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IDCR

INFECTIOUS DISEASES IN CORRECTIONS REPORT

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ABOUT IDCR

IDCR, a forum for correctional problem solving, targets correctional physicians, nurses, administrators, outreach workers, and case managers. Published monthly and distributed by email and fax, IDCR provides up-to-the moment information on HIV/AIDS, hepatitis, and other infectious diseases, as well as efficient ways to administer treatment in the correctional environment. Continuing Medical Education credits are provided by the Brown University Office of Continuing Medical Education. IDCR is distributed to all members of the Society of Correctional Physicians (SCP) within the SCP publication, CorrDocs (www.corrdocs.org).

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IDCR MISSION STATEMENT

We changed our name from HEPP Report to IDCR (Infectious Diseases in Corrections Report) to encompass all infectious diseases that impact the correctional setting. IDCR's goal is to educate correctional health care providers about the appropriate medical management of prisoners infected with HIV, hepatitis, TB, and other infectious diseases; to encourage these providers to improve their networks with correctional, academic or community-based infectious disease experts; and to promote a level of infectious disease care in correctional facilities that is equivalent to the "community standard."

IS THE WORLD FINALLY WAKING UP TO HIV/AIDS IN PRISONS? A REPORT FROM THE XV INTERNATIONAL AIDS CONFERENCE

Ralf Jürgens, LL.M., Dr.jur, Executive Director, Canadian HIV/AIDS Legal Network*

Issues related to HIV/AIDS in prisons have traditionally received little attention at the International AIDS Conference. Yet, it is a well-known fact that HIV prevalence within prison populations tends to be much higher than in the general population both in the United States and worldwide. This year's conference, "AIDS 2004," held in Bangkok, Thailand, (July 11-16) may, however, represent a turning point. Before the official conference started, a one-day satellite meeting debated issues related to HIV/AIDS in prisons in great depth. At the conference itself, two oral sessions and a large number of poster presentations were dedicated to HIV/AIDS in prisons. In addition, three United Nations agencies released an important policy brief on reduction of HIV transmission in prisons. Although most activities focused on HIV prevention, delegates also debated the question of how HIV treatment, including antiretrovirals (ARVs), can best be made available to inmates. This was particularly important in light of current efforts spearheaded by the World Health Organization to make effective treatments available to three million people in developing countries by 2005.[1] While it is impossible to provide a detailed overview of all the prison-related developments presented at AIDS 2004, this article will first provide some background information on HIV/AIDS in prisons worldwide, and then highlight some of the relevant findings presented at the conference.

HIV/AIDS IN PRISONS WORLDWIDE

HIV Prevalence

In most countries, prevalence of HIV infection within prison populations is much higher than in the general population, with some countries reporting rates in the range of 10 to 25 percent.[2] The jurisdictions with the highest HIV-prevalence within prisons are those where rates of HIV infection among injection drug users (IDUs) are high, as this group is dramatically over-represented in correctional institutions.

HIV Transmission in Prison

Incarceration has been associated with HIV infection in several countries,[3] including Thailand, where the first wave of HIV infections occurred in 1988 among IDUs. From a negligible percentage at the beginning of the year, the infection rate among IDUs rose to over 40 percent by September, fueled in part by transmission of the virus as many IDUs moved in and out of penal institutions.[4] A more recent study concluded that IDUs in Bangkok continue to be "at significantly increased risk of HIV infection through sharing

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WHAT'S INSIDE

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needles with multiple partners while in holding cells before incarceration."[5]

Additional evidence for rapid HIV transmission in prisons was documented in Scotland in 1993.[6] Among 227 Scottish inmates participating in a study of HIV risk behavior and infection at Glenochil institution, 76 (33 percent) reported a history of injection, and 33 (43 percent) of those individuals reported injecting while in the prison. Thirty-two (97 percent) of those who admitted to injecting in prison also reported sharing syringes. Of the 162 individuals who were tested for HIV, twelve (7 percent), tested positive for HIV antibodies. All of these individuals had reported injecting while in the prison. Evidence derived from serial HIV testing and prison admission records confirmed that at least eight of these inmates contracted HIV during the first six months of 1993.

Another example of a documented outbreak occurred in a prison in Lithuania. During random checks undertaken in 2002 by the state-run AIDS Center, 263 prisoners at Alytus prison tested positive for HIV antibodies. Tests at Lithuania's other 14 prisons, which house 11,700 convicts, found only 18 cases of HIV infection. Before the tests at Alytus prison, Lithuanian officials had listed only 300 cases of HIV infection in the whole country, or less than 0.01 percent of the population, the lowest prevalence in Europe. It is believed that the outbreak at Alytus prison was also due to sharing of drug injection equipment.[7]

HIV Risk Behaviors

Despite the sustained efforts of prison systems to prevent drug use by prisoners, the reality is that drugs can and do enter prisons. Many inmates come to prisons with their drug habits already established. In fact, many inmates are sentenced in the first place because of drug-related crimes. People who used drugs outside often find a way to continue drug use on the inside. Others start using drugs in prison as a way to release tensions and to cope with being in an overcrowded and often violent environment.[8]

Studies have shown that ongoing injection drug use is also prevalent in prisons in many countries.[9] As in the United States, imprisonment is a common event for IDUs worldwide. In a 12-city World Health Organization study of HIV risk behavior among IDUs, between 60 and 90 percent of respondents reported a history of imprisonment since commencing drug injection.[10] For IDUs who continue to use while incarcerated, imprisonment increases the risk of contracting blood-borne infections, including HIV and hepatitis C virus (HCV) and hepatitis B virus (HBV). This is because those who inject drugs in prison almost always share needles and syringes. IDUs have contributed to significant risk-reduction in the community through introduction of a variety of measures that include needle exchange, education, and provision of treatment. On the other hand, risk behavior in prisons (with the exception of prisons that have introduced the preventive measures described below) has remained unchanged over the last decade.[11] In one Australian study, six of the 36 participants who reported injecting and sharing needles when last in prison also reported that it was the first time they had ever shared syringes.[12] Most often, only a handful of needles will circulate among a large population of prisoners who inject drugs.

IDUs have contributed to significant risk-reduction in the community through introduction of a variety of measures that include needle exchange, education, and provision of treatment.

Because sharing of injection equipment is inherently a high-risk activity, and in some prisons a more common occurrence, sexual activity is considered to be a less significant risk factor in prisons for HIV and HCV transmission. Nevertheless, it does occur and puts prisoners at risk of contracting HIV infection. Homosexual activity occurs inside prisons, as it does outside, as a consequence of sexual orientation. In addition, prison life produces conditions that encourage homosexual activity and the establishment of homosexual relationships between inmates who do not identify themselves as homosexuals. The prevalence of sexual activity in prison is based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification, and the extent to which conjugal visits are permitted. Studies of sexual contact in prison have shown "inmate involvement to vary greatly."[13]

Responses of Prison Systems

Initially, response to the issues raised by HIV/AIDS, HCV, and drug use in prisons was slow. In many prison systems worldwide, only small steps were made to develop policies and to provide educational programs for staff and prisoners. However, in recent years a growing number of prison systems have started adopting a pragmatic, public health approach to HIV/AIDS. These systems are making condoms, bleach and even sterile injection equipment and methadone maintenance treatment available, in addition to providing substance abuse treatment and educational programs delivered or supplemented by community-based outside organizations and/or peers.

Responding to Injection Drug Use

Recognizing that drugs, needles, and syringes permeate the most secure of prison walls, and while continuing and often stepping up drug interdiction efforts and substance abuse programs, prison systems around the world are taking steps to reduce the risk of the spread of HIV and other diseases. Some of these measures are not necessarily easy to implement, and there are legal, ethical, as well as practical problems associated with them. These steps have usually been undertaken as a pilot project, but their success to date has led to their continuation, and indeed extension into other prisons and other countries.[14]

One strategy to reduce the risk of HIV transmission through the sharing of injection equipment is to provide liquid bleach to sterilize needles and syringes. Already in 1991, 16 of 52 prison systems surveyed in Europe made bleach available to prisoners.[15] Significantly, no system that has adopted a policy of making bleach available in penal institutions has ever reversed the policy, and the number of systems in Europe that make bleach available has continued to grow every year.[16] Bleach is also available in many other prison systems, including in most Canadian prisons[17] and in many prisons in Australia.[18]

While making bleach available to inmates may reduce the spread of HIV from injection drug use in prisons, sterile, never-used needles and syringes are safer than bleach-disinfected, previously-used needles and syringes.[19] The probability of effective decontamination is decreased further in prison. Because prisoners can be discovered at any moment by prison staff since injecting and cleaning is a hurried affair. Studies have shown that bleach disinfection takes more time than most

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prisoners allow. In addition, even when bleach is provided, prisoners may find it difficult to access.[20] Finally, bleach is not fully effective in killing HCV.[21]

Therefore, an increasing number of prison systems have introduced needle exchange or distribution programs. Outside prisons, in many countries such programs have become an integral part of a pragmatic public health response to the risk of HIV transmission among IDUs (and ultimately, to the general public). Extensive studies on the effectiveness of these programs have been carried out. For many years, there has been scientifically sound evidence showing that they are an appropriate and important preventive health measure.[22]

Introducing needle exchange programs in prisons has been recommended.[23] At AIDS 2004, the first comprehensive survey of the experience with existing prison-based needle exchange programs was presented (see below).

Finally, worldwide, an increasing number of correctional systems have introduced methadone maintenance treatment (MMT). Outside prisons, MMT programs have rapidly expanded in many countries over the last decade. There are ample data supporting their effectiveness in reducing high-risk injecting behavior and in reducing the risk of contracting HIV. There is also evidence that MMT is a highly effective treatment available for heroin-dependent IDUs in terms of reducing mortality, heroin consumption, and criminality. Further, MMT attracts and retains more heroin injectors than any other form of treatment. Finally, there is evidence that people who are on MMT and who are forced to withdraw from methadone because they are incarcerated often return to narcotic use, often within the penal institutions, and often via injection.[24]

As in the community, MMT, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons. Evaluations of MMT programs in prisons have shown positive results. For example, in Canada, the federal prison system expanded access to MMT after evaluation demonstrated that MMT has a positive impact on release outcome and on institutional behavior.[25]

Preventing sexual transmission of HIV

Many prison systems worldwide are also making condoms available to prisoners. In 1991, 23 of the 52 European prison systems surveyed allowed condom distribution.[26] Making condoms available has not resulted in any significant security problems,[27] and no system that has adopted a policy of making condoms available in prisons has reversed the policy. The number of systems that make condoms available has continued to grow every year. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that made condoms available rose from 53 percent in 1989 to 75 percent in 1992 and 81 percent in 1997. In the most recent survey, condoms were available in all but four systems.[28] In 1995 in Australia, 50 prisoners launched a legal action against the state of New South Wales (NSW) for non-provision of condoms, arguing that "[it] is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded."[29] Since then, at least in part because of the legal action, the NSW government has decided to make condoms available. Other Australian systems, most Canadian systems, a growing number of facilities in the U.S. and elsewhere also make condoms available.

As in the community, Methadone Maintenance Treatment, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons.

AIDS 2004 HIGHLIGHTS

The Satellite Conference on HIV/AIDS in Prisons

A one-day pre-conference seminar, which brought together 150 people from many different countries and backgrounds, debated issues related to HIV/AIDS in prisons at great length. Entitled "Human Rights at the Margins: HIV/AIDS, Prisoners, Drug Users and the Law," and organized by a group of organizations including the Canadian HIV/AIDS Legal Network and UNAIDS, the conference provided an overview of the state of the HIV/AIDS epidemic in prisons worldwide. Also discussed were responses by prison systems; key public health, human rights, legal and ethical issues; and recommendations about how to increase HIV education, prevention, care, treatment and support efforts in prisons worldwide. A background paper prepared for the conference argues that increased efforts are necessary not only for public health reasons, but are required by international law. With regard to availability of prevention measures, the paper states:

"Measures undertaken to prevent the spread of HIV and other infections will benefit prisoners, staff, and the public. They will protect the health of prisoners, who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. They will protect staff: lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered. They will protect the public. Most inmates are in prison only for short periods of time and are then released into their communities. In order to protect the general population, prevention measures need to be available in prisons, as they are outside." [31]

With regard to treatment, the paper argues that in high income countries, the right to enjoyment of the highest attainable standard of physical and mental health, in concert with the principle of equivalence, dictates that inmates should have access to a high standard of care, including specialist consultation, diagnostic testing (CD4, viral load, viral resistance) and the full range of ARVs licensed for sale within a particular country.[32] The paper is currently being finalized based on feedback received at the conference and peer review."[33]

Oral Sessions on HIV/AIDS in Prisons at AIDS 2004

The first of two major oral sessions on HIV/AIDS in prisons was entitled, "Not hard-to-reach, but still hard-to-serve? What works in HIV prevention and care in prisons." It included presentations from prison officials from Indonesia,[34] Thailand,[35] and Iran,[36] as well as a presentation on the first comprehensive survey of prison-based needle exchange programs.[37] The presenter from Thailand focused on his country's efforts to deal with the problem of TB and HIV coinfection in prisons. The officials from Indonesia and Iran discussed the measures, including condoms, bleach, and

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MMT, that have been introduced in their countries to respond to HIV/AIDS in prisons. It was encouraging to hear senior officials speak openly about heavily stigmatized and prohibited behaviors such as injection drug use and homosexual activity, and discuss the pragmatic response to prevent the greater evil: the spread of HIV among inmates and ultimately to the community. While Indonesia and Iran have not yet introduced prison-based needle exchange programs, other countries such as Switzerland, Germany, Spain and an increasing number of countries in Eastern Europe have. The survey of such programs that was presented at the session revealed that a steadily increasing number of prisons have established and evaluated needle and syringe exchange or distribution programs. All evaluations of such programs have been favorable. In particular, they have shown improvement in the health of prisoners and reduction of syringe sharing. Feared negative consequences have not materialized: needles have not been used as weapons, and there has been no reported increase in drug consumption. The presentation concluded that prison-based needle exchange programs have proven safe and effective, and the presenters opined that there remain no valid reasons not to introduce them in other prison systems.[38]

The second oral session was entitled "Preventing HIV spread in prisons" and included presentations from the U.S., Canada, Pakistan, and Thailand:

Barry Zack from California presented on the role of non-governmental organizations (NGOs) as partners of prison systems in the fight against HIV/AIDS.[39] He emphasized that a unique opportunity for collaboration exists between penitentiaries and NGOs when it comes to the provision of prevention, social support and transitional HIV services for inmates. He concluded that "prison officials who have worked with NGOs have shown that the collaboration can work for the prison, the NGO, the prisoner and the community."

Richard Wolitski presented the results of "Project START," funded by CDC to develop an HIV, STD, and hepatitis prevention program for young men aged 18-29 who are leaving prison and to test the effectiveness of a number of interventions in reducing sexual risk after leaving prison. Results showed that those prisoners who received enhanced interventions consisting of two pre-release, four post-release, and optional sessions based on participant need were less likely to engage in unprotected sex than prisoners who only received a single pre-release session intervention.[40]

A Canadian study showed that of 1,475 IDUs enrolled in the Vancouver Injection Drug Users Study (VIDUS), 1,123 (76 percent) reported a history of incarceration since they first began injecting drugs. Of these, 351 (31 percent) reported, via interviews, ever injecting in prison. Among all those interviewed, including those with and without HIV infection, incarceration during the six months prior to the interview was associated with syringe borrowing during that period. The researchers concluded that "incarceration was independently associated with risky needle sharing for HIV-infected and HIV-negative IDUs," and that the "strong evidence of HIV risk behavior should reinforce public health concerns about blood-borne diseases transmission in prisons."[41]

...''prison officials who have worked with NGOs have shown that the collaboration can work for the prison, the NGO, the prisoner and the community."

Both the presentations from Pakistan[42] and Thailand[43] focused on the growing population of children and juveniles in prisons, and emphasized the need for programs aimed at reducing their vulnerability to HIV/AIDS.

A New Resource

A final important development at AIDS 2004 was the release of a policy brief on reduction of HIV transmission in prisons by three United Nations agencies (the World Health Organization, UNAIDS, and the UN Office on Drugs and Crime).[44] Consistent with the message of the satellite conference and most oral presentations at AIDS 2004, the document calls upon governments to step up HIV prevention measures in prisons by adopting comprehensive programs that include all the measures against HIV transmission that are carried out in the community, including needle exchange. It concludes with the following "policy and programming implications":

The prevention of HIV transmission in prisons is mostly hampered by the denial of governments of the existence of injection drug use and sexual intercourse in prisons, rather than by a lack of evidence that key interventions work. There is ample evidence that drug use in general, injecting drug use in particular, and sexual intercourse among inmates are widespread in such institutions. Furthermore, there are data indicating that the risk of HIV infection in prisons is usually higher than in the general community. Once this has been accepted, governments have a wide range of program options for preventing HIV transmission in prisons.

The evidence shows that such programs should include all the measures against HIV transmission, which are carried out in the community outside prisons, including HIV/AIDS education, testing and counseling performed on a voluntary basis, the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment. All these interventions have proved effective in reducing the risk of HIV transmission in prisons. They have also been shown to have no unintended negative consequences. The available scientific evidence suggests that such interventions can be reliably expanded from pilot projects to nationwide programs.[45] At the end of the conference, some delegates expressed satisfaction that issues surrounding HIV/AIDS in prisons are starting to receive the attention they deserve. The hope is that by the time of the next International AIDS Conference, to be held in Toronto, Canada in 2006, the world will have better appreciated and responded to the reality of HIV/AIDS in prisons.

DISCLOSURES:

**Nothing to disclose.*

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Letter from the Editor

Dear Correctional Colleagues:

Many of us didn't make the International AIDS Conference in Bangkok this year. If you're like me and feel remorse over missing out on International AIDS issues, you read any updates you can get your hands on to try and assuage your guilt. This month's Bangkok Conference Update by Ralf Jürgens discusses HIV prevention efforts, such as condom distribution; AIDS service organizations and CBO involvement in corrections; HIV/AIDS counseling and testing; needle-exchange programs (NEPs) and provision of bleach for sterilization of shared injector equipment in prisons; and methadone maintenance programs (MMPs). Indeed, it was nice to see different parts of the world catching up.

At Rikers, our MMP requires patients to be involved in methadone maintenance on the outside and to qualify by criminal charges before continuation of methadone. We implement methadone detoxification for heroin-addicted patients experiencing withdrawal and for patients being transferred to prison facilities where methadone is not continued. Many of us see methadone utilization as compassionate care with the now acknowledged benefit of discouraging needle sharing.

I had a hard time imagining our jail actually implementing NEPs in prisons and provision of bleach for sterilization of shared injector equipment. I read with interest the recognized realization that injector equipment is considered contraband and there are security concerns regarding its use as weapons. Now I'm reminded *we're* behind.

The importance of prison/jail HIV/AIDS issues cannot be over-emphasized. The reality that jails and prisons are a significant part of communities is clear and undeniable. Learning that other countries grapple with these issues, and that some go leagues beyond us in their interventions, is heartening even for those institutions that have implemented different strategies to diminish the spread of HIV within corrections, and hopefully influence safer behavior outside our walls. It helps to remind us of why we have these critical prevention efforts to begin with. I once read that a prison system in Scotland actually provides a "shoot-up gallery" for their inmates. Now that's really thinking outside the box.

Karl Brown, MD FACP
Infectious Diseases Supervisor- Rikers Island

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In accordance with the Accreditation Council for Continuing Medical Education Standards for Commercial Support, the faculty for this activity have been asked to complete Conflict of Interest Disclosure forms. Disclosures are listed at the end of articles. All of the individual medications discussed in this newsletter are approved for treatment of HIV and hepatitis unless otherwise indicated. For the treatment of HIV and hepatitis infection, many physicians opt to use combination antiretroviral therapy which is not addressed by the FDA.

SPOTLIGHT: Abstracts from "AIDS 2004": Highlights in Clinical Care

Rick Altice, MD*

The fifteenth International AIDS Conference held in Bangkok was the largest AIDS conference in history. Almost 20,000 individuals from 152 countries attended this conference and presented 8,641 abstracts in five distinct tracks. These included basic science, clinical care, social and economic issues, epidemiology and prevention and policy and program implementation. While there was considerable interest in all of the above-mentioned areas, this article will focus solely on the clinical care track in order to provide new information that may be used for the care of HIV-infected patients in the correctional system.

Several studies were presented that used existing licensed antiretroviral therapy (ART). In the CONTEXT study, PI-experienced patients (patients who failed one or two PIs previously) were randomized to receive one of two ritonavir boosted PI treatments: fosamprenavir (f-APV) vs. lopinavir (LPV). All subjects must have had a viable nucleoside analogue backbone available to them using resistance testing. There were two f-APV arms: 700mg/100mg BID and 1400mg/200mg QD. The once-daily f-APV arm was discontinued prematurely because of low efficacy outcomes, suggesting that for PI-experienced patients, f-APV should be administered twice-daily. The primary 48-week outcomes demonstrated similar efficacy between the f-APV and LPV arms with a mean VL reduction of 1.49 and 1.76 log, respectively. The proportion with a VL<50 was 46% and 50%, respectively.[1]

Three studies addressed the concern about renal toxicity in patients receiving tenofovir (TDF). These studies range from very healthy antiretroviral naïve patients without baseline renal insufficiency to patients with preexisting renal disease. In the pivotal GS 903 trial that compared TDF to D4T in healthy ART-naïve patients receiving EFV+3TC, patients receiving TDF were no more likely to have laboratory changes in creatinine, phosphorus, proteinuria or glycosuria after three years.[2] An evaluation of Kaiser Permanente patients in five clinical care settings where 199 subjects received TDF for at least three months, subtle mean increases in creatinine were noted, however no increase in phosphaturia or proteinuria was noted.[3] In a case control study of patients with mild renal insufficiency, 74 patients that received TDF were compared to 84 patients who did not. Patients with other known causes for renal insufficiency were excluded (e.g., diabetes, hypertension). The proportion with a decreased GFR (34% vs. 21%) and proteinuria (36% vs. 16%) was higher among those receiving TDF compared to those not on TDF.[4] These data suggest that TDF rarely causes renal toxicity in patients without underlying renal disease. For those with baseline renal disease, renal disease remains uncommon. Renal function, however, should be carefully monitored.

Another study clearly established the inferiority of triple NRTI therapy. The ESS40013 study examined 448 ART-naïve patients who had a sustained VL<50 copies/mL at the end of 48 weeks after receiving the four-drug combination of AZT/3TC/ABC+EFV. Patients were randomized to either reduce their regimen to AZT/3TC/ABC or continue with AZT/3TC/ABC+EFV. Patients were followed for an additional 48 weeks. Efficacy measured by VL<50 was equivalent for both groups (77% vs. 79%), however subjects receiving AZT/3TC/ABC were more likely to have virological failure (16% vs. 8%) and less likely to experience medication toxicity (6% vs. 15%) than patients continuing on the four-drug regimen. These data suggest that virological potency is low in patients receiving triple nucleoside therapy, even in patients who were successfully inducing using a potent four-drug regimen that initially included EFV.[5]

New data from BMS 045 were presented in highly ART-experienced patients randomized to ATV/r vs. LPV/r. Efficacy regarding reduction in VL was equivalent between the two groups, however metabolic complications were reduced in patients receiving ATV/r. Metabolic syndrome was diagnosed (Metabolic syndrome: abdominal obesity, TGs ≥150 mg/dL, BP (≥30 mm Hg systolic or ≥85 diastolic), fasting glucose ≥110 mg/dL, low HDL (≤40 mg/dL in men, ≤50 mg/dL in women)) in 20% of LPV/r patients, compared to 10.7% of ATV/r patients and more patients receiving LPV/r initiation lipid-lowering medications (17.9% vs. 7.5%).[6]

The use of LPV/r was found to be associated with increased hepatoxicity in patients coinfected with either HBV or HCV in 816 patients in eight clinical trials. Patients with HBV/HCV coinfection had similar virological and immunological response rates as those with viral hepatitis, however the proportion with ALT >5 times the upper limit of normal was 16% compared to only 5% in patient without HBV/HCV. Death (1-2%) and discontinuation of medication due to adverse side effects (7%) did not differ between those with and without HBV/HCV infection.[7]

Important new data regarding pregnancy and HIV treatment were available. The complications of pregnancy were evaluated in 472 patients at one U.S. medical center from 1985 to 2003. Dramatic increase in preeclampsia (0.4% to 6.4%) and fetal death (0% to 4.2%) in 2001-2003 period compared to earlier time periods when less than three combination therapies were used. The only factor associated with this increased morbidity was duration of HAART therapy. Fortunately, there were no HIV transmissions in the most recent time period suggesting that HAART markedly reduces HIV transmission, however at increased risk for women on prolonged therapy.

Two studies examined pharmacokinetics of ART therapy in pregnant women in the third trimester. LPV levels (AUC and Cmin) in third trimester were significantly lower during the third trimester than in post-partum and historical controls. Ten out of the 12 women studied did not meet the target AUC exposure, suggesting the need for increased dosing. Until data are available using increased doses, LPV/r should not likely be used during this time period, and if it is, it should be used with guidance from therapeutic drug monitoring.[8] In another study, NVP AUC levels were decreased with pregnancy, however the Cmin was not adversely affected. This suggests that NVP may be used in pregnancy, but used with extreme caution in women with higher CD4 counts.[9]

DISCLOSURES:
**Consultant and Speaker's Bureau: Pfizer, Abbott, BMX, Boehringer Ingleheim, DuPont, Roche, GlaxoSmithKline, Gilead, OrthoBiotech, Merck*

REFERENCES:
1. Elston: MoOrB1055
2. Stazweski: WePeB5917
3. Horberg: WePpB2066
4. Mauss: WePeB5941
5. Markowitz: LbOrB14
6. U Iloeje. WePeB5957.
7. Chihrin: MoPeB3281
8. Stek, LbOrB08
9. Haberl, TuPeB4644

SAVE THE DATES

Infectious Disease Society of America
September 30 - October 3, 2004
Boston, MA
www.idsociety.org

ProVisions IX, the Northeast Multicultural Conference on HIV/AIDS
October 13 - 15, 2004
New Haven, CT
Call: Carla Giles, Program Committee Co-Chair
203.688.3184
Email: Carla.Giles@ynhh.org or Leif.Mitchell@yale.edu.
Visit: www.provisionsct.org

Chest 2004
October 23 - 28, 2004
Seattle, WA
Call: 847.498.1400
Fax: 800.343.2227
Visit: www.chestnet.org/CHEST/program/index.php.

Practical Management of HIV: A One Day Regional Workshop Covering the Practical Aspects of HIV Management
October 25, 2004
Sturbridge, MA
Call AAHIVM: 310.278.6380 or NEAETC: 617.262.5657
Visit: www.aahivm.org or www.neaetc.org.

44th Annual ICAAC
October 30 - November 2, 2004
Washington, DC
Call: 800.974.3621
Visit: www.asm.org

7th International Conference on Healthcare Resource Allocation for HIV/AIDS
October 3 - 4, 2004
Washington, D.C.
Visit: www.iapac.org

HIV Mini-fellowship Program
November 8, 9, 10, 2004
University of Texas Medical Branch, Galveston, TX
Call Victoria Korschgen: 409.772.8799
Email: vikorsch@utmb.edu

IN THE NEWS

FDA Approves Truvada™
(One Pill Once Daily)
Gilead Sciences recently announced that the FDA has approved Truvada™ (emtricitabine and tenofovir disoproxil fumarate), a fixed-dose combination of the company's anti-HIV medications of Emtriva® and Viread®. Truvada™ combines 200 mg of emtricitabine and 300 mg of tenofovir disoproxil fumarate in a single tablet, taken once daily in combination with other antiretroviral agents, potentially making it easier to construct convenient combination regimens.
Press Release, Gilead Sciences, August 2, 2004.

FDA Approves Epzicom™
(One Pill Once Daily)
Epizcom™, a new product by GlaxoSmithKline combining two HIV medicines into one tablet dosed once a day with no food or fluid requirements, was recently cleared for prescription use by the FDA. Epzicom™ combines two widely-used nucleoside reverse transcriptase inhibitors (NRTIs), Epivir® (lamivudine, 3TC) and Ziagen® (abacavir sulfate, ABC) for use in combination with other antiretroviral drugs. Epizicom™ tablets are recommended for use in combination with antiretroviral drugs from different pharmacological classes and not with other nucleoside/nucleotide reverse transcriptase inhibitors.
Press Release, GlaxoSmithKline, August 2, 2004.

Invirase® 500 mg Tablet Granted FDA Priority Review
Roche announced that the FDA has granted priority review status to the New Drug Application (NDA) for a 500 mg tablet formulation of its HIV protease inhibitor, Invirase® (saquinavir mesylate). If approved, the new formulation of Invirase may simplify dosing regimens by reducing pill count for each dose by more than half (from five pills to two, twice-daily). Ritonavir should be taken at the same time as Invirase. Invirase and ritonavir should be taken within two hours after a meal.
Press Release, Roche, August 17, 2004.

Study: High prevalence and late diagnosis of HIV among Black men aged 40-54 in NYC
Of 40-54-year-old Black males living with HIV/AIDS (PLWHA) diagnosed since June 2000 (n=1,523), nearly one in three had concurrent HIV/AIDS (31.4% of new HIV diagnoses) according to a study reported at the Bangkok International AIDS Conference. Since New York City began HIV reporting in June 2000, non-Hispanic Black men have comprised the largest group of PLWHA and new HIV and AIDS diagnoses. Prevalence among Black men varies by age and geography, as do concurrent HIV/AIDS diagnoses, suggesting barriers to access to testing and care. The authors concluded that prevalence of HIV/AIDS is high in Black men aged 40-54, particularly in Manhattan, while Brooklyn has the greatest number of PLWHA. The high rate of concurrent diagnoses in 40-54 year-old Black male PLWHA, especially among those born outside the U.S., indicates that many were long-infected but not tested until symptomatic. Late diagnosis may delay entry to primary care and preventive counseling.
NATAP - www.natap.org

Study: Prednisone Ineffective Against HIV-Associated Pleural Tuberculosis
Prednisone, a glucocorticoid that is sometimes added to anti-tuberculosis drug regimens, should not be used to treat HIV-infected patients who have pleural tuberculosis, nor is it recommended for those with pleural tuberculosis who are not coinfected with HIV, according to a recent study. In a double-blind, placebo-controlled study of prednisolone in 197 patients with HIV-1-associated pleural tuberculosis. Investigators found that the drug had no effect on survival but did increase the risk of AIDS-related cancer Kaposi's sarcoma. This recommendation does not extend to other uses of prednisolone, such as treatment of pericardial tuberculosis or Pneumocystis carinii pneumonia, for which the drug can prolong or save lives, regardless of the patient's HIV status.
The Journal of Infectious Diseases, August 5, 2004.

RESOURCES

Official online abstracts of the XV International AIDS Conference published by eJIAS:
www.aids2004.org

Information on prison-based needle exchange programs:
http://www.aidslaw.ca/Maincontent/issues/prisons.htm

Information on harm reduction in prisons:
www.aidslaw.ca/Maincontent/issues/prisons/NEP_150604.PDF

Updated series of 13 info sheets on HIV/AIDS in prisons:
www.aidslaw.ca/Maincontent/infosheets.htm#isohaap

Self-Assessment Test for Continuing Medical Education Credit

Brown Medical School designates this educational activity for 1 hour in category 1 credit toward the AMA Physician's Recognition Award. To be eligible for CME credit, answer the questions below by circling the letter next to the correct answer to each of the questions. A minimum of 70% of the questions must be answered correctly. This activity is eligible for CME credit through March 31, 2005. The estimated time for completion of this activity is one hour and there is no fee for participation.

1. Correctional systems that have implemented condom distribution and/or needle exchange have:
   a) Experienced a surge in use of condoms and needles as weapons
   b) Increased HIV transmission among inmates
   c) Frequency of rape among inmates
   d) None of the above

2. According to the World Health Organization study of risk behavior among injection drug users (IDUs), over half of respondents reported a history of imprisonment since commencing drug injection. True or False.
   a) True
   b) False

3. Outside prisons, the implementation of needle exchange or distribution programs is:
   a) Supported by evidence showing that they are an appropriate and important public health measure
   b) Recognized by the CDC as one component of a pragmatic public health response to the risk of HIV transmission among IDUs
   c) Mentioned in a policy brief by three United Nations agencies as a means of stepping up HIV prevention measures in prisons
   d) All of the above

4. According to a recent study, the percentage of European prison systems that make condoms available to inmates is closest to:
   a) 0
   b) 25
   c) 50
   d) 100

5. All of the following statements are true except:
   a) Methadone maintenance treatment (MMT) is a highly effective treatment for heroin-dependent IDUs in terms of reducing mortality, heroin consumption, and criminality.
   b) MMT may increase high-risk injecting behavior and the spread of HIV in prisons.
   c) The Canadian federal prison system expanded access to MMT after demonstrating that it has a positive impact on release outcome and institutional behavior.
   d) People who are on MMT prior to incarceration and who are then forced to withdraw from methadone because they are incarcerated often return to narcotic use within the correctional system.

6. Studies have shown that among IDUs, incarceration leads to a decreased risk of needle-sharing behavior. True or False.
   a) True
   b) False

IDCR Evaluation

5 Excellent 4 Very Good 3 Fair 2 Poor 1 Very Poor

1. Please evaluate the following sections with respect to:

	educational value	clarity
Main Article	5 4 3 2 1	5 4 3 2 1
Spotlight	5 4 3 2 1	5 4 3 2 1
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2. Do you feel that IDCR helps you in your work?
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