

# AIDS ALERT®

The most comprehensive source of HIV/AIDS information since 1986

October 2002 • Volume 17, Number 10 • Pages 121-132

## IN THIS ISSUE

### Linking HIV infection and methamphetamine use

HIV clinicians and prevention programs largely have been overlooking a potent link between HIV infection and a recent epidemic of methamphetamine use across the nation: Commonly called 'club drugs,' these stimulants have become a ubiquitous part of gay nightclub and party circuit settings, leading men to engage in 'barebacking' and other risky sexual behaviors. . . . . cover

### What are club drugs?

The National Institute on Drug Abuse in Bethesda, MD, provides a brief overview on the most common designer drugs and how they are used, how they affect users, and what their dangers are . . . . . 123

*In This Issue continued on next page*

### **Special Report:** **Club drugs linked to high HIV risk**

*This is the first in a two-part series about the increase in methamphetamine and stimulant use among gay and bisexual men and how this is tied to increased HIV risk. In this issue are stories about the abuse of methamphetamine and the link to HIV, an intimate look at why one HIV-infected gay man has abused stimulants, and the history of methamphetamine use in the United States. Next month, AIDS Alert will examine how clinics and HIV physicians can identify and treat meth users.*

**NOW AVAILABLE ON-LINE!**  
**[www.ahcpub.com/online.html](http://www.ahcpub.com/online.html)**

For more information, contact (800) 688-2421.

## Methamphetamine use is heightening risks among gay youth

*'Club drugs' dull safe-sex sensibilities*

A convincing body of new research suggests that a relatively recent and very important risk factor for HIV infection among men who have sex with men (MSM) is methamphetamine use.

A group of illicit stimulants, dubbed "club drugs," has become such a commonplace part of the party circuit and gay club life that in some settings, treatment centers have seen a 1,000% increase in people presenting for treatment of methamphetamine abuse.<sup>1</sup>

While the club drugs have long been associated with the Pacific Rim and the West Coast, they now are ubiquitous in other Western states, the Midwest, and most recently, the East Coast, researchers say.

The designer drugs most commonly used in the gay club/party circuit are crystal methamphetamine, 3-4 methylenedioxymethamphetamine (MDMA, which also is called ecstasy), ketamine (called Special K), and gamma hydroxybutyrate (GHB).<sup>2</sup> (See list of club drugs, p. 123.)

While HIV clinicians have long known the connection between substance abuse and HIV, especially when injectables are used, investigators are building a strong case for paying particular attention to methamphetamine and the other stimulants used by MSM. Even when these drugs are not injected, they place users at a high risk for HIV infection, new research finds.

Crystal methamphetamine can be ingested, snorted, smoked, and injected; and MSM groups

*(Continued on page 123)*

**Methamphetamine use dates to post-WWII era**

Originally manufactured by the Germans in the 1880s and later used by the Japanese as a means of keeping military personnel awake on long shifts, methamphetamine first was a significant presence in the Western United States in the late 1940s. For decades, methamphetamine use was limited to the West Coast and Hawaii, becoming popular at various times in a multitude of groups, including Hells Angels . . . . . 125

**HIV-positive Midwesterner describes why he uses methamphetamine**

The stereotypic user of methamphetamine in the Midwest is a gay or bisexual man who is an educated professional and lover of the gay party/nightclub scene. Depending on when such a person is interviewed, he also may be HIV-positive. One gay man talks about why he uses the drug . . . . . 127

**Q&A**

**WHO seeks to collaborate TB and HIV prevention/treatment**

Officials with the World Health Organization discuss the new international focus on combining TB and HIV/AIDS efforts where possible and having the two public health camps work together to prevent and treat both epidemics, particularly in sub-Saharan Africa, Asia, and other areas where the diseases work with synergy . . . . . 128

**FDA Notifications**

**Use of lamivudine expanded** . . . . . 131

**Agenerase product label changed** . . . . . 131

**COMING IN FUTURE ISSUES**

- Computer-assisted interviewing is alternative to counseling
- Using pharmacists to boost therapy adherence
- Pioneering states collaborate on prevention and treatment
- A communitywide intervention program for young gay and bisexual men
- Special coverage of 2002 ICAAC

**AIDS Alert**® (ISSN 0887-0292), including **AIDS Guide for Health Care Workers**®, **AIDS Alert International**®, and **Common Sense About AIDS**®, is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **AIDS Alert**®, P.O. Box 740059, Atlanta, GA 30374.

**Subscriber Information**

**Customer Service: (800) 688-2421. Fax: (800) 284-3291. Hours of operation: 8:30 a.m-6:00 p.m. M-Th, 8:30-4:30 F EST. E-mail: customerservice@ahcpub.com. Web site: www.ahcpub.com.**

**Subscription rates:** U.S.A., one year (12 issues), \$467. Approximately 18 nursing contact hours or Category 1 CME credits, \$467. Outside U.S., add \$30 per year, total prepaid in U.S. funds. One to nine additional copies, \$374 per year; 10 to 20 additional copies, \$280 per year. For more than 20 additional copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are \$78 each. (GST registration number R128870672.)

**Photocopying:** No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421.

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864. This continuing education program does not fulfill State of Florida requirements for AIDS education. American Health Consultants® designates this continuing medical education activity for up to 18 hours in category 1 credit towards the AMA Physicians' Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Health Consultants® (AHC) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. This CME activity was planned and produced in accordance with the ACCME Essentials.

**Statement of Financial Disclosure:** In order to reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, we disclose that Advisory Board Member Dr. Tapper is a consultant for Abbott, GlaxoSmithKlein, Amgen, Boehringer Ingelheim, Serono, Merck, Roche, and Ortho Biotech; is a stockholder in Merck; and is on the speakers bureau at Bristol Myers-Squibb, Ortho Biotech, and Boehringer Ingelheim. Dr. Thompson reports research connections with Abbott, Bristol Myers Squibb, Chiron, DuPont, GlaxoSmithKlein, Roche, Triangle, Boehringer Ingelheim, Amgen, Gilead, Serono, VaxGEN, and Oxo Chemie. Dr. Bartlett works as a consultant for Merck, GlaxoSmithKlein, Abbott, and DuPont. Board member Kalinoski reports nothing to disclose. Responses were not received from Gostin or from Drs. Bihari, Glatt, Mayer, Cottone, or Richman.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Melinda Young**, (828) 859-2066.

Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).

Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).

Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@ahcpub.com).

Senior Production Editor: **Ann Duncan**

Copyright © 2002 by American Health Consultants®. **AIDS Alert**®, **AIDS Guide for Health Care Workers**®, and **Common Sense About AIDS**® are registered trademarks of American Health Consultants®. The trademark **AIDS Alert**® is used herein under license. All rights reserved.



**Editorial Questions**

For questions or comments, call **Melinda Young** at (828) 859-2066.

## What are club drugs? Here's a quick look

Chances are that most HIV clinicians live in or near a community where gay and bisexual men, youths, and others are using club drugs, placing themselves at greater risk of HIV infection. Here's some information from the National Institute on Drug Abuse of Bethesda, MD, about the most common of these designer drugs and how they are used, how they affect users, and what their dangers are:

### ✓ **Methamphetamine**

A powerfully addictive psychostimulant that affects the central nervous system, methamphetamine also is called speed, meth, chalk, ice, crystal, crank, and glass. It is a white, odorless crystalline powder that dissolves in water and alcohol and can be smoked, snorted, orally ingested, or injected. The drug alters moods and has the short-term effects of increased attention, increased activity, decreased appetite, euphoria and rush, increased respiration, and hyperthermia. Long-term effects include dependence and addiction, paranoia, hallucinations, mood disturbances, repetitive motor activity, stroke, and weight loss. Research shows that up to 50% of the dopamine-producing cells in the brain may be damaged after prolonged exposure to methamphetamine and that serotonin-containing nerve cells may be damaged even more extensively. The drug also can cause cardiovascular problems, such as rapid heart rate, irregular heart-beat, stroke-producing damage to small blood vessels in the brain, and hypertension.

### ✓ **MDMA**

Commonly called Ecstasy, 3-4 methylenedioxy-methamphetamine is a synthetic, psychoactive drug with stimulant and hallucinogenic properties. As a neurotoxic drug, MDMA can cause a sharp increase in body temperature and lead to cardiovascular system failure and muscle breakdown. MDMA research has found that the drug injures the brain in the serotonin system and can cause psychological problems, including confusion, depression, sleep problems, craving, anxiety, and paranoia. Physical side effects include muscle tension, teeth clenching, nausea, blurred vision, faintness, chills, sweating, and rapid eye movement. MDMA also may increase heart rate and blood pressure and cause an acne-like rash, along with increasing risk of liver damage.

### ✓ **GHB**

Gamma hydroxybutyrate, also called soap, easy lay, and Georgia Home Boy, is a central nervous system depressant that was sold in health food stores until 1992 and is used by body builders to aid fat reduction and muscle building. When combined with methamphetamine, alcohol, and other drugs, GHB can cause a coma, seizure, nausea, difficulty breathing, and death. GHB, which results in disinhibition, also has been involved in date rape, poisonings, and overdoses.

### ✓ **Ketamine**

An anesthetic, ketamine, also called Special K or vitamin K, causes dream-like states and hallucinations. Its more severe side effects include delirium, amnesia, impaired motor function, high blood pressure, depression, and potentially fatal respiratory problems.

use it in any and all of these ways, explains E. **Michael Gorman**, PhD, MPH, MSW, a chief investigator of numerous studies about methamphetamine and HIV. Gorman also is an assistant professor in the College of Social Work at San Jose (CA) State University. **(For a history of methamphetamine use, see p. 125.)**

"With methamphetamine, as important as injection drug use is as a risk factor — and it's an important one — it is equally important, and some might say more important, that people become uninhibited on the drug and then it becomes an issue of sexual transmission," Gorman says. "They forget; they don't put on a condom right or don't use a condom if they think to bring one."

Evidence also shows that people using these designer drugs will tend to act in sexual ways

that they normally wouldn't choose to do, Gorman says.

For example, one HIV-positive gay man from Cincinnati described himself as an animal while high on GHB. "You're so uninhibited and so heightened and so incredibly horny that that's when I really did riskier behavior," says **Tony Lasan**, age 40. (*AIDS Alert* has selected a pseudonym for Lasan to protect his privacy.)

Lasan had tested negative for HIV prior to his experience of using GHB while in Miami bathhouses. While on the drug, he soon found himself engaging in unprotected receptive anal intercourse, a sexual activity that he said he had never been attracted to prior to ingesting GHB. Six months after his negative test and shortly after his GHB days, he tested HIV-positive.

Lasan says he performed unprotected oral sex for 25 years and remained HIV-negative. "But it was this way-out-of-control, drug-uninhibited sex and bathhouses in Florida when I'm positive that it happened." (See article on **methamphetamine use from a gay user's perspective**, p. 127.)

Ironically, research and anecdotal evidence show that methamphetamine use is ubiquitous on the gay party circuit, including at large dance venues that are sometimes sponsored by HIV outreach prevention and education organizations.

Lasan says he first tried methamphetamine at a huge dance party in Atlanta more than a decade ago. The party, attracting 5,000-plus people, was a fundraiser for AIDS organizations, and condoms were distributed freely among the crowd.

Unfortunately for the organizers, participants brought drugs, which also were distributed freely. In Lasan's case, the drugs were eagerly ingested, but he can't remember whether he used condoms during the multiple sexual encounters he had that weekend.

### **Body and mind risks**

GHB, methamphetamine, and the other club drugs appear to place users at risk for a variety of psychological and physiological reasons.

"What we see is that these drugs cause people to take more risks, cause more partnering, cause more people to have sex, create an insatiable sexual desire, and cause people to do more extreme sex than regular sex," says **Perry N. Halkitis**, PhD, assistant professor of psychology at New York University in New York City. Halkitis also is the co-director of the Center for HIV Educational Studies and Training, also in New York City.

"And if methamphetamine is inserted anally, this is a harsh substance that wears away at the lining of the rectum and increases the possibility of seroconversion because you've damaged the area where transmission can occur," Halkitis says.

Halkitis has found in his research that nearly 35% of methamphetamine users report having inserted methamphetamine in their anus.

Still popular among the gay club community of the East Coast are inhalant nitrates, which cause the anal musculature to relax, making anal intercourse less painful, further contributing to increased sexual risk behavior, according to Halkitis' latest research.

Polydrug use in the gay club/party settings has increased, and these drug combinations are

substantially more dangerous when combined with alcohol, cocaine, Viagra, which also is being distributed at these venues, HIV medications, and other substances. GHB combined with alcohol, for instance, has been deadly, Halkitis says.

But it's the link to HIV and suspected increases in HIV incidence among MSM that most worries researchers studying the phenomenon.

"What we're finding is that an occasional use of methamphetamine in gay populations is a significant predictor of HIV infection, but when you move up the level of use to dependence, then methamphetamine is an outrageous predictor of infection," says **Steve Shoptaw**, PhD, principal investigator with the Friends Research Institute in Los Angeles, and an associate research psychologist at the University of California in Los Angeles (UCLA).

At a Los Angeles substance abuse treatment center, researchers found that 62% of the gay and bisexual men who showed up for methamphetamine treatment were HIV-positive.<sup>2</sup>

"We were shocked by our numbers," Shoptaw says.

On the West Coast where the heroin injection drug using (IDU) population has traditionally had very low HIV prevalence, with rates in Seattle, and Los Angeles of less than 5%, the opposite is true of injection methamphetamine use, Gorman says.

"The Seattle/King County Health Department in Washington state had been looking at this, and in one study, they found that 60% of gay IDUs who use methamphetamine were HIV-positive," Gorman says. "Meth users, or at least gay users in Seattle, had at least as high an HIV prevalence as heterosexual heroin users in New York City."

Methamphetamine use and its tie to HIV among MSM is a trend found outside the U.S. borders, as well.

Researchers in Vancouver, Canada surveyed 495 MSM in 2001 and found that 25% had reported crystal meth use in the previous year. Those who had used the drug also were more likely than those who had not used the drug to be polydrug users and had engaged in other risky behavior, including both injection drug use and unsafe sex practices.<sup>3</sup>

"We've seen an increasing incidence of HIV in this population of MSM, and a lot of that has to do with changes in behavior, namely associated with a real increase in barebacking," says **Robert Hogg**, PhD, a principal investigator of the Vancouver study and the manager of the HIV/AIDS Drug

Treatment Program at the British Columbia Centre for Excellence in HIV/AIDS in Vancouver.

Vancouver investigators survey patients annually, and each year, the methamphetamine use has increased, coinciding with an increase in HIV incidence over the same period of time, Hogg says.

“There’s a group of men who have decided for a variety of reasons — cultural, as well as other reasons — that they will not use condoms when engaging in anal intercourse,” Hogg adds. “And obviously, club drugs or other drugs play a role in how they engage in risk behavior.”

A Brisbane, Australia study also notes a dramatic increase in methamphetamine use in the past five years. The study found that among users who injected methamphetamine, there was low needle sharing. However, the meth IDUs did place themselves at risk of HIV infection through water used to liquidize crystal meth, tourniquets, and drug-mixing vessels potentially contaminated with blood.<sup>4</sup>

Five years ago, if you asked New York City street pushers, outreach workers, substance abuse experts, and others if methamphetamine use was a problem, the answer would have been that it didn’t exist in the city. However, that answer would have been dead wrong, because the drug had already begun to take a hold on the gay and bisexual community in clubs and party circuit venues, and now it’s everywhere, says **Michael C. Clatts**, PhD, a medical anthropologist and associate professor of public health in the department of sociomedical science at Columbia University in New York City. Clatts also is the director of the Institute for International Research on Youth at Risk at the National Development Research Institutes, also in New York City. He had taken part in a study that sought information about methamphetamine use in the late 1990s.

“They all swore that there was no methamphetamine in New York in 1997 and 1998, and then we followed up and did ethnographic interviews in gay clubs in New York City and found a very different story,” Clatts says. “Methamphetamine was widely available in many forms, and the majority of the use was not injected, although there was injection present.”

## References

1. Gorman EM, Pach AP, Nelson K, et al. Ecological perspectives regarding club drug and methamphetamine use among U.S. men who have sex with other men: Prevention,

outreach, and research implications. Presented at the 14th International AIDS Conference. Barcelona, Spain; July 2002. Abstract: ThPeE7862.

2. Gorman EM, Carroll RT. Substance abuse and HIV: Considerations with regard to methamphetamines and other recreational drugs for nursing practice and research. *J Assoc Nurses AIDS Care* 2000; 11(2):51-62.

3. Weber AE, Chan K, Schilder A, et al. HIV risk profile of crystal methamphetamine users in a cohort of young men who have sex with men. Presented at the 14th International AIDS Conference. Barcelona, Spain; July 2002. Abstract: MoPeC3454.

4. Hunter AP, Davey J, Davies A. Developing safe injecting procedures for methamphetamine using recreational IDUs through peer research. Presented at the 14th International AIDS Conference. Barcelona, Spain; July 2002. Abstract ThPeE7861. ■

## Methamphetamine use dates to post-WWII era

*Drug little-known risk factor in early AIDS days*

Originally manufactured by the Germans in the 1880s and later used by the Japanese to keep military personnel awake on long shifts, methamphetamine first was a significant presence in the Western United States in the late 1940s.

“After the second World War, there were vast stores of methamphetamine released in the Japanese black market, and methamphetamine use reached epidemic proportions in post-WWII Japan,” says **E. Michael Gorman**, PhD, MPH, MSW, an assistant professor in the College of Social Work at San Jose (CA) State University.

“Supposedly, Americans then were exposed to it and brought it back to the West Coast,” Gorman says. For decades, methamphetamine use was limited to the West Coast and Hawaii, becoming popular at various times in a multitude of groups, including Hells Angels, he says. “In the early days, crystal meth was bikers’ coffee, literally put into people’s coffee and drunk.”

Since meth use didn’t pose as many law enforcement and social problems as cocaine use, the drug remained under the radar screen and was rarely studied or analyzed, he explains. “But there were a couple of methamphetamine epidemics. One was in the late 1940s and early 1950s, and the other was in the 1970s in San Francisco.”

The latest epidemic began in the late 1990s and has continued into the 21st century, this time spreading across the nation.

Gorman, who has been an AIDS researcher since the beginning of the epidemic, first saw a problem with methamphetamine use in San Francisco's early days of AIDS, before the virus was identified as the culprit behind a rash of strange diseases and deaths.

While working on the first HIV/AIDS studies in San Francisco through the University of California, San Francisco and the San Francisco Health Department, Gorman interviewed gay and bisexual men who were sick with symptoms of AIDS, before the syndrome was named.

These men told Gorman and co-investigators that they had frequented a bathhouse called the Barracks in the late 1970s and early 1980s.

"The Barracks was a methamphetamine emporium," he says. "The drug was prevalent in this institution, which was subsequently shut down, and a lot of people who had histories of this drug were among the earliest AIDS cases."

### ***Casting a wide net***

Researchers were able to document this drug connection to AIDS because of the wide net of questions they asked early AIDS patients. Since the disease's cause was unknown, the virus' first victims were asked questions about every facet of their lives, Gorman says.

However, once researchers discovered that the virus was transmitted sexually and through shared needles of heroin users, the connection with methamphetamine was mostly forgotten, he adds.

"Jump forward to 1993-1994: When working in a treatment clinic, I recognized that these are some of the same crowd I interviewed in the early 1980s," Gorman says. "It was troubling to me, and I saw this HIV connection to methamphetamine and didn't understand how it worked." After interviewing HIV-positive men who had histories of methamphetamine use, including injection drug use with meth, Gorman realized that meth users were a very diverse population, even among homosexuals. "One of the things going on is that this drug for men had a heavy sexual aspect to it. It seemed to be an aphrodisiac," he says.

However, the link between HIV and methamphetamine use largely was ignored until later in the 1990s when meth used spread to the Midwest, rural Western areas, and most recently the East Coast. The availability of methamphetamine on the East Coast is only beginning to be recognized, and it's still not being identified by many clinicians, says **Michael C. Clatts**, PhD, medical

anthropologist and associate professor of public health in the Department of Sociomedical Science at Columbia University in New York City. Clatts also is the director of the Institute for International Research On Youth At Risk at the National Development Research Institutes in New York City.

Drug monitoring systems in New York do not even include specific questions about methamphetamine, which is grouped with cocaine and other stimulants, Clatts says. "So if someone shows up at a drug treatment center all jazzed up and nervous and fidgety, it's assumed the person's a cocaine user."

As a result of public indifference the growing trend of meth abuse, researchers have witnessed a new wave of drug users among young gay men who are making the same risky behavior mistakes that were made by their counterparts 20 years ago before HIV was identified.

"The new generation of gay men is going to witness the same kind of losses as the older men who saw thousands of their friends and lovers die from AIDS," Clatts says. "The amount of anxiety that exists in the gay community around HIV is very substantial, and that's what in part is fueling some of this methamphetamine use."

If it's been difficult for clinicians and public health officials to recognize methamphetamine use as a problem on the East Coast, the problem is even more invisible in rural and Midwestern communities, where methamphetamine use has become a part of daily life for many.

"The reality is: It's part of the rural economy," Gorman states.

Besides being prevalent in some pockets of the gay and bisexual community, methamphetamine use now has been studied in women, who in some Midwestern states comprise 50% of admissions for methamphetamine treatment.<sup>1</sup>

Working class, Latino, and rural populations have been drawn to the drug for different reasons than the gay population, he says.

"I'm struck by the fact that people do meth for reasons such as they want to work harder, juggle two jobs, and in some cases, to have better sex," Gorman says. "They can do tasks like clean their house, and it's very much an action drug, unlike heroin." Plus, methamphetamine is cheap, giving users a longer and more intense high, and is a favorite drug at youth "rave" parties, he adds.

"It's a poor man's cocaine, and there are parallels with the crack epidemic, which occurred in vulnerable inner-city populations," he says.

Nonetheless, heterosexual men and women who use methamphetamine also are at increased risk for HIV infection, particularly if they inject the drug.<sup>2</sup>

Those who inject methamphetamine may share routes of HIV transmission indirectly, such as test water, Gorman says.

Now that methamphetamine use has spread across the United States and to heterosexual populations, it will require concerted private and public health efforts to treat and prevent the problem from causing a resurgence in HIV infection.

He suggests that HIV clinicians begin by asking patients whether they use methamphetamine and whether this use includes injecting the drugs. This is a good start since traditionally prevention programs have focused on asking at-risk individuals about their crack and heroin use, but have ignored methamphetamine, particularly when presented with middle-class, white, professional clients, Gorman says.

"Clinicians fail to understand methamphetamine use," he adds. "If someone is a middle-class male on the West Coast or in a Western U.S. city, the idea that the person also is an injection drug user is mind-boggling, and clinicians wouldn't think to ask."

## References

1. Pach AP, Gorman EM, Topolski J, et al. Contextual and environmental aspects of methamphetamine abuse in U.S. women and HIV risk. Presented at the 14th International AIDS Conference. Barcelona, Spain; July 2002. Abstract: ThPeE7863.

2. Gorman EM, Pach AP, Clark C, et al. Women at risk: Ethnographic perspectives on methamphetamine use and HIV risk in two U.S. sites. Presented at the 14th International AIDS Conference. Barcelona, Spain; July 2002. Abstract: WePeG6902. ■

## HIV-positive Midwesterner tells how he uses meth

*Even after 2-year prison term, attraction is there*

The stereotypic user of methamphetamine in the Midwest is a gay or bisexual man who is an educated professional and lover of the gay party/nightclub scene.

Depending on when such a person is interviewed, he also may be HIV-positive. **Tony Lasan,**

40, from Cincinnati fits the stereotype. (Lasan's true name is withheld to protect his privacy.)

Lasan began using club drugs about 15 years ago when he attended a gay dance party in Atlanta, which was a huge fundraising event for AIDS organizations. Two things most impressed Lasan at the party where thousands of young-to-middle-aged professional men danced for more than 12 hours. One was being dazzled by the creativity and choreographed stage shows both featuring and observed by an array of beautiful people. The second strong impression was of the drugs passed around like breath mints.

The HIV educational booths, condom distribution, and prevention messages also present at the fundraising event did not leave as lasting of an impression.

High on stimulants, Lasan was able to dance for 12 hours and still have stamina for later anonymous and unprotected sexual encounters.

Once Lasan tried ecstasy, he was hooked. "I swear this is true, but on a metaphysical basis, your mind just starts to meld together and it's an incredible oneness with this powerful experience and uplifting music," Lasan says of his first ecstasy experience.

Crystal methamphetamine was equally addicting, he notes. "One of the first things people talk about when they mention crystal meth is the sex," Lasan says. "It makes sex so incredible, and it turns on every cell in your body, making it 100% more sensitive."

Orgasms are more intense, and a person's sexual stamina is long lasting, Lasan says. He added that it feels like the orgasm is "from every cell in your body, from head to toe, and it's just awesome, and you can go for hours, too."

Safe sex and condoms aren't even on the radar screen during such a high, and even if someone high on crystal meth used a condom during a first sexual encounter of the night, he's unlikely to continue to use condoms during the subsequent sexual marathon, Lasan says.

"When I have marathon sex on meth, I won't do the same [thing] over and over," he adds. "I may do things that I may not have necessarily thought were risky, but they probably ended up being that way."

High on crystal meth, a gay man may experience such heightened happiness and euphoria that he doesn't think it's possible that something negative can happen to him, so why be tied to the reality of condoms at that moment, Lasan points out.

Plus, there's the common perception that if your partner doesn't ask whether you are HIV-positive, then it means you probably both are HIV-positive, he says. Lasan never asked about HIV status even in the years before he became HIV-positive, he adds.

Lasan was tested regularly, and it was six months after his last negative HIV test that he received the dreaded phone call, telling him he had the virus. During that six-month period, Lasan had spent a semiretirement vacation in Miami, partying nightly at gay bathhouses and clubs.

Lasan is certain he became infected during that party period because that was the first time he regularly used GHB, which made him so uninhibited that he engaged in unprotected, receptive anal intercourse, he contends.

### ***Viagra enters the mix***

Also, a side effect of GHB and other stimulants is temporary impotence. A user might feel incredibly sexual and turned on, but he is unable to maintain an erection, a phenomenon noted in methamphetamine research.

"There is a connection there when you're doing these drugs and you can't get it up," Lasan says. "So you can't be the giver, you have to be the receiver — you get stimulated internally since you can't externally."

Of course, in more recent years, the party circuit has found a solution to this problem in the form of Viagra, which now is passed out readily along with stimulants, Lasan says.

A couple of years after being diagnosed as HIV positive, Lasan was arrested for possession and trafficking in ecstasy, ketamine, and crystal methamphetamine. Lasan says that he would often serve as a club drug go-between for party circuit friends. Although he was a successful and affluent entrepreneur and owner of a legitimate business, he was sent to prison for two years when he refused to cooperate with the Drug Enforcement Agency.

He is monitored regularly by an HIV physician, but so far, his blood tests have shown that he is not yet ready for antiretroviral medication. Lasan says his clinician has talked with him about safe-sex practices, and his response is to notify new partners of his HIV status and to choose safer sex practices when a partner is HIV-negative.

Despite the fact that he was forced to sell his

business to pay legal fees and that he lost a couple of years of his life in prison, Lasan says he still is attracted to using the drugs within the context of gay clubs and parties, and he doesn't consider himself an addict.

"Tweakers is the term for people who do meth," Lasan says. "We cannot be bothered by doing drugs all day, and a lot of addicts will do that — like people who like needles and cross over that line."

Lasan says the difference is that his crowd of meth users consists of professionals who relegate their drug use to the weekend parties.

"I'm not saying a driven professional can't be an addict, but folks who prefer to do the drug for the drug's sake, they'll smoke it or shoot it or do anything to get more effect," Lasan says. "For them, the drug is the end; for me, the drug was the tool to reach the end." ■

## **Health leaders see need to link TB and HIV plans**

*WHO has new mission in stopping TB*

*[Editor's note: AIDS Alert asked officials with the World Health Organization (WHO) in Geneva to discuss the new international focus on combining TB and HIV/AIDS efforts where possible. They want the two public health camps to work together to prevent and treat both epidemics, particularly in sub-Saharan Africa, Asia, and other areas where the diseases work with synergy in creating worst epidemics than what these areas would otherwise be experiencing. Dermot Maher, BM, BCh, medical officer in the Stop TB Department of WHO; Ian Smith, MB, ChB, MPH, and Ger Steenberg, MD, from the Stop TB Partnership offer some insight into the new focus and why it is necessary in this question-and-answer interview.]*

**AIDS Alert:** According to a WHO abstract presented in July at the 14th International AIDS Conference, held in Barcelona, Spain, there is a need for a comprehensive response to HIV/AIDS, along with effective action against TB/HIV. Why hasn't this response been launched previously?

**Maher:** Although there is long-standing recognition of the epidemiological overlap between TB and HIV, and the ways in which these two

problems interact, the formulation and implementation of a joint response have lagged behind a little. On the one hand, it has taken some time for TB program to fully grasp the need for joint TB and HIV program activities to tackle the growing epidemic of HIV-related TB, and on the other hand, it has taken some time for HIV/AIDS programs to fully grasp the need for joint activities to tackle TB as a leading cause of HIV-related illness and death. This has been partly because TB appears as one of a long list of problems on the HIV/AIDS agenda, and so there has been a tendency to say, "Well, let's leave that to the TB people." Also, until recently, TB often didn't appear very high on the HIV agenda, because in the course of the HIV epidemic, the emphasis was largely on HIV prevention until the mid-late 1990s. Since then, the development of highly active antiretroviral treatment (HAART) has put HIV treatment and the care of people with HIV-related diseases firmly on the agenda.

**AIDS Alert:** What sort of changes in international and national policy do you (and the Global Working Group on TB/HIV) advocate, and how might these be most efficiently and effectively implemented?

**Maher:** International policy is set out in the World Health Organization document (produced jointly by the Stop TB Department and the Department of HIV/AIDS) "Strategic Framework to Decrease the Burden of TB/HIV," which the Global Working Group on TB/HIV has endorsed. With the current huge global interest in making HAART widely available, there is more opportunity than ever before for HIV and TB programs to work closely together.

There is greater interest in, and understanding of, the need for comprehensive HIV/AIDS care, including effective diagnosis and treatment of TB as a leading cause of HIV-related illness and death. In the health sector, the international policy advocated by WHO and by the Global Working Group on TB/HIV is to promote the implementation of a strategy of expanded scope to tackle the problem of HIV-related TB.

This strategy comprises interventions directly against TB (e.g. intensified TB case finding among those most at risk, effective treatment of all TB patients, and isoniazid preventive treatment), and interventions against HIV and therefore indirectly against TB (e.g. HAART, HIV prevention measures, and prevention of common HIV-related diseases through the use, for example, of cotrimoxazole). Joint TB and HIV

program activities are necessary to deliver this range of interventions.

For example, TB and HIV programs need to collaborate in ensuring that people who test positive for HIV are screened for TB, with effective TB treatment for those found to have TB and isoniazid preventive treatment for those found not to have active TB. Collaboration between TB and HIV programs is essential in the monitoring and evaluation of activities aimed at decreasing the burden of TB/HIV. The key elements of a public health program of access to HAART are similar to those for access to anti-TB treatment, namely political commitment, case detection, treatment under good case management conditions, a secure drug supply, and a system of recording cases and reporting their treatment outcomes in order to enable program evaluation.

### **Five key elements**

The direct observational therapy strategy (DOTS) for TB control embraces these five key elements and therefore provides a possible model for delivery of HAART. This provides another fertile field for TB and HIV program collaboration.

**AIDS Alert:** Will this sort of international commitment require additional funding to what has already been requested by WHO and others for the long-term prevention and treatment of HIV/AIDS populations? What else is needed?

**Maher:** The Global Plan to Stop TB, endorsed by the Global Partnership to Stop TB, represents a good start in attempting to quantify the resources needed for a comprehensive response to TB/HIV.

It remains to be seen to what extent the countries most badly affected by HIV/AIDS, TB, and malaria, and the G8 countries, will mobilize the extra resources needed to be able to achieve the targets they agreed on for tackling HIV/AIDS, TB, and malaria.

**AIDS Alert:** Why has it been so difficult for international scientists and health care organizations to slow the TB epidemic? Was there a possibility of this disease successfully being contained to a small percentage of the world's population if it were not for the HIV epidemic?

**Maher:** Progress in slowing the TB epidemic depends on the effectiveness of the tools available (drugs, diagnostics, and vaccines) and the extent to which they are put into effect.

The tools available to slow the TB epidemic actually represent quite old technology — for example, no new test has been developed, which

is effective in detecting the infectious TB cases since Robert Koch pioneered diagnostic microscopy for TB in 1882.

Fortunately, there are now signs of increasing scientific efforts to improve the tools for TB control (drugs, diagnostics, and vaccines). Under the overall auspices of the Global Partnership to Stop TB, there are now global scientific working groups on new TB drugs, new TB diagnostics, and new TB vaccines. Despite the limitations of the currently available tools for TB control, there has been significant progress over the past decade in increasing the extent to which these tools are put into effect.

The number of countries implementing the DOTS strategy for TB control is increasing year by year, and the proportion of the world's TB patients treated under the DOTS strategy has increased from 7% in 1994 to 27% in 2000.

Increased international commitment is necessary to achieve the target of 70% global DOTS coverage by 2005.

**AIDS Alert:** Is it possible for a comprehensive TB plan to bring affordable TB drugs to a majority of those who need them in at least some of the areas where there is a high rate of active TB disease? If not, what should be done in place of this course of action?

**Smith:** Clearly a plan alone won't do anything — it's action on the basis of the plan that will make the difference. The Global Plan to Stop TB includes a description of the Global TB Drug Facility (GDF) — a new initiative of the Stop TB Partnership to secure access to high TB drugs in support of DOTS expansion.

Established in March 2001, the GDF already has processed applications from more than 40 countries and made grants to 24, totaling more than 1.1 million patients. Prices of TB drugs purchased through the GDF have fallen 30% compared with previous international prices, so that a full course of six to eight months' treatment now costs less than \$10. The GDF demonstrates that there are innovative ways of rapidly increasing access to affordable drugs. The Global Plan to Stop TB also emphasizes the importance of additional investments in developing health service infrastructure and strengthening human resources to ensure these drugs are used effectively and reach those who need them.

**Maher:** The big picture is that every country has some sort of house service and house service providers, such as nongovernmental organizations (NGOs), missions, government entities, employer health, and military policy services. We want to

harness all of these to deliver DOT strategy.

We want to see the day when all other providers deliver DOT strategy, and we're looking very hard at community groups and whether NGOs or formal groups can deliver DOTS for TB control. DOTS is only one process, and as different health service providers get involved in providing DOT strategy, we can identify people to support patients, TB treatment supports, and to provide counseling, etc. We know that very few people can manage such an arduous task of six months of TB treatment on their own, and none of us are likely to do that. So we want everyone to have a TB supporter, who can be someone on the house staff or someone in the community. This is someone who is willing to be trained and willing to be supervised and will be a buddy for the TB patient, providing emotional and psychological support and practical support.

**AIDS Alert:** How realistic are the goals (or even the name) of the Global Partnership to Stop TB?

**Steenbergen:** The goal of the Global Stop TB Partnership, to significantly reduce the burden of tuberculosis through the detection of 70% infectious cases and curing 85%, is admittedly ambitious. Peru provides a good example of a high TB burden country, which has achieved these National TB Programme targets. The broad support from the partners for the Global Plan to Stop TB brings political commitment, technical know-how, and operational expertise and experience together. This unique forum with such a wide scope of interests and expertise, guided by global principles for tuberculosis control as initiated by the World Health, has the best opportunity to tackle this disease at this point in time.

TB control is not the exclusive domain of the medical experts, but it requires input also from other disciplines. Meeting the goals of the partnership is realistic with these multidisciplinary and multisectoral collaborations and the synergy between the partners (including a wide representation of donor agencies).

**AIDS Alert:** Are there significant public health advantages to treating active TB among HIV patients when these same HIV patients will not ever have access to HIV antiretroviral treatment and will perhaps remain susceptible to TB disease?

**Maher:** Irrespective of HIV status, people with TB need prompt diagnosis and effective treatment with anti-TB drugs from the individual perspective (in order to be cured of TB) and from the public health perspective (in order to become

noninfectious to others). There is some evidence from countries badly affected by HIV that those countries with better TB control programs have been more successful in limiting the impact of HIV on TB.

While it is the case today that a tiny proportion of people with HIV in the high HIV-prevalence countries who need HAART have access to HAART, this proportion is certain to increase as the international community is galvanized into action. With widespread HAART, the incidence of TB in the countries most badly affected by HIV is likely to fall, as HAART restores immunocompetence. The public health advantages of treating TB are likely to continue at the same time that more and more people with HIV receive HAART, for three reasons:

1. HIV will continue to fuel the TB epidemic among the people with HIV who are still waiting for access to HAART during the time that availability is increasing.
2. Even in populations where HAART is widely available, not everyone benefits from HAART (e.g. some people still do not have access to HAART even where HAART is widely available, some people do not tolerate HAART, some people do not manage to adhere to HAART) with the result that HIV-related diseases still will occur in a proportion of people with HIV.
3. HAART is not curative, so it may be that HAART postpones the occurrence of HIV-related diseases such as TB until a certain period when HAART no longer controls HIV replication and people become once more immunodeficient. ■

## **FDA** *Notifications*

### **The use of lamivudine has been expanded**

In June, the Food and Drug Administration approved a supplemental new drug application from GlaxoSmithKline expanding the labeled indication to provide for the use of Epivir (lamivudine) once daily for the treatment of HIV infection in combination with other

antiretroviral agents, and a new 300 mg tablet.

The product label has been modified to reflect these changes. The "Dosage and Administration" section of the label reads:

"Dosage and administration: Adults: The recommended oral dose of Epivir for adults is 300 mg daily, administered as either 150 mg twice daily or 300 mg once daily, in combination with other antiretroviral agents (see description of clinical studies, precautions, microbiology, and clinical pharmacology). If lamivudine is administered to a patient dually infected with HIV and HBV, the dosage indicated for HIV therapy should be used as part of an appropriate combination regimen (see warnings)."

For a copy of the complete product label, go to <http://www.fda.gov/cder/approval/index.htm> by clicking "E" in the index and scrolling down to Epivir. Label is dated 6/25/02. ▼

### **Agenerase product label changed**

The labeling has been changed for Agenerase (amprenavir) Capsules and Agenerase (amprenavir) Oral Solution to reflect new precautions related to use of Agenerase with Methadone, and with oral (hormonal) contraceptives.

The new labeling reads:

"Methadone: Coadministration of amprenavir and methadone can decrease plasma levels of methadone. Agenerase may be less effective due to decreased amprenavir plasma concentrations in patients taking these agents together. Alternative antiretroviral therapy should be considered. Dosage of methadone may need to be increased when coadministered with Agenerase. Oral contraceptives: (Ethinyl estradiol/norethindrone). Those taking Agenerase should be instructed not to use hormonal contraceptives because some birth control pills (those containing ethinyl estradiol/norethindrone) have been found to decrease the concentration of amprenavir. This may lead to loss of virologic response and possible resistance to Agenerase. Alternative methods of nonhormonal contraception are recommended."

For the complete Agenerase label, go to [www.fda.gov/cder/foi/label/2002/21007s11,21039s101bl.pdf](http://www.fda.gov/cder/foi/label/2002/21007s11,21039s101bl.pdf). ■

# CE/CME

questions

13. HIV investigators say there is a growing epidemic of "club drug" use among men who have sex with men (MSM) in the United States and that this problem is placing more people at risk for HIV infection. Which drugs are rising in popularity among club-going MSM?
- cocaine, marijuana, inhalants
  - crack, heroin, marijuana
  - designer drugs, such as crystal methamphetamine, ecstasy, ketamine, GHB
  - inhalants, amphetamines, sheep tranquilizers
14. Which statement is true about the history of methamphetamine?
- Methamphetamines were invented by the Germans in the 1880s.
  - The Japanese used methamphetamine to boost alertness among WWII soldiers.
  - Methamphetamines spread from the Japanese black market in post-WWII Japan to the Pacific Rim and the West Coast of the United States.
  - All of the above are true.
15. Which is not a reason why the WHO and the international public health community have begun to embrace the idea of a joint HIV-TB prevention and treatment effort worldwide?
- Scientific evidence has shown that TB and HIV infection work synergistically to make each disease more potent.
  - Recent research has shown that by eradicating TB, communities simultaneously will begin to eradicate the HIV epidemic.
  - With the current huge global interest in making HAART widely available, there is more opportunity than ever before for HIV and TB programs to work closely together.
  - There is greater interest in, and understanding of, the need for comprehensive HIV/AIDS care, including effective diagnosis and treatment of TB as a leading cause of HIV-related illness and death.
16. A recently released survey by the FDA showed that about 89% of patients received written information about the drugs prescribed for them, but the usefulness of this information was about what percent?
- 60%
  - 50%
  - 45%
  - 35%

## EDITORIAL ADVISORY BOARD

**Kay Ball**  
RN, MSA, CNOR, FAAN  
Perioperative Consultant/  
Educator, K & D Medical  
Lewis Center, OH

**John G. Bartlett, MD**  
Chief  
Division of Infectious Diseases  
The Johns Hopkins University  
School of Medicine  
Baltimore

**Bernard Bihari, MD**  
Clinical Associate Professor  
State University of New York  
Health Science Center  
Brooklyn, NY

**James A. Cottone, DMD, MS**  
Professor and Director  
Division of Oral  
Diagnosis & Oral Medicine  
Department of Dental Diagnostic  
Science  
University of Texas  
Health Science Center  
San Antonio

**Aaron E. Glatt, MD**  
Chief  
Division of Infectious Diseases  
Catholic Medical Center  
of Brooklyn and Queens  
Jamaica, NY  
Professor of Clinical Medicine  
Albert Einstein College of Medicine  
Bronx, NY

**Lawrence O. Gostin, JD**  
Professor of Law  
Georgetown Center for Law and  
Public Policy  
Georgetown University  
Washington, DC

**R. Scott Hitt, MD**  
President, American Academy  
of HIV Medicine  
Former Chairman,  
Presidential Advisory Council  
on HIV/AIDS  
Los Angeles

**Jeanne Kalinoski, RN, MA**  
Director of HIV  
Health and Human Services Planning  
Council  
Office of the Mayor  
AIDS Policy Coordination  
City of New York

**Kenneth Mayer, MD**  
Director  
Brown University AIDS Program  
Providence, RI

**Cliff Morrison, ACRN, FAAN**  
Regional Director, Staff Development  
Telecare Corp.  
Alameda, CA

**Douglas Richman, MD**  
Chief, Virology Section  
Veterans Administration of San Diego  
Professor of Pathology and Medicine  
University of California  
San Diego

**Michael L. Tapper, MD**  
Chief, Section of Infectious Diseases  
and Hospital Epidemiology  
Lenox Hill Hospital  
New York City

**Melanie Thompson, MD**  
President and Principal Investigator  
AIDS Research  
Consortium of Atlanta  
Atlanta

*Newsletter binder full?*  
Call **1-800-688-2421**  
*for a complimentary*  
*replacement.*



## CE objectives

After reading this issue of *AIDS Alert*, CE participants should be able to:

- identify the particular clinical, legal, or scientific issues related to AIDS patient care;
- describe how those issues affect nurses, physicians, hospitals, clinics, or the health care industry in general;
- cite practical solutions to the problems associated with those issues, based on overall expert guidelines from the Centers for Disease Control and Prevention or other authorities and/or based on independent recommendations from specific clinicians at individual institutions. ■