancy

In settings where there is easy and free access to HIV medication and care, a young adult diagnosed with HIV has an estimated median survival rate of more than 35 years. However, this median survival rate is significantly lower than that of an HIV-negative person, according to a Danish study published in *Annals of*

Internal Medicine. The study also found that HIV-positive individuals who were coinfecting with hepatitis C virus, and patients who were older at the time of HIV diagnosis could expect to have poorer survival than younger, hepatitis C-uninfected HIV-positive patients.

The objective of the study was to estimate survival time and age-specific mortality rates of HIV-positive people and compare the estimates with that of the general population. The study included data from all HIV-positive individuals treated in Danish HIV clinics from January 1995 until May 2005.

Source: Aidsmap

Toronto man jailed for knowingly spreading HIV

A 30-year-old man who had repeated unprotected sex with two women while knowing but not telling them that he had HIV was sentenced to four years and eight months in prison by a Toronto judge. One of the women later contracted the virus.

The judge described the man's behaviour as "wanton, reckless and self-indulgent" for ignoring an order from health officials to warn his sexual partners that he had HIV. He had earlier pleaded guilty to two counts of aggravated sexual assault.

Source: The Toronto Star

Rates Of HIV dementia sky-high in Africa

The rate of HIV-associated dementia is so high in sub-Saharan Africa that it has become one of the most common types of dementia in the world, according to

an international study led by Johns Hopkins Medical Institution. In the study, researchers found 31 percent of a small but representative group of 178 HIV-positive patients in Uganda had HIV dementia.

"If the rate we saw in our study translates across sub-Saharan Africa, we're looking at more than eight million people in this region with HIV dementia," said Ned Sacktor, a Johns Hopkins neurologist and senior author of the multi-institutional study.

HIV dementia encompasses memory, learning, behavioural, and motor disabilities that interfere with normal daily life. In extreme cases, it can lead to total disability. Unlike the Alzheimer's and stroke-induced varieties, HIV dementia is treatable with antiretroviral medication. Treatment can restore completely normal cognitive function to some of those affected.

Source: The Advocate ☉

CORRECTION

On page 23 of the January/February 2007 issue of *living* ☉ magazine, the time frames were incorrect in the "General health checklist." Please see page 18 of this issue for the corrected checklist. We apologize for any inconvenience or confusion this error may have caused.

FIGHTING WORDS



Getting the VPD to button its lip

by Poonam Sharma

The BCPWA Society plans to file a complaint with the BC Privacy Commissioner to prevent unnecessary and unwarranted public disclosure of citizens' HIV-positive status by the Vancouver Police Department (VPD). The Society had filed a complaint with the VPD in June 2006 over a specific case, but the VPD dismissed the complaint in December 2006.

In March 2006, a man travelled from his home in Toronto to Vancouver to face charges of aggravated sexual assault. He allegedly had unprotected sex with two men after denying he was HIV-positive. He appeared in court on March 21, 2006 and fully cooperated with police investigations before returning to Toronto. On March 30, 2006, the VPD issued a media advisory publishing his name, photograph, and HIV-positive status. This information was picked up and widely broadcast by mainstream media.

In response, BCPWA filed a policy complaint with the Vancouver Police Board. "There are a lot of grey areas and decisions have to be made on a case-by-case basis," says Glyn Townson, vice-chair of BCPWA. "Guidelines need to be established that consider both the grievousness of the case and privacy issues. This release was an example of inappropriate use of information."

The BCPWA complaint stated:

"Were it necessary for the VPD publicly to solicit contact from 'anyone

who can provide further information on (the accused)'—a questionable activity in itself—it would certainly be possible to do so without 'outing' him as HIV-positive.

"We at BCPWA have been growing increasingly concerned over the course of the last few years as the constraints on the VPD's making public individuals' HIV-positive status seemed to have loosened to the point of complete ineffectuality.

"We strongly urge you, consequently, to establish policy for the VPD providing that, except in instances where there is unambiguous evidence of an individual charged with a serious offence involving their HIV-positive status placing members of the public at risk through ongoing reckless personal behaviour, the VPD be constrained from publishing any individual's HIV-positive status in any manner that may become publicly known except as may be required in the furtherance of related court proceedings."

Upon receiving BCPWA's complaint, in July 2006 the Vancouver Police Board's Service and Policy Complaint Review Committee asked the VPD to conduct a review of its policy on publicly communicating information about an individual's health status. The matter was discussed at a Service and Policy Complaint Review Committee meeting on December 15, 2006. The review stated that the press release in question was not a public safety warning, but an "investigative tool." It also stated

that although the release could have been worded differently, it was necessary to reveal the accused's HIV-positive status, and his denial thereof, so that others who had engaged in consensual unprotected sex with the accused could identify themselves as victims. The Committee thus dismissed BCPWA's complaint with the conclusion that current policies and procedures regarding disclosure of personal information are adequate, and that no changes are required.

"Any evidence collected couldn't have been used in the case in progress, but only to build a new case," says Townson. "What process do they have in place? What is the litmus test? They haven't given evidence that they have weighed the benefits of disclosure versus privacy issues."

We need an effective system of checks and balances to ensure that what information is publicly released stems from an informed case-review and decision-making process. BCPWA's next step will be to consult with the BC Privacy Commissioner on further action in their complaint. ☺

Poonam Sharma
is a freelance writer
and communications
department intern
with BCPWA.





Opening the floodgates

The new eHealth digital record-keeping system may spell the end of your medical confidentiality

by Ross Harvey

Imagine, for a moment, that much of the confidential personal information you've shared with your doctor over the years is suddenly available to all kinds of other health-care workers across BC—from the specialist at St. Paul's, to the pharmacist at the drug store down the street, to the emergency paramedics at the local fire hall.

That information could include your name, residence, age, sex, and ethnicity; it could include current medical conditions (including HIV status), past medical and surgical history, allergies/alerts, current medications, immunizations, advance directives, and most recent and critical diagnostic data.

These are the components of a "core data set." As Dr. Jel Coward reported in the September/October 2006 issue of *living* ⊕ ("Not-so private records"), all physicians in BC are now being encouraged to collect such digital core data sets on each of their patients. The provincial government will pay up to 70 percent of the costs that physicians incur converting their offices to digital records-keeping systems that can store this information, which is compatible with the government's planned master system for sharing these data.

Good intentions, but at a price

For several years now, the BC Ministry of Health has been planning and developing this digital system it calls "eHealth." The idea is that all your healthcare providers will be able to get a complete picture of your entire health status at any time by calling up your information on-line. This, proponents claim, will enable them to give you health care and advice that is thoroughly informed and thus, better attuned to your needs

and less prone to error. As well, should you ever require emergency treatment anywhere in the province, the emergency response personnel attending you will have similar access, and will therefore have a better sense of how to treat you and which medications or procedures to avoid.

But the price may be the confidentiality of your previously privileged doctor-patient health records.

BCPWA is pressing hard for modifications that would permit individuals to determine for themselves which pieces of their medical information would be included in their core data sets.

The system's proponents claim all information collected will be entirely safe and kept strictly confidential in accordance with existing privacy legislation. But because the purposes for which any individual working in the healthcare system would try to see your health information is assumed to be consistent with the reasons for which it was originally collected—that is, providing you with proper health care—the safeguards in provincial privacy legislation may not apply. And because access to the system will necessarily have to be so widespread—to enable it to provide the benefits for which it is being constructed—tracing breaches and leaks will be difficult. This reduces the threat of detection.

There are also serious questions about whether the system as presently designed will permit individuals to screen, much less have control over, the information in their core data sets, and any other information on them in the system. This is a time-tested recipe for error—perhaps catastrophic error—to creep into the records. Consequently, there is a tremendous risk that what is intended to be a beneficial system will in some instances prove to be a harmful one.

A data management firm will have access

As well, plans call for all core data sets to be routed through one master server, which will be maintained by a contracted private sector data management company. So all the privacy concerns that surrounded the province's contract with the wholly-owned BC subsidiary of the American MAXIMUS corporation to manage the BC Medical Services Plan and PharmaCare records come leaping back to the fore (see "Private and confidential" in the March/April 2005 issue of *living* and "No end in sight for cross-border spying" in the July/August 2005 issue).

BCPWA is not calling for the system to be scrapped. The potential benefits are too great. However, to protect individuals' confidentiality, and the privileged nature of the doctor/patient relationship, BCPWA is pressing hard for modifications that would permit individuals to determine for themselves which pieces of their medical information would be included in their core data sets.

To this end, BCPWA has accepted an invitation to place two representatives on an ad hoc committee, assembled by the provincial Ministry of Health's eHealth team, that is tasked with examining the proposed system and making recommendations for safeguarding patient/client confidentiality. Initial indications are that there may be ways of doing this, and of placing individuals at the centre of control over their health information.

But those methods might be difficult and expensive, so there is no guarantee that they will be recommended by the ad hoc committee, much less accepted by the architects of eHealth. BCPWA will keep its members informed of these developments. ⊕



Ross Harvey is BCPWA's executive director.

Take action—protect your privacy!

The BCPWA Society has written a background paper on this privacy issue, called "Confidentiality at the Crossroads," and is circulating it widely. It's available at www.bcpwa.org/articles/BCMA-IT-Backgrounder080106.pdf.

If you're concerned about maintaining your medical confidentiality, write to your doctor and specifically withhold consent to share any personal health information beyond that which has traditionally occurred among healthcare professionals. You can find a form letter at www.bcpwa.org/articles/SampleLettertoPhysicians-Appendix6.pdf.

Write directly to the Health Minister, George Abbott, and let him know that major changes in the eHealth system are needed to make it acceptable. You can find a form letter for this at www.bcpwa.org/articles/SampleLetter2BCHealthMinister-ElectronicMedicalRecords.pdf.



**BCPWA
Advocacy
gets
results!**

The BCPWA Society's Advocacy Program continues to work hard to secure funds and benefits for our members. The income secured for October and November 2006 is:

- **\$59,833** in debt forgiveness.
- **\$29,570** in housing, health benefits, dental and long-term disability benefits.
- **\$51,195** monthly nutritional supplement benefits
- **\$2,250** in ongoing monthly nutritional supplement benefit for children

An age-old dilemma

Positive Gathering workshop explored the issues around aging with HIV

by Melissa Davis

Another issue that participants raised in the workshop was the physical aspects of aging with HIV. Often, Macdonald and Morrissey explained, it's difficult to determine whether the source of a medical problem is age-related or specific to HIV disease. For example, joint pain could be symptomatic of aging, the onset of an age-related condition such as arthritis, or a manifestation of a side effect from anti-retroviral medication or another drug prescribed to treat an HIV-related condition. The course of treatment depends on the source of the symptom, so quality medical care—HIV specialists as well as general practitioners who are knowledgeable about HIV and age-related health issues—is particularly important.

One of the most sensitive psychosocial issues explored in the workshop, according to Macdonald, was the notion of “death as a constant companion.” Among long-time PWA survivors in particular, there's an understanding and an acceptance of the transient quality of life. “When I was diagnosed with HIV in 1989, and people were literally dying all around me, the impact of the disease was always present,” Macdonald says. “And the reality is, it's still present.”

“Ultimately, a group of people with common experiences and concerns came together and found out that they weren't alone,” says Macdonald, reflecting on the outcomes from the workshop. There is some reassurance in that initial step. But based on feedback from participants, he adds, there's clearly a need and a demand for services geared specifically to HIV-positive gay men who are approaching their senior years. ☪

Meet with other seniors

Gay, HIV-positive men who are interested in meeting together on an ongoing basis to explore these issues can contact Stephen Macdonald at 604.893.2290 or by email at stephenm@bcpwa.org

Melissa Davis
is BCPWA's acting
director of communications
and education.



“It wasn't until about a year ago that I felt comfortable publicly disclosing my age,” admits Stephen Macdonald, BCPWA Society's human resources manager and a gay man living with HIV for 17 years. Macdonald proudly celebrated his 60th birthday last spring. “I did a lot of self-examination in the months prior to my birthday,” he says. “Issues around aging as a gay man and a long-time PWA were at the forefront of my mind.”

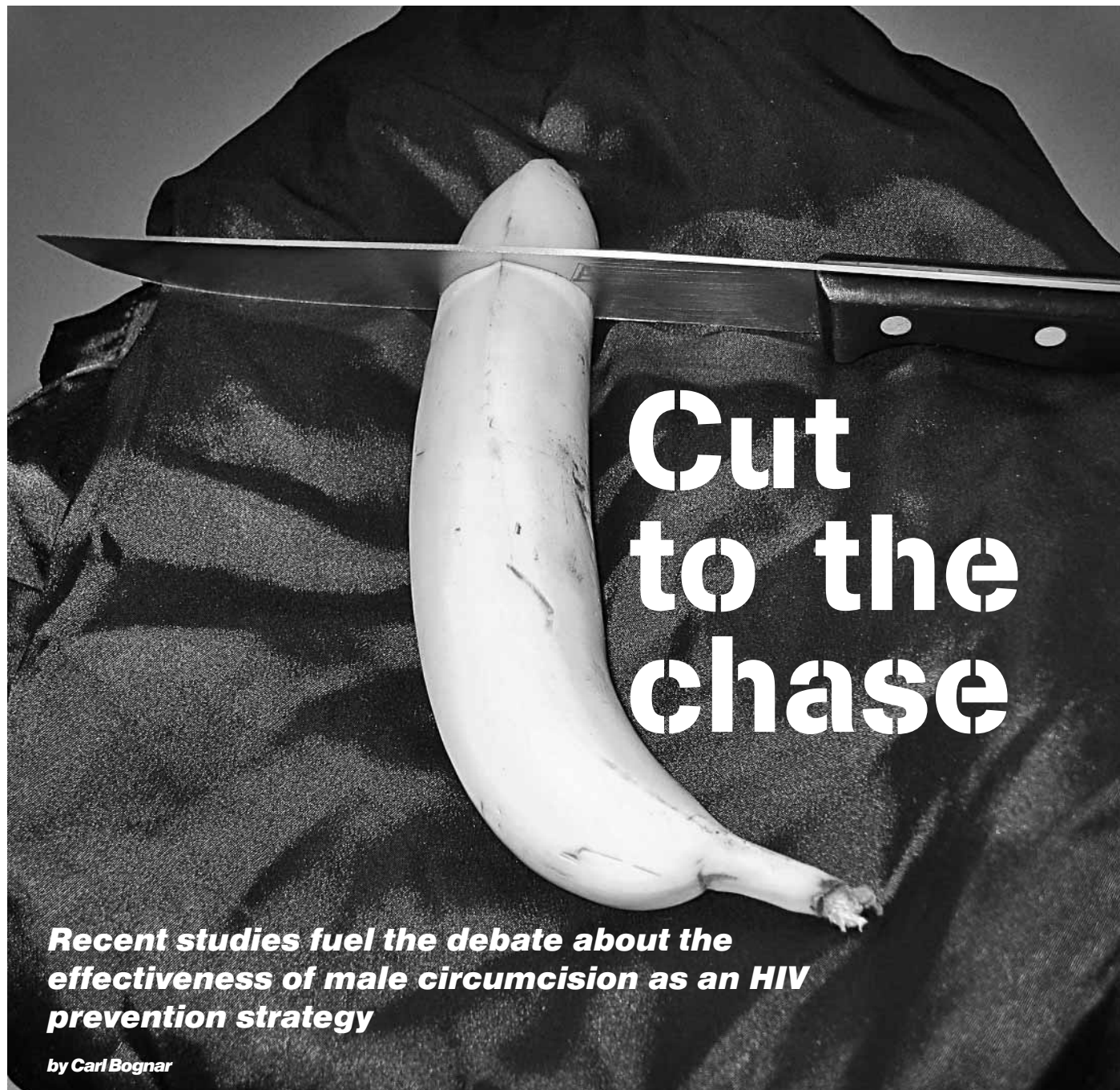
Macdonald is in good company—which he discovered when he coordinated last fall's Positive Gathering, the provincial conference by and for people living with HIV/AIDS. Focus groups conducted among PWAs from across BC before the gathering revealed that the experience of aging with HIV was a topic of interest among prospective conference attendees.

Macdonald volunteered to co-facilitate a conference workshop with Chris Morrissey,

coordinator of the Lesbian Gay Bisexual Transgendered (LGBT) Centre's Generations Project. The session, entitled *Aging Gracefully? Life After 55*, attracted more than 40 participants from both urban and rural parts of BC.

Workshop topics ranged from physical aspects of aging with HIV to psychosocial issues. Participants expressed some concerns that are common to aging populations irrespective of HIV status or sexual orientation: the need for safe, affordable housing; quality, subsidized health care; home care; and social supports.

While all seniors commonly encounter such issues as loneliness, the need for companionship, and the desire for a satisfying sexual life, gay male culture can present additional challenges. “In a community that values youth, beauty, and the perfect body, older gay men typically feel invisible, undesirable, and unwanted,” says Macdonald.



Cut to the chase

Recent studies fuel the debate about the effectiveness of male circumcision as an HIV prevention strategy

by Carl Bogner

Early in the AIDS epidemic, observational studies suggested that male circumcision could provide a protective benefit in reducing HIV transmission from females to males. To explore the role that male circumcision might play in HIV prevention, three major experimental studies were conducted in Africa. The findings led to proposals to use male circumcision as a

method of HIV prevention, particularly for countries in sub-Saharan Africa. It should be noted that none of these three studies investigated the impact of male circumcision on HIV transmission to females; they looked only for a possible protective effect for males who have been circumcised.

continued on next page

In the first study, researchers from France and South Africa collaborated on a randomized control trial on a group of 3,200 South African men aged 18 to 24, in a study that has become known as the Orange Farm Intervention Trial—after the South African township where the research was conducted. The investigators presented preliminary results at the International AIDS Conference in Toronto last year.

In the study, uncircumcised men who were willing to be circumcised were randomly assigned to an intervention group or a control group. Men in the intervention group were circumcised, while men in the control group were not. The researchers conducted follow-ups at 3, 12, and 21 months, testing participants' HIV status each time. There were 20 new HIV infections in the intervention group, compared with 49 in the control group. This represents an overall 60 percent reduction in the rate of acquisition for circumcised men.

What they didn't highlight

However, two curious incidental findings didn't draw as much attention in the study report as this apparent reduction rate. First, the data indicated that men who had been diagnosed with genital ulceration (in the year previous to any of their follow-up visits for this study) were six times more likely—or 600 percent more likely—to acquire HIV. This is in line with other studies indicating that genital ulceration, due to herpes or other sexually-transmitted infections (STIs) such as syphilis, greatly increases the probability of HIV acquisition by males. In an apparent bias towards circumcision, the authors didn't indicate in the published paper that their own analysis suggested that prevention of STIs might prove 10 times more effective than circumcision in preventing HIV acquisition.

Second, in screening for the study, the investigators rejected 146 potential participants because they were already HIV-positive. In a research protocol approved by an ethics committee, the researchers didn't inform these HIV-positive men of their HIV status because of the stigma attached to HIV in many parts of Africa. The study has been strongly criticized for leaving so many participants unaware of their HIV infections. Nearly 150 men were potentially transmitting HIV to their sexual partners, while the circumcision campaign averted only 30 new infections. Editors of the British medical journal *The Lancet* found this aspect of the research so objectionable that they refused to publish the initial report on the study.

Two studies similar to the Orange Farm study were conducted among 7,700 men in Kenya and Uganda. The Kenya study was partially funded with \$2.5 million from the Canadian Institutes of Health Research. Details of this study are still in press, although the outcomes are known: 44 circumcised men became infected through the course of the study, compared with 90 of the uncircumcised men, a reduction of approximately 50 percent. Researchers stopped the study in December 2006 because the results were statistically significant and indicated a protective effect of circumcision.

Circumcised men still need condoms

The fact remains, though, that male circumcision is a highly imperfect method of HIV prevention. It reduces, but does not eliminate, the dangers of unprotected sexual activity. And it in no way relieves men of the need to use a condom to protect themselves sexually every time. If men are always using sexual protection, then circumcision is only a potential ally in the fight against HIV in cases where there is condom failure. This presents a paradox, since condom failure appears to be more common among circumcised men, who produce a smaller amount of natural self-lubrication. Furthermore, research suggests that circumcised men are already less likely to enjoy using a condom, and therefore less likely to use condoms, since their penises have already been desensitized through the loss of normal erectile tissue and nerve endings that results from circumcision.

Male circumcision in no way relieves men of the need to use a condom to protect themselves sexually every time.

While circumcision may have an overall preventive impact, it doesn't allow for behaviour change—and may complicate condom usage—at the individual level. This may hinder efforts to promote condom usage, particularly when circumcision is touted as a means of HIV prevention. As a result, wide-scale male circumcision would complicate much-needed prevention messages, and it would create the need for additional funding to develop and implement more complex prevention initiatives.

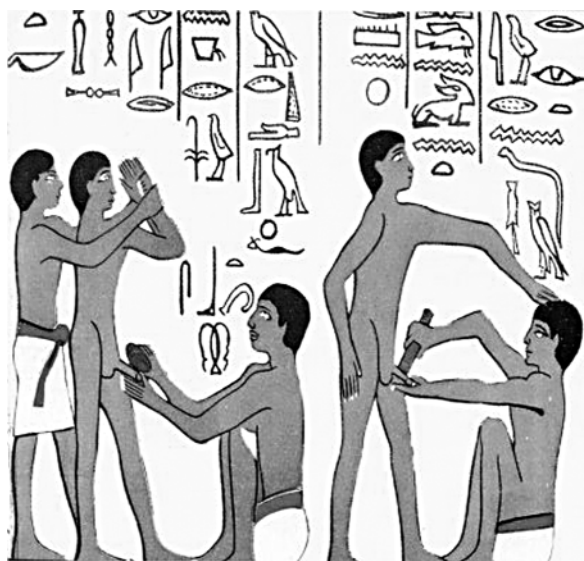
A questionable use of scarce resources

The cost-effectiveness of widespread circumcision also needs to be assessed, particularly in view of the relative impoverishment of healthcare systems in Africa. While male circumcision can be relatively low cost, it's difficult to quantify how much it would cost to improve African systems of medical care to ensure that circumcisions are performed by adequately trained staff who have appropriate equipment in hygienic settings. In resource-poor environments such as sub-Saharan Africa, we must ask whether a medical intervention that produces a very imperfect prevention measure is justifiable when more highly-effective approaches are available.

It will be difficult to justify allocating scarce resources to male circumcision programs when there isn't enough funding to provide antiretrovirals for all pregnant mothers, an intervention that we know is virtually 100 percent effective in preventing HIV transmission. We also know that viral load is one of the major variables in HIV transmission. Controlling HIV infection

through antiretrovirals greatly reduces the probability of HIV transmission, but few Africans have access to treatment. In the absence of adequate funding for universal treatment, or for condoms, or for universal prevention of mother-to-child transmission, how can we justify spending scarce resources on circumcision?

We also need to consider the broader social contexts of implementing wide-scale male circumcision, for example, its acceptability in the various tribes in sub-Saharan Africa. Historically, some tribes have favoured circumcision as part of initiation rites, while others haven't. Because of these factors, the medicalization of male circumcision will inevitably give rise to complicated social and cultural issues.



Egyptian bas-relief from 2400 BC depicting circumcision ritual.

This is a complex problem: there are many tribes and cultures within Africa, so there can't be a single solution for all African males. So far, these social and cultural issues haven't been considered. "The cultural meaning of [circumcision] is much more profound than this kind of research can take account of," Australian community-based researcher Gary Dowsett has stated. "Social scientists have been deliberately excluded from this field because they know we'll mess up the field."

Still need to deal with the stigma of HIV

Finally, there is the troubling issue of HIV stigma raised in the Orange Farm study. How can any HIV prevention strategy be successful if people aren't aware of their HIV status? How can prevention be successful in the face of stigmatization of the disease? It might be more effective to scale up testing, counselling, and anti-stigma programs, rather than instituting a wide-scale surgical program.

In the past, male circumcision has been touted to prevent or cure masturbation, cervical cancer, alcoholism, epilepsy, asthma, hernia, gout, rheumatism, headaches, curvature of the spine,

and penile cancer. There is absolutely no medical evidence, however, that it offers any of these benefits. No medical authorities currently recommend routine male circumcision. Anti-circumcision advocates claim that up to one-third of normal penile tissue is lost through circumcision; they insist that without any demonstrated medical benefit, it is an abusive, unethical practice that ought to be stopped.

In the absence of adequate funding for universal treatment or for universal prevention of mother-to-child transmission, how can we justify spending scarce resources on circumcision?

Responding to the African research, the World Health Organization (WHO) has taken the position that safe circumcision should be offered in cases where men want it, but WHO won't recommend wide-scale male circumcision until further studies have been completed to assess human rights, ethical, and cultural issues, as well as clinical capacity and knowledge gaps. The WHO states that "male circumcision should never replace other known effective prevention methods and should always be considered as part of a comprehensive prevention package, which includes correct and consistent use of male or female condoms, reduction in the number of sexual partners, delaying the onset of sexual relations, and HIV testing and counselling."

Margaret Somerville, the noted medical ethicist from McGill University, has written that a medical intervention is ethical only when it is necessary for the preservation of the health or life of the patient, when the intended effect can't be attained in any other way, and when therapeutic benefits outweigh potential risks and harms. Given the relationship between male circumcision and HIV prevention, and the overall status of health care in Africa, these ethical criteria can't be met by instituting wide-scale male circumcision.

Meanwhile, Africa urgently requires assistance to address other critical—and more effective—HIV prevention methods. ☉



Carl Bognar is the former BCPWA prevention coordinator.

Gone to pot

Access to medical marijuana takes a few steps backward

by Carl Bogner

How legal is marijuana when it's used for therapeutic purposes? The Canadian AIDS Society (CAS) recently published its findings of a legal review and national consultation on the medicinal use of marijuana in Canada, titled *Cannabis as Therapy for People Living with HIV/AIDS: Our Right, Our Choice*, which provides answers to questions like that. The answers, however, are complex.

In 2001 Canada became the first country to authorize the use of cannabis for medical purposes. In 2000, the case of *Regina v. Parker* ruled that under Section 7 of the Charter of Rights, "the choice of medication to alleviate the effects of an illness with life-threatening consequences" is a fundamental personal liberty.

Before the *Parker* decision, the federal Minister of Health had the discretion to provide authorization for individuals to use marijuana therapeutically, but in *Parker* the courts ruled that it gave the Minister of Health too much discretion in individual cases. As a result, Health Canada developed the Marihuana Medical Access Regulations (MMAR).

Resistance from provincial medical associations

Under MMAR, a physician had only to sign a declaration that an individual required medicinal marijuana, thus shifting the discretionary power from the Minister of Health to the individual's physician. However, the MMAR failed to specify how or where patients could legally obtain a supply of marijuana. Further court cases led to revisions to the MMAR in 2005, streamlining the application process, treating marijuana as a drug (thus supporting research and clinical trials), raising the possibility that marijuana could be distributed through pharmacies, and increasing surveillance to monitor safety and effectiveness.

The MMAR cast physicians in the role of gatekeepers of the medicinal marijuana program, but the Canadian Medical



Association resisted. Some provincial medical associations warned their doctors against completing MMAR forms for the therapeutic use of cannabis. Furthermore, the Canadian Medical Protective Association (CMPA), which insures about 95 percent of doctors in Canada, advised its members against signing application forms. The CMPA claimed that doing so could go beyond the scope of their expertise, given that marijuana is not a controlled drug and that clinical research into its long-term effects is not conclusive, especially within the context of specific illnesses.

While the Canadian approach is progressive and compassionate, Canada's obligations under the 1961 United Nations Convention on Narcotic Drugs led to a curious situation. A patient could designate one person to grow on his or her behalf, but a designated grower couldn't collaborate with more than two other designated growers. Health Canada didn't allow designated growers to group together because such a move was viewed as being contrary to Canada's treaty obligations under the 1961 Convention.

Many PWAs are technically breaking the law

Health Canada's website states that "without authorization under the MMAR, persons using marijuana for therapeutic purposes in Canada are breaking the law." As of September 2006, about 1,500 Canadians have obtained this authorization.

However, this is only a small portion of Canadians who would be eligible; in fact, Vancouver's Compassion Club alone

has about 3,500 members. It's estimated that between 17 and 37 percent of PWAs use marijuana for therapeutic purposes, which translates to at least 10,000 people. People with a range of other medical conditions, including multiple sclerosis, spinal cord injury, spinal cord disease, severe pain, persistent muscle spasms, cancer, and epilepsy, are also eligible for authorization under the MMAR, so we can only conclude that the medical marijuana program isn't as accessible as it should be.

Under existing law, Canadian cannabis clubs remain an illegal source of cannabis. However, some clubs continue to exist with tacit arrangements with local police departments, and some have obtained status as non-profit charitable societies.

While police have raided a few clubs, to date none has been successfully prosecuted. It hasn't been determined why cannabis clubs remain a more popular choice with users of medical marijuana, although the process to join most compassion clubs is less stringent than obtaining a legal authorization through the MMAR.

Not-so-simple access to marijuana

The authorization to use marijuana therapeutically under the MMAR also doesn't provide easy access to medicinal marijuana. People must grow their own marijuana, authorize someone to grow it for them (at no cost), or purchase it from Prairie Plant Systems (PPS), a Manitoba biotech firm licensed by Health Canada to grow marijuana for its medical marijuana program. There have been complaints, however, about the poor quality of marijuana from PPS.

One of the major stumbling blocks in all this is that there hasn't really been adequate research to study the risks and benefits of marijuana used therapeutically. Until recently, research was actively thwarted, particularly in the US. Health Canada is empowered to regulate the use of pharmaceuticals in Canada, but does so only after reviewing pertinent research literature that follows strict scientific protocols. But such research results aren't generally available for cannabis products.

Usually, requests to add drugs to approved lists are championed by large pharmaceutical corporations, and marijuana has no such champion. That's why in 1999, Health Canada instituted a Medical Marijuana Research Program, funded through the Canadian Institutes of Health Research. But in 2006, Stephen Harper's Conservative government suspended the program. This places the status of therapeutic marijuana in a catch-22 situation: clinical evidence is needed before cannabis can be approved for use as a medicine, but there's no longer support to develop this clinical evidence. As the CAS report notes, "it is critical that clinical research be conducted, otherwise the federal medical cannabis program will remain a special access program rife with unnecessary regulatory and bureaucratic barriers."

Meanwhile, Cannasat Therapeutics of Toronto announced in November 2006 that the National Research Council of Canada's Industrial Research Assistance Program was providing funding toward the research and development of CAT 210, a cannabinoid-based product. So, while the Harper government

won't support research into the effects of marijuana as a natural product, it will support research into pharmaceutical derivatives of marijuana.

Conservative feds unlikely to act on CAS recommendations

The CAS report makes a number of recommendations, including an audit of all aspects of the current MMAR program, raising awareness of the program among people with serious illnesses, increased clinical trials and community-based research, and the provision of information about medicinal marijuana. The report also recommends lifting the regulations with respect to designated growers, and recognizing compassion clubs that meet certain operational standards as legal dispensaries.

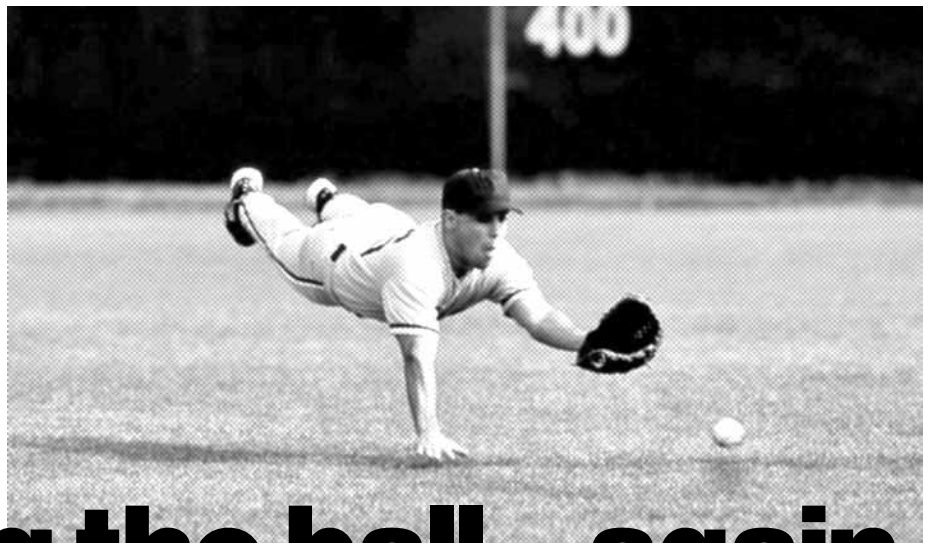
One of the major stumbling blocks is that there hasn't really been adequate research to study the risks and benefits of marijuana used therapeutically.

These are all excellent recommendations, but the Conservative government doesn't appear to be receptive to the use of marijuana for medical purposes despite the fact that, according to opinion polls, 93 percent of Canadians approve of legal access to marijuana for health purposes. Some of the government's reluctance may result from pressure from the US: a meeting with top US drug officials is scheduled to take place in Ottawa early in 2007. The US government has always taken a tougher stand on all aspects of drug use than the Canadian government, and no doubt the US-Canada meeting will result in increased pressure against more liberal attitudes toward drug use. As well, the discontinuation of the \$4 million in funding for the Medical Marijuana Research Program is a step in the wrong direction.

Finally, there are rumours that the current government plans to move Canada's Drug Strategy from the Department of Health to the Department of Justice, despite the fact that a recent study from the BC Centre for Excellence in HIV/AIDS shows that 73 percent of the government's drug-related spending is on enforcement, rather than on prevention, harm reduction, or treatment.

While there have been significant advances in the use of marijuana for therapeutic purposes in Canada, it appears unlikely that further advances will be made under our current Conservative government. ☹

Carl Bognar is the former BCPWA prevention coordinator.



Dropping the ball—again

The 2005 Annual Progress Report reveals how once again the BC government is failing to meet targets

By Glyn Townson

In September 2003, the BC Ministry of Health Services released *Priorities for Action in Managing the Epidemics: HIV/AIDS in British Columbia 2003-2007*, a strategic plan that outlined provincial goals and set objectives to tackle HIV in BC. Last year, the government published its first annual progress report for 2004, and in almost all categories, they had failed to meet targets.

The province recently released its *2005 Annual Progress Report*, and the results are a mixed bag. The tone of the 2005 report has changed, for the better. For starters, it acknowledges that people living with HIV are an important part of the solution—along with the other major players from the Health Authorities, the BC Centre for Excellence in HIV/AIDS (BCCfE), the BC Centre for Disease Control (BCCDC), and the many community groups invested in working towards solutions. That's a far cry from the lofty numbers set out in the 2004 report card. The BC government had no stake in many of those grandiose achievements sited in the 2004 report; several accomplishments that the report highlighted were funded through federal or private grants and had nothing to do with the BC government.

There isn't much to report on changes in the HIV infection rates in this province, so let's look at the original objectives. (To set the context, we'll refer to numbers in the federal epidemiology reports in conjunction with the BC numbers; this is important, since for their 2006 report, the federal government adjusted estimates of the number of people who didn't know that they are infected with HIV from 30 percent in 2002 to 27 percent in 2005.)

Some number crunching

The *2005 Annual Progress Report* shows an overall reduction in new HIV infections from 10.07 per 100,000 people in 2004 to 9.6 in 2005. The closest corresponding number was from the BCCDC, which reported a rate of 9.9 per 100,000 people in its

own 2005 report. The 2005 BC report quotes numbers that are unpublished by the BCCfE, therefore unverifiable. One set of numbers that stands out is the estimate of 8,600 to 12,200 HIV-positive British Columbians in 2005, down from 9,000 to 15,000 in 2004. Much of this difference can be accounted for by Health Canada's revisions to its estimates of HIV prevalence throughout the country.

A few numbers couldn't be reconciled. The BC document reports 410 newly diagnosed cases of HIV as of year-end 2005, whereas the Health Canada document quotes 422 cases. By comparison, the BCCDC statistics report 420 cases.

As a result, this year's BC report boasts an decrease in the overall infection rate per 100,000; however, the report acknowledges there hasn't be a statistically significant drop in new infections, certainly not the target of 25 percent goal in the strategic plan.

On the bright side, while not one of the original goals, in 2005 approximately 76 percent of people who met the requirements for antiretroviral therapy (ARV) were receiving it. The 2005 report also states that the government would like to be able to provide ARVs to all patients who want them and meet the therapeutic guidelines by the end of 2007. Bear in mind the problems that the BCCfE faced when it exceeded its budget on ARVs this past year, and the government threatened to limit the kinds of medications available through the BCCfE when it went \$12 million over budget.

Large proportion of new infections among First Nations

The report also addresses issues that people within the HIV movement are already familiar with, such as the low proportion of women currently accessing ARVs and barriers to accessing treatment by other minority groups that are rapidly growing in numbers. First Nations are still overrepresented, making up 14

Goal	Specifics	Grade	Comments
1 Prevention	Reduce the number of new HIV infections by 50 percent by 2003 and 2007	F	Using the government's own number of 410, this year's target was 308 new cases, missed by over 100.
Care, Treatment, and Support	To increase the proportion of HIV-positive individuals linked to appropriate care, treatment, and support services by 25 percent between 2003 and 2007	C	The ARV treatment numbers keep this grade up, however, other community based services and supports are still sadly lacking.
3 Capacity	To enhance the province's capacity for monitoring the HIV epidemic by 2007	C	This could have been higher, but services outside the major urban centres are still lacking.
Coordination and Cooperation	To create and sustain broad-based support for the approach outlined in the Priorities for Action	F	In 2005, several of the Health Authorities still did not have strategic plans for HIV management in their service areas. Missed opportunities to utilize PAN to assist with these issues.

percent of new infections, while representing only 4 percent of BC's population. The other anomaly with First Nations is that new cases in 2005 were evenly split between male and female, disproportionately high compared with the general population in the province, where the ratio of new infections is currently 6:1 male to female.

Although the report is definitely a more honest snapshot of HIV in the province, the largest barrier continues to be lack of funding to community-based groups. In the appendix of the report, there are recommendations from the Health Authorities and key informants about gaps in the current service structure. While it's admirable to seek 100 percent uptake on ARV treatment, costs won't be sustainable if the numbers of newly infected continue to grow at the current rate. More effort is needed to slow the rate of new infections. That's not going to happen without adequate funding to the community partners to focus prevention efforts throughout the province. Remember that BCPWA was forced to close its Prevention Department due to budget shortfalls in 2004.

There are some other inaccuracies in the report: the Positive Gathering, which was a partnership between BCPWA and nine other organizations throughout BC, was reported as hosted by the Pacific AIDS Network (PAN). Beyond that, there's little mention of PAN in the report, which is unfortunate, as the skills building sessions and community building it provides are vital and the organization does receive some funding from the province.

Grading the province's performance

The recommendations in the report are fine except that once again, there are no firm numbers, and no dollar amounts have been committed to reach the proposed goals. So, based on the

evidence, here's my report card on the *2005 Annual Progress Report*. The government's grades have slightly improved in this year's report in a couple of areas; however, without more focus and attention to funding and details, the *Priorities for Action* plan will not meet its goals. ⊕



Glyn Townson is BCPWA's vice-chair.

Compare and despair

Check out the following links for the full documents:

www.healthservices.gov.bc.ca/hiv/pdf/hivpriorities.pdf
Priorities for Action in Managing the Epidemics: HIV/AIDS in British Columbia 2003-2007

www.healthservices.gov.bc.ca/hiv/2005_Progress_Report.pdf
2005 Annual Progress Report

www.healthservices.gov.bc.ca/hiv/pfa_2004_progress_report.pdf
2004 Annual Progress Report

www.phac-aspc.gc.ca/publicat/aids-sida/haic-vsac1205/index.html
HIV and AIDS in Canada: Surveillance Report to December 31, 2005, Public Health Agency of Canada

www.bccdc.org/downloads/pdf/epid/reports/Epid%202005%20annual%20FINAL.pdf

2005 British Columbia Annual Summary of Reportable Diseases, BC Centre for Disease Control



The disclosure dilemma

by Elgin Lim

If you're a person living with HIV, dating and sex often involve that uncomfortable moment of if, how, and when you disclose your HIV status. Should you do it before you have sex? During the first date? Only if asked? Only if things get serious?

In 1998, investigators at the University of San Francisco examined how many patients on highly active antiretroviral therapy (HAART) were having sex without disclosing their HIV status. They found 29 percent of gay men, 41 percent of heterosexual men, and 48 percent of heterosexual women always told their partners they were HIV-positive. However, 42 percent of gay men, 19 percent of heterosexual men, and 17 percent of heterosexual women had some form of sex without disclosure. Furthermore, 16 percent of gay men had unprotected anal sex without disclosure, and 5 percent of heterosexual men and 7 percent of heterosexual women had unprotected anal or vaginal sex without disclosure.

Among the gay men, disclosure was least frequent in casual sexual encounters. Investigators also found that most sex without disclosure was happening with partners of unknown HIV status, implying mutual non-disclosure.

Investigators suggested their findings may have been the result of HIV prevention campaigns that encouraged gay men to regard all their sexual contacts as potentially HIV-positive; as a result, gay HIV-positive men had come to regard disclosure as optional. The researchers said that because rates of HIV were higher among gay men, some HIV-positive individuals assumed their sexual partners were aware of HIV infection risks even if they didn't disclose their status.

Unfortunately, current research shows that many individuals still make assumptions about their sexual partners: HIV-negative individuals expect HIV-positive sex partners to disclose, and people with HIV assume their sex partners know the risks. What's more, the barriers to disclosure—stigma, fear of rejection, discrimination, and violence—persist. Most likely, any efforts to address non-disclosure will continue to fail until these very real concerns are tackled.

Given the difficulties of disclosure, HIV-positive gay and bisexual men may be deliberately seeking sex venues where

disclosure is uncommon. Bathhouses, parks, and cruising areas often cater to anonymous encounters, where little talking occurs and disclosure is rarely requested or volunteered.

Meanwhile, community AIDS organizations continue to struggle to find ways to reduce HIV transmission. Their main approaches have been awareness and risk-reduction. Although safer sex practices have reduced HIV transmission, people aren't always consistent with safe sex.

Is there a better way to help reduce HIV transmission? According to an article published in *Sexually Transmitted Diseases*, a small-scale experiment in Seattle suggested that HIV disclosure in bathhouses and sex clubs is perhaps becoming more acceptable. A group obtained consent from a local sex venue to give patrons three stickers—one indicating HIV-positive, one HIV-negative, and one stamped with a question mark—which patrons were supposed to post accordingly on their doors. Many patrons used the stickers; some reported avoiding sex with partners of different HIV status or engaging in safer sex based on the posted sticker. The majority of participants wanted to use this posting method again.

Forms of non-verbal communication aren't a new idea for the gay community. Rainbow flags and pink triangles proudly announce our queer identity. Hanky codes indicate sexual preferences. Non-verbal forms of HIV-status disclosure could be part of this tradition, and could take some of the sting out of disclosure. ☺

What do you think?

Do you think the sticker options is a good idea?

Do you have an innovative idea of your own?

Email your comments and suggestions to prevention@bcpwa.org



Elgin Lim is BCPWA's director of prevention.



treatment. information

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

In accordance with our mandate to provide support activities and facilities for members for the purpose of self-help and self-care, the BCPWA Society operates a Treatment Information Program to make available to members up-to-date research and information on treatments, therapies, tests, clinical trials, and medical models associated with AIDS and HIV-related conditions. The intent of this project is to make available to members information they can access as they choose to become knowledgeable partners with their physicians and medical care team in making decisions to promote their health.

The Treatment Information Program endeavours to provide all research and information to members without judgment or prejudice. The program does not recommend, advocate, or endorse the use of any particular treatment or therapy provided as information. The Board, staff, and volunteers of the BCPWA Society do not accept the risk of, or the responsibility for, damages, costs, or consequences of any kind which may arise or result from the use of information disseminated through this program. Persons using the information provided do so by their own decisions and hold the Society's Board, staff, and volunteers harmless. Accepting information from this program is deemed to be accepting the terms of this disclaimer.

More bark than bite

Community-acquired MRSA is not as rampant as news reports suggest

by Sam Friedman



Community-acquired methicillin resistant staphylococcus aureus (CA-MRSA) is a bacterium that can cause serious infections. It's resistant to several antibiotics, including penicillin and methicillin and, as its name denotes, it's acquired in the community and not in healthcare facility settings. CA-MRSA is a considerably less virulent and more antimicrobial agent-susceptible variant of hospital-acquired (HA) MRSA.

In general, people are infected with MRSA through casual contact; for example a person with an MRSA-infected cut may pass the infection to another person by direct contact—usually through the hands—or through direct transfer from MRSA-contaminated surfaces and objects, such as towels, sheets, and razors. It also infects indirectly through the toxins in food poisoning and toxic shock syndrome. An MRSA infection—or any staph infection—can be simple and localized, such as an infected cut or surgical wound, however it can also be widespread by infecting the blood and can thereby seed itself throughout the body, infecting bones and organs. In very rare cases, MRSA can cause pneumonia and even necrotizing fasciitis (flesh-eating disease) and necrotizing hemorrhagic pneumonia.

Historically, MRSA has been limited to institutional healthcare settings such as hospitals, nursing homes, and hospices. It has been one of the main culprits behind large numbers of infections and deaths in these facilities, usually striking people who are already seriously ill, are advanced in age, and/or who are severely immune suppressed.

Over the last decade, more and more cases of MRSA have been occurring among PWAs in the community. For the most part, these infections affect individuals who have multiple risk factors, including: pre-existing illnesses, co-infections, low CD4 cell counts, high HIV viral loads, injection drug use, homelessness, and poor hygiene. Another risk factor is residing in communal and/or crowded settings such as prisons, homeless shelters, detox centres, and group homes.

CA-MRSA cases are still quite rare and they can still be well controlled and resolved with antibiotics. Most CA-MRSA infections affect the skin, causing pimples and/or boils on the skin that are often red in colour, swollen, painful, and filled with pus or mucous. It's extremely rare for the CA-MRSA variety to lead to a systemic infection and even more rare to cause pneumonia or

continued on next page

worse, necrotizing fasciitis or necrotizing pneumonia. The vast majority of these infections are transmitted from people with active MRSA infections and primarily by the hand.

Community-acquired MRSA cases are still quite rare and they can still be well controlled and resolved with antibiotics.

It's important to seek medical attention as soon as possible if you suspect you have a skin or soft tissue infection, so that it can be properly identified, diagnosed, and treated with an appropriate antimicrobial agent. Keep in mind that even after an infection clears up, a recurrence is possible.

There's been a fair amount of fear created by some erroneously sensationalized media reports, with newspaper headlines referring to a "staph superbug". These staphylococcus bacteria are in no way superbugs; they are simply resistant to several antibiotics and have the capacity to cause serious illness. Capacity in no way equates with causality.

You can help prevent an infection or a recurrence with good hygiene. Keep your hands clean by frequent washings with soap and/or a hand sanitizer. Keep your cuts and wounds clean and covered until they heal. Avoid contact with other people's skin wounds and avoid sharing personal care items, such as towels and razors. ☺

Sam Friedman is living with HIV in Vancouver and is a dedicated AIDS community writer, activist, and advocate.



On page 23 of the January/February 2007 issue of living☺ magazine, the time frame were incorrect in the "General health checklist." Here is the corrected checklist.



A general health checklist	
Monthly exams	Women should perform skin, oral, and breast self-exams. Check for any warts, sores, and yeast infections. Report to your doctor if you see something unfamiliar or odd. Men should perform testicular, skin, oral, anal, and breast self-exams. Check for any warts, sores, or lesions. Report to your doctor if you see something unfamiliar or odd.
Every 2-3 months	Your doctor should be checking your CD4 count and viral load.
Yearly	Men and women should have a full physical exam checking such things as lymph nodes, skin, blood pressure, heart, lungs, eyes, ears, and mouth. Your doctor may also do a blood chemistry profile, urinalysis, rectal exam, and tests for sexually transmitted infections. Women should have a pelvic exam, pap smear, and breast examination. Men should ask for a prostate exam.
Every 2 years	Ask for a bone density test.
Every 5 years	Ask for a tuberculosis (TB) skin test and pneumonia vaccine (called Pneumovax).
Every 10 years	Ask for a tetanus/diphtheria booster. This is also referred to as the tetanus shot.

A gut feeling



***Helicobacter cinaedi* is rare—but you should be aware of if you have persistent gastrointestinal problems**

by Lawrence C.

Abdominal pain, chronic diarrhea, and skin conditions such as rashes can result from side effects of certain medications. But these symptoms may also be the result of other infections. One of them is a rare gastrointestinal infection that some BCPWA members have experienced lately, called *helicobacter cinaedi*.

Helicobacter cinaedi (or *H. cinaedi*) is from the family of *helicobacter bacteria* known to be at the root of such diseases as peptic ulcers and the majority of inflammatory gastrointestinal disorders. Gastrointestinal disorders can include such symptoms as abdominal pain, chronic diarrhea, rectal bleeding, and weight loss. The more common *helicobacter* infection is *helicobacter pylori*—previously known as stomach ulcer—which was widely thought, for many years, to be caused by such things as unusual stress factors, smoking tobacco, and spicy foods.

Helicobacter pylori causes chronic gastritis and can lead to peptic ulcer disease. Some of the symptoms of chronic gastritis include upper abdominal pain, abdominal indigestion, nausea, vomiting, and loss of appetite. It can be effectively treated with antibiotics.

Whereas both HIV-positive and HIV-negative individuals can get *helicobacter*

pylori, *H. cinaedi* is found predominantly among immunocompromised individuals. For people living with HIV, *H. cinaedi* infection includes a recurrent high fever and may be accompanied by skin infections. *H. cinaedi* grows slowly and you might not notice the growing infection; that's why you need specialized blood culture techniques and prolonged incubation to isolate and diagnose these infectious organisms.

Whereas both HIV-positive and HIV-negative individuals can get *helicobacter pylori*, *H. cinaedi* is found predominantly among immunocompromised individuals.

Recently, when a PWA from Vancouver arrived at hospital, he had red and copper-coloured blotches on his left ankle that spread up his legs, arms, chest, and face. He also had a high fever of 39.4C, though he didn't have any gastrointestinal symptoms of note. He was treated with cephalixin, 500mg four times a day, which

made his symptoms worse. Doctors then gave him ciprofloxacin, 250mg twice a day for 14 days, which cleared the infection.

H. cinaedi was likely first found in homosexual HIV-positive men because of their sexual behaviours. The main route of transmission is contact with or consumption of contaminated water and fecal-oral transmission (rimming). In addition to gay men, these *H. cinaedi* organisms are also seen among young children who have had contact with animal fecal matter.

H. cinaedi infection is treated with antibiotics, although it appears that treatment with penicillin or tetracycline may be more effective than treatment with cephalosporin or erythromycins. In addition, prolonged treatments prove to be the best way of killing the bacteria.

For most HIV-positive men, there's no reason to assume you have *H. cinaedi* if the usual medications cure your gastrointestinal infection. But if gastrointestinal difficulties persist even with medications, you should ask your doctor about the possibility of a *helicobacter bacterium*. You should always rely on the experience of a qualified health professional to help make the right choice of antibiotics to treat the bacterial infections. ☺

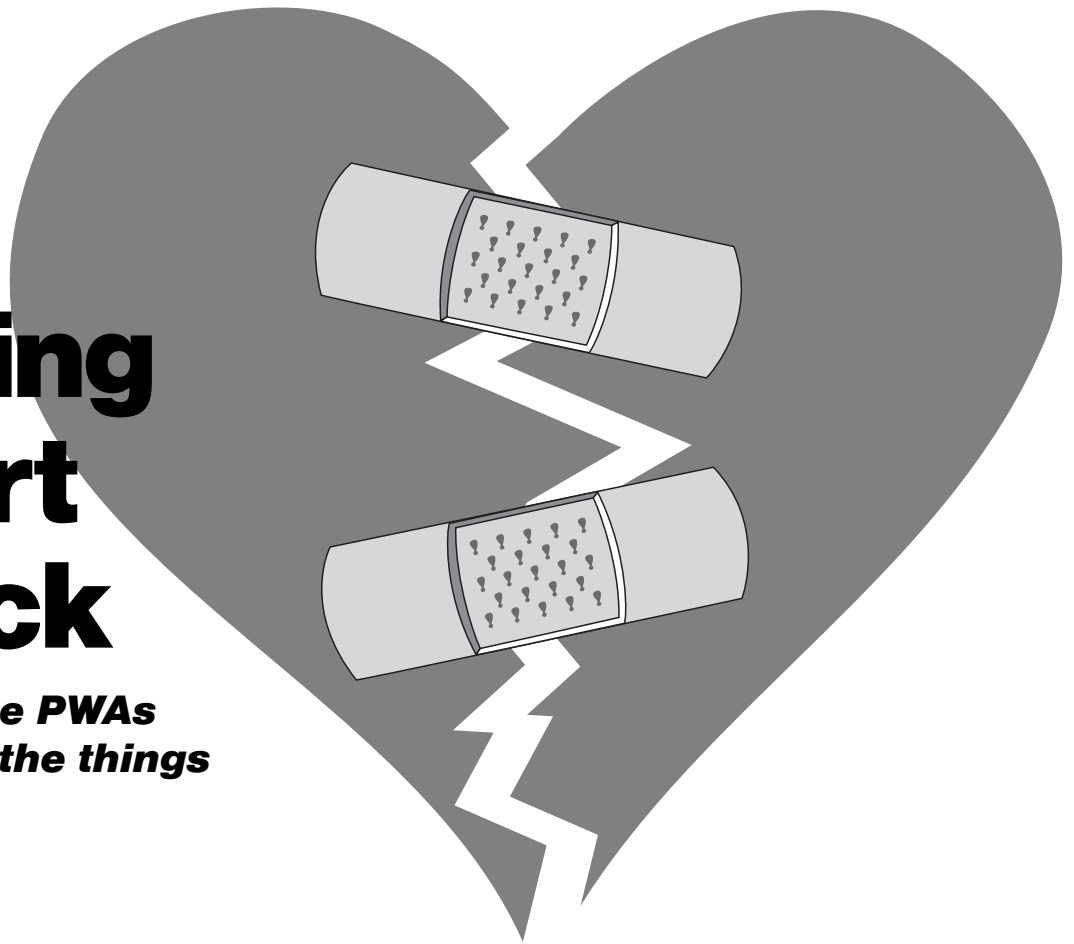
Lawrence C is a volunteer with BCPWA's Treatment Information Program.



Surviving a heart attack

The stories of three PWAs highlight some of the things you should know

by Zoran Stjepanovic



Cardiovascular problems are on the rise among people with HIV. Part of that is due to the fact that more and more PWAs are living longer and thus getting older. However, there's conflicting information whether your HIV medications increase your risk of heart problems. Some studies show a risk of heart attack with protease inhibitors, while other studies have shown no greater likelihood of a heart attack with antiretrovirals.

A number of BCPWA members have had heart attacks in recent months. The stories of three of these members provide first-hand insight into how to recognize the signs, what to do in such a situation, and how to survive.

“Like something was pressing against it”

Ramon is a treatment information volunteer with BCPWA. One day last year, Ramon felt a lot of pain in his chest. “It felt like something was pressing against it,” he says. The pain caused discomfort, and it wouldn't subside even when he tried resting. When he began to sweat and feel nauseous, he realized he was experiencing a heart attack.

Because Ramon had read that aspirin is beneficial when experiencing a heart attack, he took an aspirin and called 911. Aspirin can be used as a first aid measure for heart attacks. When the paramedics arrived, they sprayed nitrate in his mouth. Nitrate sprays work to open up the arteries to the heart, increasing blood flow and relieving chest pain. When he

arrived at the hospital, Ramon was diagnosed with a massive blockage and soon after had surgery to clear the blockage. After a few days, he felt well enough to go home.

Ramon's cardiologist placed him on three different medications: beta blockers, ace inhibitors, and statins (lipid lowering drugs). Beta blockers can be used to treat high blood pressure, abnormal heart rhythms, and chest pain. Ace inhibitors are also a common treatment for people with heart problems.

Ramon had read that aspirin is beneficial when experiencing a heart attack, so he took an aspirin and called 911.

Ramon's recovery also involved attending the Healthy Heart Program at St. Paul's Hospital in Vancouver, where he obtained nutritional advice and was expected to exercise twice a week for four months. “I had increased energy after only one month in the program,” he says. The Healthy Heart Program also provided regular monitoring of his condition. He's now fully recovered.



Since his heart attack, Ramon has undergone a lifestyle change: he exercises more often and eats a healthier diet. That means no junk food. He also stresses the importance of taking aspirin when having a heart attack, as this may reduce the severity of the heart attack.

When asked what he thinks caused his heart attack, Ramon attributes it to the high level of stress that he was experiencing at the time.

Recognize the warning signs of a heart attack

- Pain that spreads from the chest to the back, neck, jaw, upper abdomen, or one or both shoulders or arms (the left shoulder and arm are more commonly affected)
- Sweating
- Shortness of breath
- Nausea or vomiting
- Dizziness or light-headedness
- A fast, slow, or irregular heartbeat
- If you have any of these symptoms, call 911 immediately. Don't wait—heart damage is permanent.

A progressively intensive exercise program

Colin is another BCPWA member who had a heart attack recently. At the time of the attack, he experienced a lot of pressure on his chest—as if someone was sitting on his chest—and he had difficulty breathing. Colin didn't experience the other symptoms such as sweating or nausea. When he went to his doctor, blood work revealed that he had some recent heart damage, so they sent him directly to emergency.

Doctors performed an angiogram, a procedure used to widen narrowed coronary arteries, with three stents (metal tubes) installed to open up his blood vessels, which were severely blocked (up to 97 percent). After his surgery, Colin had to go on numerous medications, including: beta blockers; lipitor, a cholesterol-lowering drug; hydrochlorothiazide, a water pill; ramipril to lower blood pressure; and niaspan.

Colin also underwent a lifestyle change. As soon as it was advisable, he joined the Healthy Heart Program at St. Paul's Hospital, where a crew of well-trained staff placed him on a progressively intensive cardio and weight-training exercise program. Colin stayed with that program for three months and then developed his own exercise program.

Colin now works out three times a week. At 63 years of age, "I'm feeling better than ever," he says. "My cardiologist told me that I did better on a stress test than most young people out of high school."

Colin doesn't think his heart attack was medication related, since his triglyceride and cholesterol levels were normal. He

suspects the clogged arteries may have been the result of many years of eating a high-fat diet.

A heart attack in his sleep

Bobby's situation was much more complicated: he was asleep at St. Paul's Hospital, undergoing treatment for viral pneumonia, when he had his heart attack. He had been rushed to emergency suffering from a fever, vomiting, and diarrhea—but no chest pain at that time. "I think maybe my high level of anxiety while I was in emergency could have caused my heart attack," he says. When he was admitted, he needed full ventilation to help him breathe. He was on ventilation for a week, and stayed in the hospital for 22 days, 16 of those in intensive care or the cardiac care unit.

Bobby didn't need surgery for his heart; instead he was given lipid-lowering medication and blood thinners, as well as antibiotics for the pneumonia. He continues to take these medications. Bobby also made some lifestyle changes, such as eating a healthier diet, getting more fresh air, and exercising. However, he hasn't been able to quit smoking.

Though Bobby has recovered from his heart attack, the pneumonia has recurred. Recently, he fell asleep on his arm, which caused neuropathy. When he awoke, his heart was pumping fast so he called his doctor. Thankfully, it wasn't a heart attack. But these days he's definitely paying more attention to his heart, and to his overall health.

Knowing the signs of a heart attack and contacting 911 immediately are keys to survival. Having a heart attack doesn't have to be fatal. As these three men reveal, you can go on to live an active, full life. Better yet, don't wait until you have a heart attack; be proactive, start living that healthier lifestyle now. Read the articles on the following pages and find out how. 🍎



Zoran Stjepanovic is BCPWA's treatment information coordinator.

Are women's symptoms different?

According to a US National Institute of Health study, women may experience different physical heart attack symptoms than men. The research revealed that women noted new or different symptoms—most notably unusual fatigue, sleep disturbances, and shortness of breath—a month or more before they had their heart attacks.

That said, chest pain is the most important heart attack symptom in both women and men. One key difference, however, is that women may describe their pain differently than men, according to the Heart and Stroke Foundation of Canada.



Heart health 101

How much is too much cholesterol?

by Derek Thaczuk

Zero percent fat is not a goal anyone should shoot for. Fats are a necessary part of the human diet: you need them to stay alive. But heart health, and health in general, depends on the right amount—and kind—of fats. HIV treatment can complicate the picture: some antiretrovirals—including many, though not all, of the protease inhibitors—can affect the levels of fat in your bloodstream, and usually not in a good way.

Blood tests can easily measure levels of fat in the bloodstream, so checking for healthy levels should be a regular part of your blood work, especially if you're taking antiretroviral medication. But what are healthy levels?

Calculating risk

Several different kinds of fat can be found in the human body and bloodstream. The blanket term for these is lipids. (This is where we get the term lipodystrophy syndrome, or fat redistribution). Excessive lipid levels—specifically, excess cholesterol and triglycerides—put you at risk for coronary heart disease (CHD, or heart attack and heart failure) and other health problems. However, the risk of coronary heart disease depends on many other risk factors as well. Therefore, the overall risk depends on weighing the different risk factors together. This is done using a system known as the Framingham score (see sidebar).

The Framingham score for risk of coronary heart disease is calculated using a point system based on age, sex, blood

pressure, cigarette smoking, family history of heart disease, and lipid levels. Target lipid levels depend on the overall risk: if you're at high risk for CHD, it's important to control lipid levels more tightly. For people with lower overall risk for CHD, there is usually a little more wiggle room.

In HIV-positive people, the long-term consequences of antiretroviral-related effects on lipid levels aren't yet fully understood. The same standards that are used for HIV-negative people may apply just as well to those on antiretroviral treatment, but that isn't completely certain yet. Many doctors believe that

the goal for patients on antiretroviral therapy is to keep triglyceride and LDL cholesterol levels (so-called "bad" cholesterol) as low as possible.

Understanding cholesterol

Cholesterol is a type of fat found in food, but also manufactured within the body itself by the liver. Cholesterol plays several essential roles in the human body, such as producing hormones and forming cell membranes. Excessive cholesterol levels are dangerous and can lead to atherosclerosis (hardening and narrowing of the arteries) and CHD.

Table 1. Measuring cholesterol levels

Cholesterol levels	Canada (mmol/L)	US (mg/dL)
LDL cholesterol (fasting)		
Optimal	Less than 2.59 mmol/L	Less than 100 mg/dL
Near optimal	2.60 – 3.36	100 – 129
Borderline	3.37 – 4.14	130 – 159
High	4.15 – 4.91	160 – 189
Very high	4.92 or over	190 or over
HDL cholesterol		
Low	Less than 1.03	Less than 40
High	1.56 or over	60 or over
Total cholesterol		
Optimal	Less than 5.17	Less than 200
Borderline	5.17 – 6.21	200 – 239
High	6.22 or over	240 or over

To convert cholesterol measurements from US to Canadian units, or vice versa, use the following equations: cholesterol in mmol/L = mg/dL ÷ 38.7
cholesterol in mg/dL = mmol/L × 38.7

Since fats do not dissolve in water, and blood is mostly made of water, cholesterol can't be directly transported through the blood. Instead, it clumps together with proteins to form compounds called lipoproteins, which can dissolve in the bloodstream. These lipoproteins then carry the cholesterol throughout the body. Low-density lipoproteins (LDL) are relatively small molecules, which generally carry fats from the liver out to other parts of the body. Excessive LDL levels can cause fat to build up on artery walls, reducing blood flow and frequently leading to CHD or heart attacks. That's why LDL has earned the nickname bad cholesterol.

Larger molecules, called high-density lipoproteins (HDL), tend to do the opposite, carrying fats back to the liver for further processing. Higher HDL levels reduce the risk of heart disease, causing HDL to be known as "good" cholesterol.

LDL cholesterol has to be calculated from blood samples taken on an empty stomach. That's not necessary for HDL and total cholesterol measurements, but it's best to just get all the lipid blood work done at the same time, on an empty stomach. Also (just in case this was getting too simple!), two different numbering schemes are used to measure cholesterol levels. In Canada, cholesterol is measured in millimoles per litre (mmol/L). In the US, the standard units are milligrams per

decilitre (mg/dL). See Table 1 for Canadian and US cholesterol levels.

Target cholesterol levels depend on the overall risk of coronary heart disease. LDL cholesterol levels in the optimal-to-borderline range are usually considered acceptable for people with few risk factors for CHD. Optimal or near-optimal levels are recommended for those with more risk factors.

should be measured fasting, that is, on an empty stomach. Like triglycerides, there are two sets of units for measuring cholesterol.

Generally, high triglycerides aren't believed to pose the same risk of heart disease as LDL cholesterol, but they are still significant. Many doctors will recommend treatment for elevated triglyceride levels if they're in the

Table 2: Measuring triglycerides levels

Fasting triglyceride levels	Canada (mmol/L)	US (mg/dL)
Optimal	Less than 1.69 mmol/L	Less than 150 mg/dL
Borderline	1.69 – 2.24	150 – 199
High	2.25 – 5.63	200 – 499
Very high	5.64 or over	500 or over

To convert triglyceride measurements from US to Canadian units, or vice versa, use the following equations: triglycerides in mmol/L = mg/dL ÷ 88.5
triglycerides in mg/dL = mmol/L × 88.5

Measuring triglycerides

Triglycerides are the most common form of fat in the human body. Overly high triglyceride levels can lead to heart disease and other serious health problems. The Adult Treatment Panel III guidelines (see sidebar) classify triglyceride levels as optimal (that is, most desirable), borderline, high, or very high (see Table 2). Since blood levels rise quickly after meals, triglyceride levels

very high range, if there are other risk factors for CHD, or if cholesterol levels are affected as well. ⊕

Derek Thaczuk has worked in information and support services within the HIV community for over a decade and is now a freelance writer and editor.



Clinical guidelines: ATP III and the Framingham scoring system

The most recent, comprehensive analysis of lipid levels and CHD risk comes from the Adult Treatment Panel III (ATP III) guidelines of the National Cholesterol Education Program. These guidelines are revised periodically to reflect current knowledge about lipids and heart disease, and the target values change from time to time. ATP III was published in September 2002.

The complete Framingham model is too lengthy to include here. Essentially, points are assigned based

on your age, sex, blood pressure, baseline cholesterol levels, and whether or not you smoke. The total point score gives your percentage risk of coronary heart disease within the next ten years.

Versions of the ATP III guidelines, including the full report, shorter summaries, and calculation tools for Framingham heart disease risk, are available through the US National Institutes of Health website at www.nhlbi.nih.gov/guidelines/cholesterol/



Nutrition for a happy heart

A heart-healthy diet and exercise can help reduce your risk of cardiovascular disease

by Sarah Fielden

Heart attacks happen when the blood flowing to your heart is blocked, usually because of fatty deposits from triglycerides and cholesterol that have built up in the coronary arteries—causing cardiovascular disease (CVD). The fatty deposits, called plaque, build up gradually and harden the arteries, limiting and sometimes stopping blood flow to the heart and brain.

Highly active antiretroviral therapy (HAART), especially protease inhibitors, has been linked to metabolic abnormalities such as lipodystrophy, elevated blood lipids (fats), hypertension, and insulin resistance. These are all risk factors for CVD and possibly heart attack. With HAART, changes that may occur in your blood include increases in levels of triglycerides, LDL cholesterol, total cholesterol, glucose, and insulin, and decreases in HDL cholesterol levels. This isn't good news, but a heart-healthy diet and exercise can help to prevent and manage these complications.

Six easy steps to better eating

Nutrition that includes balanced meals and healthy snacks can reduce your risk of heart disease by making sure that you consume heart-healthy nutrients, manage your weight, keep your blood pressure down, control your blood sugar levels, and lower your cholesterol. Studies have shown that a heart-healthy diet and exercise program can reduce fats in the blood of people living with HIV.

The *BC HealthFiles*—fact sheets on a wide range of 180 health and safety topics, from the BC Ministry of Health—recommend these six steps to heart-healthy eating:

- ▶ Reduce all fats, especially saturated fat
- ▶ Eat a variety of vegetables and fruits every day
- ▶ Eat more whole grain products
- ▶ Choose lower fat dairy products
- ▶ Select smaller, leaner portions of meat, poultry, fish, and alternatives
- ▶ Limit high fat snacks and desserts

These steps are consistent with most messages about healthy eating. *Canada's Food Guide to Healthy Eating* can help you

figure out how much and which foods to eat daily from the four food groups: grains, vegetables and fruits, dairy products, and meat and alternatives.

When choosing foods to include in your diet, select foods that are high in fibre, such as vegetables, fruit, beans, and whole grains. Twenty-five to 35 grams of fibre/day is recommended. Soluble fibre—found in psyllium products like some brand formulations, high-fibre cereals, oats, and legumes—is especially good for your heart because it limits cholesterol absorption. Legumes are also a healthy alternative to meat sources of protein, which tend to be higher in fat and cholesterol. Soy products are high in phytoestrogens, which reduce the risk of cardiovascular disease if your diet has a lot of them; eat about 25 grams of soy protein per day, or 8 ounces of tofu.

Minimizing your consumption of fats doesn't have to be difficult. It doesn't require any more hassle to replace less healthy, high-fat foods with lower-fat foods. For example, eat lower-fat cheeses or cuts of meat. Also, when you're at a restaurant, do your heart a favour: instead of ordering fried foods, order foods that have been grilled, broiled, barbecued, stir-fried, steamed, poached, or roasted. All these cooking options contain little or no fat but still taste good.

If you're HIV-positive, you can help their heart even further by eating fruits and vegetables that are high in antioxidants (such as vitamin C) and flavonoids; these help to reduce damage to the blood vessels. Increasing your consumption of fruits and vegetables is a good way to get the heart-healthy nutrients you need. B vitamins, such as B6, B12, and folate, are also heart healthy, because they lower homocysteine levels, an amino acid that has been linked to heart disease risk.

The skinny on fats

Generally speaking, men should eat about 50–70g of fat daily, and women should eat 40–60g of fat daily, depending on how many calories you need. Reducing fat doesn't mean eliminating it altogether. A healthy diet includes 20–35 percent of your day's calories from fat.



Checklist for a healthier heart

- Limit your alcohol intake, since it boosts triglycerides
- Limit your salt intake, since it can lead to high blood pressure
- Limit your sugar intake, since high amounts get turned into triglycerides
- Check food labels, to choose heart-healthy foods. Look for grams of fat, amount of calories from fat (aim for less than 30 percent), types of fat, and fibre content. Check for a heart-healthy checkmark on food products and in recipe books
- Seek help to quit smoking, a main cause of heart disease
- Seek help to quit other stimulants, such as cocaine, that make your heart work too hard
- Relax. If you're stressed, so is your heart. Try some yoga or meditation

Some examples of fat content in common foods.

- ▶ Pretzels, 1 serving, less than 2 grams of fat
- ▶ Poultry (no skin) 3 oz, 5 grams of fat
- ▶ Lean red meat, 3 oz, 10 grams of fat
- ▶ 2% cottage cheese, 1/2 cup, 3 grams of fat
- ▶ Cheddar cheese, 1 oz, 10 grams of fat
- ▶ Chocolate, 1 oz, 10 grams of fat

It isn't just the amount of fat that's important. Not all fats are equal when it comes to the heart. Here's a rundown of the healthy and unhealthy fats:

Saturated fats and trans fats pose a risk to heart health and can increase your cholesterol. They're found in most animal foods and palm and coconut oils. Trans fats are mostly vegetable oils that have been hydrogenated. They can be found in processed foods such as potato chips, shortening, and some margarines.

In terms of the healthier fats, monounsaturated and polyunsaturated fats help lower cholesterol when substituted for saturated fats. Nuts, seeds, and olive oil are high in monounsaturated fats.

Polyunsaturated fats include omega-3 fatty acids found in fish, flaxseed, canola, and soybean oils. These help reduce your risk of heart disease. Eat fatty fish—such as canned tuna, halibut, herring, salmon, and sardines—at least twice a week. Omega-3 fatty acid supplements (usually salmon oil or a blend of fish oils, but NOT liver oil) can reduce triglycerides. Recommendations vary from 3 to 10 grams a day, so talk to your doctor about appropriate dosage. Also, if you're pregnant, consult with your doctor about which fish and fish oils are safe for you to consume.

Dietary cholesterol is found in animal products only. It's important to reduce your intake by cutting down on high cholesterol foods like eggs and organ meats. However, cholesterol in your blood is influenced by a lot of factors, not just cholesterol in foods. The most important factor in lowering blood cholesterol levels is to limit saturated and trans fats.

Keep your body and heart moving

Exercise is essential to keep your heart in good shape. Exercise helps your body use insulin and sugars properly, so it decreases insulin resistance. It also helps to decrease the fats and cholesterol in your blood and control your weight.

In addition to helping the heart, exercise has other great benefits if you're HIV-positive, including improved appetite, increased metabolism, increased energy and bone mass (especially with weight-bearing exercises like walking), improved sleep habits and mood, and improved immune function. Regular exercise doesn't have to be strenuous to be beneficial.

If you're recovering from a heart attack, talk to your physician about introducing exercise slowly back into your life. Begin with non-strenuous activities, like walking. Ask your physician or rehabilitation team how to build up to a good routine. Cardiac rehabilitation programs provide informative classes as well as medically-supervised exercise sessions.

To prevent heart disease, aim for 30 minutes of exercise per day. Pick an activity that you enjoy doing or that you can enjoy with friends, so that you keep motivated. Include a stretching routine: simple stretching can help with flexibility, immune function, and may reduce blood pressure and other heart disease factors.

In addition to working with a multidisciplinary team of HIV healthcare professionals to maintain your overall health, good daily nutrition and exercise are key to keeping your heart healthy with HIV. A registered dietitian can help you develop heart-healthy meal plans to support HIV medication regimens, side effects, and exercise. ☺

Sarah Fielden is a student in the Individual Interdisciplinary Studies Graduate Program with the Institute of Health Promotion Research at UBC and a Michael Smith Foundation for Health Research graduate trainee.



Further reading

For a copy of Canada's Food Guide to Healthy Eating, visit:
www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html

BC HealthFiles

www.bchealthguide.org/healthfiles/index.stm

Heart and Stroke Foundation

www.heartandstroke.ca

Hump away

PWA gets the provincial government to pay for his surgery

by Taz Fletcher

It's not easy being first. Just ask Sandy, a First Nations PWA who was the first person to get the BC government to pay for surgical removal of his "buffalo hump."

The term buffalo hump refers to a common side effect of anti-HIV medications: due to lipodystrophy, fat accumulates on the back of the lower head, the neck, and middle of the upper back, creating a hump many times larger than the average grapefruit. It causes such physical problems as loss of range of motion of the head and neck, inability to sleep without assistive devices, and problems with standing and balance. Even more disabling is the psychological and social impact of having a visible disfigurement.

"Being out in public was a living hell," says Sandy. "As the hump grew, I became more self conscious in social situations. Eventually, all anyone sees is the hump. It's like the person beneath it no longer exists." Like many people with buffalo humps, Sandy developed social anxiety, struggled with depression, and eventually confined himself to his home except when absolutely necessary.

In April 2002, Sandy's family doctor wrote a letter to BC Medical Services Plan (MSP) stating that the liposuction surgery for removal of Sandy's hump was a medical necessity.

MSP refused to cover the surgery.

Sandy went to see a specialist who put him on a drug regimen in an attempt to lessen the hump.

Drug treatment didn't help, so Sandy's specialist prescribed daily shots of a human growth hormone. MSP refused to

cover the prescription; fortunately, though, the federal First Nations and Inuit Health Program agreed to pay for it. The cost for a month's supply of human growth hormone was around \$6,900, meaning that the annual cost of Sandy's prescription would be approximately \$83,000. Sandy considered this outrageous.

"The liposuction surgery was around \$5,500, which meant at least twelve people could have had their humps removed for what it cost for me to be on hormones for one year," says Sandy. "I decided I needed to become an advocate, not just for myself but for others suffering with buffalo humps. Someone had to lead. I decided, right then and there, that someone would be me."

And lead he did. Countless doctors had told Sandy that he'd never get the government to cover his surgery. "Just you wait," was his reply.

He applied to MSP over and over again; finally, in December 2004, they agreed to cover the cost of his surgery. In April 2005, Sandy had his precedent-setting surgery, easing the way for another person's surgery the next year.

"I couldn't stand up straight," says the other person, Jeremy. "The growth hunched my back over, straddling my shoulders, upper neck, and into the middle of my back. I needed three pillows to support it just to sleep. I had a 15-inch neck that couldn't fit in 20-inch collars."

Luckily for Jeremy, he and Sandy shared the same family doctor, who told him how MSP had just agreed to cover Sandy's liposuction surgery. In October 2005, Jeremy's plastic surgeon wrote a letter to MSP requesting coverage for the surgery. He received approval in January 2006 and had his surgery the following month. (The surgery removed four litres of fat and fluid—equal to a gallon-sized jug of milk.)

"I'm sure the reason it happened so fast was because of the precedent Sandy had set," says a grateful Jeremy.

It took three lonely, frustrating years of doctors' letters, photos, measurements, applications, and denial of coverage for Sandy to set that precedent. It wasn't easy being first, he says, "but I'm First Nations, so I know what it means to be first." ⊕



Taz Fletcher is a volunteer with the BCPWA Advocacy Department.



Look for your AGM package in the mail beginning July 10, 2007.

Notice of Annual General Meeting

The membership will meet to receive the Annual Report of the Directors, consider amendments to the by-laws of the Society, if any, and conduct other such business as is deemed necessary in accordance with the constitution and by-laws of the Society.

Please note that SIX two-year term positions on the Board of Directors of the Society are to be elected for the period 2007-2009.

WHEN:

Saturday, August 18, 2007 at 11:00AM

WHERE:

TO BE ANNOUNCED

REGISTRATION:

10:00 – 11:00AM

MEETING BEGINS AT:

11:00 AM (sharp)

IMPORTANT DATES TO REMEMBER

By June 11, 2007

Resolutions from the Members to be submitted to the Secretary of BCPWA

Not later than July 20, 2007

Mail out of AGM Packages

On July 31, 2007

For individuals who do not receive mail, AGM Packages will be ready for pick up from Member Services (Reception) Desk

August 3, 2007

Last day Proxies are Mailed

August 3, 2007

Last Day Proxies May be Requested for Pick up

Members wishing to have business placed on the agenda for the Annual General Meeting should submit it prior to June 11, 2007. A letter to the Secretary of the Society containing:

- (1) a brief paragraph describing the specific intent of the business, and
- (2) a properly worded motion pertaining to the business should be sent to the Society's registered office at: 1107 Seymour Street, Vancouver, BC, V6B 5S8

If you have any questions or would like to receive a copy of the Society's Annual Report, please call Wayne Campbell, Secretary, at 604.646.5350 and leave a confidential message. To ensure accuracy, please spell your last name slowly and leave a contact phone number.

If you require ASL interpretation, please contact the Secretary of the Society.

A lunch will be served.

Mix and match

Integral spirituality embraces a broad range of mind states and practices—and throws in science and psychology, too

by Jari Dvorak

The brave souls hoping to include spirituality in their healing regimen are facing baffling choices. The spiritual scene seems like a pharmacy of weird potions with questionable efficacy. Is the New Age spiritual enough? Is religious pluralism the real answer? Should you swallow your pride and join the holy rollers? How do you make sense of it all?

Enter Integral Spirituality. In this context, “integral” means inclusive and balanced. The Integral Spirituality approach honours all the truths. The basic premise is that everything has a grain of truth and you should use whatever works.

The concept isn't new. A good example is the mindfulness stress reduction classes that psychiatry departments in some Canadian hospitals offer HIV/AIDS patients. A recent bestseller, *Integral Spirituality: A Startling New Role for Religion in the Modern and Postmodern World* by American author Ken Wilber, is giving this branch of spirituality new credibility.

Some readers call it the most important book on spirituality in our time. They report feeling rewired by it. Others find it too dense and complex. Both might be right. Reading this book is a bit like using a word processor: at first it's hard to learn, but eventually it becomes incredibly simple to use.

Wilber, founder of the Integral Institute, mastered most of the known spiritual traditions while being tutored by some of the best spiritual teachers around. He also comes from a serious scientific background. He might be on the way to becoming a huge phenomenon—a prolific, media-friendly philosopher with a large and growing number of adherents. They know him through his many books and from spiritual magazines such as *What is Enlightenment?*

Spirituality as a map for personal transformation

Wilber sees each spiritual tradition as a “map” for how to grow and strive as a person. In his book, *Integral Spirituality*, he tries to give us the best map possible. It's about learning to look at things from many points of view. “You need to know what the entire human terrain consists of,” writes Wilber. “So that something isn't going to jump up and bite you in the ass when you are not looking.”

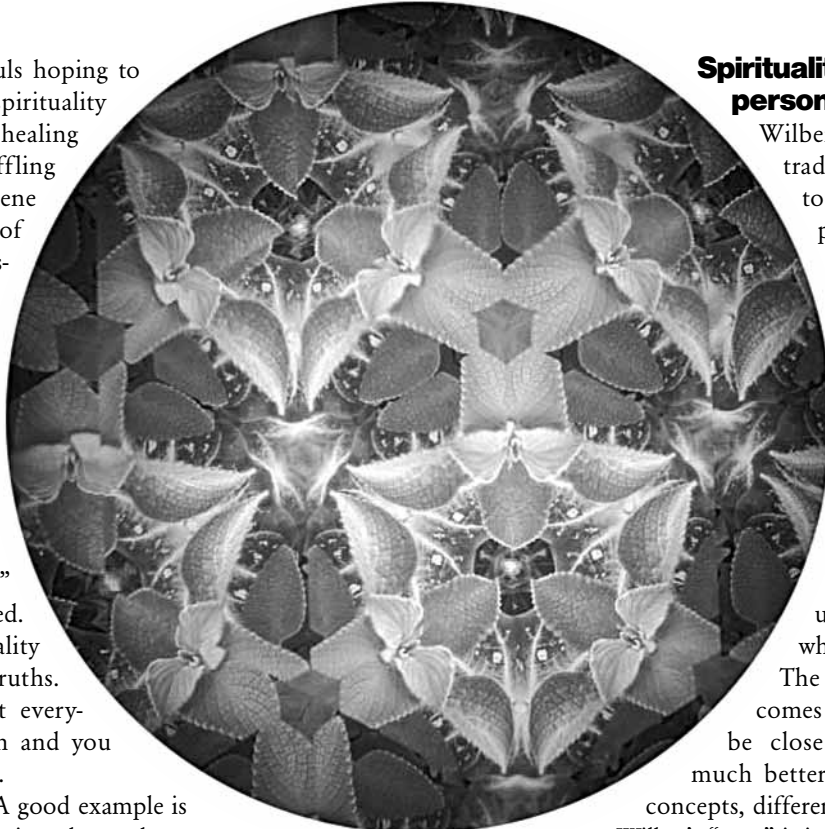
The premise is that when it comes to healing or just how to be close to someone, you'll do much better if you embrace different concepts, different maps.

Wilber's “map” is indeed comprehensive. Apart from an astonishing array of mind states and practices, it also utilizes up-to-date insights from science, morality, interpersonal skills, emotions, psychology—even art. He takes us on a tour of a variety of the most common spiritual distortions, such as the trap of believing that everything is loaded with spiritual meaning.

For Wilber, the ultimate spiritual secret is that fully enlightened and ever-present divine awareness is not difficult to attain, but rather that it's impossible to avoid. Our understanding of this divinity changes as our understanding of God progresses from a magic God to a mythic God, then to rational God, then interfaith God, then to integral God, and so on.

How you interpret a mystical experience depends on your stage of personal development and cultural background. A very rational person, for example, who experiences radiant light will interpret it in rational terms. Someone in India might perceive an identical experience as a deity with 10,000 arms, whereas a Southern Baptist will see Jesus.

To Wilber, each mystical experience is a micro-transformative event. It can be triggered by making love, walking in nature,



listening to exquisite music, or even by drugs. Being plunged into an unusual mind state (“Wow, what was that?!”) allows you to get a peek at a higher level of consciousness. It can be the first small step towards personal transformation into a higher developmental stage. You’re more likely to have that spiritual experience through meditation or drugs, but the actual transformation into a higher state isn’t that simple. It involves enhancement of your intellect, morals, emotional understanding, interpersonal skills, and the appreciation of beauty.

According to Wilber, relationships are absolutely important to spiritual understanding. There is also a great emphasis on ethics and morality in integral spirituality. This comes up again and again. It isn’t enough to have compassion for yourself, your family, tribe, or nation, you must have compassion for all humanity, the entire planet.

Wilber sees each spiritual tradition as a “map” for how to grow and strive as a person. In his book, he tries to give us the best map possible. It’s about learning to look at things from many points of view.

Wilber foresees a radically new role for the world’s religious traditions. Because religion has such a tremendous influence on the majority of earth’s population, it’s in a privileged position to address some of the biggest conflicts facing the world. By adopting a more integral view, religion can act as a facilitator of human development—to a global society that honours and includes all stations of life.

The detractors among theologians and scientists

Just like any major innovator, Wilber has his critics. Theologians and scientists alike object to how Wilber decides what’s right or wrong within their field of knowledge. Wilber’s response is that these detractors need to acknowledge the limitations of their own fields.

He uses chemistry and Zen Buddhism as examples. Just as a chemist is quite certain about the composition of water, so is the Zen master secure in knowing if the awakening experience of a disciple is real or imaginary. The Zen community has been training and passing on this knowledge for over 1,000 years. The problem comes when the chemist and the Zen master begin to make claims about each other’s subject. The fundamental rule Wilber follows is simple: when a knowledge

discipline makes claims about its own discipline—listen to it. When it makes claims about other disciplines, don’t.

He also faces criticism from feminists. They see Wilber’s talk about personal growth as just another validation for power hierarchy. Wilber is quick to note that critics of power hierarchies have power hierarchies of their own. Instead, to him it’s important to distinguish between growth and a domination hierarchy. Growth is a way of overcoming domination.

Including psychotherapy in the mix of practices

So how do you figure out what works and what doesn’t? Wilber’s solution is strikingly similar to the combination of practices that many PWAs use in their HIV treatment. His Integral Transformative Practice (ITP) involves sharpening your intellect, regular exercise (with emphasis on keeping up body mass), daily meditation, and psychotherapy.

The inclusion of psychotherapy is an improvement that sets ITP apart from most other spiritual approaches. The great spiritual traditions excel in many things, but they’re not very good at spotting hidden personality problems. And these are probably the single biggest saboteur of spiritual practice.

There are also differences between men and women in terms of their spiritual practice needs. Gays and lesbians are somewhere in between the two. Most meditative systems were developed by men, who like to sit and observe. By contrast, women, who tend to be into feelings and flow, have developed few systems. That leaves the Sufi spiritual tradition as one of the few that satisfies both spiritual needs. That could be because Rumi, the founder of Sufism, was gay. Integral spirituality allows everyone to find a place on this spiritual practice continuum.

Finally, the most important question: how do you know if it’s working? We have in the back of our minds the notion that the enlightened, fully-realized person is free of all pain and suffering, just breathing through life. To Wilber, that’s far from the truth. Even the most accomplished saints are developing on a never-ending scale.

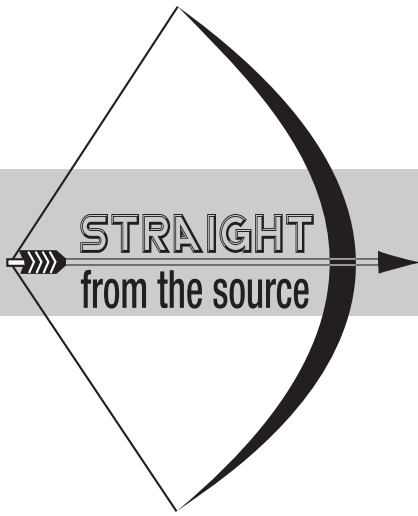
There’s really no such thing as achieving less pain, less turmoil. Rather, you become more accepting of the pain and turmoil. The more you grow, the more you become sensitive—even psychic. (If you’re not getting more sensitive, you’re probably doing something wrong.) Your capacity to get hurt increases dramatically, your capacity to handle it increases even more. You become open to more perspectives.

Wilber concludes his book with this piece of wisdom: “The new human is integral, and so is the spirituality.”

I like the ring of that! ⊕

Jari Dvorak is an AIDS activist, spiritual seeker, and a passionate promoter of meditation. He lives in Toronto with his schnauzer, Dasa.





New lab test available for abacavir hypersensitivity

by Dr. Richard Harrigan

The immune system protects people from disease-causing organisms. One key part of the immune system is called the human leukocyte antigen system (HLA). This part of the immune system allows you to tell if a cell contains proteins from only yourself or if they may have come from an infectious intruder.

People have many different genetic variations in their HLA—in fact it's one of the most variable parts of human genes. You inherit these variations from your parents. About one in every 20 Caucasians has a particular genetic variant called HLA Class I B*5701. Having it can be both a good thing and a bad thing where HIV is concerned. It's a good thing because if you have the B*5701 variation, then your immune system tends to decline more slowly after you're infected with HIV than if you don't have it. However, it can also be bad, because if you go onto an anti-HIV therapy that includes abacavir (Ziagen), then you are about 100 times more likely to have a hypersensitivity—or allergic—reaction to this drug. This is important not only if you're on abacavir, but also if you are taking medications that contain abacavir, such as Trizivir (abacavir/zidovudine/lamivudine) or Kivexa (abacavir/lamivudine).

It isn't clear exactly why people who have this B*5701 genetic variation are more likely to have a bad reaction to an abacavir-containing medication. Until recently, there wasn't really any way to tell who had this variation, so about 5 percent of people who took the drug suffered a reaction.

However, the good news is that there's now an experimental test being offered at the BC Centre for Excellence in HIV/AIDS that can detect whether you have

the B*5701 variation. This means that, if you wish, you can have a blood sample drawn and be tested to determine the likelihood that you'll have a reaction to abacavir. (If you don't have the B*5701 variation, it's unlikely that you'll have a bad reaction to this drug, although it's still possible.) This test isn't appropriate if you have already had a reaction to abacavir, since you shouldn't go back on this medication regardless—the reaction will be much more severe, and possibly fatal, the second time around.

It isn't clear exactly why people who have the B*5701 genetic variation are more likely to have a bad reaction to an abacavir-containing medication.

If you have never taken abacavir, even if you aren't planning to take it right away, it might be a good idea to have the test done and keep the results in your doctor's file, in case you need to take abacavir later on. You only need to take the test once, because your HLA type won't change. ⊕

Dr. Richard Harrigan is the director of research laboratories at the BC Centre for Excellence in HIV/AIDS in Vancouver.



Community approval a must for CTN trials

by Jennifer Chung

It takes more than good science and innovative research for the Canadian HIV Trials Network (CTN) to put its name on a clinical trial. In order to become a CTN-endorsed study, all research proposals require the Community Advisory Committee's (CAC) stamp of approval. With 115 approved trials on the CTN's roster and more than 220 trials reviewed since 1990, it's clear that the CTN's CAC has played an active role in shaping HIV clinical research in Canada.

The CAC was created to provide formal community input into clinical research. The eight-member committee brings together people from across Canada who are living with HIV or representing organizations dealing with HIV/AIDS. Members review clinical trial proposals and informed consents and make recommendations to the CTN's oversight body, the Steering Committee. By including a community perspective in the clinical trial process, the CAC aims to improve communication between researchers and community representatives, thereby ensuring that proposed research is relevant and of interest to the HIV/AIDS community.

To assist investigators, the CAC developed a model informed consent form that sets out guidelines and recommendations, such as choice of language, suggested statements that help clearly explain the design of a study, methods and procedures, as well as potential risks and possible benefits to volunteers. "Our job is to look at informed consent of clinical trials from the point of view of the participant," says David Hillman, a CAC member from BC for the past seven years. "Pharmaceutical companies that run clinical trials don't usually get input from the community. The CTN goes out of its way to get feedback."

When doing an extensive review of trial protocols, CAC members are responsible for providing a list of recommended and required changes to the principal investigator. If the investigator doesn't make the required changes, the CTN can't approve the trial protocol. "We have very high standards for clinical trials," says CAC Chair José Sousa. "The community has the power to approve or disapprove a protocol."

The CAC strives to provide geographic representation and representation of populations most affected by HIV. "We try to be representative of everyone in Canada," says Sousa. "We always include women and also someone from the Canadian Hemophilia Society." Additionally, the CAC encourages the participation of Aboriginal people through the Canadian Aboriginal AIDS Network (CAAN), people with experience with injection drugs, gay and bisexual men, people from countries where HIV is endemic, and other affected populations.

Several times each year, the CAC spends hours meticulously pouring over detailed scientific proposals. According to Hillman, by bringing community members to the table as part of the review process, both people living with HIV/AIDS and researchers benefit. "We're the people without whom there would be no trials. We're the guinea pigs, and it's important to be involved in the process for safety and ethical reasons." ☺



Jennifer Chung is the information and communications coordinator at the Canadian Trials Network in Vancouver.

Trials enrolling in BC

CTN 147 — Early Versus Delayed Pneumococcal Vaccination
BC sites: Downtown Infectious Disease Clinic (DIDC) and St. Paul's Hospital, Vancouver; Medical Arts Health Research Group, Kelowna General Hospital

CTN 205 — Valproic Acid and HIV
BC sites: St. Paul's Hospital, Vancouver

CTN 214 — Effect of a One-Year Course of HAART in Acute/Early HIV
BC sites: DIDC, Vancouver; Cool Aid Community Health Centre, Victoria

To find out more about these and other trials, check out the **Canadian HIV Trials database** at www.hivnet.ubc.ca/ctn.html or call Sophie at the CTN 1.800.661.4664.

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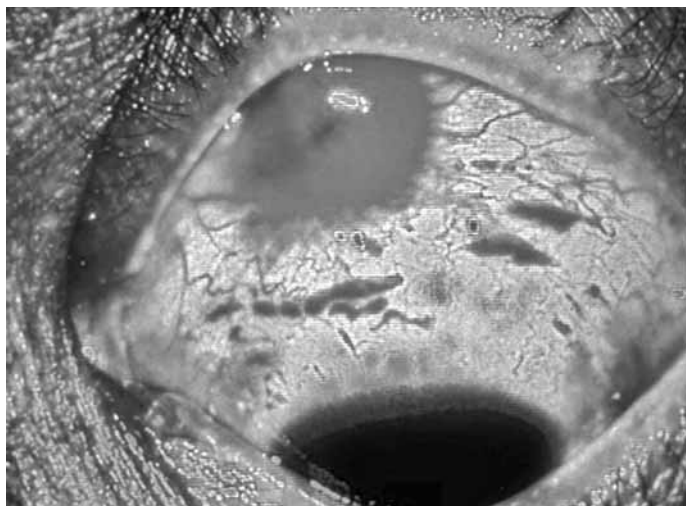
Treating CMV

Treatment for this virus has changed little in recent years, but there may be new options on the horizon

by Derek Thaczuk

Cytomegalovirus (CMV), a member of the herpes family of viruses, can become a serious infection in people with very low CD4 cells. In CMV retinitis, the most common form of infection, CMV infects and damages the retina of the eye, quickly leading to blindness if untreated. CMV can sometimes infect other organs of the body as well.

Since CMV very rarely affects anyone whose CD4 counts are above 30, treating HIV is a key strategy for treating CMV. Even when CMV requires treatment, you can usually (cautiously) stop that treatment after HIV treatment has restored CD4 counts to high enough levels. As a result, CMV retinitis has become very rare in countries where HIV treatment is widely available.



Retina infected with Cytomegalovirus. Photo Canadian Ophthalmological Society

Current treatments

While CD4 counts remain low, however, treatment depends on using antiviral drugs that are active against cytomegalovirus. For people with active CMV infection, treatment options have changed very little over the past several years. The current first-line standards of care are the intravenous drug ganciclovir (Cytovene) and the oral valganciclovir (Valcyte). (Valganciclovir, an oral “pro-drug” of ganciclovir, is actually converted to ganciclovir in the body.) CMV can become resistant to ganciclovir and valganciclovir, leaving few treatment options.

Ganciclovir resistance can develop with prolonged drug exposure. Resistance has been seen in 11 percent of HIV-related

CMV retinitis cases after six months, and 28 percent at nine months. The usual alternative treatments are the intravenous drugs foscarnet (Foscavir) and cidofovir (Vistide), which may not be usable because of severe kidney toxicity. Foscarnet and cidofovir resistance also develop about as frequently as ganciclovir resistance, and cross-resistance between drugs can develop relatively easily. There have been a few reports of using immune boosting drugs—including sirolimus (Rapamune), roscovitine, and leflunomide (Arava)—to treat CMV, but these reports are sporadic, and such treatments are not established.

New treatments

Several new anti-CMV medications have been in development for some time. The development process has been fairly slow, probably because CMV is no longer a widespread infection. Tomeglovir, by Bayer, and GlaxoSmithKline’s GW275175X, which inhibit CMV DNA processing, are in pre-clinical stages of development.

Furthest along is maribavir, a kinase inhibitor being developed by ViroPharma. Maribavir is available in oral form, has shown low toxicity thus far, and has reduced CMV viral shedding a thousand-fold in Phase I trials. Clinical trials of maribavir have continued into Phase II. So far, there has been little information about how well maribavir works at controlling clinical CMV disease, but that question should be answered by a larger Phase III trial that is being planned among transplant patients. This Phase III study, the first of two major pivotal maribavir trials, was announced in September 2006, and is expected to begin enrolling in Europe and North America in 2007.

Analyses so far have shown that maribavir-resistant CMV is still susceptible to ganciclovir, meaning that maribavir could have the potential to become a first-line treatment for CMV while leaving ganciclovir as an option for second-line treatment. ☺

This article first appeared, in slightly different form, as a news report at www.aidsmap.com.

Derek Thaczuk has worked in information and support services within the HIV community for over a decade and is now a freelance writer and editor.



British Columbia
Centre for Excellence
in HIV/AIDS

Antiretroviral update from the BC Centre for Excellence

by Carley Taylor

The BC Centre for Excellence in HIV/AIDS recently held an antiretroviral therapy update. One of the key presentations, by Dr. Marianne Harris, was on the side effects of new antiretroviral agents. Dr. Harris broke new antiretroviral agents into three groups: new agents in existing classes, new agents with new targets, and older agents in new formulations.

New agents in an existing class

New agents in an existing class include the protease inhibitors tipranavir (Aptivus) and darunavir (TMC114; Prezista) and the non-nucleoside reverse transcriptase inhibitor etravirine (TMC125). Both tipranavir and darunavir have been designed for patients who are treatment resistant to other protease inhibitors (PIs). Side effects of tipranavir include elevation in liver enzymes and an increase in lipids. Tipranavir is also associated with reports of clinical hepatitis and fatal and nonfatal intracranial hemorrhage. Due to safety concerns with tipranavir, it's only used for treatment resistance to protease inhibitors, and not for treatment-naïve patients.

Darunavir has been associated with less severe side effects than tipranavir. The most common side effects of darunavir include diarrhea and elevated cholesterol. There have been some reports of severe rash, including Stevens-Johnson Syndrome, but only 0.3 percent of people have discontinued the drug due to rashes. Pancreatitis is also a rare side effect associated with darunavir.

The non-nucleoside reverse transcriptase inhibitor (NNRTI) etravirine is a second generation NNRTI that may be helpful in treating patients with resistance to other NNRTIs. TMC125 will be available through an expanded access program early this year. The most common side effects associated with this drug are diarrhea and rash, although no severe rashes have been observed.

New types of agents

Two new types of agents are in the early stages of development: integrase inhibitors, which work by blocking the reproduction of HIV once it's inside the CD4 cell; and CCR5 receptor

antagonists that are aimed at a cellular target and not a viral target. Because these new agents are aimed at new targets in the viral replication cycle, they shouldn't have cross-resistance with existing agents.

Two promising integrase inhibitors are in development: MK-0518 and GS-9137. MK-0518 has been shown to be very benign, with no concerns identified in clinical trials. This agent will be available early this year through an expanded access program. GS-9137 is not as far along in its development and has only been evaluated through a 10-day monotherapy study. The study showed that adverse effects were generally mild and resolved on treatment with no serious adverse events. It is expected that GS-9137 may come into clinical trials in Canada this year.

The drug maraviroc, a CCR5 receptor antagonist, appears to be safe in clinical trials to date at doses of less than 300 mg. At higher doses, however, postural hypotension (head rush) appears to be a problem.

Older agents, new formulations

A number of older agents in new formulations have been developed. These include Truvada (tenofovir/emtricitabine combination), Kaletra (lopinavir/ritonavir combination) and Invirase 500 (saquinavir). Truvada is a fixed-dose combination pill. The emtricitabine (FTC) has mild side effects, and hyperpigmentation appears to be a problem in eight percent of African Americans.

Invirase 500, another PI, is a 500 mg tablet. Preliminary studies comparing Invirase 500 and Kaletra show that Invirase 500 has fewer side effects and a less adverse impact on lipids than Kaletra.

You can watch Dr. Harris's presentation and the other presentations at the antiretroviral update session by visiting the "Live Broadcast" section of the BC Centre for Excellence's website at www.cfenet.ubc.ca.

Carley Taylor is a volunteer with the BCPWA Society's Treatment Information Program.

Swallow this

Kaletra is now in a more convenient tablet form, but beware of drug interactions

by *Kristin De Girolamo*

Protease inhibitors (PIs) are drugs that stop the enzyme protease from allowing viruses to replicate, particularly the HIV virus. HIV uses protease enzymes to make copies of itself in the final stages of its replication process.

Kaletra, manufactured by Abbott Laboratories, is a combination drug of two PIs, lopinavir (200mg) and ritonavir (50mg). The small amount of ritonavir enhances the activity of lopinavir by making more of the drug available in the blood to act on the HIV/AIDS virus. It does this by inhibiting the enzymes that would normally break down lopinavir. This creates a PI that's more effective in fighting HIV.

Originally manufactured as an oral solution, in September 2006 Health Canada approved the tablet formulation. Kaletra tablets are more convenient since you can take them with or without food, whereas the oral solution must be taken with food to allow for maximum absorption.



The recommended dosage for Kaletra tablets is two tablets twice a day. With the older soft gel formulation, the dosage used to be three capsules twice a day. Kaletra should only be used in adults and children six months or older. There is also a once-daily dosing of Kaletra available, which shouldn't be used in children aged six months to 12 years, as it hasn't been studied in this age group.

Kaletra does have some interactions with other drugs. Since lopinavir is metabolized by the liver enzyme group CYP3A P450, if you take any drugs that alter these enzyme levels, the level of lopinavir available to act in the body will also be altered. Always check with your pharmacist for any potential interactions.

As well, there are several drugs you should avoid if you're taking Kaletra, as they can produce serious and/or life threatening side effects. The list of drugs to avoid includes: antihistamines such as astemizole and terfenadine (both no longer available in Canada); ergot derivatives (for migraines) such as dihydroergotamine, ergonovine, and ergotamine; gastrointestinal motility agents such as cisapride (no longer available); neuroleptic drugs such as pimozide (Orap); and sedatives/hypnotics such as midazolam (Versed) and triazolam (Halcion).

You should also avoid drugs for erectile dysfunction such as sildenafil (Viagra), tadalafil (Cialis), and vardenafil (Levitra), because Kaletra can cause an increase in blood levels of these drugs, leading to an increase in side effects such as hypotension, fainting, and visual changes.

Kaletra tablets are more convenient since you can take them with or without food, whereas the oral solution must be taken with food to allow for maximum absorbance.

Cholesterol-lowering drugs such as lovastatin (Mevacor, Altoprev, and Advicor) and simvastatin (Zocor and Vytorin), which belong to the same drug class of HMG-CoA reductase inhibitors, will also have their concentrations increased if you take them with Kaletra. This can cause an increase in side effects such as myopathy, or nerve pain.

Also, watch for interactions with over-the-counter products such as St. John's wort. Always consult your doctor or pharmacist before starting any new medications, even if they're non-prescription.

Store your Kaletra tablets at room temperature and try to avoid storing them in rooms where the temperature and humidity are subject to change, such as your bathroom.

If you have any other questions, visit your healthcare professional. ☺

Kristin De Girolamo is a volunteer with BCPWA's Treatment Information Program and a pharmacy student at the University of British Columbia.

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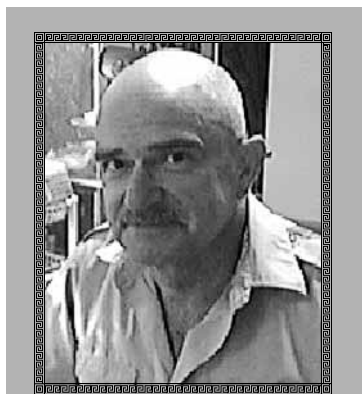


British Columbia
Persons With AIDS Society

Volunteering at BCPWA

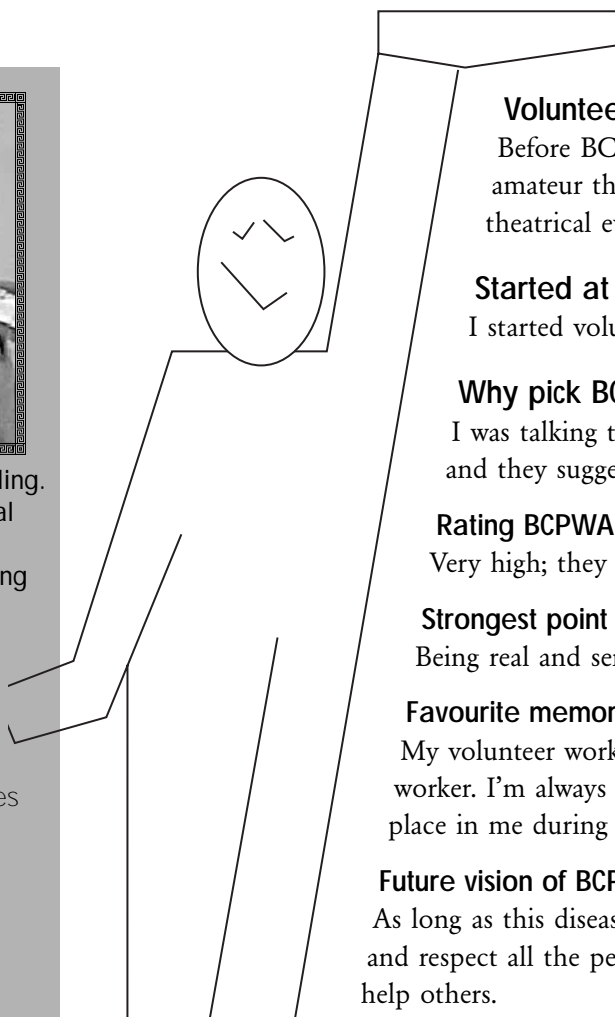
Profile of a volunteer:

Colin Curtis



Colin is dedicated to healing. He delights us with annual creative and hilarious performances at our healing retreat talent night. Colin travels from the Sunshine Coast to devote his talents to our retreats.

Jackie Haywood
Director of Support Services



Volunteer history

Before BCPWA my volunteer history was in amateur theatre and corporate promotional theatrical events.

Started at BCPWA

I started volunteering at the retreats in 1999.

Why pick BCPWA?

I was talking to one of the retreat team members and they suggested I volunteer for the retreats.

Rating BCPWA

Very high; they have always made me feel welcome.

Strongest point

Being real and sensitive to members' needs.

Favourite memory

My volunteer work has been at the retreats as a body worker. I'm always overwhelmed by the trust clients place in me during the Reiki sessions.

Future vision of BCPWA?

As long as this disease is with us, we need to encourage and respect all the people who give their time to help others.

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where to find help

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Suite 100 – 1300 Richards St,
Vancouver, BC V6B 3G6
604.682.6325
e clients@alovingspoonful.org
www.alovingspoonful.org

AIDS Memorial Vancouver

205 – 636 West Broadway,
Vancouver BC V5Z 1G2
604.216.7031 or 1.866.626.3700
e info@aidsmemorial.ca www.aidsmemorial.ca

AIDS Society of Kamloops

P.O. Box 1064, 437 Lansdowne St,
Kamloops, BC V2C 6H2
t 250.372.7585 or 1.800.661.7541
e ask@telus.net

AIDS Vancouver

1107 Seymour St, Vancouver BC V6B 5S8
t 604.893.2201 e av@aidsvancouver.org
www.aidsvancouver.bc.ca

AIDS Vancouver Island (Victoria)

1601 Blanshard St, Victoria, BC V8W 2J5
t 250.384.2366
e info@avi.org www.avi.org

AIDS Vancouver Island (Cowichan Valley)

t 250.701.3667

North Island AIDS (Campbell River) Society

t 250.830.0787

North Island AIDS (Port Hardy) Society

t 250.902.2238

AIDS Vancouver Island (Nanaimo)

t 250.753.2437

North Island AIDS (Courtenay) Society

t 250.338.7400 or 1.877.311.7400

ANKORS (Nelson)

101 Baker St, Nelson, BC V1L 4H1
t 250.505.5506 or 1.800.421.AIDS
f 250.505.5507 e info@ankors.bc.ca
http://kics.bc.ca/~ankors/

ANKORS (Cranbrook)

205 – 14th Ave N Cranbrook,
BC V1C 3W3
250.426.3383 or 1.800.421.AIDS
f 250.426.3221 e gary@ankors.bc.ca
http://kics.bc.ca/~ankors/

Asian Society for the Intervention of AIDS (ASIA)

210 – 119 West Pender St,
Vancouver, BC V6B 1S5
t 604.669.5567 f 604.669.7756
e asia@asia.bc.ca www.asia.bc.ca

BC Persons With AIDS Society

1107 Seymour St, Vancouver BC V6B 5S8
604.893.2200 or 1.800.994.2437
e info@bcpwa.org www.bcpwa.org

Dr Peter Centre

1100 Comox St,
Vancouver, BC V6E 1K5
t 604.608.1874 f 604.608.4259
e info@drpetercentre.ca
www.drpetercentre.ca

Friends for Life Society

1459 Barclay St, Vancouver, BC V6G 1J6
t 604.682.5992 f 604.682.3592
e info@friendsforlife.ca
www.friendsforlife.ca

Healing Our Spirit

3144 Dollarton Highway,
North Vancouver, BC V7H 1B3
t 604.879.8884 or 1.866.745.8884
e info@healingourspirit.org
www.healingourspirit.org

Living Positive Resource Centre Okanagan

101–266 Lawrence Ave.,
Kelowna, BC V1Y 6L3
t 250.862.2437 or 1.800.616.2437
e lprc@lprc.ca
www.livingpositive.ca

McLaren Housing Society

200 – 649 Helmcken St,
Vancouver, BC V6B 5R1
t 604.669.4090 f 604.669.4092
e mclarenhousing@telus.net
www.mclarenhousing.com

Okanagan Aboriginal AIDS Society

101 – 266 Lawrence Ave.,
Kelowna, BC V1Y 6L3
t 250.862.2481 or 1.800.616.2437
e oaas@arcok.com www.oaas.ca

Outreach Prince Rupert

300 3rd Ave. West
Prince Rupert, BC V8J 1L4
t 250.627.8823
f 250.624.7591
e aidspr@rapidnet.net

Pacific AIDS Network

c/o AIDS Vancouver Island (Victoria)
1601 Blanchard St.,
Victoria V8W 2J5
t 250.881.5663 f 250.920.4221
e erikages@pan.ca www.pan.ca

Positive Living North

1–1563 2nd Ave,
Prince George, BC V2L 3B8
t 250.562.1172 f 250.562.3317
e info@positivelivingnorth.ca
www.positivelivingnorth.ca

Positive Living North West

Box 4368 Smithers, BC V0J 2N0
3862 F Broadway, Smithers BC
t 250.877.0042 or 1.866.877.0042
e plnw@bulkley.net

Positive Women's Network

614 – 1033 Davie St, Vancouver, BC V6E 1M7
t 604.692.3000 or 1.866.692.3001
e pwn@pwn.bc.ca www.pwn.bc.ca

Purpose Society HIV/AIDS program

40 Begbie Street
New Westminster, BC V3M 3L9
t 604.526.2522 f 604.526.6546

Red Road HIV/AIDS Network Society

804 – 100 Park Royal South,
W. Vancouver, BC V7T 1A2
t 604.913.3332 or 1.800.336.9726
e info@red-road.org www.red-road.org

Vancouver Native Health Society

441 East Hastings St, Vancouver, BC V6G 1B4
t 604.254.9949
e vnhs@shaw.ca

Victoria AIDS Resource & Community Service Society

1284 F Gladstone Ave, Victoria, BC V8T 1G6
t 250.388.6620 f 250.388.7011
e varcs@islandnet.com
www.varcs.org/varcs./varcs.nsf

Victoria Persons With AIDS Society

#330-1105 Pandora St., Victoria BC V8V 3P9
t 250.382.7927 f 250.382.3232
e support@vpwas.com www.vpwas.com

Wings Housing Society

12 – 1041 Comox St, Vancouver, BC V6E 1K1
t 604.899.5405 f 604.899.5410
e info@wingshousing.bc.ca
www.wingshousing.bc.ca

YouthCO AIDS Society

205 – 1104 Hornby St.,
Vancouver BC V6Z 1V8
t 604.688.1441 f 1.877.968.8426
e information@youthco.org
www.youthco.org

**For more comprehensive
listings of HIV/AIDS
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Upcoming BCPWA Society Board Meetings:

Date	Time	Location	Reports to be presented
March 14, 2007	4:30	Board Room	Written Executive Director Report / Executive Committee / Director of Support
March 28, 2007	4:30	Board Room	Standing Committees / Financial Statements — February / Director of Development
April 11, 2007	4:30	Board Room	Written Executive Director Report / Director of Prevention
April 25, 2007	4:30	Board Room	Quarterly Department Reports / Executive Committee / Financial Statements — March
May 9, 2007	4:30	Board Room	Written Executive Director Report / Standing Committees

BCPWA Society is located at 1107 Seymour St., 2nd Floor, Vancouver.

For more information, contact: Alexandra Regier, office manager Direct: 604.893.2292 Email: alexr@bcpwa.org

BCPWA Standing Committees and Subcommittees

If you are a member of the BC Persons With AIDS Society, you can get involved and help make crucial decisions by joining a committee. To become a voting member on a committee, please attend three consecutive meetings. For more information on meeting dates and times, please see the contact information on the right column for the respective committee that you are interested in.

Board & Volunteer Development

Contact: Adriaan de Vries
 ☎ 604.893.2298 ✉ adriaand@bcpwa.org

Community Representation & Engagement

Contact: Marc Seguin
 ☎ 604.646.5309 ✉ marcs@bcpwa.org

Education & Communications

Contact: Melissa Davis
 ☎ 604.893.2209 ✉ melissad@bcpwa.org

IT Committee

Contact: Marie Cambon
 ☎ 604.893.2280 ✉ mariec@bcpwa.org

living+ Magazine

Contact: Jeff Rotin
 ☎ 604.893.2206 ✉ jeffr@bcpwa.org

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Contact: Elgin Lim
 ☎ 604.893.2225 ✉ elginl@bcpwa.org

Support Services

Contact: Jackie Haywood
 ☎ 604.893.2259 ✉ jackieh@bcpwa.org

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Contact: Jane Talbot
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 or call 604.893.2206

Mid-life crisis

The short distance between being hip and breaking a hip

by Rob Gair

I think I'm having a mid-life crisis—at the ripe age of 43. Up until recently, it was nothing major: a little boredom with my life and a general awareness I'm not as robust as I once was (like sore knees in the morning). But for the most part I was content to let it simmer. Then about a year ago, things started ramping up.

Last spring, I was asked to participate in Dr. Julio Montaner's osteoporosis study. The researchers explained that thinning of the bones is relatively common in HIV-positive men and they wanted to do some tests to see if they could find commonalities. First, a bone density test determined that I did in fact have osteoporosis. "This can't be," I thought, "osteoporosis is for grannies."

I tried taking extra calcium over the next few months to help build up my bones, but I had to stop because it interacted with my tenofovir. For a while, I tried to put the whole diagnosis in the back of my mind. Then I experienced a quintessential geriatric event: I broke my hip.

It was a sunny late August morning and I was in good spirits as I started out on my bicycle. The plan was to run some errands then go to work late in the afternoon. About midday, I came upon a traffic calming area where city workers were doing some gardening. I decided to cycle through without getting off my bike. Big mistake. The sidewalk was wet from the landscaping and when I turned the front wheel of my bike to the right, the back tire began slipping to the left. Instinctively I put my right foot on the ground to break the fall but the bike kept

slipping and, with my left leg straddled over it, I did the splits. Then snap!—and I was on the ground.

When the paramedics arrived, one of them asked me if I wanted laughing gas to ease the pain. "It works great for hip fractures in old ladies," he said. I thought it was an inappropriate comparison, but I was in too much pain to be proud so I sucked it back before we headed to the hospital.



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Once I got to St. Paul's Hospital, things happened with amazing efficiency. To get me onto the x-ray table, I was placed in a harness like the ones they use to get nursing home residents into the bathtub. Soon after the doctor came by to tell me that—surprise—I had broken my hip and I needed urgent surgery to repair it because the fracture was disrupting the blood supply to my hip socket.

The next morning I found myself in the hospital flat on my back. An elderly lady was in the bed across from me with a bleeding nose (apparently no beds in the bleeding nose ward). My right leg felt like a lead pipe, it ached constantly, and I had to literally hoist it with both hands to move it anywhere.

When the surgeon dropped by, she told me I had two screws in my hip and that I wouldn't be able to weight-bear on my injured leg for at least six weeks. This posed a major problem because I live alone on the top floor of a three-story walk-up. After a couple of quick lessons from the physiotherapist on how to navigate stairs with only one leg, I was discharged along with a "good luck" and a list of equipment that I needed to borrow from the Red Cross: an elevated toilet seat, a

bench for the bathtub, a walker, and a wheelchair. The final blow came when I was told that I didn't qualify for home assistance because I was "too young." At the time, I was too shell-shocked to fully appreciate the irony of this.

The next six weeks were a flood of ups and down. Ultimately, I managed to get through the ordeal, but not without the help of a few people—most notably my friends Steve, John, Lynn, and other friends and co-workers. And thank God for television and Sudoku puzzles.

As for the mid-life crisis: it's now on a rolling boil, but at least I'm here and I'm more or less in one piece. And that's a good thing. ☺

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