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VOLUME 7 ISSUE 8

NEWS & VIEWS

AUGUST 2013

INSIDE THIS ISSUE

Meet Shirley Client Advisory Committee Member

Name: Shirley Rule - Member

How long have you been a client of ODC? Eight years, I am very happy that I found Open Door, they have giving me great care from the start.

How long have you been on the CAC? I have been an active member for five years

What types of things do you want to see done on the CAC? To keep helping the clients, improve the services and to help the clients live a better quality of life through getting them information.

Describe your family (define family however you want) I truly believe that my family has giving me the love, strength and support to me so that I can keep myself healthy.

What do you enjoy doing in your free time? I like to take walks, participate on the social committees that the CAC has and last but not least take care of my family and friends.

Where is the farthest place from home you have ever been? The furthest I been to the South east is Florida I went to Universal Orlando Resort and to the West I went to Aurora Colorado to visit friends.

What is your favorite food? Tofu and Chicken

What one thing do you want to do that you haven't done yet? I would like to go back to school and my degree in counseling or something that I am able to help others.

Who is the most impactful person in your life or most impactful person on humanity (dead or alive)? GOD, My mother is not here, she is the one that inspired me to be the woman that I am today. She went back and got her GED and then went to college and got her degree in teaching at the age of 40. She was a teacher for two years before she past from this earth.

What have you learned since being on the CAC? That no matter what race, sexual preference or orientation you are that we can come together as one to help make a difference in someone's life.

CAC MEET AND GREET!

PIZZA PARTY

Come join the Client Advisory Committee as we recruit new members.

The Client Advisory Committee will be holding 2 open meetings. The first was held on 7/18 in Aurora. Come meet the members, learn what the CAC does, hear about opportunities to join and become part of the team. It will also be a chance for the committee to meet clients and receive valuable input and suggestions that they can take back to help improve or enhance services at Open Door.

August 15, 5:30 Elgin Clinic

Please let us know you plan on attending by contacting Bryan Gooding 847-695-1093 x23

Open to clients only

August 10th First Congregational church of Geneva will be hosting the second annual Open Door Clinic School Supply Picnic Event.

And this year we have a special treat for everyone! We will have a Fire Truck that will be giving free rides to those in attendance.

Once again, the men's group from the church will be grilling hot dogs, hamburgers and corn on the cob. All attending can bring sides to share if they like.

Pre-assembled backpacks will be available based off school supply lists

So mark your calendars for—

AUGUST 10TH from 4pm - 7pm

What Is Most Pressing Issues In HIV Care Today?

TheBodyPRO.com

In terms of HIV care in the U.S., we've certainly come a long way in the 30 years since the virus was discovered. People with full access to care are generally living long and healthy lives, thanks to potent antiretrovirals and support from care providers, advocates and community activists alike. However, there are still many barriers when it comes to getting patients into care and on treatment, achieving undetectable viral loads and reducing inflammation and comorbidities.

We asked some of the leading experts and advocates in HIV care what they think is the biggest obstacle we still need to overcome. These interviews were conducted at the 20th Conference on Retroviruses and Opportunistic Infections in Atlanta, Ga., earlier this year.

Access to Treatment

"My research is focused on eradication and actually curing people, but right now what people need is treatment. Treatment is very good, but everybody's got to have access to it. It's not as big a problem in the U.S., but certainly internationally. Treatment's extremely good. That's one of the reasons why there's a lot of attention shifting to: How do we actually cure people?"

Non-HIV Primary Care

"What I spend most of my visits with my patients on is actually everything other than HIV.

"In other words, the virus is controlled, the CD4s are doing well, the regimens are minimally intrusive. So it's depression, blood pressure, sugar control, weight, exercise. It's internal medicine, the rest of health, because we've done a pretty good job in finding the right regimens that control the virus and don't cause a lot of problems.

"Of course, there are some toxicities -- diarrhea or whatever it may be -- or people that don't like their regimen, the number of pills or what have you. Nevertheless, that's a minor part of our visit. We focus most of the time on the rest of medicine, which is obviously great in a lot of ways. We've done the hard work and now we can focus on the 'easy' part, which is: It's tough to have a healthy life sometimes."

Fighting HIV Stigma and Ignorance

"The thing I think that's not getting discussed in proportion to its importance is stigma, trauma, ignorance, silence, denial -- all these things that feed off each other. You could have the best clinic in the world, but if right outside the door, in your neighborhood, people's notions of HIV are from the '80s, they're not going to come to your clinic.

"We've got a long way to go in adjusting to where people live and what their notions of what HIV are."

Inflammation and Accelerated Aging

"I think the most pressing issue is inflammation. We know that patients with HIV -- especially those with chronic infection -- suffer with a lot of inflammation, which leads to accelerated aging, grinding down on the organs (heart, brain, kidney) and other issues. We don't really have an effective strategy for managing this.

"I think a lot of our therapies are very anecdotal -- aspirin, statins, diabetic control -- but I don't think we have any very specific agents to address this on a global level, in terms of decreasing inflammation in patients in a way that's going to make a clinical difference.

"I really welcome hearing about how I can better manage my patients, especially those that are aging and I know have had ongoing inflammation for years.

Funding for Health Coverage

"Continued federal funding for those who are uninsured and underinsured. For states like Georgia, North Carolina, potentially Texas, we're not going to do Medicaid expansion right away. If we don't have these continued Ryan White funds, we won't be able to provide care."

Emerging Comorbidities

"What I see now for HIV care -- the stable, in-care patients -- is all the other things in life they're running into: problems with aging that we think may be accelerated by underlying HIV, even well controlled; some of the other complications that have emerged, including sexually transmitted hepatitis C [among] HIV-infected MSM; new manifestations of old [complications] and possible new infections that are being introduced, including increases in syphilis as our patients are getting more used to being healthy.

"So I think our biggest challenges are now going to be continuing to live a full life and not running into extra risks or extra morbidities, either from the HIV infection itself or from other behaviors that come with living longer and having other consequences."

Access to Care

"In the [United Kingdom], we have free delivery of HIV care, so patients can access HIV care without having to forgo any resources. What we see is that system is very attractive to patients. They've got high levels of patients engaging in care, remaining in care, high levels of viral suppression and therefore low rates of complications.

"Our impression of the U.S. is that many patients find it difficult to access care or to remain in care, and therefore levels of engagement are much lower, resulting in lots of people remaining at risk of complication and therefore higher rates of complications that are avoidable with better access to HIV care."

Cultural Competence

"Culturally incompetent service providers are one of the first barriers impacting care. Also, transportation [to care facilities] and the other health disparities that people are dealing with. They should be put on the forefront, because those are the most pressing issues in a person's life.

"Mental health: If you don't have a good mind, how can you see about taking medication every day? If you don't have a place to stay, how are you going to take your medicine? It's all those things."

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No Evidence of Premature Aging Effect in HIV-Positive Patients

Similar to some other conditions including diabetes, hyperlipidaemia and rheumatoid arthritis, HIV-positive people are at higher risk of developing serious age-related co-morbidities including myocardial infarction and kidney and liver disease. It is still unclear whether HIV-positive patients experience these conditions at similar or younger ages compared to HIV-negative individuals and this is often discussed under the contentious concept of accelerated and premature aging.

Keri Althoff and colleagues from the Veterans Aging Cohort Study (VACS) compared mean age at diagnosis for myocardial infarction (MI), end stage renal disease (ESRD) and non AIDS defining cancers, and also compared their incidence by HIV status.[1]

Premature aging was defined as differences in mean age at MI, ESRD and cancer diagnosis. All analysis were adjusted for race, sex and body mass index (BMI), alcohol use, cigarette smoking, hepatitis C infection, anaemia and diabetes. Myocardial infarction and end stage renal disease analysis only were adjusted for hyperlipidaemia, lipid lowering medication, hypertension, anti hypertensive medications and statin use.

The analysis was based on data collected from 2003 to 2008 on >100,000 patients with HIV-positive cases matched by age, race and ethnicity 1:2 to HIV-negative controls from the same cohort. HCV was more common in HIV-positive people (35% vs 15%) but diabetes (17% vs 25%), hypertension (25% vs 38%) and dyslipidaemia (36% vs 44%) was more common in HIV-negative people.

In the HIV-positive group, 19% had a CD4 count <200 cells/mm^3, 61% had undetectable viral load (<500 copies/mL) and 25% had an AIDS diagnosis. PI-based and NNRTI-based were each used by about 45% of people on ART. Mean age was 55 (+/- 8) years.
Mean age for each of the primary endpoints are detailed in Table 1 and although incidence rates remained higher for HIV-positive vs. -negative people, there were no differences in the adjusted analyses for age at diagnoses for MI and ESRD with the marginally lower age for cancers (0.7 years) unlikely to have clinical significance.

In conclusion HIV-positive individuals had a greater rate of MI, ESRD and HIV associated cancers compared to HIV-negative individuals.

There was no difference in mean age or adjusted mean age at MI and ESRD by HIV status. There was a modest difference at the age of non AIDS defining cancers in HIV patients (about 6 months younger in HIV-positive groups). There was higher incidence of Hodgkin's disease but over all no difference in the incidences of other HIV associated or non-AIDS defining cancer rates in HIV patients.

Table 1: Mean Age at Diagnosis and Adjusted Rates by HIV Status

	HIV pos (yrs)	HIV neg (yrs)	adj. mean difference, years (95% CI)	aIRR vs HIV neg (95% CI)
MI	55.3	55.3	-0.04 (-0.62, +0.64)	1.81 (1.49, 2.20)
ESRD	55.3	58.5	-0.23 (-0.69, +0.23)	1.43 (1.22, 1.66)
HIV-related cancer **	54.9	57.8	-0.57 (-0.93, -0.21)	1.84 (1.62, 2.09)
Other cancers	58.5	58.7	-0.45 (-0.78, -0.12)	0.95 (0.85, 1.06)

** HIV-associated cancers were defined as anal, lung, liver and oral/pharynx cancers and Hodgkin lymphoma.

Even when a small age difference was found, the different risk factors and pathogenesis in HIV-positive people are likely to explain this which is very different to the less scientific concept of premature aging.

An analysis by Kathy Petoumenos from DAD group also found limited evidence of accelerated risk of cardiovascular disease (CVD) in HIV-positive patients.[2]

The study hypothesised that accelerated aging in HIV-positive patients would mean an accelerating risk of CVD with older age, and that the increased risk per year older would be higher in D:A:D relative to the results from risk equations developed for the general population (Framingham, CUORE, ASSIGN). The researchers included 24,323 men (man age 41 years) prospectively followed in the D:A:D study (approximately 139,000 patient years of follow up) who had data collected on conventional CVD risk factors but who had no prior CVD events.

Primary events included 474 MIs, 683 cases of coronary heart disease and 884 cases of cardiovascular disease events. Crude event rates for each of these endpoints was 2.29, 3.11 and 3.65 per 1000 PYFU at age 40-45 and 6.53, 11.91 and 15.89 at age 60-65 years. They showed that there was a slowly accelerating risk of cardiovascular disease for year older and which was somewhat raised compared to the general population based on the equations for cardiovascular disease. The relative risk with MI was not different between D:A:D and the general population. The researchers did not find evidence of accelerating risk of cardiovascular disease with age in their study population.

Continued From Page 3

The Cascade

"One of the most interesting things to emerge in the last few years is this new concept of a care continuum or the cascade of care. What that shows is that we lose people from our health care system at multiple steps, multiple levels. We start out with about 20% of the U.S. population who we think have HIV, but they don't know it. Then we [have] the group of patients that are actually tested and they know their HIV status. [Then] we have a drop-off that is significant, in terms of engagement in care.

"Getting people who are HIV infected and known to be HIV infected into care is our first challenge, because we have a lot of treatments that are very effective, but if you're not in care, you can't get them.

"I think getting people into care efficiently and effectively is a huge challenge. I hope we will begin to see monitoring of that, because right now we don't really always know how many people are not linked to care.

"As we monitor that, I think we can begin to measure how well we do at getting people in care and then once they are linked to care, they have to stay in care to have effective antiretroviral therapy -- in terms of individual benefit -- and also to benefit society, in terms of HIV prevention."

Morbidity and Mortality Rates

"I think the most pressing issue is the need to decrease the morbidity and mortality of HIV-treated patients with CD4 counts above 200. That is what the biggest issue is in my practice now, as far as treatment is concerned.

"I can treat people who have AIDS with effective regimens. I can keep people undetectable when they're on [treatment], but I'm still seeing death rates that I'm not happy with, [despite] good CD4 counts. We have to have some impact on that.

"It goes along with what is going on with the patients and their cardiovascular, liver, kidney -- all these toxicities, some of which is related to drugs, but some of it is because people have had HIV for five, 10, 15, 20 years. The question is: Can we make an impact on those inflammatory pathways that have been associated with all these toxicities? Do we have markers to find these inflammatory pathways that may be a benefit to the long-term survival of HIV patients?"

Test and Treat

"There are a number of things that are important. Probably the most important is getting everybody that's infected on treatment. There are still a large number of people in the U.S. that don't know they're infected and could be treated. That would do a lot for them and also do a lot to inhibit transmission."

Non-HIV Chronic Diseases

"As an epidemiologist and researcher with the HIV Outpatient Study, I think one of the biggest issues is the burden of chronic diseases, many of which are untreated and undiagnosed or underdiagnosed and therefore shortening survival and decreasing quality of life in HIV-infected patients."

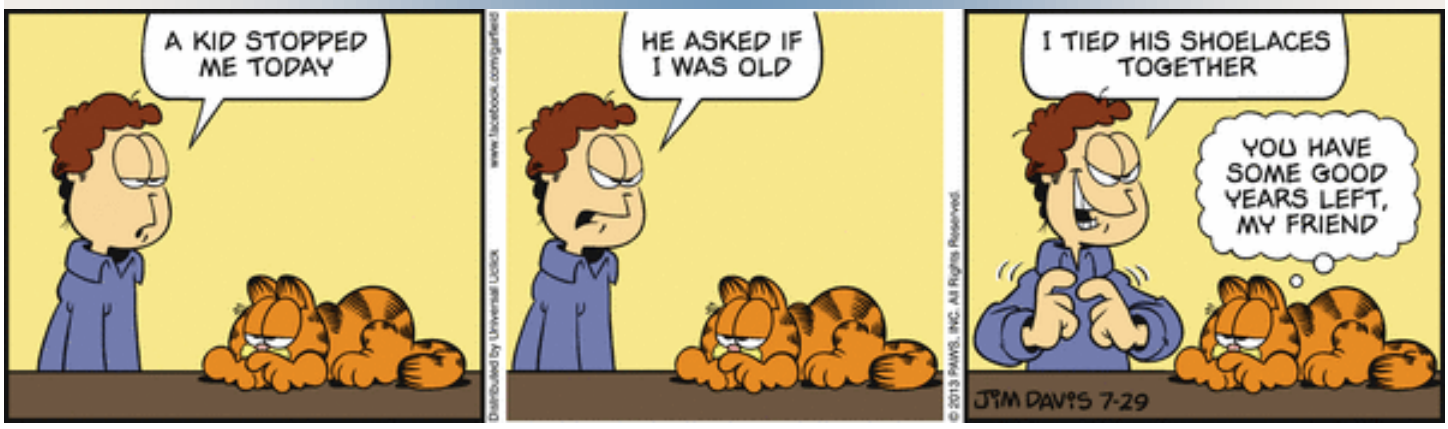
For More Information

To explore the issues raised by these HIV care providers, researchers and advocates in more depth, check out the following resources on TheBodyPRO.com:

HIV Care Today, a multiauthor blog in which care providers discuss the everyday challenges of their jobs, recent developments in their fields and issues relevant to the evolution of HIV/AIDS care.

HIV Management Today, an interview series in which top experts go in depth to discuss critical issues in HIV clinical management.

Garfield Comic



AUGUST EVENTS

01 - Positive Mental Health Support Group 3:30p - 4:30p (A)
02 - Positive Group HIV Ed 4p-6p (A)
02 - Positive Group HIV Ed 4p-6p (E)
07 - Making Stress Work 12:30p - 1:30p (W)
08 - Positive Mental Health Support Group 3:30p - 4:30p (A)
09 - Peer to Peer Support Group 4p-6p (A)
09 - Peer to Peer Support Group 4p-6p (E)
10 - FAMILY PICNIC 4pm - 7pm (G)
12 - Game Night 4pm - 6pm (W)
15 - Happy Birthday Karen (CAC - E)
15 - CAC Meeting 5:30p - 7p (E)
15 - Positive Mental Health Support Group 3:30p - 4:30p (A)
16 - Game Night Positive Support Group 4p-6p (A)
16 - Bingo Positive Support Group 4p-6p (E)
20 - Newsletter Available at the Clinics
22 - Positive Mental Health Support Group 3:30p - 4:30p (A)
23 - Combined Positive Support Group 4p - 6p (G)
26 - Game Night 4pm - 6pm (W)
29 - Positive Mental Health Support Group 3:30p - 4:30p (A)

(A) Aurora
(E) Elgin
(LA) Love & Action
(G) Geneva -1st Cong. Church
(W) Wheaton - Canticle Place

Dates are subject to Change
Please call to verify dates

Questions and Answers

Q **Dosing Adjustment**

I have started medication in February of this year and with good success - no major side effects and viral load undetectable after just one month. I am using Truvada (once a day in the a.m.) and Isentress (2 x a day, one in the a.m. and once in the p.m.). As I take one Isentress at night sometimes it is later than planned and I am worried about forgetting. Given that the viral load is now undetectable, and to improve adherence in the future, do you think it is safe/ok to take all pills at once - that is take Truvada plus 2 x Isentress in the a.m.?

A Sounds like you're doing very well on your current regimen. You correctly point out that adherence is an important aspect to the success of your health program.

Raltegravir is recommended as a twice-daily medication; in the QDMRK study, those people who were randomized to take once-daily were slightly more likely to have treatment failure than those who took the medication twice daily. Now, it might be a different scenario if one was already suppressed on twice-daily and was to consider switching to once-daily; it's just that the data to support this isn't there.

So for now, what I recommend to my many patients on raltegravir regimens is to take the medication twice daily, but if you miss a dose to simply catch up by taking the two pills together

Q **Responsable Meds and Checkups**

Thanks a lot for the previouse response to the choice on starting medication for the first time. It was REALLY reasuring information. Here in Peru there is no truvada but you're alowed to import it only for personal use. That's what I'm doing now. the question:

-How soon does the treatment start taking effect? (-->how soon is it worth to do another round of labs after starting meds for the first time?)

-after the first post-treatment labwork checkup, how offten would be the IDEAL timeframe for regular VL and CD4 counts? other labs to check on kiddney/ liver/cholesterol?

last but not least...

- I'll have to move countrys next year as I'm starting a residency (saddly not in infectious medicine) and will then probabbly only be able to do VL and CD4 once a year for 3 years(when I come back home) is it dangerous to only check labs once a year?

-there is truvada available where I'm going but no stocrin. They have CIPLA-Efavirenz there, do you know that manufacturer? is it trustworthy?

(on the CIPLA webpage I found another product "ODIMUNE" that has a composition similar to Atripla, is it a viable/ TRUSTWORTHY alternative? (could be a lot cheaper for a lot of people)

Thank you very much for your time and pacience, reassurence from expert guidance like yours makes all this a lot easyer to bear.

A 1) Treatments work quite quickly-- though the answer depends on what aspect of work you're asking about. Viral loads should drop to undetectable levels in a matter of a few months; CD4 cell counts will rise between 100-250 cells in the first year (and generally continue upwards afterwards).

2) In the first year of treatment, I generally recommend getting quarterly clinic visits (more frequently if you're ill or have a very low CD4 cell count). Here in the US, we'd obtain a VL and CD4 count test at each of these visits. Later, if adherence is established, VL undetectable and CD4 count reproducibly above 350, we can decrease the frequency of laboratory monitoring- to even once annually.

3) See #2.

3b) You can still do HIV medicine even if one is not infectious disease trained.

4) Cipla is a well recognized generic drug manufacturer from India. I'd have no significant concerns about the Cipla product.

IF YOU ARE INTERESTED IN GETTING THE OPEN DOOR CLINIC'S MONTHLY NEWSLETTER VIA E-MAIL OR HAVE ANY TOPICS THAT YOU WOULD LIKE TO SEE IN THE NEWSLETTER.

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