New HIV Cases Still Increasing in MSM Population

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN FRANCISCO — New HIV and AIDS cases still occur most commonly in the gay male population, and one of the reasons may be because a substantial proportion of infected persons do not know that they are infected.

"We increasingly have been focused on [new infection cases in] women, but the only group in which we have evidence that HIV or AIDS cases are increasing is in the group of men who have sex with men," Dr. Susan Buchbinder said at a meeting on HIV management sponsored by the University of California, San Francisco.

A high proportion of infected persons are not aware of their serostatus; they engage in risky behavior and come in for testing and treatment way too late, said Dr. Buchbinder, the director of the HIV research section of the San Francisco Department of Public Health.

About 40% of all new HIV/AIDS diagnoses in 2001 were in men who have sex with men (MSM), and by 2004, that figure had risen to 45%, according to Dr. Buchbinder.

Figures from the Centers for Disease Control and Prevention indicate that there were 16,625 new cases in the transmission category of male-to-male sexual contact in 2001. By 2004, there were 18,203.

The annual number of cases in other transmission categories—including intravenous drug use and heterosexual contact—remain flat or are declining.

Another salient feature of the epidemic's evolution is that although roughly 80% of cases still occur in major metropolitan areas, increasing numbers of HIV/AIDS cases are occurring among women in suburban and rural areas, Dr. Buchbinder noted. A disturbing feature of these cases is that almost half of the women are getting infected through heterosexual contact with a man whose risk factor they do not know.

"This is that hidden epidemic … that is increasingly moving into less populated areas and heavily impacting women in this country," she said.

Dr. Buchbinder also discussed the new CDC guidelines for HIV testing adopted in September 2006, which call for "opt-out" testing, meaning that all patients are informed that they will undergo testing unless they choose to forgo it.

The rationale for the new guidelines is based on the estimation that at least 25% of infected persons in the United States are not aware of their serostatus, and that too many people seek treatment when it is too late.

Dr. Buchbinder said that in some populations, the number of people who are not aware that they are HIV positive might be even higher than the estimated one-quarter. In 2004-2005, the CDC randomly interviewed and tested gay men in four cities and found that 48% of those tested were unaware of their infection (MMWR 2005;54:597-601).

Moreover, of those testing positive for the virus the first time, 38% do so within 1 year of developing AIDS. That is too late, said Dr. Buchbinder. People who know that they are HIV positive report that they change their behavior, and the earlier treatment starts, the better, she added.

In a large retrospective review of data from Kaiser Permanente patients going back to the mid-1990s, the investigators found that 43% of patients had a CD4 cell count of fewer than 200 cells/mcL when they first were tested as positive, and another 19% had CD4 cell counts of 200-350 cells/mcL, the point at which it is advised that antiviral treatment should start (J. Acquir. Immune Defic. Syndr. 2003;32:143-52).

Those patients could perhaps have been detected earlier because the group had been in the Kaiser system for a mean of 5 years before testing positive. However, only 26% of the patients had their intravenous drug abuse history or their homosexual activity—possible pointers to infection risk factors—documented in their charts before they tested positive, Dr. Buchbinder noted.

Dr. Buchbinder also discussed the practice of "serosorting." In serosorting, men who know they are HIV positive modify their behavior depending on their partner's HIV status, such that they have sex only with other men who are positive, or always use a condom when having sex with a negative partner, or ensure that the positive partner is always the receptive partner when having anal sex with a negative partner because of the perceived lower risk of transmission.

She added that data from San Francisco and California suggest that since the late 1990s, the number of MSMs who have unprotected anal sex and the number of cases of rectal gonorrhea and syphilis have increased. However, in San Francisco—where many infected men report that they have sex with uninfected partners less frequently since becoming aware of their serostatus—the HIV infection rates do not seem to be increasing to the same extent. ■

HAART Halt Did Not Lead to Neuro Decline

BY BETSY BATES
Los Angeles Bureau

LOS ANGELES — Relatively healthy individuals who opted to discontinue highly active antiretroviral therapy did not appear to suffer any neurocognitive repercussions and in fact performed better on a standard battery of neuropsychological tests during their drug vacations.

"This was not what we expected," said Kevin Robertson, Ph.D., who presented the findings at the 14th Conference on Retroviruses and Opportunistic Infections.

An initial group of 167 HIV-infected patients was enrolled in the observational, multicenter study when they made a decision to discontinue highly active antiretroviral therapy (HAART).

At study entry, their mean age was 42 years and they had spent 4.5 years on HAART. They represented a "uniquely healthy population," Dr. Robertson stressed, with a mean baseline peripheral blood CD4 count of 833 cells/mcL and a low viral load (71% had fewer than 50 copies/mL plasma HIV RNA).

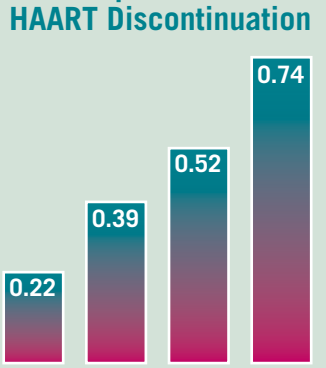
A brief neuropsychological battery of tests, including Trailmaking A/B and Digit Symbol, was administered at 24 weeks, 48 weeks, 72 weeks, and 96 weeks to assess psychomotor speed, attention, concentration, cognitive sequencing, and shifting cognitive sets—skills known to be affected by HIV.

"We felt that when subjects stopped HAART, it would lead to a decline in neuropsychological performance," said Dr. Robertson, director of neuropsychology and a member of the NeuroAIDS Working Group at the University of North Carolina at Chapel Hill.

In fact, the opposite occurred, with mean neuropsychological summary (NPZ3) scores improving by 0.22, 0.39, 0.52, and 0.74 over the course of the 96-week study.

Among a group of 46 subjects who eventually decided to reinitiate HAART, there was no significant change in composite neurocognitive scores over 72 weeks of follow-up, although Dr. Robertson noted that the final study group represented a "very small sample size" of 37 patients by week 24 of the follow-up study.

Neuropsychological Summary Score Improvement After HAART Discontinuation



Note: Based on a study of 167 HIV-infected patients.
Source: Dr. Robertson

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Numerous possible confounding factors were explored by the investigative team from the University of North Carolina; Harvard University, Boston; the University of California, San Francisco; and Baystate Medical Center, Springfield, Mass. However, they statistically ruled out a practice effect, selection bias, or a possible link between neurocognitive function and efavirenz-containing HIV regimens.

"Many people in this room, myself included, have shown improvement [in neurocognitive function] with ART, especially in later disease," said Dr. Robertson from the podium during his presentation.

"This study does not suggest you shouldn't take your antiretroviral treatment at all.

"What we know is that HIV gets into the CNS within days. … The virus is presumably chipping away," he said.

He suggested that further research should focus on "potential sources of HAART toxicity on CNS function," because neurocognitive decline did not follow discontinuation of the powerful therapies in healthy subjects who were able to remain off HAART for extended periods of time. ■