



The Network News

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OREGON HIV/AIDS CASE MANAGEMENT

Thanks to Linda Drach and Kari Greene from PDES for their informative and interesting presentation on the Out of Care Study.
Also to Graham Harriman for his presentation on Title I data.

STRUCTURED HIV TREATMENT INTERRUPTIONS: SMART OR STUPID?

It has been several months since the HIV treatment world was turned on its head by the premature cessation of SMART, one of the largest studies ever to investigate any kind of HIV treatment strategy. Although many were hopeful that SMART would discover some value in a CD4-guided approach to HIV treatment interruption, SMART met an unexpectedly early demise when preliminary data indicated that patients following the CD4-guided strategy developed AIDS-related illnesses at a much higher rate than patients who remained on treatment continuously. SMART's cancellation has led to a great deal of hand-wringing over why the study went wrong, and what this bodes for the future of HIV treatment interruptions. In this analysis, Richard Jeffreys takes another look at why the SMART study was halted -- and what lessons, if any, can be learned from the results.

<http://www.thebodypro.com/tag/apr06/smart.html?mb63t> From The BodyPro Newsletter 5/30/06

Next Meeting:

July 11, 2006

"NUTRITION & HIV "

State Office Building
800 NE Oregon
Portland
Room 120-C

8:30 to 10:30 a.m.

MMWR Reviews 25 Years of HIV Prevention Efforts

For a review of the state of HIV prevention, 25 years into the epidemic, see a report in the June 2, 2006 issue of CDC's Morbidity and Mortality Weekly Report. The report examines the state of the HIV/AIDS epidemic in the U.S. since 1981. Since 1981, more than 500,000 people in the U.S. have died of AIDS-related causes and more than one million are living with HIV/AIDS. The report includes sections on successes in HIV prevention; remaining challenges in the domestic fight against the disease; the epidemiology of HIV/AIDS in the U.S.; the success in reducing mother-to-child HIV transmission; and the evolution of HIV prevention programs.

To view the report go to: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a1.htm>
From HAB informational email 06/08/06

After 25 years, HIV prevention still falling short

Twenty-five years after AIDS was first recognized, the world is in better shape than ever to put an end to the epidemic, but is falling short on many fronts, the United Nations said on Tuesday.
<http://www.aidsmeds.com/news/20060530epid002.html>

Statewide Prevention Service Available

Partnership Project's Supporting Healthy Options for Prevention (SHOP) is available in person or via the phone for those living outside the Portland metro area or those concerned about privacy. SHOP partners with individuals interested in reducing their risks around sexual and drug using behavior. Eligible clients are either those living with HIV/AIDS or those engaging in high-risk behavior. Incentives available for eligible participants. Available in Spanish and English. Contact 503-230-1202 or 1-877-795-7700.

See <http://www.ohsu.edu/partnership/SHOP.html> for more information.

<http://www.aska.hrsa.gov/>



This column is provided as a public service by Attorney Sarah Patterson (www.sarahpattersonlaw.com), by e-mail: sarah@sarahpattersonlaw.com, (503) 281-4766. Sarah is a lawyer in private practice representing claimants with HIV, and is not associated with the Social Security Administration.

Continuing Disability Reviews (CDR's)

The Social Security Administration (SSA) is required by law to devote resources to Continuing Disability Reviews (CDR's). These reviews are to determine whether people on benefits are still disabled. In Fiscal Year (FY) 2005, SSA processed 1.569 million CDR's, an increase from 1.537 million in FY 2004.

The law requires that all cases be reviewed every three years for anyone for whom medical improvement is a possibility. In the past AIDS cases have not been routinely reviewed, but with a general improved medical prognosis for many, this may change.

Some reviews are being done by mail, and some individuals may be requested to have a physical or psychological examination. Termination of benefits can be made on the basis of these exams. We have seen cases where a treating physician's records are included in a decision or used in the termination decision. Sometimes doctors' offices do not respond to requests for records from the disability determination office. Often just getting the proper records into the file will stop the review process and allow the client to continue benefits. If there has been "no change" or "no improvement" in status, a letter from a treating physician stating that may be enough to retain benefits. The legal standard is that SSA must prove that there has been "medical improvement." To cut off benefits, SSA must show that something has changed.

SSA was strongly criticized during the Reagan years when CDR's were thought to have improperly terminated thousands of beneficiaries, many of them homeless and mentally ill. SSA promises to "protect the rights" of those being reviewed with new safeguards. With such a large volume of reviews, there is the risk that errors could be made. By being aware of the processes clients and case managers can respond quickly to avoid a loss of benefits.

If any of your clients receive termination notices, file appeals immediately. There is a special form for appealing "cessation" cases, as they are called, available from any Social Security district office. The form is available at <http://www.ssa.gov/online/ssa-789.pdf>. Benefits should continue *during* the review process if the appeal is filed within ten days of the notice.

Delay in filing the appeal can be a very costly mistake. I advise people to file this in person and get a date stamped on the receipt since the date can be critical. If it is mailed in, there will be no receipt. Have your clients go immediately, in person, to their local Social Security office and file the appeal of the cessation, and get a date stamped receipt.

For more information go to What You Need To Know When You Get Social Security Disability Benefits at <http://www.ssa.gov/pubs/10153.html#6>.

We are planning in upcoming issues to highlight individuals who are working with HIV/AIDS in Title II areas. If you know of someone or a group that is making a difference in a part of the state outside the Portland EMA, please contact me with their information and story. Thank you.

Rick Stoller, 503-20-1202 stollerr@ohsu.edu



ASK DEBBY:

Are there any drug interactions I need to be aware of between dietary supplement products or herbs and HIV meds?

Dietary supplements and herbs are very popular; the supplement industry has become a thriving business. Reasons vary but include the belief that the supplements have health benefits, distrust of prescription medicine and the belief that 'natural' products are safer.

Unfortunately, despite their wide use, there are many unknowns about nutritional supplements. The companies are not required to test for effectiveness, drug interactions, safety or quality of the product as they are required to do with prescription products. There is no guarantee you are buying what is on the label, in fact there have been numerous reports of products not containing the labeled ingredients at all or at lower concentration. It is important to buy from a reputable and knowledgeable source. Many products have 'studies' supporting their use, but in most cases the study design does not hold up to strict scientific requirements so the results are subject to doubt.

Another unknown is the potential for drug interactions. HIV medications have high potential to be involved in drug interactions, so it is very important to know if there is a potential to interfere with your treatments or to increase the potential for toxicities. Most herbs and supplements have not been evaluated for drug interaction potential. Some examples of known drug interactions are St. John's Wort can interfere with HIV medications (the combo should not be used) and garlic supplements might change levels of HIV medications too.

There are many reasons that people reach for nutritional supplements, including general health support. Many studies have supported the use of a multivitamin in HIV disease. But it is possible to get too much of some vitamins including fat soluble vitamins (Vitamin A, for example), iron, zinc and vitamin B6....more is not necessarily better, talk to someone who is knowledgeable before you make decisions to start a vitamin routine.

Liver support is another reason people reach for nutritional supplements. A very common herb used for this is Silymarin (milk thistle). There may be a drug interaction potential between HIV meds and milk thistle, but it is not thoroughly understood yet.

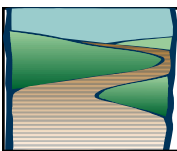
Other agents are reported to have immune support or anti-viral activity. Examples are Lysine for cold sores (herpes), Olive Leaf, Echinacea and Cat's Claw. Most experts do not recommend Echinacea in HIV disease because of the concern about possibly increasing viral load. The safety, efficacy and drug interaction potential is largely unknown about Olive Leaf and Cat's Claw in HIV disease.

Side-effect management of HIV medications is another reason people purchase supplements including Glutamine, probiotics, NAC and DHEA, in hopes to prevent or treat conditions such as diarrhea, peripheral neuropathy and weight loss.

A few nutritional supplements have been found to have toxicities such as Kava Kava (liver toxicity), Ma Huang (active ingredient is Ephedrine) and heavy metals can be present in some Chinese herbs.

In summary, talk to someone knowledgeable about both nutritional supplements and HIV disease before making the decision to start taking supplements, 'natural' is not necessarily safe. A review article entitled *Herbs, Supplements and HIV* by Project Inform can be found at: <http://www.thebody.com/pinf/pdfs/herbs.pdf>

**Ask Debby is graciously provided by Debby Parrish RPh, MPA:HA
a pharmacist who specializes in HIV**



Comings and Goings

CAP opened a Men's Wellness Center located at 928 SW Stark. Wade Meadors is the Men's Wellness Center coordinator and is the point person for activities at the Center.

Partnership bids farewell to MSW Intern Emily Graham-Berks. Thanks Emily for your work.

Hepatitis C Follow Up Information

Alison Goldstein, LCSW with Multnomah County HIV and Hep C Community Prevention Program has offered the below information as follow up to the Hepatitis C column provided last month.

HCV is transmitted by direct blood-to-blood contact. An infected person must emit blood and a non-infected person must get that infected blood into their blood stream for transmission to occur. The most efficient way that this happens today is through sharing of injection drug equipment, including shared syringes, cotton, cookers/spoons, shared water source for cooking or rinsing, and ties or tourniquets. ^{4, 1}

Before 1992, many people contracted HCV through blood or blood product transfusions. In 1992, a reliable blood test to identify HCV antibodies became available. Since then, the blood supply has been screened. Today the likelihood of contracting HCV through infected blood is less than .01%. ^{1, 2}

Transmission may also occur when sharing drug paraphernalia for non-injection drugs (i.e. straws, pipes, etc.) but is significantly less likely than through shared injection equipment.

An estimated 1-3% of people may contract HCV through unprotected sexual activity. This is most likely to occur when the genital or rectal tissue is compromised and directly exposed to infected blood, such as when there is an untreated sexually transmitted infection. ^{4, 1} Consequently, we do NOT consider this to be a major risk factor for HCV transmission and acquisition.

Likewise, perinatal transmission from mothers with HCV to their infants before or during birth occurs less than 5% of the time. Whether or not transmission occurs may depend on the presence of high levels of the virus in the mother's blood; mothers co-infected with HBV or HIV are more likely to transmit HCV to their babies. HCV transmission via breast feeding is believed to be extremely rare. ^{4, 1}

Needles and other equipment used for tattooing, body piercing, and acupuncture may also spread HCV when shared among high prevalence populations (i.e. injectors) and in unregulated settings (i.e. prisons). However, transmission through these activities is rare and confounded by other risk factors. ^{4, 1} Additionally, sharing personal items coated with infected blood such as razors, toothbrushes, or nail files poses a small risk and is extremely rare. ^{4, 1}

Healthcare workers may be at some risk for HCV infection because of needle-stick accidents and unavoidable situations may result in direct contact with blood from an infected individual; however, this too is rare and is often confounded by other risk factors. ^{4, 1}

HCV is not transmitted by casual contact such as sneezing, coughing, hugging, or sharing eating utensils and drinking glasses. ^{1, 3}

Finally, we do not commonly use the term "contagious" to reference Hepatitis C, as many understand this word to mean something that is easily diffused or spread from one person to another, such as with respiratory illnesses. HCV is considered a communicable disease among high-risk populations.

1 http://www.hcvadvocate.org/hepatitis/hepC/hcvinformation_2003.html

2 <http://www.cdc.gov/ncidod/diseases/hepatitis/c/index.htm>

3 <http://www.medscape.com/resource/hepc>

4 NIH, Consensus Conference Statement, Management of Hepatitis C:2002. <http://onsensus.nih.gov/2002/2002HepatitisC200216html.htm>

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Comments and questions about this publication should be directed to: Rick Stoller at stollerr@ohsu.edu, or call (503) 230-1202, FAX (503) 230-1213, 5525 SE Milwaukie Ave. Portland, OR 97202 This issue, and issues from Feb 2002 on, can be found electronically at <http://egov.oregon.gov/DHS/ph/hiv/services/news.shtml>