Racial Gap Persists in HIV Care, Especially HAART

Blacks are more likely than whites to be uninsured and thus are less likely to have access to HAART.

BY SHERRY BOSCHERT
San Francisco Bureau

OAKLAND, CALIF. — The gap in HIV care received by black patients compared with white patients has narrowed, but disparities remain a problem, William D. King, M.D., said at a conference sponsored by the American Foundation for AIDS Research.

A 2005 study found that 84% of HIV-infected patients overall receive highly active antiretroviral therapy (HAART), but blacks were less likely than whites to get HAART, said Dr. King, an internal medicine/HIV specialist in Los Angeles. Dr. King is a speaker for Pfizer Inc., which makes antiretroviral medication.

Blacks are more likely than whites to be uninsured or on Medicaid and thus are less likely to have access to HAART, compared with patients who have private insurance. Among Medicaid recipients, blacks and Hispanic patients are less likely to receive HAART than are whites, according to a recent study by Dr. King and his associates that has been submitted for publication.

Other data have shown that within the Veterans Affairs system, HIV-infected blacks and Hispanics have higher mortality than do HIV-infected white patients.

Physician attitudes play a role in the disparities, he added. Physicians are more reluctant to treat a patient who they think will not adhere to therapy. A 2000 study found that physicians who were given patient vignettes were more likely to rate them as unlikely to adhere to therapy if the patient was described as African American rather than white, even if the rest of the vignette was identical.

The interval between seeing a physician for HIV care and receiving a protease inhibitor to treat it averaged 409 days for black patients, significantly longer than the 311 days for white patients and 306 days for Hispanics, a 2003 study found. Patient attitudes and distrust also play a role in these disparities by making some less willing to seek care, Dr. King said at the conference, which was cosponsored by the Pacific AIDS Education and Training Center.

In a 2005 study of 500 African Americans, 75% said they believe institutions are trying to stop HIV, but 15% felt that AIDS is a form of genocide. Overall, 59% said they believe information about AIDS is being withheld from the poor, and 53% stated that a cure for AIDS exists but is being withheld from the poor. Men who had the highest level of conspiracy beliefs had more negative attitudes about condoms and were less likely to use them.

Dr. King suggested that more HIV services come to minority neighborhoods, and that more educational materials get translated into languages other than English. Physicians should pay attention to the quality and quantity of their communications with minority patients, and develop culturally relevant materials. More community education is needed to reduce the stigma associated with HIV and to reach out to stakeholders in black communities, such as religious organizations, he said.

Physicians are more reluctant to treat a patient who they think will not adhere to drug therapy.

DR. KING

A separate study of 8,319 records on 1,717 patients seen for HIV at two medical centers between 2000 and 2003 found that blacks were more likely than whites to be hospitalized, Linda Wotring, Ph.D., and Jonathan A. Cohn, M.D., reported in a poster at the meeting. The odds of being hospitalized were 70% higher for black men and 80% higher for black women, compared with white men, reported Dr. Wotring of the Michigan Department of Community Health, Detroit, and Dr. Cohn of Wayne State University, Detroit.

The chances of hospitalization remained significantly higher for blacks than for whites after adjustment for other factors that increased the risk of admission, including injection drug use or noninjection drug use, a history of an AIDS-defining illness, no history of a clinic visit, and having Medicare or Medicaid rather than private insurance.

The investigators will study whether the risk for hospitalization is associated with less access to medications and other health services for blacks.

Distrust and misconceptions about HIV remain widespread, Jerry T. Nessel, M.D., and Beny J. Primm, M.D., reported in a separate poster presentation. In surveys of 1,440 attendees at nine medical and health conferences, only 9% of respondents knew that HIV was not created in the laboratory, and that the virus came from chimpanzees or monkeys, said Dr. Nessel and Dr. Primm of the Addiction Research and Treatment Corp., New York. ■

Novel Protease Inhibitor Has Strong Antiviral Activity

BY CHARLENE LAINO
Contributing Writer

RIO DE JANEIRO — An investigational protease inhibitor, TMC114, has potent antiviral activity in heavily pretreated HIV-infected patients with primary protease inhibitor mutations, according to results from the POWER-1 study.

The agent plus low-dose ritonavir was effective even in patients harboring three or more primary protease inhibitor (PI) mutations in the 24-week, randomized study (Performance of TMC114/r When Evaluated in Triple-Class-Experienced Patients With PI Resistance), reported Christine Katlama, M.D., of the AIDS clinical research unit at the Hôpital Pitié-Salpêtrière in Paris.

In a poster session at the International AIDS Society Conference on HIV Pathogenesis and Treatment, Dr. Katlama said that overall, the primary end point of 1 $\log_{10}$ or greater viral load reduction from baseline was achieved by 77% of 65 patients taking 600 mg of TMC114 plus 100 mg of ritonavir twice daily, compared with 25% of 63 control patients taking investigator-selected PIs.

A viral load of less than 50 copies/mL was achieved by 53% of the patients on 600 mg of TMC114 plus ritonavir vs. 18% of the control patients

Of the 29 patients with three or more primary PI mutations, 59% of those treated with 600 mg of TMC114 plus ritonavir achieved HIV-1 viral loads below 50 copies/mL vs. 9% of control patients.

There was no excess toxicity in the TMC114 group, Dr. Katlama said. Grade 3 and grade 4 events were observed in 29% of control patients vs. 23% of those treated with 600 mg of TMC114.

For the phase IIb study, 300 patients were randomized to receive one of four doses of TMC114 plus ritonavir, or to receive investigator-selected protease inhibitors. Dr. Katlama presented detailed data only on the most effective regimen of 600 mg of TMC114 plus 100 mg of ritonavir twice daily, which has been chosen for future study.

The patients in this study received an optimal background regimen of nucleoside reverse transcriptase inhibitors, with or without enfuvirtide. They had triple-class experience, had more than one primary PI mutation, were on stable antiretroviral therapy, and had HIV-1 RNA levels greater than 1,000 copies/mL at baseline. TMC114 binds to HIV protease, providing a wide range of durable activity, Dr. Katlama said.

Mark A. Wainberg, Ph.D., director of the McGill University AIDS Centre in Montreal and moderator of the session, said that more than half of the patients on TMC114 achieved viral loads of less than 50 copies/mL. TMC114 "looks to be the next generation PI. It has excellent potency and can make an important difference in experienced patients and probably naive patients as well," he said. ■

One-Year Survival Is Rising in HIV-Infected Organ Transplant Recipients

BY KERRI WACHTER
Senior Writer

WASHINGTON — The introduction of highly active antiretroviral therapy, more effective prophylactic regimens, and improvements in surgical technique and antirejection therapy have made solid organ transplantation a possibility for HIV-infected patients, said Marla J. Keller, M.D., at a meeting sponsored by the National Kidney Foundation.

Based on the most recent analysis from an ongoing, multicenter, prospective, observational study, survival among HIV-infected kidney transplant patients at 1 year was 93.8%. For comparison, the 1-year survival for kidney transplant patients in the Organ Procurement and Transplantation Network database was 95.6% (1999-2001), said Dr. Keller of Mount Sinai School of Medicine in New York.

This analysis included 29 patients, 18 of whom received kidney transplants. The patients were enrolled in the study between 2000 and 2003. Potential kidney recipients were included in the study if they had CD4 T-cell counts of at least 200, HIV RNA less than 50 copies/mL, and no history of opportunistic infections. Patients are being followed for up to 5 years.

Initial immunosuppressive therapy included cyclosporine or tacrolimus in combination with prednisone, with or without mycophenolate mofetil. Rejections were managed with steroid pulses, changing calcineurin inhibitors or doses, and/or adding sirolimus and/or Thymoglobulin. All antiretroviral drugs were allowed, though AZT and stavudine (d4T) use was minimized. Standard transplant prophylaxis was used for several opportunistic organisms.

Most of the kidney transplant recipients (17) were male. There were slightly more white patients (10) than African American patients (8). Kidney donors were fairly evenly split: five related, living; three unrelated, living; six deceased; and four high infectious risk, deceased. Organs from deceased donors were considered high infectious risk if they were serologically negative for HIV and hepatitis B and C but the donor might have engaged in behavior putting them at risk for recent acquisition. The median baseline CD4 T-cell count was 439 cells/mm^3. Median follow-up was 869 days at the time of the current data analysis.

One opportunistic infection occurred in a diabetic patient, who developed *Candida* esophagitis. Surprisingly, 12 kidney recipients (67%) had graft rejection, mostly of the early acute cellular type. Seven patients received Thymoglobulin in response to eight rejection episodes. The 1-year cumulative rejection estimate was 52%, said Dr. Keller. One kidney transplant recipient died because of congestive heart failure, and two patients had graft loss—one because of rupture from severe acute rejection and one due to chronic allograft nephropathy. ■