



keep taking the pills

The Birchgrove

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Bath

Success

A brief report

NATIONAL BIRCHGROVE CONFERENCE REPORT

BATH 24TH - 26TH JULY 1998

INTRODUCTION

The 5th National Birchgrove Conference was held at the Stakis Hotel, Bath, over the weekend of 24th - 26th July 1998, on the theme of "Treatments and Alternatives". The intention of the conference organisers was to provide a forum for discussion of conventional combination therapies and complementary treatments for haemophiliacs co-infected with HIV and Hepatitis C.

Friday 24th July

REGISTRATION AND WELCOME

Delegates from all over the country began to arrive at the Stakis early on Friday afternoon. Registration was completed by 7.00 pm with a total of 60 delegates in attendance. Rather than scheduling seminars for Friday evening, this time was set aside for old acquaintances to be renewed and for first time attendees to meet with and get to know the old hands. A three course dinner was arranged for 8.00 pm in the Willow Suite, where a fine meal was accompanied by some lively discussion on the business of the conference.

Afterwards, people retired to the main bar where the talk continued into the early hours. The atmosphere throughout the evening was relaxed and convivial, and there appeared to be a note of cautious optimism about the future.

Saturday 25th July

HIV/HEPATITIS C CO-INFECTION

Following a hearty breakfast, delegates decamped to the Willow Suite for the first Seminar. Cady Khudabux, on behalf of the National Birchgrove Steering Committee, welcomed the delegates to Bath and introduced them to other members of the organising committee. He outlined the agenda for the weekend and then introduced the first

speaker, Nigel Hughes, the Clinical Nurse Specialist at Preston Hall Hospital, Maidstone in Kent. Nigel gave a lively and informative talk on HIV and Hepatitis C co-infection, speaking for approximately 45 minutes on a number of issues relating to this topic, including current treatments with alpha-interferon, and also the long-term prognosis for those who were co-infected. Subsequently, questions were invited from the floor and the number of people wishing to put questions to Nigel was indicative of the high level of interest his talk had generated.

MACFARLANE TRUST OPEN FORUM

After a break for tea and coffee, there was an Open Forum with three representatives from the Macfarlane Trust describing the workings of the Trust and their roles and responsibilities within the organisation. Tim Hunt, Fran Dix and Anne Hithersay gave delegates a valuable insight into the Trust's policies and procedures on a number of issues, ranging from how decisions are made regarding grant awards, to the criteria needed to apply for such grants. Enthusiastic delegates raised a number of pertinent questions on past decisions and on the future direction of the Trust.

CHILDREN'S TRIP TO BRISTOL ZOO

The Birchgrove Children and Families worker, Martha Cirino, with the help of volunteer Choy Sterio, had organised a children's day out at Bristol Zoo. A total of seven children were taken by train to Bristol in the morning, thus allowing their parents to attend the day's seminars. All the kids were returned safe and sound to the Stakis at around 4.30 on the Saturday evening.

ATP: COMBINATION THERAPIES

After the morning's sessions, lunch was served between 1.00 and 2.00 pm, with delegates returning to the Willow Suite for the main business of the afternoon, a question and answer session on the latest

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news regarding Combination Therapies. This talk was conducted by Rafi of the AIDS Treatment Project and provided a platform for delegates to voice their fears and concerns regarding a wide variety of treatment issues. With different levels of knowledge emanating from the delegates, Rafi managed to conduct the discussion at a level which seemed to offer something to everyone. Issues raised included when was the best time to begin treatment; what was meant by CD4 counts, viral load tests and HAART; the consequences of delaying treatment; the different classes of drugs, i.e., nucleoside analogue reverse transcriptase inhibitors (NRTIs), such as AZT, DDI, 3TC and D4T, non-nucleoside analogue reverse transcriptase inhibitors (NNRTIs), such as Nevirapine, Delaviridine and DMP 266, and protease inhibitors (PIs) such as Ritonavir, Indinavir and Saquinavir. Other issues discussed related to drug side-effects, and when and if it would be possible to cease drug treatment.

Rafi also gave delegates up to the minute feedback on developments at the recently held World AIDS Conference in Geneva. While some of the news was relatively depressing – for example on the serious side-effects connected with long term treatment on Protease Inhibitors, other news struck a more cautiously optimistic note. Doctors and AIDS specialists were developing what had been termed 'Protease Sparing Regimes' for treating HIV infection, and there was talk of new NRTIs being available in the near future, as well as the development of a whole new class of anti-HIV drugs.

The seminar ran for over two hours, with a coffee break in between, and while there was a lot of information to take on board, much of it new to many delegates, it proved to be an interesting and informative session.

MEAL AND DISCO

In the evening, another three course dinner was followed by a disco in the Willow Suite. This provided ample opportunity for various delegates and steering committee members to make spectacles of themselves either on the dance floor, or through their truly appalling taste in music. The disaster of the Haemophilia Society's soon to be wed HIV worker ending up having a midnight dip in the Stakis lake, courtesy of a number of female delegates, was narrowly averted by the judicious – and as yet unrewarded – intervention of two members of the steering committee. That he didn't get ducked perhaps indicates the high esteem in which he is held. Or maybe not, as the case may be.

Sunday 26th July

TRADITIONAL CHINESE MEDICINE

Unfortunately, the representative from John Tindall's Gateway Clinic in London, scheduled to give a talk on Traditional Chinese Medicine, did not turn up. Instead,

Mike O'Driscoll gave a talk on the subject from a patient's point of view. Mike had been using Chinese Herbs for two years in the treatment of both his HIV and Hepatitis C infections. He explained how the initial consultation with John Tindall was designed to enable the practitioner to gain an overall picture of the patient's health and well-being, with particular attention being paid to specific indicators – pulse, respiration, tongue, mental and emotional health, etc. A prescription was then drawn up by the practitioner, which could include up to twenty or thirty different Chinese Herbs in various quantities. Whilst the consultation with John Tindall is free of charge, the patient has to pay for the herbs, which, according to the prescription, can vary in cost up to £35.00 for a months supply.

Treatment consists of boiling a quantity of herbs in a litre of water, straining and reserving this mixture and then repeating the process. The resultant liquid was enough for four days treatment, which consisted of approximately half a cup drunk twice a day. The liquid could be drunk hot or cold, but Mike advised that it was best to drink it down in one quick gulp, and have something more palatable at hand to get rid of the unpleasant aftertaste. Mike talked for about twenty minutes and then answered questions from delegates. From a personal point of view, he told the conference that he felt the herbs had had a beneficial effect on his health, and that it was a shame that a representative from the clinic had not turned up, as they did have statistical evidence to show such benefits to health.

HAEMOPHILIA SOCIETY'S HIV WORKER

Steve Fouch held a question and answer session during the second half of the morning. Steve, the Society's HIV worker, explained his role within the society and how it related to the Birchgrove Group. He is closely involved in projects with both National Birchgrove and Birchgrove Wales, and sees part of his role as developing links with local Birchgrove groups in other parts of the country – the North-west, north-east, East Anglia and the Midlands, for example. He also intends to encourage other HIV+ haemophiliacs that he may come into contact with, and who have not previously had any links with Birchgrove, to get in contact with the group.

Again, this was an interesting and informative session with lots of questions from the floor. Given that this was largely an impromptu session, due to the non-appearance of the Chinese Herb specialist, delegates felt that it was worthwhile in that it gave people a chance to meet Steve and gain an understanding of his role.

Sunday Lunch was served between 12.30 and 2.00 pm, after which the conference drew to a close, with delegates returning to all corners of the country.

RESISTANCE

KEEP TAKING THE PILLS

After a person is infected with HIV, many different strains of the virus appear over time as the virus copies itself. Each new generation has tiny differences, or mutations, in its structure. Some of these mutations occur in the parts of HIV which are targeted by anti-HIV drugs. This can result in strains of HIV that are less vulnerable to treatment.

When an anti-HIV drug is started, HIV strains that are highly vulnerable to the drug disappear rapidly. This leaves strains behind that can copy themselves despite the drug's presence. In time, the 'pool' of viruses will include fewer and fewer drug-sensitive strains and more and more resistant ones. These may or may not be capable of harming the body.

Resistance is an important reason why many anti-HIV drugs have only limited or short-term effects.

Whenever HIV is still able to reproduce in the body of someone who is taking anti-HIV drugs, it is extremely likely that resistant strains will eventually emerge, and the viral load will increase. This increase is sometimes called viral load 'rebound'.

MINIMISING THE RISK OF RESISTANCE

Using two or more anti-HIV drugs at once, known as combination therapy, delays resistance, because viruses that are resistant to one of the drugs may still be controlled by the other(s).

Studies have shown that the risk of viral load rebound is related to the point to which viral load falls after starting treatment, called the 'nadir'. The lower the nadir, the lower the risk of rebound, and therefore the risk of resistance.

People whose viral load falls, and remains, below 50 copies are at a much lower risk of developing resistance. However, resistance may emerge even in these people over the longer term. (Most viral load tests currently in use in the UK measure viral load to a lower limit of 400 or 500 copies. Ask your doctor about the tests available in your clinic).

Adding or changing a single new drug to a combination which is not suppressing viral load is likely to lead to the development of drug resistance, because the impact of that single new drug is likely to be insufficient to block replication. Experts now advise that treatment changes should always include at least two new drugs, wherever possible.

Continuing with the same drugs after your viral load begins to go up can also encourage the development of resistance. This is because resistance to some drugs develops progressively; as more resistant mutations accumulate, sensitivity to the drug will fall. However, resistance to drugs emerges at different speeds. For example, 3TC and nevirapine resistance emerges very quickly, but d4T and ddC resistance emerges slowly.

Also, people whose viral load remains high or rebounds whilst taking anti-HIV drugs may still experience a rise in CD4 count, and delayed disease progression. Though resistance is a common reason for viral load rebound, it is not the only reason.

It is important to take anti-HIV drugs exactly as they have been prescribed, by sticking rigidly to the suggested dose and timetable, and observing instructions about food.

Taking too little drug (by missing or reducing doses) could allow drug levels in the blood to fall to inadequate levels, allowing viral replication to occur and increasing the risk of the emergence of resistance.

CROSS-RESISTANCE

Single mutations, or sets of mutations, in the virus can produce resistance to several different drugs. This means that once resistance to one drug has emerged, this virus population may also be resistant to drugs you haven't taken yet.

This is called cross-resistance and may affect all currently available anti-HIV drugs to a greater or lesser extent. For example, it is possible that if you develop resistance to a protease inhibitor or a non-nucleoside reverse transcriptase inhibitor (NNRTI), you will also be resistant to all others in the same group.

RESISTANCE TESTING

Several tests are being developed to detect which drugs you are resistant to and your level of resistance to them. It is not currently known how useful these tests will be in guiding treatment decisions.

DISCLAIMER

The views expressed in each of the articles are those of the individual authors, and not necessarily those of the Birchgrove Group.

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Two Three or Maybe FOUR BY DR STEPHEN ASH

One reads reports of clinical trials of new drugs and combination therapy and how good they are at producing quite dramatic drops in viral load (expressed as multiple log falls*) and rises in CD4 counts. But how well are things going in the real world outside of clinical trials?

Certainly there are reports of hospital wards closing due to reductions in the numbers of opportunistic infections in people who have responded to HAART (highly active antiretroviral therapy). On the downside we have heard about problems with HAART, for example drug failure due to viral resistance, and side-effects such as lipodystrophy – abnormal distribution of fat in the body.

It is more than two years since patients at Ealing Hospital were first offered HAART (which in practice has usually meant triple combination therapy including a protease inhibitor) and it seems like a good idea to take stock of the situation and see what can be learnt. Although the following data is very preliminary, it gives a rough idea of trends and responses to HAART we have encountered.

Over 50 patients are on triple or quadruple therapy at Ealing Hospital, in most cases including at least one protease inhibitor. The majority of these patients are gay males as we would expect from the pattern of infection.

However, over forty per cent are heterosexual and almost twenty five per cent are women.

More than eighty per cent of those starting HAART achieved an undetectable viral load (less than 200 copies/ml) within four months. Most of the twenty per cent who didn't achieve this goal hadn't taken the drugs regularly as advised. However, about half of all patients on HAART had to change their therapy in the first year. About one third changed a single drug due to side effects, although their viral load was less than 200.

The remaining two thirds had to change two or more drugs on the basis of rising viral load. Poor compliance accounted for many of these instances, but not all. Those people with previous experience of taking antiretroviral drugs tended to be more likely to develop drug failure.

Despite all the problems of HAART, it has been a privilege to witness the amazing benefits that some patients have clearly received from these drugs. The hospital admission rate has dropped as a result of a fall in the number of opportunistic infections and other serious infections that one would have expected to see. Although this parallels the rise in CD4 count seen in most patients, even those patients with only a modest rise in CD4 count seem to get some form of protection against infections.

All this has resulted in an increased life-expectancy for people on HAART. The rate of CMV and MAI infection has fallen by ninety per cent; that of *Cryptosporidium* and *Pneumocystis pneumonia* by one hundred per cent (no new cases). The incidence of *Candida* seems to have been reduced by a more modest seventy per cent. We have witnessed the regression of Kaposi's sarcoma upon commencement of HAART, as well as some improvements in PML and HIV encephalopathy. However, there has been no improvement in the incidence of HIV-related tumours such as lymphomas.

As has been reported by other centres, the enhanced immune system response that follows HAART can be temporarily harmful. We have seen one patient with a flare-up of their CMV retinitis although this did settle fairly quickly with prompt treatment.

Additionally there have been several patients who started HAART with very low CD4 counts whose previously undiagnosed MAI of the lymph glands became obvious once the immune system became strong enough to attack the infection. This resulted in swelling and discharge from the lymph glands. Once again the eventual outcome was good thanks to rapid diagnosis and early treatment.

As time goes by, we are more and more aware of the longer term problems of HAART and we routinely monitor for all sort of complications such as:

- High blood sugar levels
- High cholesterol and triglyceride (fat) levels
- High blood pressure
- Lipodystrophy
(abnormal fat distribution)
- Osteoporosis
- Kidney stones
(associated with indinavir in particular)

Early warnings and intervention can minimise the impact of such problems.

Despite much emphasis on side-effects and worries about as yet unrecognised long-term problems with the use of many of the new drugs that make up a HAART combination, it is nevertheless clear that most people who start HAART receive enormous benefit and it appears that for most people this is an effect that can last for years.

Dr Stephen Ash is Consultant Physician in General Medicine and Infectious Diseases at the Ealing Hospital NHS Trust.

*Multiple Log Falls (of viral copies)

From 1,000 to 100 = 1 log fall (10^3 to 10^2)

or

From 10,000 to 10 = 3 log fall (10^4 to 10^1)

Dear Manor House group

I'm the partner of a dual infected haemophiliac. I have wanted to access your group for a while now but I have heard of evidence that dual infected men and their families are not welcomed within your group. This seems ludicrous to me as, is it not the fact that all these boys and men share common factors, they all have haemophilia. They were all infected with one or all of the following diseases; hep B, hep C, HIV, through contaminated blood products.

Should it not be possible for the Manor House group to work and learn from members of such groups as the Birchgrove group and the Macfarlane trust. After all we are struggling with hep C, issues as well. I feel unhappy with the knowledge that the haemophilia community is divided in this way.

Yes we have our "recompense" (ed) for HIV/AIDS, but out of 1200 infected there are only 480 still living. Surely 480 extra voices to the cause of compensation is better than no extra voices at all. Obviously we don't know if all the remaining men are hep C positive, as patients records are out of bounds to other haemophiliacs.

I have also discovered that there are no up to date national statistics at present relating to haemophiliacs with any of the afore mentioned diseases.

I would like to know how many men have never taken any treatments for HIV or HEP C? I would like to know how many men are not responding to treatments like interferon and combination therapies? What symptoms are they experiencing? We as loved ones have a

right to know these statistics! How many haemophiliacs are there alive infected with HEP C?

If every centre director in the UK allowed the Haemophilia Society to collate this valuable information, then we as a community would have some solid evidence to show the government exactly how many lives have been destroyed.

You would then have solid evidence of exact numbers of HEP C positive haemophiliacs. Also please note that dual infected men are at greater risk of liver disease or full blown AIDS/death. HEP C therefore speeds up the degeneration of the immune system.

Another point I would like to make is that my partner and I were very disappointed with the news coverage and press conference relating to the lobbying of parliament. Using speculative figures, 90% of men infected with HIV were already infected with HEP C. There was no mention of the men who have both diseases.

You have let my family and countless others down by not stressing this point to the media and parliament.

I'm sorry that you didn't get the result that you wanted but ask the Birchgrove group and the Haemophilia Society for help and maybe we can win the battle next time. Thank you for reading my thoughts and I hope this may stir all your families to unite with us isolated and still very angry old hats!

Awaiting your responses,

Claire Moirano.