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The British Columbia Persons With AIDS Society seeks to empower persons living with HIV disease and AIDS through mutual support and collective action. The Society has over 4400 HIV+ members.

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think ⊕

opinion & editorial . . .

HIV as a murder weapon

by Glyn Townson

The past few months have seen an all-out media frenzy over a small number of high-profile legal cases involving HIV-positive people facing criminal charges for allegedly not disclosing their status to sexual partners and practising unsafe sex.

The public seems to eat these stories up with a voracious appetite, waiting for more juicy and sordid details. After all, inquiring minds want to know.

What does it say about our human rights—and our legal system—when a judge in Ontario insists that a HIV-positive individual be masked and gloved before his case is heard in court? And what does it say about the law, and its protection of citizens, when a Quebec women files charges against her partner for domestic abuse and then winds up sentenced for non-disclosure of her HIV status while all charges against her ex-partner are dismissed? And when the RCMP is exposed for funding research aimed at undermining Canada's only supervised injection site, who are we to believe or trust?

This issue of *living⊕* paints some broad strokes about the criminalization of HIV (see "Risking arrest," pg. 6), referring to some of the cases that have attracted considerable media attention in recent years, and comparing the Canadian legal system to guidelines and decisions from the UK. Future issues of the magazine will report and comment on several cases currently before the courts.

Survey and epidemiological data as well as personal experience show that the overwhelming majority of people who know their HIV status adapt their behaviours to protect others from risk of infection. In fact, the vast majority of new infections are attributed to individuals who have no idea that they are HIV-positive.

Of course, that bit of information doesn't make for a front page story, won't sell more papers, and won't keep the public glued to their TV screens.

After living with this virus for over half of my life, I cringe when the accusations start flying: dirty, filthy, degenerate, evil, reckless behaviours. I take a moment to pause and then take a deep breath.

Whatever happened to personal responsibility? Or self-empowerment? Or, for that matter, common sense?

HIV has been a social reality for nearly 30 years now. We still can't talk about condoms in schools or give out clean rigs in prisons, but there's no shortage of judgments about those dirty, reckless, evil-mongers who intentionally spread HIV everywhere.

Ignorance, once again, seems to trump all. ⊕



Glyn Townson is the chair of BCPWA.



REALITYBITES

News from home & around the world



BCPWA department name change

BCPWA's Treatment Information and Advocacy Department (TIAD) has been renamed the APT Department (Advocacy, Prison outreach, Treatment information) to acknowledge and include the work of the Prison Outreach Program.

The play on the word "apt" is intentional: Miriam Webster online dictionary defines "apt" as: 1: ready; 2a: likely b: inclined; 3: suited to a purpose; 4: intelligent and responsive. Synonyms are fit and quick.

Treatment during primary HIV infection has limited benefit

A short course of HIV treatment soon after a person is infected with HIV protects CD4 cell count in the long term, but only if such treatment lasts for at least 12 months, according to the results from the CASCADE cohort collaboration published in the November 30, 2008 edition of *AIDS*.

Investigators found few other benefits of treatment at this stage of HIV infection—often called primary infection—although individuals who received treatment at this time were less likely to die of non-HIV-related causes than people whose HIV treatment was started at a later stage.

There is uncertainty about the benefits of starting HIV treatment during primary HIV infection. There is some evidence to suggest that treatment at this time can have long-term benefits for the immune system. However, such evidence is inconclusive and a large randomized controlled trial, the SPARTAC study, is currently investigating the possible benefits or risks of early HIV therapy.

Source: www.aidsmap.com

Expect HIV vaccine within five years: Nobel winner

A therapeutic vaccine to inhibit the spread of HIV will be available within five years, according to a Nobel Prize-winning scientist who helped discover the virus.

Luc Montagnier, director of the World Foundation for AIDS Research and Prevention, said he thinks it's "a matter of four to five years" before such a vaccine is developed. Restricting the transmission of HIV, he said, would change how the disease is managed and controlled.

Montagnier said a therapeutic vaccine, to be given to those who are already infected in order to inhibit the likelihood of transmission, would be a key step in fighting the virus. By comparison, a preventative vaccine would protect people from contracting HIV in the first place.

Montagnier didn't explain why he believes the discovery will be made in that specific time frame.

Source: www.cbc.ca

SFU prof heads new network to boost HIV treatment

A BC university professor will head a new national network aimed at boosting treatments for the 58,000 people living with HIV in Canada. The network, to be headed by Simon Fraser University health sciences professor Robert Hogg, will study the effectiveness of antiretroviral therapy across the country.

The group, which will bring together 31 HIV/AIDS clinicians and researchers in BC and Ontario to form the Canadian Observational Cohort, plans to follow 5,000 people, who started on antiretroviral medication in 2000, for the next five

years. More people will be added each year. The study will also investigate the different trends in treatments, provincial access to medications, and what causes people to stay on the drugs or to discontinue them.

The aim is to develop a research program in HIV treatment that will better inform doctors and people living with HIV/AIDS and identify gaps in the system.

Source: *The Vancouver Sun*

Adherence of 80-95 percent not good enough

Adherence of less than 95 percent is associated with a substantially lower chance of a good response to treatment, even using relatively relaxed definitions of virologic and immune success, according to a new analysis. BC investigators used patient data from the BC Centre for Excellence in HIV/AIDS.

They found that people who took less than 80 percent of their medication—people likely to be missing doses on a weekly basis—had only a 10-15 percent probability of achieving and maintaining a good response to treatment during the four-year follow-up period, while those taking between 80 and 95 percent of all doses had no more than a 41 percent probability of a good response to treatment.

Source: www.aidsmap.com

High prevalence of vitamin D deficiency in PWAs

Almost one-third of HIV-positive people have vitamin D deficiency, Dutch researchers report in the November 2008 edition of *AIDS Research and Human Retroviruses*. Dark skin colour was the most important risk factor for this disorder. Among patients with white

continued on next page



REALITYBITES

News from home & around the world



skin, more patients taking non-nucleoside reverse transcriptase inhibitor-based HIV treatment had vitamin D deficiency than did patients taking antiretroviral therapy based on a protease inhibitor.

Investigators designed a cross-study to examine the prevalence and causes of vitamin deficiency among 252 HIV-positive people who were receiving HIV care between January and August 2006.

Blood levels of the vitamin were measured by analyzing levels of 25-hydroxyvitamin D. The investigators also conducted a number of other laboratory tests, measuring levels of parathyroid hormone, serum calcium, CD4 and CD4 cell counts, and HIV viral load. Data was also gathered on demographics including race and age, the duration and stage of HIV infection, the use of antiretroviral treatment, medical history, and body mass index.

Source: www.aidsmap.com

Exercise intolerance may be due to impact of HIV treatment on heart

The lowered tolerance for exercise seen among people taking HIV treatment may be an early manifestation of silent cardiac dysfunction, says a research letter published in the November 30, 2008 issue of *AIDS*. The report's authors recommend regular cardiac assessment of patients on therapy may reveal subclinical abnormalities and help clinicians take steps to help patients preserve a healthy heart.

Experts have proposed several reasons for the lower tolerance to aerobic exercise seen among people with HIV taking HIV treatment, including smoking, anemia, and a loss of fitness due to living with a

chronic disease. Some anti-HIV drugs, specifically non-nucleoside reverse transcriptase inhibitors, are also implicated because of the oxidative stress they place on the body's tissues, including muscle.

Earlier in 2008, French investigators added another possible cause when they reported lower exercise tolerance and signs of dysfunction of the heart's left ventricle among a group of HIV-positive men.

Source: www.aidsmap.com

Survey indicates that a strong stigma still exists

Twenty-five years after the discovery of HIV, a large majority of Canadians living with HIV/AIDS still feel stigmatized and there is still a strong need for further and continuing education, outreach, and better treatments.

The HIV+25 Survey was conducted in collaboration with five key Canadian AIDS service organizations. It asked 381 people living with HIV/AIDS across Canada about the impact of the disease on their lives, explored their level of knowledge, and their satisfaction with healthcare and current treatments.

"The survey illustrates...that the disease affects all sectors of society regardless of sexual orientation," said Stephen Alexander, programs consultant at the Canadian AIDS Society. "These findings demonstrate the need for further and continuing education to eradicate stigma attached to being HIV-positive, and for greater and improved resources and support services to help people cope with being HIV-positive and overcome the barriers that still exist for them."

Source: www.newswire.ca ⊕

Does shopping at Polli & Esther's feel like a Macy's basement sale day?

If you're tired of arriving at our shop and having to wait for your number to be drawn from the lottery, or if you're coming from out of town with limited shopping time, you'll be pleased to know about our two new initiatives:

1) Shopping by appointment:

Call 604.664.5324 to book an appointment or drop by during business hours to book a time

2) Members may now visit Polli's once a month only: Any Tuesday, Wednesday, or Thursday per month,

from 11:00AM - 2:30PM

Exceptional emergency situations can be referred to the Director of Support Services.

You can drop off donations Monday - Friday from 9:00AM - 4:00PM and Wednesdays from 9:00AM - 9:00PM. We are grateful for your donation. Pass the word around to friends and family clearing out closets or downsizing.

Polli & Esther's Closet is located at BCPWA, 1107 Seymour St, 2nd floor, Vancouver.

FIGHTING WORDS



Same old same old

by Ross Harvey

So, after all of the sound and fury from the October 14 federal election, where does the fight against HIV/AIDS stand with Canada's federal government?

The short answer is, pretty much where it stood before: benign neglect on a good day, resentful (even hostile) suspicion on a bad one.

Consider the bald facts. Despite concerted efforts by a number of groups across the country—the Canadian HIV/AIDS Legal Network, the Canadian AIDS Society, the Ontario AIDS Network, the BCPWA Society (BCPWA), and others—to raise the profile of HIV/AIDS as an election issue, voters' attention was firmly riveted elsewhere.

The financial crisis that exploded internationally in September made sure of that.

The remarkable thing is that, under the circumstances, Stephen Harper's Conservatives didn't win more seats than they did. They effectively destroyed Liberal leader Stéphane Dion's credibility through relentless character assassination (including millions of dollars in negative advertising). They were also viewed as the "safe" choice during this period of economic tribulation; Conservatives are, for elusive reasons, widely believed to be the best and most prudent economic managers on offer. And in spite of having by far the biggest election "war chest" of any party, they still came up short of a majority by 11 seats.

Notwithstanding the advance in the Conservatives' polling numbers occasioned by the late November attempt by the opposition Coalition to defeat and replace the government, this election may well prove to have been the Conservatives' best chance at a majority government in a generation. And they still couldn't pull it off. Next time they will face a "renewed" Liberal opposition, with a more credible leader running on a more carefully crafted platform, along with their own record of unpopular decisions made during hard economic times.

But, for a while at least, the Conservatives can govern as if they held that elusive majority. The Liberals will not risk an election until they've secured a new leader and given that person a chance to woo the Canadian electorate.

So, back to the implications for HIV/AIDS.

First, harm reduction will remain out of favour at the federal level. This means, among other things, that Vancouver's *Insite* supervised injection facility will lose its exemption under the *Controlled Drugs and Substances Act*. Whether the Vancouver Coastal Health Authority (VCHA)—supported, however silently, by the BC government and the Vancouver municipal government—will have the stomach to keep *Insite*'s doors open, quite possibly in the face of harassment by the RCMP, remains a key question. But that now is the goal of harm reduction activists in BC: pressuring VCHA and the BC government to keep *Insite* open, regardless of the federal government's decision. Needless to say, it is highly unlikely that facilities of a similar ilk planned for Victoria, Montreal, and elsewhere will be opened—unless there's a general city governments' revolt against such short-sighted federal policy.

Second, the campaign by national HIV/AIDS organizations and the Ontario AIDS Network to restore federal government funding to the levels previously budgeted before the Liberal cuts of 2005 (we're currently short by about \$11 million per year) will undoubtedly fail. Indeed, there's a very real prospect of federal funding cuts.

Third, Canadian assistance in the global fight against HIV/AIDS will remain desultory and grudging. There will be no effective roll out of Canadian manufactured generic HIV meds for Africa (and elsewhere), and already modest Canadian contributions to the Global Fund will stagnate or decline.

But, in the words of the ancient seers, "this, too, shall pass." HIV/AIDS activists must continue to wage essential battles with an eye on the long term, certain of the value and necessity of their work and cause. ⊕



Ross Harvey is BCPWA's executive director.



Risking arrest

The criminalization of HIV

by Glyn Townson

This past year, a number of high profile criminal cases involving HIV-positive individuals have appeared in Canadian courts. Some of the underlying issues, problems, and questions arising from these cases have left many people living with HIV/AIDS feeling perplexed and vulnerable.

Duty to disclose

Historically, the Canadian legal system has criminalized HIV infection and, by extension, people living with HIV. In October 1995, Bill C-354 was put before the House of Commons. Under that proposed bill, any kind of sexual intercourse with a HIV-negative person involving a person who knows or “should reasonably know” that he or she is HIV-infected would constitute criminal activity, regardless of precautions taken or whether the HIV-negative person knew his or her partner’s HIV status and consented to sexual intercourse. Fortunately, Bill C-354 died within four months.

Three years later, Canada’s *Currier* decision (1998) left PWAs with the duty to disclose our status to any sexual partner we might place at “significant risk to contract HIV.” In the absence of disclosure, the sexual act could be construed as non-consensual, potentially leading to a criminal charge of aggravated sexual assault. However, the law remains unclear about whether an HIV-infected person has a duty to disclose his or her status when engaging in activities that pose a lower risk of HIV transmission—such as sexual acts other than unprotected anal or vaginal intercourse.

Additional Canadian court rulings have touched on the “condom defense,” where the reduction of risk to the person is

below the threshold of significant risk. Even with this defense, there remains a lot of grey area. In one case, the judge and jury simply didn’t believe that the defendant had used condoms during each sexual encounter.

In many recent criminal cases, the accused HIV-positive individuals have entered guilty pleas. As a result, there haven’t been sufficient opportunities to argue a safer sex defense, or even the potential for an undetectable viral load defense; rulings and decisions based on more realistic or even more measurable criteria could address some of the current ambiguity. Some cases currently before the courts may provide clarification on these matters.

Recent cases

The criminalization of HIV infection varies widely, from cases involving an infinitesimal risk of exposure to the actual alleged transmission of HIV causing death.

In February 2008, an Ontario man was convicted of 15 counts of aggravated sexual assault for knowingly exposing women to HIV through unprotected sexual intercourse. He was sentenced to 18 years in prison. Five of the 15 women upon whom the charges were based were found to be HIV-positive.

Earlier this year, a 49-year-old HIV-positive woman in Quebec filed a police report documenting domestic violence against herself and her 18-year-old son by her partner. Ultimately, she was found guilty of criminal HIV exposure after her partner subsequently complained to police that she hadn’t disclosed her HIV status for the first two years of their seven year relationship. Her former partner was given an unconditional

discharge, with no criminal record of domestic violence, while the woman received a one-year sentence—to be served in the community, due to her poor health. HIV activists were outraged by the decision of the court to dismiss the case against the allegedly abusive partner and focus exclusively on the HIV-positive woman's behaviour.

In October 2008, a Canadian citizen who immigrated to Canada from Uganda was charged with two counts of first degree murder, along with 11 counts of aggravated sexual assault. Seven of the man's 11 partners tested positive for HIV, including two who died of what the Crown identified as "HIV-related cancers." This is the first case in Canada where an individual has been charged with lethally infecting a partner. The case is currently before the courts.

Canadian law requires clearer guidelines on the meaning of "significant risk" to an individual in the context of HIV transmission

In the US, the criminalization of HIV is heightened, with associated charges and rulings even more extreme. An HIV-positive man convicted of spitting into the eye and mouth of a Dallas police officer was sentenced to 35 years in prison without eligibility of parole for 17 years; in this case, the jury found the individual had used his saliva as a deadly weapon. His sentence was increased from 25 years because of prior convictions for attacking two other police officers, biting two inmates, and other offences.

Exaggerated sentences and judicial reactions to cases such as these risk undermining HIV prevention and education efforts, by exacerbating stigma and fear about people living with HIV.

Progressive guidelines in other jurisdictions

Canadian law requires clearer guidelines on the meaning of "significant risk" to an individual in the context of HIV transmission. Some other jurisdictions have developed and are using guidelines to assess the viability of criminal prosecution in cases involving alleged HIV transmission.

For example, England and Wales Crown Prosecution Services (CPS) have prepared guidelines for Crown prosecutors and the courts to evaluate the charge of reckless transmission before cases are brought before the courts. A major difference between Canada and the UK is that a person wouldn't be charged in the UK unless the alleged actions actually resulted in the transmission of infection; the guidelines explicitly state that there is no offence of "attempted recklessness." In other words, either you have exposed someone to HIV or you haven't.

Although the ultimate authority resides with the judicial system in England and Wales, the legal system solicited input from all stakeholders in an attempt to develop balanced guidelines. Advocates from the HIV community continue to focus the issues on a health-centred model, dealing with HIV in the same manner as other sexually transmitted infections. The CPS guidelines now form the basis of detailed evidence, what is required to prove responsibility for infection, knowledge, recklessness, and appropriate use of safeguards. An informed understanding of these elements should result in fewer and fairer prosecutions. Time, of course, will tell.

Looking ahead

Canada doesn't have any HIV-specific legislation; instead it has used existing sections of the Criminal Code to prosecute cases brought before the courts.

Most of the high-profile cases in Canada have centred on heterosexual, predominantly male-to-female HIV transmission. More recently, same-sex cases have emerged in the courts and in media headlines. In BC earlier this year, the Canadian HIV/AIDS Legal Network and BCPWA filed for intervener status in a same-sex legal case. Intervener status was granted, and evidence was presented at the appeals court level, including the submission of reference materials such as the CPS guidelines. Unfortunately, the appeals court of BC recently dismissed our submissions, and the case is expected to convene in late January, 2009.

So, ten years after *Currier* we still find ourselves with grey areas in the Canadian legal system. We can also continue to expect a media feeding frenzy every time an HIV-positive individual is accused of reckless behaviour. Clear distinctions must be drawn between willful reckless transmission of HIV—in fact, a small number of cases which garner a disproportionate amount of media attention—and those acts that present only a very small chance of infection, such as the spitting case in the US.

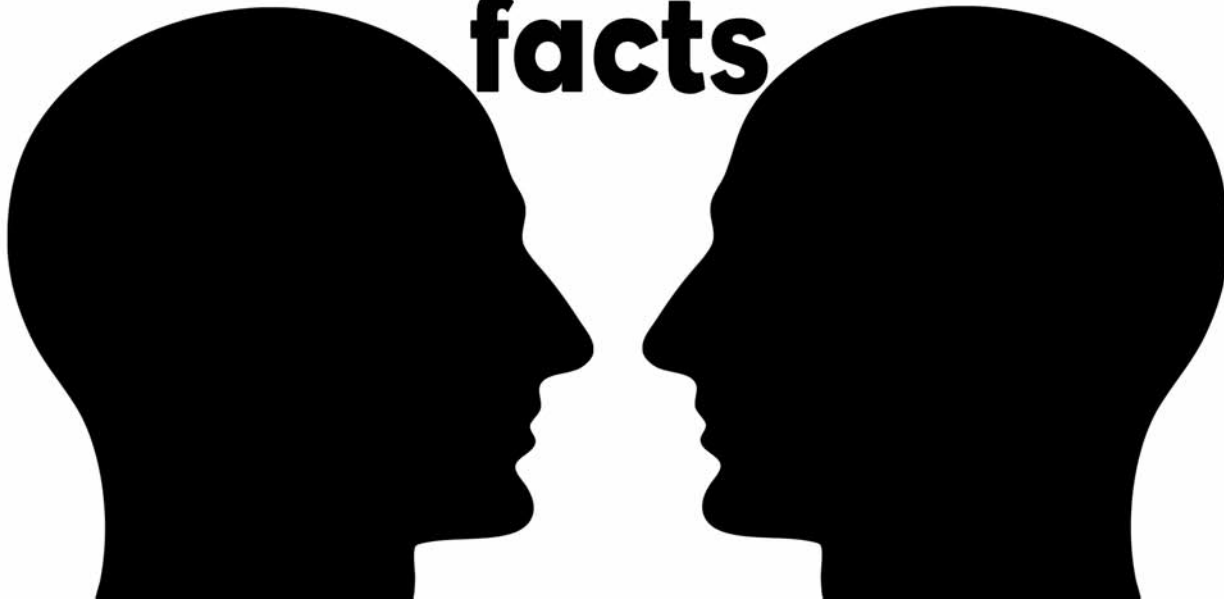
Canadians living with HIV have legitimate worries about revenge charges from former partners, such as the case in Quebec. Realistically, how can we as HIV-positive individuals prove that disclosure actually occurred? Many of the court decisions have boiled down to who the court believes to be telling the truth. ⊕

Glyn Townson is the chair of BCPWA.

Online resources on HIV criminalization

- ▷ Living 2008: Positive Leadership Summit - webcasts & session reports: www.living2008.org
- ▷ AIDS Map website: news section/HIV & the law sub-section: www.aidsmap.org
- ▷ Canadian HIV/AIDS Legal Network: fact sheets & articles on HIV disclosure, criminalization & links to CPS Guidelines: www.aidslaw.ca

Facing facts



The battle rages on for medical insurance coverage to treat facial lipoatrophy

by Zoran Stjepanović

Since 2006, BCPWA has been lobbying the BC Ministry of Health to provide provincial medical insurance coverage of restorative surgical procedures for HIV-associated facial lipoatrophy. Facial wasting, caused both by HIV and by certain antiretroviral medications affects many people living with HIV/AIDS. Corrective treatments such as the injectable poly-L-lactic acid (Sculptra) or polyalkylimide gel (Bio-Alcamid) aren't covered by the province's Medical Services Plan (MSP) or PharmaCare. Instead, PWAs who need these expensive procedures are forced to pay out-of-pocket.

In 2007, we reported on BCPWA's early advocacy efforts (see "A slap in the face," *living* ⊕, Jan/Feb 2007). Here are our ongoing advocacy activities on this issue since then.

Winter 2007: BCPWA receives a response from the BC Ministry of Health's Medical Services Operations and Policy Medical Services Division apologizing for their delay in replying to our previous letter. Their letter essentially summarizes how the billing system works under MSP and PharmaCare. They also advise us that inquiries about coverage of injectable compounds such as the injectable poly-L-lactic acid or polyalkylimide gel should be directed to PharmaCare.

Spring 2007: BCPWA's chair sends a letter to PharmaCare's Formulary Management Pharmaceutical Services, asking specifically what medical evidence they require in order to secure approval of injectable compounds for reconstructive surgery for people with HIV-related lipoatrophy.

Summer 2007: Pharmaceutical Services responds, stating that they're unfamiliar with the use of injectable compounds as treatments for HIV-associated facial lipoatrophy, and that they require more information in order to answer our question concerning medical insurance coverage.

Fall/Winter 2008: BCPWA's chair writes directly to the BC Minister of Health, requesting a meeting whereby an HIV specialist, a reconstructive surgeon, and BCPWA community members can present information on causes of facial lipoatrophy and the use of injectable compounds as a restorative treatment. To prevent further delays due to protracted correspondence, the meeting is proposed as a more efficient and effective way to present information so that the Ministry can make an informed decision on the issue.

February 2008/Teleconference #1: The Ministry responds by coordinating a teleconference with BCPWA and staff from the Ministry's Drug Intelligence Pharmaceutical Division. BCPWA presents information on facial lipoatrophy as a debilitating, disfiguring condition resulting from HIV and antiretroviral medications; in addition, the physical, mental, and psychological impacts and quality of life issues resulting from this condition are also explained. We raise questions about the legislation's applicability to PWAs (section in Medical Services Commission Payment Schedule on Surgery for Alteration of Appearance). We also provide information on injectable poly-L-lactic acid and polyalkylimide gel as a surgical procedure to restore appearance due to HIV medication side effects. As a follow-up,

we send teleconference participants a literature review on treatments for facial lipoatrophy, and names of surgeons who perform these procedures in Vancouver. We are told we deserve a response from the Ministry.

March 2008: BCPWA's Treatment Information Program organizes a community forum. Dr. Marianne Harris, from the BC Centre for Excellence in HIV/AIDS (BC-CfE), presents on facial lipoatrophy and its relationship to HIV and antiretroviral medications. Dr. Alastair Carruthers explains the different injectable compounds used to treat HIV-associated facial lipoatrophy. An invitation is extended to contacts at the Ministry of Health; however, Ministry staff decline the invitation, claiming that they're still considering our request for medical insurance coverage.

Spring/Summer 2008: BCPWA receives a letter from the Ministry of health's Medical Services Branch informing us that reconstructive procedures must be requested by the attending surgical specialist and MSP will authorize funding for facial surgery if surgical treatment is required to alleviate physical symptoms, or to restore or improve function to any area altered by disease, trauma, or congenital deformity. BCPWA's chair writes a letter in response, expressing dismay that the Ministry hasn't addressed why HIV is apparently not considered a disease according to its legislation.

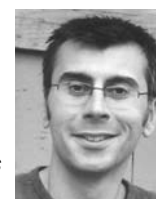
Fall 2008 – Teleconference Call #2: A second conference call takes place with the Ministry's Medical Services Branch and

BCPWA. Dr. Marianne Harris also participates, contributing her clinical expertise; BCPWA provides names of physicians in Vancouver who perform reconstructive procedures, as sources to provide expertise on the injectable compounds. We question why acne treatment is covered under the legislation, but not HIV; the Ministry refers this matter to one of its medical consultants, and advises us that they'll update us by the end of the year.


So, the advocacy efforts continue. We know that coverage for injectable compounds used to treat HIV-associated facial lipoatrophy is already approved in Ontario and Quebec. BCPWA will continue to lobby for medical coverage for this procedure as it's of paramount importance to many of our members. ☺

Get involved

If you wish to be involved in this advocacy issue, contact Zoran Stjepanovic at 604.893.2239 or email zorans@bcpwa.org.



Zoran Stjepanovic is BCPWA's treatment information coordinator.



CAPTURING OUR BCPWA HISTORY

Oral History Project

This project will capture firsthand accounts of BCPWA's history through the experiences of its members by means of filmed interviews in a digital format.

Volunteer(s) needed

- With technical skills in all aspects of digital pre-post production
- With related (specific) skills interested in participating on this project

BCPWA Photo Archivist Project

The project goals are to archive, preserve, identify, arrange and inventory BCPWA photographs so they are accessible for later reference in a safe, permanent format.

Volunteer(s) needed

- Project leader with motivation and skills to spearhead all aspects of this project

For more information contact
 Volunteer coordinator *Marc Seguin*
 e marcs@bcpwa.org t 604.893.2298

Feature Story



Best face forward

Four people share their experiences with the psychosocial effects of facial lipoatrophy and reconstructive treatment

by Jennifer Tsui

One of the most prominent and challenging side effects associated with HIV is lipoatrophy—a condition that causes erratic fat production of cells and the unequal distribution of fat in the body. Manifestations of lipoatrophy can vary from excessive accumulation of fat around the abdomen to severe fat and muscle wasting in the arms, legs, buttocks, and face.

Lipoatrophy is caused by HIV as well as certain classes of antiretroviral medications. These drugs damage or destroy the body's fat cells, resulting in disfigurement. While the condition isn't life-threatening, it can cause various medical problems.

Changing faces, changing lives

Lipoatrophy is often confused with AIDS-related wasting—a sign of advanced HIV disease. Unfortunately, the medication designed specifically to help individuals fight HIV often gives the unwanted impression they're losing the battle. Moreover, the obvious physical disfigurement caused by facial lipoatrophy, in particular, is a source of severe psychological and emotional distress for many people living with the condition.

"There's this sense that everyone knows you're HIV-positive," says Lorne, who was on one of the lipoatrophy-causing antiretroviral medications for eight years.

“I started wearing a hat—which I’d never done before—and I started walking with my head down,” says Bradford MacIntyre, whose face began rapidly sinking one summer. “I tried to stay incognito, I didn’t want people to notice.”

Malsah, who suffered from severe lipoatrophy, often chose not to go out in public because he was so self-conscious: “I looked like a walking corpse.” He felt that the lipoatrophy advertised his HIV status, and he could feel the judgment in strangers’ stares.

Moffatt’s drug regimen was not only causing lipoatrophy, drug toxicity was destroying his liver and killing him. When his doctors changed his medication, Moffatt was just grateful to be alive. “I thought: I might look a little weird, but at least I have a heartbeat.”

However, not everyone is as grateful. While they’re alive and—for the most part—healthy, people with lipoatrophy often feel that they’ve lost their quality of life and are powerless to change their situation.

“With lipoatrophy, your body’s out of your control,” says Lorne.

“On the surface, it makes the fact that you have HIV less obvious, which is attractive. But it gives you a new face and it doesn’t feel natural.” – Lorne

Getting under the skin

Reconstructive treatments are one way people try to reclaim their bodies and sense of self. These procedures involve a series of polymer gel injections—the most commonly used compounds are marketed under the names Sculptra and Bio-Alcamid—into or beneath the skin to give the impression of a fuller face. Regrettably, these treatments aren’t presently subsidized by BC’s Medical Services Plan (MSP) or PharmaCare, although BCPWA has been lobbying the provincial government since 2006 to obtain such coverage (see “Facing facts,” pg. 8). And while the treatments are expensive—well over \$2,000—for many, the price tag is well worth a life free from stigma, judgment, and self-consciousness.

“The treatment changed my life,” says Bradford, who underwent the procedure as a subject in a Bio-Alcamid training session for doctors. “Now, everything’s perky—nothing sags or falls down! I went from everyone looking at me and thinking I was sick and dying, to everyone thinking I’m the picture of health.”

For Malsah, who was also the subject of a Bio-Alcamid demonstration session, the effect was immediate: “It looked way, way better. I didn’t look like a corpse or a junkie anymore, and strangers seemed to treat me with more respect.”

Moffatt, too, felt that the procedure greatly improved his quality of life and self-esteem. He first participated in a clinical study with Radiesse and, when the effects of it began to diminish, he paid \$2,100 for a second procedure with Bio-Alcamid.

“After the first procedure, it was like I was miraculously transformed overnight,” he says. “I felt like me again. I would look in the mirror and say, ‘hey stranger, there you are, where have you been?’”

“After the first procedure, it was like I was miraculously transformed overnight. I felt like me again.” – Moffatt

Some aren’t so thrilled with the results

Not everyone who gets the treatment is as happy about their decision, though. For Lorne, who paid \$3,500 for a Bio-Alcamid procedure, he initially felt better about himself, but the change felt unnatural and triggered acute self-consciousness. “I looked at my face a lot more and it became really tiring to be so self-aware all the time.”

He found himself questioning whether his face looked real, if it was symmetrical, and whether people could tell he had something done. He noticed lines and bumps, and even after going back for touch-ups, he thought his face wasn’t as smooth as others’. He also felt that he had somehow interfered with a natural process, that his face had been artificially constructed and sculpted by doctors.

“I have a strong sense of self and I feel my face doesn’t always reflect that because sometimes it feels ‘done,’” says Lorne. “There’s definitely a difference between the changes nature makes to your body and those you choose to make to it.”

Facing forward

After the swelling goes down and the initial euphoria of the procedure wears off, how do treatment patients feel about their decision years after it’s been made?

“It changed my life in a big way. I wouldn’t change it for the world,” says Bradford. “Now, without me telling people I’m sick, they wouldn’t look twice.”

Feature Story

Even Malsah, who experienced complications after his procedure—his cheeks were asymmetrical and he needed numerous follow-up treatments to correct the problem—has no regrets. “It was still worth it. Definitely, definitely worth it,” he says. “Now people don’t stare, and if they do, I don’t assume it’s because of the lipoatrophy.”

For Moffatt, removing the signs of facial lipoatrophy gave him a greater sense of well-being: because he looked better, his motivation around self-care increased. His diet improved, he exercised more, and looked after his skin. “When I look at pictures of myself before, I realize I’ve forgotten how disfigured I was,” he says. “Generally, though, I don’t even think about the procedure. It’s a chapter of my life that has closed.”

That isn’t the case with everyone. It’s been almost three years since Lorne’s treatment and he still struggles to feel comfortable with his face—and his decision. “In general, I think it looks good,” he says. “On the surface, it makes the fact that you have HIV less obvious, which is attractive. But it gives you a new face and that doesn’t feel natural.”

For Lorne, it’s difficult to believe that changing how your face looks won’t affect your identity in some way. “I feel like I’ve lost a certain sense of integrity in my face and my personality,” he says. “It strips away a bit of your history.”

This sense of loss has had a big impact on how Lorne feels about his decision to get treatment. While he says he’s accepted it and has gotten used to it, he’s still not sure he made the right decision. “Was it worth it? I’m not sure, I’m really not sure. I’m ambivalent.”

“This isn’t about beauty or vanity, it’s about correcting a problem caused by HIV and the drugs used to treat it.” – Bradford

Facing reality: vanity or necessity?

Lipoatrophy can severely alter not only how you look, but also how you feel about yourself. It seems only natural to want to correct the situation. But many people considering treatment are conflicted. Some feel that opting for the procedure makes them vain—as though they value their physical appearance more than their overall health.

Bradford begs to differ. “This isn’t about beauty or vanity,” he says, “it’s about correcting a problem caused

by HIV and the drugs used to treat it. It’s like getting something back that was taken away from you.”

Still others feel lipoatrophy is a small price to pay for the ability to manage HIV. When Moffatt began noticing the lipoatrophy, he struggled to reconcile the shame that came with the disfigurement with the knowledge that the drugs causing it were keeping him alive. But then his Radiesse treatment made him realize it wasn’t just a procedure to address a superficial issue. During the procedure, he joked with his doctor that he’d never thought he’d get cosmetic surgery.

“The doctor stopped what he was doing, looked me straight in the eye, and said, ‘this isn’t cosmetic surgery. It’s a therapeutic procedure to rectify the negative effects of antiretroviral drugs,’” he recalls. “It was a very profound statement that cut straight to the heart of the psychological distress I was experiencing about my decision.”

While Lorne would recommend treatment to someone with severe lipoatrophy, he would tell someone with a mild case to think carefully before having the procedure. “If you’re doing it to be more attractive, the work doesn’t make that much difference if you don’t feel that way on the inside already,” he says. “Your gut feeling about yourself is so deep that often medical procedures don’t do anything to change that.”

If people do choose treatment, Lorne advises them to keep realistic expectations. “Nothing’s perfect,” he says. “Don’t go in expecting perfection or expecting to look like you did before.”

Undergoing reconstructive treatment for facial lipoatrophy is an extremely personal decision, and it isn’t for everyone. There are several factors to consider. Ultimately, it’s up to you to decide what’s most important to you and how much you can bear.

For Moffatt, that question is simple: “The bottom line for me is life,” he says. “If I was offered HIV treatment that made me look funny and weird but kept me healthy and alive, I would take it. I would—and I have—endured the nasty side effects if it meant I would be alive. I just so happened to be in the right place at the right time for a treatment opportunity.” ⊕

Jennifer Tsui is a Vancouver-based freelance writer.



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Generation next: Newly diagnosed with HIV

Life lessons

by Bernard

This article is the first in a series of installments about being newly diagnosed with HIV. The series includes personal stories by men, women, and youth about how their daily lives, their physical and mental health, and their relationships have been impacted by their recent diagnosis. Their journeys are unique and powerful, but—as the next generation living with HIV—they’re also considerably different than the experiences of people diagnosed ten or 20 years ago.

I’ve always been healthy and active, but about a year ago I began to notice changes in my health. It was easy to attribute it to getting older—I’m in my 40s—or increasing stress levels at work. Still, I was worried. I hadn’t been [HIV] tested for quite a long time, and even though a good friend kept encouraging me, I resisted. My attitude was that I would deal with it if something happened.

Well something *did* happen.

I went hiking in Central America in May 2008 for a couple of weeks and came back with what seemed like a very bad cold. At one point, I actually thought I had contracted malaria (denial is such a powerful force). I eventually ended up in emergency at St. Paul’s Hospital because my breathing was laboured and I had lost a lot of weight. After a barrage of tests, I was diagnosed with HIV-related pneumonia [*Pneumocystis carinii* pneumonia, or PCP], due to a compromised immune system.

First thoughts and feelings

In the hospital, my first thoughts were that I would only confide in one or two people and keep my diagnosis hidden from family and friends. When I returned home, I began by sending a couple of emails to trusted friends with the subject line “not good news: prepare yourself before reading.” Using email helped me contain my emotions while giving people time to reflect on my news; it also allowed them to respond when they were ready. In most cases, responses were immediate, with unqualified love and support.

The biggest challenge for me in all of this was overcoming my own shame and self-blame in contracting HIV. I was fearful of being judged and rejected, and quickly came to realize that it was because I hadn’t yet forgiven myself for having made a “mistake.” It was then I decided to be honest and direct with the people in my life who I valued most.

Over the course of the next month, I shared my news with family and friends. The experience has profoundly strengthened my relationships with people, and only one friendship was lost.

Accessing the network of services

In the ensuing weeks, I stepped into a coordinated network of services through Vancouver Coastal Health, St. Paul’s Immunodeficiency Clinic, Spectrum Health, and BCPWA. Public health nurses, social workers, and doctors provided information and health services with compassion and respect. I’m acutely aware of how fortunate I am to live in Vancouver and have access to a range of HIV and queer-friendly resources—not to mention free medications!

You could almost say I’m grateful for the opportunities it has afforded me to reflect on my life, my relationships with others, my goals, and priorities.

At first I was skeptical when healthcare providers told me about the advances in antiretroviral medications. But I started treatment in July and my health quickly rebounded. I was lucky to experience very few minor side effects and was back to work by August.

After much deliberation, I also decided to sign up for BCPWA’s new workshop series for newly diagnosed gay men. This was an incredibly empowering experience that greatly improved my understanding of HIV.

Surprisingly, I’m not angry or resentful about my diagnosis and I refuse to live with regret. You could almost say I’m grateful for the opportunities it has afforded me to reflect on my life, my relationships with others, my goals, and priorities. I still have moments of panic and feel vulnerable, particularly when telling a new person or service provider about my status. I am, however, determined to focus on what is good in my life and the mantra I repeat daily to myself is simply: enjoy. ☺

*Recently diagnosed with HIV, **Bernard** is a 40-something queer identified man (currently single!) who navigates life’s journey as best he can. He draws strength and inspiration from nature, the arts, and social justice movements.*

Continuum of care

Ensuring that newly diagnosed people tap into integrated clinical and support services right away
by Glen Bradford

Being newly diagnosed with HIV isn't just devastating and disorienting news for many, it's also a time when there's a high risk of infecting others. That's why BCPWA's Positive Prevention program is working to ensure that newly diagnosed people have a continuum of care that supports them from post-test counselling through to ongoing clinical and community-based HIV services and support.

Immediately after a person is infected with HIV, he or she enters a stage of hyper-infectiousness. In this brief period before the body begins producing HIV antibodies, the virus replicates unimpeded—and viral load increases rapidly. Some studies suggest that this hyper-infectious period may account for as many as 50 percent of all new infections. Fortunately, this initial spike in viral load typically declines significantly after approximately two months, as the body activates an immune response and produces HIV antibodies.

While emotional reactions to an HIV-positive diagnosis vary from person to person, most report a sense of shock, fear, and uncertainty about the future, followed by a period of grief and depression. In this state of turmoil, some individuals

may even engage in reckless behaviours that place others at risk of infection.

These physiological and psychological factors, combined with a general lack of knowledge about prevention and the hyper-infectious period, amplify the potential for new infections. Therefore, it's critical for people newly diagnosed with HIV to receive immediate and appropriate support and education.

Post-test counselling

There has been a long-standing difference of opinion between healthcare providers and people living with HIV about what happens at the point of post-test counselling.

In relating their post-test counselling experiences, many HIV-positive people recall being confronted with intensely personal questions about their sexual histories and previous sexual partners before having sufficient time to adjust to the initial shock of diagnosis. They describe a sudden shift from shock and grief to blame and culpability. Trust isn't established, the process isn't clearly explained, and the comfort level of the client is inadequately assessed or

considered before shifting the discussion to reportability/partner notification.

The BCPWA Society's Positive Prevention program is discovering that many members withdraw and isolate themselves immediately after diagnosis. It can take many months—sometimes years—before they surface to seek help. It's unclear whether there's a causal connection or a correlation, but experiences around diagnosis definitely impact how and when recently infected people begin to access HIV services and support.

Many people withdraw and isolate themselves immediately after diagnosis. It can take many months—sometimes years—before they surface to seek help.

The conflicting priorities in the post-test counselling process versus reportability/partner notification requirements are obvious. Inevitably, newly diagnosed people wonder: is the healthcare provider looking out for me or is he/she primarily interested in protecting the public? Both functions are important. People newly diagnosed with HIV deserve post-test counselling information that is clear, thorough, and delivered with sensitivity and respect. At the same time, the purpose of partner notification is to reduce the number of undetected, hyper-infectious HIV-positive people; current studies estimate this number to be 30 percent of the HIV-infected population.

In an effort to address this problem, the Positive Prevention team at BCPWA has been working with public health nurses in the Vancouver Coastal and Fraser Health regions and the BC

Centre for Disease Control (BCCDC) to create a model for a continuum of care once receiving a positive HIV test result.

BCPWA hopes to offer peer counselling for newly diagnosed individuals that is made available immediately following the post-test counselling provided by a public health nurse.

In addition, the Positive Prevention team is developing a take away resource package for doctors and nurses to distribute to their patients at the time of post-test counselling, allowing newly diagnosed people the opportunity to review key resource information when they are ready. The take away package will likely include the booklet *Information for People Newly Diagnosed with HIV* (available in eight languages), information about accessing the HIV physician registry (a database of physicians in BC with HIV experience), as well as information about BCPWA's newly diagnosed peer counselling team and workshop series. Other programs and services that would be highlighted include BCPWA's retreat programs, treatment information, and the Complementary Health Fund.

The Positive Prevention team is also working with the BCCDC on a pilot project that will research and evaluate the impact of peer counselling shortly after diagnosis. Referrals are made to a professional counsellor for one session and to the BCPWA newly diagnosed peer counselling service, workshop series, and take-away resources package.

Hopefully, this new continuum of care model will eventually be the standard across all of BC so newly diagnosed HIV-positive people will flow into support services rather than spin away from them. ☺



Glen Bradford is a BCPWA member and a volunteer in the Positive Prevention Program.

**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 2008 and November 2008 is:

- ◀ **\$25,000 in debt forgiveness.**
- ◀ **\$15,061 in housing, health benefits, dental and long-term disability benefits.**
- ◀ **\$2,700 in ongoing monthly nutritional supplement benefit for children**

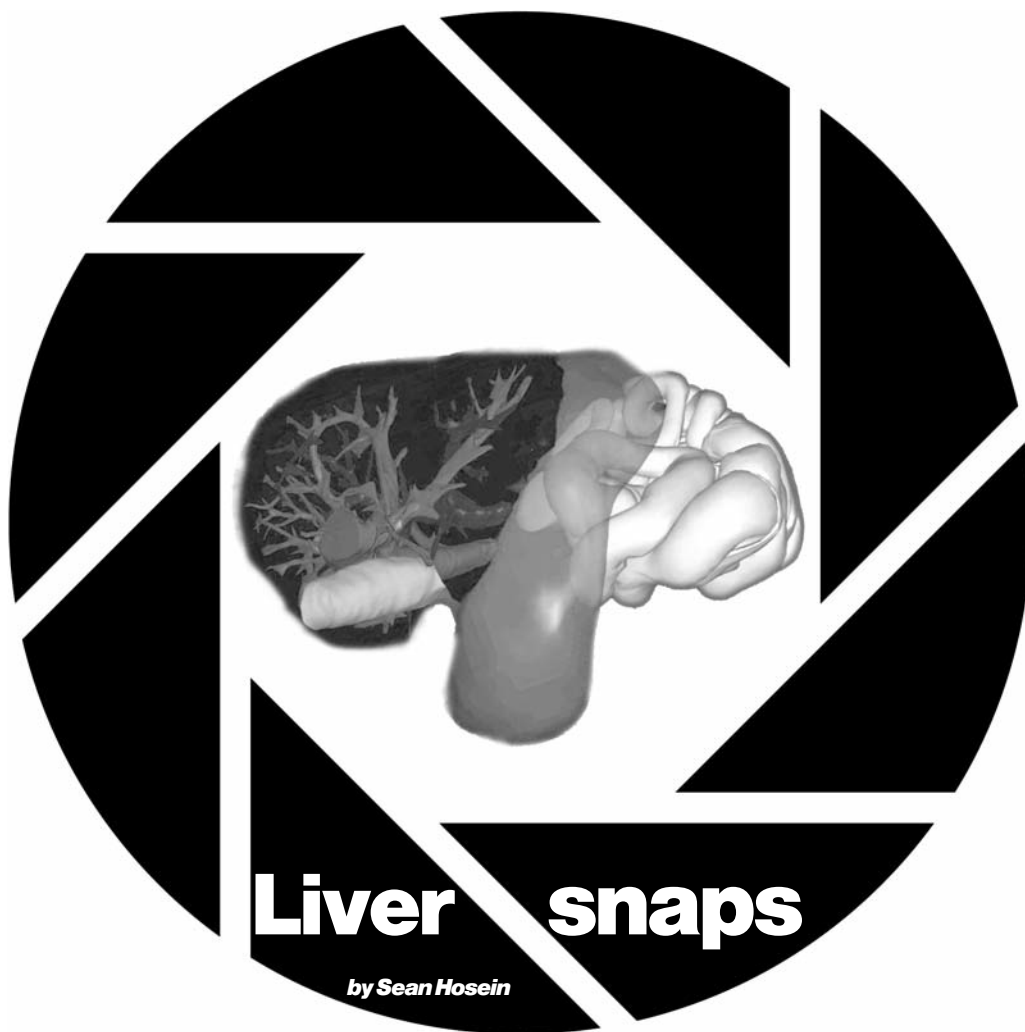


treatment. information

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.



Study of unexpected liver damage points to ddl as culprit

Liver damage is not common among average HIV-infected individuals living in high-income countries, assuming they aren't co-infected with hepatitis-causing viruses. Yet cases of unexplained liver disease have been reported in this population.

To explore this issue, research teams in Spain and Italy collaborated in reviewing the health of their HIV-infected patients with unexplained liver damage. Their findings suggest that exposure to the anti-HIV drug didanosine (ddl, Videx), may be the culprit.

Liver Health

Researchers collected health information from three clinics and analyzed data on all their HIV-positive patients with unexplained and unexpected liver disease. All patients underwent extensive medical tests to determine the cause of their problem(s). In total, the teams found 13 patients (two females and 11 males) who exhibited a number of similar characteristics, including: elevated/above normal levels of liver enzymes; no obvious causes of liver problems; no detectable hepatitis-causing viruses; no alcohol misuse; presence of swollen blood vessels and bleeding in the throat and/or abdomen; abdominal water retention; unintentional weight loss; black stools; and exposure to ddI for a minimum of two years.

Researchers recommended that all 13 patients discontinue ddI and replace this medication with another suitable anti-HIV drug. Shortly thereafter, liver enzyme levels fell and symptoms began to subside.

Researchers speculate that ddI may decrease levels of a protective compound in the cells known as glutathione (GSH). GSH manufactures enzymes that help detoxify harmful chemicals in the blood; low levels of GSH may increase cells' susceptibility to ddI-related toxicity.

Researchers speculate that ddI may decrease levels of a protective compound in the cells known as glutathione.

Studies in the 1980s and 1990s found lower than normal levels of GSH in the blood of some HIV-positive people who weren't on treatment. It appears that HIV infection may eventually trigger a GSH deficiency, possibly by increasing the body's need for the amino acid cysteine, which is converted into GSH inside cells. It is possible that ddI

exposure may intensify the GSH deficit in HIV infection.

Experiments with HIV-positive patients suggest that supplements of the amino acid cysteine can increase GSH levels in the blood. A formulation of cysteine known as N-acetyl-cysteine (NAC) is used to help detoxify the liver in cases of overdoses from the pain medication acetaminophen (Tylenol). No clinical trials of NAC appear to have been done among ddI users to assess its impact on GSH and liver health.

The study team didn't recommend against using ddI as an anti-HIV drug, although the research results clearly expose the possible liver-damaging effects of ddI.



Good news about HAART and liver health

Weakened immunity associated with HIV infection can accelerate hepatitis C (HCV)-related liver damage. Because highly active antiretroviral therapy (HAART) can help to partially restore the immune system, researchers have speculated whether it might indirectly help decrease HCV-associated damage. Results from a German study suggest that this is indeed the case.

Researchers in Bonn, Germany, enrolled 84 HCV mono-infected people and 57 HIV/HCV co-infected people (eight females, 49 males) whose average profile at the start of the study was approximately 42 years of age, with CD4 cell counts at roughly 430. Among study participants, 82 percent

had HCV genotype 1, and 83 percent were taking HAART.

The research team used a special ultrasound device known as a FibroScan to assess the degree of liver damage. Although FibroScan is often routinely used in France and other parts of Western Europe, it remains a research tool in Canada and the US. FibroScan has limitations, since it doesn't always accurately assess liver health; to be fair, however, a liver biopsy may miss diseased parts of the liver as well. Still, for now liver specialists in North America prefer to conduct liver biopsies to determine their patients' liver health.

The assessment found that there was no difference in the degree of liver damage exhibited by HIV/HCV

co-infected patients compared to the HCV mono-infected group.

The Bonn team concluded that suitable and successful HAART regimens may decrease the rate of liver damage in co-infected people to near-normal levels—that is, levels typically exhibited in HCV mono-infected patients. These results are promising and hopefully other research centres will conduct similar studies to confirm the German results. ☉

Sean Hosein is the science and medicine editor at the Canadian AIDS Treatment Information Exchange (CATIE) in Toronto.



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Cover Story



**Study of mental health and
people co-infected with HIV/AIDS
and HCV yields shocking results**

by Carlene Dingwall

Early in 2008, the Provincial Health Services Authority (PHSA) commissioned a province-wide study on mental health, HIV/AIDS, and hepatitis C (HCV). The aim of the study was to gather evidence and determine the prevalence and range of mental health conditions affecting people living with HIV/AIDS and HCV in British Columbia from the perspectives of AIDS service organizations (ASOs). I undertook responsibility for collecting data and writing the report.

I had certainly observed, both as a therapist and in my former position as executive director with Positive Living North in Prince George, that mental health issues are fairly common for PWAs, and that it's often difficult for them to access appropriate care to manage these conditions.

Curiously, to date, no real data has been collected to measure the mental health experiences and needs of PWAs or the prevalence of mental illness within this population. In addition, while attention to mental health conditions, particularly substance use, should play a key role in HIV prevention initiatives, this issue has been largely overlooked. Probing into why this kind of data has not been available and why mental health has been mostly ignored in funding and treatment arenas requires further investigation. However, the PHSA study's findings represent an opportunity to begin addressing these issues.

The study involved collecting data from key professionals working in community-based ASOs, public health agencies, and mental health and addictions services across the province.

Over 45 interviews and questionnaires were completed. We asked people to describe the climate in their communities in relation to mental health and HIV/AIDS, as well as the experiences of people in their communities living with mental health conditions and HIV/AIDS/HCV. Findings are culminated in a report entitled: *Trap Doors: Revolving Doors - A Discussion Paper*.

Prevalence of mental health conditions

According to current prevalence rates, one in five Canadians experiences a mental health disorder during their lifetime. These disorders encompass the entire range of mental illness, including depression, post traumatic stress disorder, substance misuse, bipolar disorder, psychosis, schizophrenia, and others.

Among British Columbians living with HIV/AIDS and HCV, the prevalence of mental health disorders is significantly higher; support service providers reported that four in five—nearly 80 percent—of their clients experienced some form of mental illness during their lifetime. In fact, over 70 percent of organizations polled stated that 80 percent or more of their clients experienced a mental health condition.

Despite the prevalence of mental health conditions among PWAs co-infected with HCV, only 10.7 percent have been able to access formal mental health supports. This finding is in contrast to a 40 percent access estimate for others with mental health conditions. Thus, mental health conditions affect people living with HIV/AIDS and HCV at four times the rate of the rest of the Canadian adult population and yet they access mental health support services at one-quarter of the rate of the average Canadian.

We know that mental health conditions place people at increased risk both for contracting and transmitting HIV and HCV. Mental illness can seriously impact decision making abilities regarding self-care and the care of others. Failure to provide mental health treatment options has serious implications for individual case management, quality of life, and for the overall management of the HIV and HCV epidemics.

Range and frequency of mental health issues

In BC, PWAs with HCV experience the full spectrum of mood disorders, from depression and bipolar disorders to schizophrenia and dementia. Severity ranges from mild and manageable to debilitating and unmanageable.

Data were also collected to determine the most frequently occurring mental health disorders among PWAs with HCV. Depression was identified as the most common condition affecting this population.

Depression is clearly on the rise. According to research conducted in the US, 40 - 60 percent of people living with HIV experience depression. Long-term survivors of HIV/AIDS are especially vulnerable and susceptible. Moreover, in spite of its prevalence, depression is believed to be under-diagnosed, under-identified, and disproportionately manifested in “invisible groups” that are not accessing health care or support services.

Depression is also linked to side effects from HCV and anti-retroviral treatment. Service providers stated that there is often a causal relationship between treatments regimens and depression among their clients.

Despite the prevalence of mental health conditions among PWAs co-infected with HCV, only 10.7 percent have been able to access formal mental health supports.

Post-traumatic stress disorder (PTSD) and substance misuse are also common disorders experienced by PWAs. PTSD is associated with other co-occurring psychiatric disorders, particularly substance misuse. In addition, PTSD was identified by survey respondents, and also within some of the HIV prevention literature, as the most frequently observed pre-existing mental health condition among PWAs. High rates of PTSD are evident among Aboriginal people and are correlated to historical and current colonization and generational trauma.

Distressed community climate

The community climate in each region is distressed. Resoundingly, study respondents spoke to the increasing stress levels and disenfranchisement of community members who are living with HIV/AIDS and HCV or who are at risk. Similar concerns were expressed in rural communities as well as large urban centres. Issues of homelessness, poverty, addictions, and mental illness figure prominently across the province.

Not only are the populations co-infected with HIV/AIDS and HCV diversifying and increasing in number, so are the range and complexity of the medical and mental health issues experienced. Increasing substance misuse, particularly amphetamine-based drugs, has clearly contributed to the escalating levels of untreated psychoses and other conditions identified.

In addition, the prevalence of mental illness in communities has escalated significantly since the closures of mental health institutions in BC in 1992. The policy to reintegrate institutionalized people into their communities wasn't accompanied by an adequate plan or the resources necessary to ensure a sustainable transition. This situation has imposed increasing pressures on service providers. Resources continue to be cut back at the same time that organizations are required to respond to external pressures to expand mandates and services.

Barriers to accessing mental health support services

Survey respondents described various reasons why PWAs aren't getting their mental health needs addressed. Conditions are often undiagnosed and untreated and community service providers frequently don't have the specialized training necessary to conduct mental health assessments. Further, the stigma and discrimination associated with mental illness can prevent PWAs from accessing services. However, the most frequently identified challenge to accessing mental health support services was the limited resources available. Therefore, despite the prevalence and severity of mental health challenges faced by people living with HIV/AIDS and HCV, those affected often have nowhere to turn to for support services and treatment.

Conditions are often undiagnosed and untreated, and community service providers frequently don't have the specialized training necessary to conduct mental health assessments.

Some systemic problems within the mental health sector are to blame. Mental health treatment often focuses on pharmacology, with little attention paid to examining the underlying causes of distress. This approach tends to pathologize the person and his or her experiences. In many instances, diagnosed disorders can also be viewed as normal responses to difficult and extreme life events. Also, over time there has been a radical shift in mental health care from longer term counselling and therapy to short-term solution-focused therapy, which may be a less satisfying experience for those who seek ongoing professional support. Furthermore, there are very few mental health clinicians qualified to provide expert care for people with complex and interrelated health issues involving HIV/AIDS and HCV co-infection.

By far the biggest barrier in providing mental health care to PWAs is the limited access to BC Mental Health and Addictions Services (BCMHAS). The most common complaint expressed by community service providers is the number of clients requesting formal mental health support and the lack of available referral services. Community service providers further noted the lack of available referral options for their numerous clients who are presenting with behaviours and concerns that suggest an underlying mental health condition.

The full integration of mental health and addiction services in the province hasn't been achieved and this has resulted in an uneven, disjointed practice. Existing services for mental health and addictions are fragmented across a range of agencies. Frequent leadership changes have resulted in a pattern whereby new initiatives are implemented and then abandoned.

In addition, there is an inconsistent understanding of harm reduction within the BCMHAS. For example, the disjointed merger between the BCMHAS' mental health and addictions departments has been stymied by the mental health departments' slow progression to adopt a harm reduction philosophy. Clients presenting with co-occurring mental health and addiction problems have been turned away because of an inability to proficiently manage multiple disorders present in the same client. And some clinicians have been philosophically opposed to providing mental health support to clients with active substance abuse issues.

Finally, many people living with HIV/AIDS and HCV and mental health disorders are street involved with very limited access to or trust in healthcare systems. Mental health services are visibly absent from the places where vulnerable people reside. Consequently, mental health care must be accessible and services must be relevant to the populations that require treatment and support.

A continuum of connected mental health support is needed. This includes mental illness prevention and mental health promotion. It means providing a range of supports and services from prevention to chronic disease management. The stigma associated with mental health disorders also needs to be addressed through mental health education and promotion.

Finally, the BCMHAS needs to enhance accountability to community members. Services need to be fully integrated and accessible to the community. Indeed, BCMHAS needs to collaborate with community ASOs and public health organizations by identifying PWAs and those at risk as key target populations, and work together to ensure that services are appropriate and meet current demands.

The report was successful in garnering support to establish a province-wide working group to determine how to best implement the recommendations identified by the study. The working group has membership from ASOs, PWAs, BCMHAS, and the PHSA. ☉

Carlene Dingwall is an Aboriginal woman with a M.Ed. in counselling from the University of Northern British Columbia. She is currently working at the University of British Columbia, Okanagan Campus.



HAARTening news

A recent study reveals benefits of antiretroviral treatment to IDUs

by Leslie Leung

Combination antiretroviral medications known as highly active antiretroviral therapy (HAART) have revolutionized treatment outcomes for HIV-infected patients since their introduction in the mid-1990s. HAART has not only significantly reduced disease progression, it has also increased longevity and reduced HIV-related deaths.

Despite these promising results, injection drug users (IDUs) haven't received the full benefits of HAART. Earlier reports found some clinicians' under-prescribing HAART among HIV-positive IDUs on the premise that this population's unstable lifestyle results in worse treatment outcomes. However, until recently, there were no studies to compare HAART treatment outcomes among IDUs with others.

In an observational cohort study published earlier this year in the *Journal of the American Medical Association*, Dr. Evan Wood and colleagues investigated this issue by comparing survival rates among HIV-infected patients initiating HAART with or without a history of injection drug use.

A total of 3,116 HIV-positive British Columbians were enrolled in this study, with a mean age of 39.4 years. None of these people had previously received antiretroviral treatment. Among them, 915 were IDUs and 579 were female. All of them initiated HAART between August 1996 and June 2006. They subsequently received follow-up treatment and monitoring through a centralized free antiretroviral distribution program and a province-wide vital statistics registry. The mean duration of follow up was 5.3 years for IDUs and 4.9 years for non-IDUs.

Using time to death as the established end point, statistical results were analyzed based on deaths associated with HIV infection. Other causes of death—such as accidental drug overdose, suicide, and trauma—were analyzed separately and statistically adjusted for evaluation.

Study findings revealed no differences in all-cause mortality rates between IDUs and non-IDUs in the seven-year period after initiating HAART. Overall, 622 deaths were reported. The difference in mortality rates of the enrolled IDUs and non-IDUs were not statistically significant: 26.5 percent and 21.6 percent respectively. Furthermore, the mortality rates for both groups were also similar after adjustment for confounding factors that could skew results. These factors include age, sex, baseline AIDS diagnosis, baseline CD4 cell count, adherence, and physician experience. The authors

concluded that in this study population, injection drug use wasn't associated with decreased survival among HIV-infected patients initiating HAART.

The authors noted a few limitations of this study. First, as a population-based observational study, they couldn't generalize a definite conclusion that survival rates among IDUs and non-IDUs in all populations are equal after initiating HAART. Second, the study doesn't fully address all confounders; for example, some study participants may have adhered more closely to their medication regimens than others. Third, IDUs were only identified during the enrollment phase of the study; therefore, the impact of discontinuing drug use among IDUs or the initiation of injection drug use by non-IDUs during the study is uncertain.

Study findings revealed no differences in all-cause mortality rates between IDUs and non-IDUs in the seven-year period after initiating HAART.

Finally, this study enrolled IDUs who had access to HAART; however, IDUs are more likely to die without having access to treatment. As a result, the mortality rate would be higher in IDUs than non-IDUs when considering all HIV-infected patients.

Despite these limitations, this study challenges prior beliefs that IDUs are less likely to benefit from HAART than non-IDUs. ☺

Leslie Leung is a community pharmacist who is actively involved in breast cancer research, youth leadership, and first-aid training with St. John Ambulance. He also volunteers with BCPWA's Treatment Information Program.

Antiretrovirals



British Columbia
Centre for Excellence
in HIV/AIDS

BC-CfE's November antiretroviral update

by R. Paul Kerston

On November 17, 2008, the BC Centre for Excellence in HIV/AIDS (BC-CfE) held their semi-annual antiretroviral update meeting.

The morning program began with Dr. Silvia Guillemi, clinical associate professor in the Faculty of Medicine at the University of British Columbia (UBC) and clinical coordinator at the Immunodeficiency Clinic at St. Paul's Hospital in Vancouver. Dr. Guillemi presented an overview of HIV pathogenesis, which included estimated risks of HIV infection: from blood transfusions or products (95 in 100); mother-to-child without antiretroviral (ARV) medications (one in four); needle sharing (one in 150); occupational exposure/needle sticks (one in 300); male-to-male receptive sex (between one in ten and one in 1,600); male-to-female vaginal sex (between one in 200 and one in 2,000); between female-to-male vaginal sex (between one in 700 and one in 3,000).

Current treatment guidelines

Dr. Julio Montaner, director of the BC-CfE and president of the International AIDS Society (IAS), provided an update on treatment guidelines. Presently, he explained, IAS-US guidelines for highly active antiretroviral therapy (HAART) are being used as the current North American standard since the BC-CfE's guidelines are due to be released but are still being finalized. There are now six fixed-dose combinations approved, while zalcitabine (ddC, Hivid), and amprenavir (Agenerase)—replaced by fosamprenavir (Lexiva)—have been removed from the list of available drugs. In addition, there are three novel HAART agents: maraviroc (Celsentri), a CCR5 receptor antagonist for

use with a virus strain that attaches to co-receptor CCR5 and requiring a tropism assay to distinguish between virus that attaches to CCR5 or to CXCR4; raltegravir (Isentress), an integrase inhibitor; and etravirine (Intelence), a non-nucleoside reverse transcriptase inhibitor (NNRTI). These three newer medications are currently reserved for multi-drug resistant and experienced HIV-positive patients.

Dr. Montaner expressed concern about treatment guidelines overemphasizing CD4 cell counts as the primary factor in determining when to start HAART; in fact, he argues, there's "no excuse to wait" until CD4 cell counts drop below 350. He identified other important indicators for initiating HAART, including a high viral load (above 100,000); CD4 count decreases greater than 100 cells per year; and risks of other serious health conditions such as cardiovascular, kidney, and liver disease. He further stated that once the profile for initiating ARV therapy is fully understood, it becomes clear that "very few people don't fit."

Montaner referred to findings from the controversial Swiss study that claimed that a suppressed viral load (along with other additional factors) was sufficient to prevent the transmission of HIV. Calling this "too much of a generalization," he nevertheless expressed the view that treatment is the most effective prevention tool at a *populational*-health level.

With respect to preferred regimens, Montaner chooses tenofovir/emtricitabine (Truvada) over abacavir/lamivudine (Kivexa), partly because abacavir appears less effective in suppressing very high viral loads, and also due to current concerns about abacavir and possible cardiovascular risks—addressed in a later presentation by Dr. Marianne Harris.

The two first-line regimens recommended now are boosted atazanavir (Reyataz) and lopinavir/ritonavir (Kaletra), along with two nucleoside/tide reverse transcriptase inhibitors.

Interestingly, Montaner noted that single-agent substitutions in a regimen are acceptable in cases of intolerance, inconvenience, or toxicity. He also indicated that the goal of having a viral load measuring fewer than 50 is now attainable for all PWAs.

Cardiovascular risks for HIV-positive people on HAART

Dr. Harris, clinical research advisor to the AIDS Research Program at St. Paul's Hospital, presented on cardiovascular risks associated with HIV and HAART. She noted that smoking doubles the risk of cardiovascular disease, and added that risk is cumulative. Among ARV treatments, protease inhibitors (PIs) pose the highest risk for heart disease; and despite almost universal boosting with ritonavir, unboosted PIs cause fewer problems. Among PIs, saquinavir (Fortovase) and atazanavir seem to be less problematic. HIV medications with the worst cholesterol profiles were stavudine (d4T, Zerit), an NRTI, largely out of favour, and tipranavir (Aptivus), a PI. Evidently, lamivudine (3TC, Epivir) and emtricitabine (FTC, Emtriva) both appear to have no effect on blood cholesterol levels (lipids). In the NNRTI class of drugs, nevirapine (Viramune) and etravirine have good lipid profiles, while raltegravir and maraviroc have relatively little effect on lipids.

Commenting particularly on the risk of abacavir on heart health, Harris said that recent studies demonstrate selection bias: people already considered at higher cardiovascular risk have been placed on abacavir for that reason; thus, there is no direct correlation between abacavir and cardiovascular risk. Nevertheless, the US Department of Health and Human Services ARV guidelines removed abacavir from its list of first-line recommended regimens.

Dr. Thomas Kerr, assistant professor in the division of AIDS at UBC's Department of Medicine and director of the Urban Health Research Initiative at the BC-CfE, spoke about *Insite*, Vancouver's supervised injection site. Recent statistics documenting *Insite*'s effectiveness, according to a survey of service users, include a decrease in violence against women, an increase in condom use, and the prevention of 12 overdoses per year. Also of note: approximately 17 percent of clients surveyed indicated that the Vancouver Police had referred them to *Insite*.

The need for immunizations and screenings for opportunistic infections

Dr. Rolando Barrios, community medicine specialist at the BC-CfE, spoke about the need for immunizations and screenings. Screening for tuberculosis should be done using the Purified

Protein Derivative skin test; in HIV-positive patients, a tuberculosis skin test is considered positive if there is greater than a 5mm reaction.

Concurrent sexually transmitted infections—including gonorrhea, chlamydia, and syphilis—increase the likelihood of HIV transmission. In addition, Dr. Barrios reported that HIV-positive individuals are more likely to have a dangerous secondary syphilis strain. For this reason, the rapid plasma reagin (RPR) blood test for syphilis, is recommended every three months.

Dr. Montaner expressed concern about treatment guidelines overemphasizing CD4 cell counts as the primary factor determining when to start HAART.

Approximately ten percent of tests for hepatitis B (HBV) produce a false-positive test result. Consequently, in cases of conflicting HBV results with confirmatory tests, the HBV-RNA test is recommended to provide a definitive result.

With respect to vaccines, the standard practice for HIV-positive patients is unchanged: inoculations should consist of killed or inactive strains, and never live vaccines. Flu, pneumococcal, and hepatitis A and B vaccines are recommended for HIV-infected persons. Flu vaccines are of the Fluviral or Vaxigrip designation; either is fine, regardless of CD4 levels. For people in early stages of HIV infection, inoculations for measles, mumps, and rubella are recommended, as well as the chicken pox vaccine for children. The oral typhoid plus oral polio vaccines are not required for HIV-positive persons, while the diphtheria, pertussis, tetanus, polio, rabies, meningococcal, and *Haemophilus influenzae* type b (Hib) are not altered by HIV status.

The next antiretroviral update meeting is expected to take place in late May or early June, 2009. ☉

R. Paul Kerston is BCPWA's treatment outreach coordinator and community representation and engagement (CRE) coordinator.



Antiretrovirals

Here's to life

Advances in antiretroviral treatments measured by longer, healthier lives

by **Kristin de Girolamo**

At first glance, it shouldn't seem like such a difficult question to answer: with new, more effective antiretroviral medications, what's the average life expectancy for PWAs? Is this an improvement over the early days of monotherapy? The answer, of course, is an overwhelming yes, but this data is very hard to collect and apply, given the broad demographic of PWAs. Lumping everyone in the world—or even just Vancouver, for that matter—into an average increase in life expectancy does not tell the entire story, since so many variables in addition to ARVs will impact lifespan.

A study published in the July 26, 2008 issue of the *Lancet* provides a detailed look at life expectancy among PWAs through the antiretroviral therapy cohort collaboration, a compilation of different HIV cohort studies in Europe and North America. A cohort study is simply an observation of a group of people who share a similar characteristic in order to compare a variable in the group; in this case, the cohort is HIV-positive people on antiretrovirals, and the variable being investigated is life expectancy.

Participants in this study were HIV-positive, over 16 years of age, and had never used antiretrovirals until being enrolled in the cohort. To control for the advances in antiretrovirals, the study was further split into three time frames: patients who started antiretrovirals in the 1996 - 1999 period; from 2000 - 2002; and from 2003 - 2005. The group designations provided controls for patients who received the newest therapies versus those who began in the mid-1990s when fewer drug options were available. The data was also divided in order to compare people by sex, baseline CD4 cell count, and history of injection drug use.

Finally, the remaining number of years expected to be lived by those treated with combination antiretrovirals at age 20 and age 35 were estimated, as well as potential years of life lost from age 20 - 64 years and mortality rates. The age of 20 - 64 was selected because of the average age of retirement (65 years) in the high-income countries involved in the study; on this basis, researchers concluded that any death before age 65 would be considered premature.

Decreasing rate of death, increasing life expectancy over time

A total of 18,587 patients started combination antiretroviral therapy between 1996 - 1999; 13,914 began antiretroviral treatment during 2000 - 2002; and 10,854 started between 2003 - 2005. During the entire research period, 2,056 deaths were reported—4.7 percent of those enrolled in the study. When the deaths were analyzed in relation to the three established time frames, it wasn't surprising that the majority of deaths occurred in the early period grouping while the fewest occurred in the 2003 - 2005 time frame. Deaths per person-years (the number of years a person has been HIV-positive) were reported as follows:

- ▷ 16.3 deaths per 1,000 person-years in 1996 - 1999
- ▷ 12.4 deaths per 1,000 person-years in 2000 - 2002
- ▷ 10 deaths per 1,000 person-years in 2003 - 2005

Based on these findings, an overall death rate of 12 deaths per 1,000 person-years was reported for the entire duration of the study. The gradually declining death rate, reflected in the more current data, is largely attributed to the availability of newer, more effective antiretroviral medications.

When numbers are expressed in person-years, researchers divided the total number of deaths during each specified time period by the total number of person-years of follow-up. In other words, they calculated the total number of years of follow-up for each patient during the three-year time frame.

Similarly, with respect to the potential years of life lost, 65 years of age was established as a benchmark, based on the average age of retirement. Potential life years lost due to premature death among study participants was as follows:

- ▷ 1996 – 1999 was 365.9 years per 1,000 person-years
- ▷ 2000 – 2002 was 260.4 per 1,000 person-years
- ▷ 2003 – 2005 was 189.4 per 1,000 person-years

Like the overall death rate, the potential life years lost before age 65 also decreased, again most likely reflecting advances in antiretroviral therapy.

The study also showed an incremental increase in life expectancy over the course of the three time frames and based on the age of the individual at the time of diagnosis (see figure 1). Again, a similar trend was observed, with an increase in life expectancy from 56 – 60 years in the 1996 – 1999 cohort to 69.4 – 72.3 years in the 2003 – 2005 cohort. With the average life expectancy in Canada being 80.4 years, according to 2008 Statistics Canada data, PWAs in high-income countries are significantly closer to meeting the national average.

Women in the study had a longer life expectancy

When the data was divided to compare men and women, the HIV-positive women exhibited a lower mortality rate and a longer life expectancy, on average, which mirrors national statistics comparing Canadian men and women in the general population.

Women in this cohort had an overall mortality rate of 9.1 per 1,000 person-years compared to men at 12.9 per 1,000 person-years. Also, the mortality rate among women 20 – 44 years of age was only 7.9 percent; in the men’s group, it was 10.3 percent. Women beginning treatment at age 20 had a life expectancy of 64.2 years on average, while those commencing antiretroviral treatment at age 35 had a life expectancy of 67.5 years on average. By contrast, the data on HIV-positive men’s life expectancy in the cohort was 52.4 years on average for those

beginning ARVs at age 20 and 62 years on average for those starting treatment at age 35.

These differences in life expectancy and mortality rates between men and women can be attributed to the fact that women usually have higher CD4 cell counts at diagnosis, as well as lower viral loads, which predispose them to achieve better results on antiretrovirals.

Life expectancy for IDUs versus non-IDUs

The data for injection drug users (IDUs) compared with non-users showed a higher mortality rate, 20.7 versus 10.5 per 1,000 person-years as well as a higher number of deaths in the 20 – 44 year age range: 18.6 percent versus 7.8 percent. Similarly, the average life expectancy of a PWA who also uses injection drugs was lower: 52.6 for IDUs versus 64.7 for non-IDUs at age 20, and 58.4 for IDUs versus 68 for non-IDUs at age 35. Discrepancies here are attributed to numerous factors, including different adherence rates to antiretrovirals, inadequate or unequal access to treatment, and various addiction-related circumstances that decrease the likelihood that PWA IDUs will seek health care for related issues such as co-infection with hepatitis C; such factors worsen treatment outcomes (see also “HAARTening news,” pg. 23).

Overall, there’s a trend of gradually increasing life expectancies and decreasing mortality rates for PWAs in high-income countries taking antiretrovirals—particularly non-injection drug users and women. However, it’s worth noting a few gaps in the data. In a research project of this magnitude, and one that includes hard-to-reach populations, consistent patient follow-up is a challenge, and lost patient information can potentially skew data and findings, particularly under-representing mortality rates. In addition, changes to antiretrovirals are also not accounted for in the study. As well, information on cause of death was only captured for 85 percent of deceased patients—50 percent of whom died from AIDS-defining conditions.

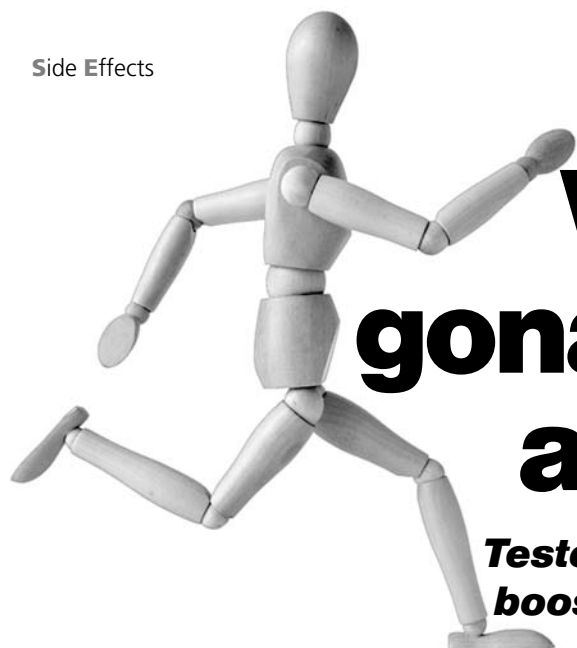
In spite of these limitations, the study presents encouraging findings with respect to increasing life expectancies due to advances in antiretroviral treatments. ☺

Kristin DeGirolamo is a third year pharmacy student at the University of British Columbia.

Figure 1: Life expectancy over the three time frames

Life expectancy	1996 – 1999	2000 – 2002	2003 – 2005	1996 – 2005
At 20 years	36.1 more years = 56.1 years total	41.2 more years = 61.2 years total	49.4 more years = 69.4 years total	43.1 more years = 63.1 years total
At 35 years	25 more years = 60 years total	30.1 years = 65.1 years total	37.3 years more = 72.3 years total	31.7 more years = 66.7 years total
Percentage of people surviving age 20 to 44	75.5%	79.5%	85.7%	81.1%

Side Effects



When your gonads get up and go

Testosterone replacement may give you a boost, but be careful of long-term use *by Rob Gair*

Who agrees with the statement that testosterone makes men manly? Certainly it's true if popular culture is any indication, and truer still if one understands the dominant role of this important hormone in the male human body.

Testosterone is produced in the gonads and secreted into the body, where it influences male sex characteristics such as hair and genital growth, development of muscles and bones, and sexual virility. Production of testosterone peaks by age 17, then gradually declines so that an 80-year-old man possesses about 40 percent of the levels he had in his youth. In men with HIV, the process of declining testosterone may be accelerated, leading to problems like decreased energy and sexual interest.

Before the introduction of highly active antiretroviral therapy, roughly 50 percent of men with AIDS-related wasting had low testosterone levels in their blood, likely due to severe illness and undernutrition. Once more effective HIV medications became available, low testosterone levels among HIV-positive men changed, but didn't disappear. A recent study highlighted the problem of low testosterone in older HIV-positive men: in both gay and straight men, findings linked low testosterone levels to factors such as high viral loads, injection drugs, and use of psychiatric medications. Interestingly, people co-infected with HIV and hepatitis C were most likely to have low testosterone levels, while HIV-infection by itself was associated with low testosterone only in the cohort of gay men.

So what does it mean if HIV-positive guys have low testosterone and what about testosterone replacement?

Unfortunately, medical science isn't very helpful with answers. The dilemma is that testosterone is a complex hormone with many subtle changes that occur throughout a man's life. The only way to properly understand its influence on the body is to assemble and study a large cohort of both HIV-positive and HIV-negative men over the course of many years. And to study the effects of testosterone replacement, research would involve comparing the impact of testosterone injections to placebo injections over the same time period.

While long-term studies aren't practical, short-term studies suggest testosterone replacement has a positive effect on sex drive, mood, and overall well-being. In the days following an injection, people commonly report a burst of energy and sexual interest, sometimes accompanied by side effects like headaches, irritability, and insomnia. These reactions are less common with testosterone patches or gels because the dose is delivered more slowly through the skin. Perhaps for the same reason, some guys feel that patches and gels don't work as effectively as injections. Testosterone pills are also available, but they don't absorb very well into the bloodstream and may cause liver damage.

Another concern is the potential for testosterone treatment to cause prostate cancer. The argument is that since reducing testosterone levels in men helps shrink prostate tumours, adding testosterone may cause tumour growth, especially when administered over a number of years. So far, there's little evidence to support this theory, but the issue is unresolved since no one has studied these effects over the long term.

And so we're left to draw our own conclusions about testosterone, mostly based on our beliefs and experiences. It seems that those of us who have low testosterone are likely to notice improved sexual energy and well-being when taking testosterone replacement. Still, the science geek in me says to be cautious about possible problems caused by long-term use.

On the other hand, a certain 40-something poz guy who's feeling the need for some lead in his pencil is admittedly curious. ☺

Rob is a pharmacist in his day job and a wannabe writer. He's a regular contributor to living☺ magazine.



A bloody necessity

Get your blood values regularly monitored to manage your health

by Ashley Smith

Although sometimes unpleasant, blood work is a necessary part of maintaining good overall health if you're HIV-positive. As an essential part of monitoring every organ system in the body, a blood profile provides vital information to health care providers, allowing them to investigate and analyze what isn't otherwise immediately discernable, confirm a diagnosis, and plan the most effective course of treatment.

In the age of effective antiretroviral therapy, HIV is treated as a chronic health condition, and the progression of HIV disease must be monitored as it would be with any other health issue, through frequent checkups and blood work.

At the November 2008 antiretroviral update meeting at St. Paul's Hospital in Vancouver, researchers and clinicians from the BC Centre for Excellence in HIV/AIDS released and presented their most recent guidelines on regular blood work recommended for HIV-positive patients.

The new guidelines state that a recently diagnosed individual should have an immune panel completed, including the HLA-B

507-1, which looks at the patient's ability to tolerate abacavir (Ziagen), as well as a complete blood count, liver profile, and renal test. These tests, excluding HLA-B570-1, should be repeated once every two months if the patient's CD4 cell counts remain above 350 cells mm³ and they are not on antiretroviral therapy.

If you are newly diagnosed and taking antiretroviral medications, you should repeat the tests on a monthly basis until you achieve stability through either an undetectable viral load or a significant reduction in your viral load. Once stable, you can reduce your blood work checkups to every two to three months.

The accompanying chart provides a more detailed description of the immune panel and complete blood count profiles, what these tests reveal, and the normal blood values associated with each test. ⊕

Ashley Smith is a volunteer with BCPWA's Treatment Information Program.

Test	Why?	Normal value
Immune panel	<i>These tests monitor HIV and the cells it targets</i>	
CD4 cells	<ul style="list-style-type: none"> ◊ Cells infected with HIV ◊ At the end of the virus replication cycle, the cell dies releasing HIV 	<ul style="list-style-type: none"> ◊ Less than 500 cells/mm³ indicate immune dysfunction; AIDS is defined as below 200 cells/mm³ ◊ Treatment begins once CD4 counts fall below 350 cells
CD4 percentages	<ul style="list-style-type: none"> ◊ CD4 compared to the other types of lymphocytes ◊ Accounts for normal non-HIV-related fluctuation in CD4 counts between checkups 	<ul style="list-style-type: none"> ◊ HIV-negative: approximately 40% ◊ HIV-positive: approximately 25%
Viral load	<ul style="list-style-type: none"> ◊ Amount of virus in the blood ◊ Allows for disease progression to be monitored 	<ul style="list-style-type: none"> ◊ Viral load varies among individuals ◊ When the virus present in blood can't be detected by monitoring tests, it is classified as undetectable
Viral genotype	<ul style="list-style-type: none"> ◊ HIV has a high mutation rate which creates resistant strains ◊ Genotyping investigates viral mutations in blood ◊ Allows for a customized treatment regimen based on the strains of HIV identified 	<ul style="list-style-type: none"> ◊ Since this test examines genetic information, there are no normal values
Complete blood count	<i>This test provides information on the various components in your blood.</i>	
Red blood cells	<ul style="list-style-type: none"> ◊ Responsible for oxygen transportation to body ◊ HIV treatment may lower red blood cell counts 	<ul style="list-style-type: none"> ◊ Male: 4.7 – 6.1 million cells/mL ◊ Female: 4.2 – 5.4 million cells/mL
Hematocrit	<ul style="list-style-type: none"> ◊ Measures the percentage of blood made of red blood cells ◊ Makes sure blood isn't too thick as this can cause blood circulation problems 	<ul style="list-style-type: none"> ◊ Adult men: 42 – 54% ◊ Adult women: 38 – 46%
Platelets	<ul style="list-style-type: none"> ◊ Acts as a blood clotting factor ◊ Some HIV medications have been shown to disrupt platelet counts 	<ul style="list-style-type: none"> ◊ 150,000 – 400,000 cells per mL
White blood cells	<ul style="list-style-type: none"> ◊ A count of all cell types involved in the immune response 	<ul style="list-style-type: none"> ◊ 4,300 and 10,800 cells per mm³

Conversations with my selves

Voice dialogue therapy can give expression to your sub-personalities

by Jari Dvorak

Lately, I've been thinking about sexual identity. In our circles—especially in the AIDS movement—we refer to *men who have sex with men*. I wonder: why the fuzziness? To me, people are either gay or straight. The idea that I might be bisexual seems far-fetched. It implies a degree of choice that I don't think I have in the matter. I decided to take this issue up with my new psychotherapist, Ann.

Ann is very skilled in a new form of psychotherapy known as voice dialogue. Voice dialogue is a conversation-based form of therapy that aims to identify, explore, understand, and integrate the various aspects of ourselves.

Before I started working with Ann, I assumed that my psyche was composed of a single personality. According to the principles of voice dialogue therapy, this is a misunderstanding: while I'm most familiar and comfortable with my dominant or primary self—those aspects of my identity that make me acceptable to others—my personality is actually made up of many additional suppressed sub-personalities.

Through the voice dialogue method, Ann initiates conversations directly with my sub-personalities. And to my surprise, the various parts of me react, respond, and communicate freely with her.

My conversations... with my selves... give me new ways to look at myself. These days, I view my personality as a kind of a music player loaded up with a collection of CDs. Each sub-personality represents a single piece of music burned onto the disk—and each piece includes a set of memories, ideas, agendas, and needs that were recorded long ago. As with all CDs, only the pre-recorded music can be played, and only one piece at a time. My sub-personalities are similarly pre-recorded from the distant past; and I can only play or express one sub-personality at any given time. Different people and different situations activate my various sub-personalities.

Giving expression to sub-personalities

It turns out that I have many sub-personalities. Some of them are familiar and comfortable—I strongly identify with them. Others seem a bit scary and risky, suppressed or disowned in the shadowy part of my consciousness. According to the voice dialogue system, there is nothing inherently good or bad about any of the sub-personalities. Each has its gifts and limitations.

But because of family upbringing and social values, individuals will have habitual preferences for some over others.

The disowned sub-personalities, as they're known in voice dialogue parlance, hold emotional energy, repressed needs, mistaken and internalized beliefs that stifle our capacity to live and grow to our full potential. This is why the objective is to give our sub-personalities expression—to grow in self-awareness and integrate the various parts of our selves.

Ann gives each sub-personality a name. Right now my *Inner Pusher* is active—motivating me to write this article. *Lazy Bum* is suppressed for the moment. When I meet someone new, the first sub-personality to emerge is invariably the *Pleaser*—that one is self-evident. But the next sub-personality to appear is usually the *Inner Critic*, that little voice that makes me feel embarrassed and guilty. The *Protector* keeps me from hurting myself and others. And my *Rational Analyst*—evidently way too active—interferes in my ability to experience joy and emotion. I'm learning how to adjust my *Controller* to keep my *Rational Analyst* from acting so much. My *Sexual Rebel* could also use more control.

I also have a suppressed, less visible side: the *Vulnerable* self and the *Romantic* self. Since they've emerged in conversation with Ann, I feel compelled to connect with them more often. My *Inner Homophobe* is also suppressed, but that's okay and for my own good. When I was young, my *Inner Clown* used to make me the life of the party; now the *Inner Clown* is suppressed by my *Inner Critic*. This makes me way too serious. Let's bring back that clown.

I'm learning to become more aware of the sub-personality known simply as *Being*. The *Being* holds me in the present moment. It allows me to experience intimacy. The *Being* becomes more visible through spiritual practice.

Sexual identity, HIV, and voice dialogue therapy

So, how does sexual identity fit in all of this? I asked Ann to interview my gay sub-personality. She did, but very little came out, so to speak—other than the fact that my gay self likes having sex with men. Is that all there is to being gay? Maybe my gay sub-personality was reluctant to communicate openly with a straight therapist.

To encourage further exploration of my gay sub-personality, Ann put me in touch with three gay voice dialogue ther-

apists. Through email exchanges, each of them disclosed how early incidents and experiences shaped their sub-personalities and sense of sexual identity. All of them claimed that there is probably an inherent spectrum of gay and straight sexual attractions in everyone; and what we consider gay or straight in terms of personality is, in fact, an amalgamation of various sub-personalities.

According to the principles of voice dialogue therapy, while I'm most familiar and comfortable with my dominant or primary self, my personality is made up of many additional suppressed sub-personalities.

But a series of comments by one gay therapist particularly resonated for me. Reflecting on his period of sexual awakening, he recalled that homosexuality was still illegal at the time. Rather than unleashing his *Sexual Rebel*, his *Conformist* sub-personality took over. His *Sexual Rebel* didn't manifest until his 30s; by then, during the height of the AIDS epidemic, he invested considerable effort into understanding and controlling the *Rebel*. He feels that he made the right decision since, otherwise, he likely would have contracted HIV and might not be alive today. In terms of relationships, the sub-personalities emerging were more affected by fears of intimacy than by

homosexuality. He suspects that for many gay men, the *Inner Homophobe* links up with the *Inner Critic*, generating considerable turmoil.

I hadn't considered, until then, the impact and influence of the AIDS epidemic in the development of sub-personalities; but, for so many gay men—myself included—who have lived through the last two decades, our sense of identity is inextricably linked to HIV. I began to imagine applying the principles of voice dialogue therapy to people recently diagnosed; to long-time survivors; to people who have experienced the loss of a lover; to people in serodiscordant relationships—perhaps even for more effective HIV prevention outreach.

If I had worked with Ann before I contracted HIV, I wonder which sub-personalities would have participated in the conversation? How might it have impacted my understanding of my *Inner Critic* and my *Inner Homophobe*? Might I have had better control of my *Sexual Rebel's* sense of entitlement to pleasure and desire?

As it is, the dialogues soften the sense of uncertainty and fear that I experience about my health and my life. Embracing all of my sub-personalities rather than rejecting them is a novel idea for me. Learning about them gives me a fresh look at myself as well as my relationships and what I expect from them. It feels as if I'm getting a personality tune up. And with that comes a remarkable sense of peace, contentment, and harmony. ☺

Jari Dvorak is an AIDS activist, spiritual seeker, and a passionate promoter of the benefits of meditation. He lives in Toronto.



There are many different ways to get involved!

Volunteer



BCPWA

- 1) Volunteer weekly helping out with our many programs & services (Mon-Fri)
- 2) Volunteer at special events, AccoAIDS Gala, Pride Parade, AIDS Walk for Life
- 3) Volunteer on projects, in meetings or with our *living*☺ magazine

To find out about these & other volunteer opportunities, contact Marc > 604.893.2298 or marcs@bcpwa.org



Age and cardiovascular disease

by *Adriaan de Vries*

Cardiovascular health is complex and multi-faceted. The cardiovascular system includes the heart, lungs, arteries, capillaries, and veins. The most common cardiovascular illnesses are hypertension (high blood pressure), hyperlipidemia (high cholesterol and elevated triglyceride levels), as well as insulin resistance (metabolic syndrome), and diabetes. In addition, the risk of heart disease, diabetes, and stroke also increases with high blood sugar levels, excess body weight, and low levels of “good” cholesterol (HDL).

There is some evidence to suggest a correlation between HIV infection and cardiovascular disease. Lipid abnormalities are quite common among people living with HIV/AIDS, both as a result of the disease itself, as well as from a number of highly active antiretroviral therapies (HAART), which elevate triglycerides and cholesterol.

One researcher analyzing findings from the D:A:D study found that for every five-year increment in age, cardiac risk increased by approximately about 40 percent.

Reviewing recent research

One researcher analyzing findings from the often-cited D:A:D study (data on adverse events of anti-HIV drugs)—an observational study of more than 23,400 people with HIV from 11 cohorts in Europe, Australia, and the US—found that for every five-year increment in age, cardiac risk increased by approximately about 40 percent. Another US-based study several years ago reported that HIV-positive people were more frequently diagnosed with chronic obstructive lung disease than their HIV-negative counterparts, reinforcing the link between cardiac risk, aging, and HIV.

More encouraging findings in the literature reveal that HAART doesn't appear to increase the risk of coronary atherosclerosis (hardening of the arteries), which is commonly associated with aging and associated lifestyle changes. In another study comparing HIV-positive and HIV-negative men, researchers found a very similar prevalence of coronary artery calcium (CAC), an

independent predictor of coronary heart disease; and among those with CAC, treatment experienced patients appeared to have the lowest CAC levels.

Abacavir and heart attacks

At the XVII International AIDS Conference in Mexico City, there was considerable discussion about the incidence of myocardial infarction (MI or heart attack) among people on the antiretroviral drug abacavir (Kivexa). Subsequently, abacavir manufacturer GlaxoSmithKline reviewed their data but found no correlation. As well, cardiovascular data collected from the SMART study was extracted and analyzed, but also found no direct correlation between abacavir and MIs; however, interruption of HAART reportedly increased the incidence of cardiovascular problems among study participants.

Still, for older people living with HIV, cardiovascular risk increases with age. And the Framingham protocol review of abacavir did find an increase risk of cardiovascular incidents—including MI—among people already at higher risk for cardiovascular incidents; this protocol measures associated factors such as smoking, blood pressure, cholesterol, age, diet, exercise, and gender. Older HIV-positive men on abacavir may want to discuss these risks with their doctor.

HAART has greatly improved the survival of PWAs, but isn't without side effects. The only conclusive finding is that age-related risk of cardiovascular disease is increased when other traditional risk factors co-exist, such as a family history of heart disease, associated health problems—including diabetes and high blood pressure—and lifestyle factors like smoking, alcohol, and obesity. And HAART may increase risks further, especially when combined with other risk factors. If you're over 50 and living with HIV, talk with your doctor. ☉

Adriaan de Vries is the director of BCPWA's Treatment Information and Advocacy Department and has been involved with HIV issues since 1983.





The little engine that can

Managing your metabolism with exercise

by Dani Shahvarani

Metabolism refers to all the chemical reactions in our bodies that are necessary for health. Our metabolism functions like an automobile engine. With HIV, the engine runs very fast all the time, which means it can run out of fuel very quickly. This phenomenon is called wasting, where a higher than normal metabolic rate leads to loss of nutrients, causing muscle and bone loss as well as other vitamin and mineral deficiencies. The engine can also run at an unpredictable rate, irrespective of the amount of fuel available. This is the case with lipodystrophy, where fat production is accelerated in some cells while it is virtually non-existent in others. Both HIV and certain antiretroviral medications are known to cause lipodystrophy.

An accelerated or unpredictable metabolism that changes fat production can have significant health implications for people living with HIV. Fat production changes can increase waist circumference causing insulin resistance. With this condition, the body's cells aren't as sensitive to circulating insulin levels in the blood, leading to high levels of cholesterol, blood fat (triglycerides), and blood sugar (glucose).

For many people living with HIV/AIDS who experience wasting or lipodystrophy,

pharmacological treatments are prescribed. Drugs such as megestrol acetate (Megace), cannabis derivatives such as dronabinol (Marinol), and testosterone injections are often used to increase weight, appetite, and muscle mass, while statins are prescribed to reduce cholesterol levels. However, the drug-centred approach may not be used in instances of drug interactions, poor tolerance, or ineffectiveness.

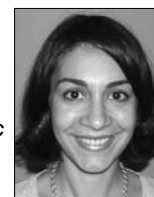
Moderate exercise, particularly resistance or weight training, has proven to be a relatively effective alternative, pill-free option for men and women to help correct some HIV-related metabolic issues. Lifting light weights three to four times a week for about 30 minutes can help increase your muscle mass, body weight, and bone density. In fact, the metabolic effects of exercise can help you regulate some of the "engine damage" caused by HIV since it stimulates the building of proteins, improves your cellular response to insulin, clears blood fats from your system, and regulates your appetite.

In terms of quality of life, exercise can help you reduce fatigue, build self-esteem, encourage social interaction, and improve sleeping patterns. Although lipodystrophy is more difficult to treat with exercise, cardiovascular activity—such as jogging, swimming,

or brisk walking—helps reduce belly fat as well as cholesterol levels and blood sugar. If you have diabetes or a history of high blood sugar, taking a brisk walk for 15 - 20 minutes following a meal can be very helpful in metabolizing the excess sugar in your blood.

Many people think they need to eat more protein to regain lost muscle mass. In fact, the only way to build muscle is to exercise. Of course, good nutrition will help you get the most out of your workout routine. So, like most things, dietary protein is all about balance. If you consume too much, it's excreted in your urine and, over time, damages your kidneys. If you eat too little, you risk compromising your workouts by using muscle protein for energy. As a general guideline, have a serving of protein and carbohydrates—like half of a peanut butter sandwich or fruit and yogurt—before you exercise, to prevent protein breakdown during the activity. ☺

Dani Shahvarani is a registered dietitian who has worked in HIV care at St. Paul's Hospital in Vancouver, and is now undertaking her Master's of Science in Public Health at the University of British Columbia.





STRAIGHT
from the source

what's new in research

First-line therapy for advanced HIV disease

by Dr. Marianne Harris

At the XVII International AIDS Conference in Mexico City in August 2008, Dr. Julio Montaner presented results of a study comparing efavirenz (Sustiva) with lopinavir/ritonavir (Kaletra) as a first-line therapy for advanced HIV infection. The study was conducted in Mexico, where a large number of people already have CD4 counts below 200 cells/mm³ when diagnosed with HIV. The ideal treatment strategy is unknown in this case, particularly whether a non-nucleoside reverse transcriptase inhibitor (NNRTI) such as efavirenz or a protease inhibitor (PI) like lopinavir/ritonavir will be most effective.

In the study, 189 adults who hadn't previously received antiretroviral therapy and whose CD4 cell counts were less than 200 cells/mm³ were randomly assigned to receive either efavirenz 600 mg daily plus AZT (Retrovir) and 3TC (Combivir), or lopinavir/ritonavir 400mg/100mg twice daily plus AZT and 3TC. Most study participants were men, with an average age of 36 years. Before starting antiretroviral therapy, the average CD4 cell count was around 60 cells and almost half of participants had CD4 counts below 50 cells/mm³. As well, 87 percent of participants had a viral load greater than 75,000 copies/mL.

This study showed that efavirenz was more effective in suppressing HIV viral load than lopinavir/ritonavir capsules in people with advanced HIV infection. After 48 weeks, more people in the efavirenz arm had a viral load below 50 copies/mL than in the lopinavir/ritonavir arm. This difference was due to a higher rate of virologic failure in the lopinavir/ritonavir arm and more people discontinuing treatment due to side effects such as nausea and diarrhea, likely caused by the use of the older capsule formulation of lopinavir/ritonavir. After one year, average CD4 cell count increases were similar: 157 cells/mm³ with efavirenz and 167 cells/mm³ with lopinavir/ritonavir.

These results are consistent with those of the larger ACTG 5142 study, which were presented at the XVI International AIDS Conference in Toronto in 2006. In that study, 250 participants were randomly assigned to receive efavirenz 600 mg daily plus

two nucleoside reverse transcriptase inhibitors (NRTIs) selected by the investigator; another 253 participants received lopinavir/ritonavir capsules 400mg/100mg twice daily with two NRTIs. Before starting antiretrovirals, the average CD4 cell count was approximately 185 cells/mm³, so this group had less advanced HIV disease than the Mexican study group. After 96 weeks, efavirenz-based antiretroviral therapy was more effective at suppressing viral loads to less than 50 copies/mL than lopinavir/ritonavir-based therapy.

Other interesting differences in the two treatments were discovered. In both studies, lopinavir/ritonavir caused greater increases in triglyceride levels than efavirenz. Such increases might lead to a greater risk of heart disease; however, changes in cholesterol levels didn't differ significantly between the treatments. The ACTG study also examined body fat changes and found that efavirenz seemed to be associated with more lipoatrophy than lopinavir/ritonavir. NNRTIs hadn't previously been associated with lipoatrophy (fat loss); this finding remains controversial and is still being studied.

Based on the findings of these and other studies, the British HIV Association—for the first time in their 2008 guidelines—recommended NNRTI-based therapy, specifically efavirenz, as first-line treatment for HIV in preference to PI-based therapy. At present, other major international antiretroviral guidelines and those of the BC Centre for Excellence in HIV/AIDS still recommend either the NNRTI efavirenz or ritonavir-boosted PIs as equal alternatives, with the choice of antiretrovirals being tailored to the individual situation. ☺



Dr. Marianne Harris is a family doctor with the AIDS Research Program at St. Paul's Hospital in Vancouver.

Volunteering at BCPWA

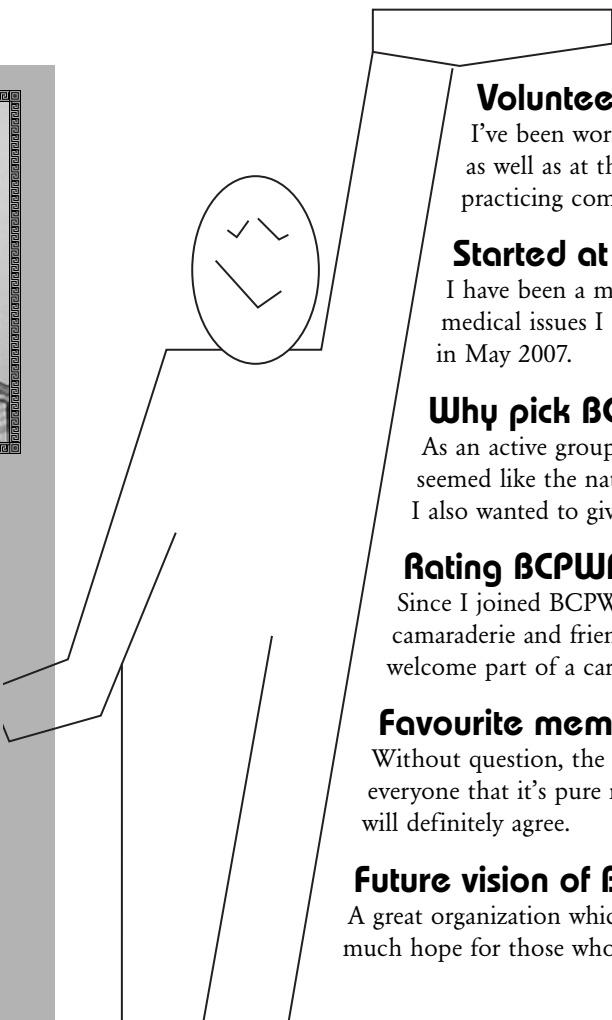
Profile of a volunteer:

Chuck Osborne



Chuck is very knowledgeable on treatment information issues, and his calm demeanor promotes a welcome environment among other volunteers and members. We're glad Chuck is part of the team.

Paul Kerston,
Treatment outreach /
CRE coordinator



Volunteer history

I've been working in treatment information and outreach as well as at the front desk. And recently I've started practicing complementary therapy (Reiki).

Started at BCPWA

I have been a member for five years, but because of some medical issues I only became actively involved as a volunteer in May 2007.

Why pick BCPWA?

As an active group helping people with HIV/AIDS, BCPWA seemed like the natural choice for support and other services. I also wanted to give back to those who had helped me.

Rating BCPWA

Since I joined BCPWA, I have never looked back. Because of the camaraderie and friendship among members, I have always felt a welcome part of a caring family.

Favourite memory

Without question, the Loon Lake Retreat. I keep telling everyone that it's pure magic; and those who have been there will definitely agree.

Future vision of BCPWA?

A great organization which won't let us forget the past, but offers much hope for those who will need to access services in the future.



Polli & Esther's Closet

Your peer-run, second time around store!

Bring your membership card and pay us a visit at
1107 Seymour Street, 2nd Floor

Open Tuesdays, Wednesdays & Thursdays,
11AM to 2PM for your shopping convenience



Great selection!



SIMPLY POSITIVE

An easy-to-read page on HIV treatment & care.

At BCPWA we want to ensure that HIV related information is accessible to everyone, regardless of reading ability. So the easy-to-read page aims to explain HIV as simply as the ABCs.



Working With Your Doctor

Living with HIV can be hard. Regular visits with a good doctor will make life easier.



It is important that you feel comfortable with your doctor. If you are not comfortable, you can change doctors.

Don't be shy. It's okay to ask your doctor any questions about your health. There are no silly questions.



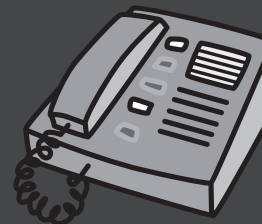
Write a list of questions and health problems you want to talk about and take it with you when you see your doctor.



Get regular medical check ups, including blood tests. Blood test results will tell you and your doctor how well you are fighting HIV.



It is important to keep your appointments. If you are unable to make an appointment, contact your doctor's office.



Learn about test results and what they mean so that you can discuss your health with your doctor.



It is okay to bring a friend to your doctor's visits. A friend can help you remember what was talked about with your doctor.



You may refuse any treatment or test you do not want.

If you have a problem with the medical care you receive, talk with someone who can help you.



The following contacts can help you with medical care problems.

- College of Physicians and Surgeons of BC
1.800.461.3008
- BC Human Rights Coalition
1.877.689.8474
- an HIV/AIDS community organization
- an advocate

www.bcpwa.org

where to find help

If you're looking for help or information on HIV/AIDS, the following list is a starting point.

A Loving Spoonful

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 or 1.800.665.2437
e info@avi.org www.avi.org

AIDS Vancouver Island

(Cowichan Valley Mobile Needle Exchange)
t 250.701.3667

AIDS Vancouver Island (Campbell River)

t 250.830.0787 or 1.877.650.8787

AIDS Vancouver Island (Port Hardy)

t 250.949.0432

AIDS Vancouver Island (Nanaimo)

t 250.753.2437

AIDS Vancouver Island (Courtenay)

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 info@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 info@oaas.ca 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 VOJ 2N0
3862 F Broadway, Smithers BC
t 250.877.0042 or 1.886.877.0042
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 organizations and services please
visit BCPWA's website at www.bcpwa.org
and click on "Links and Services" under the
"Empower Yourself" drop-down menu.**

Last Blast

The root of all pains

A trip to the dentist brings up more than needles and drills

by **MT O'Shaughnessy**

While two lovely women pressed down on my shoulders to hold me in place—offering gentle reassurances (“breathe...”) that slowly evolved into directive shouting (“BREATHE!”)—I considered: why had I waited so long?

Oh, right. This was a dental appointment. The dentist: a person poking around in my mouth in a manner I have pretty much avoided for a decade. Hey, there's even more fun with drills.



In the middle of a root canal, you don't really have a lot of time to do much else than consider how, exactly, you got to this point.

Which brings us back to the internal screaming.

In the middle of a root canal, you don't really have a lot of time to do much else than consider how, exactly, you got to this point. That, and think about removing all your teeth right then and there.

Even though I was aware I needed a root canal for a while, and even as I examined the inside of my mouth every day to see how bad things were, I kept waiting. Okay, I admit, part of it was making sure I had the money to pay people to torture me. With medical coverage at work, I'm fine. The benefit plan reimburses me—as long as I can come up with the cash to pay for things up front. And, really, who doesn't have a couple thousand bucks to throw out at a moment's notice?

Apparently I didn't.

But two or three months later, here I was under almost triple freezing, *still* wanting to scream as they poked needles into tiny, delicate places that should never have to encounter needles.

A large part of this, I guess, was because I just didn't want to have someone messing around with my teeth. Hell, I've got a pretty good pain threshold, but I seriously dislike pain in my mouth or in my head. And since I couldn't feel anything around the tooth itself—and while I knew better—I let it sit, and sit. And sit.

Result? Some seriously less-than-fun time spent in the dentist's chair having an emergency root canal. And a rather festive bunch of bacteria that apparently decided to party in my dead tooth.

Recently, I've noticed I'm not feeling as run down as I was while all this was going on. My body isn't splitting its energy between so many issues anymore. But I've come to realize that I was willing to let my health decline because of one small thing—an internal blip that I need to get rid of. I had developed some major pain issues. Hell, I was taking Dilaudid: that's some serious painkiller right there, let me tell you. But it's not really about the pain. It's about how I have been willing to let my health slide because I didn't see the need to get all that upset.

And, frankly, there's a whole other story about how a few select healthcare professionals along the way didn't seem too concerned, either. But I digress.

Having spent the last year coming to terms with an overall energy level that is far lower—with far fewer reserves to draw on—than what I had before my HIV diagnosis, I've had to face up to a bunch of things. This was just another prod to remember, to pay attention. My body doesn't have the ability it had before, to pound away at an infection and pretend nothing's wrong. And I'm not 20-something anymore. Okay, that's more about me than my body.

It wasn't serious—this thing with my tooth. Not in the big picture of my overall health. But it was a bit of a wake-up call: those days of carelessly putting things off are well and truly over. ☺

Mike O'Shaughnessy is not allowed to sum himself up as “born in 1972, not dead yet.” Instead, he describes himself as: a fairly average person, last seen in the presence of rather extraordinary people, living as best as he's able. Send chocolate.

