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Multicampus outbreak of HIV in North Carolina spurs quick state action

Prevention, testing program targets black colleges

An HIV RNA screening program in North Carolina has uncovered the beginning of an outbreak of HIV infection among college students and has led state health officials to speculate that the outbreak could have an impact on youth across the Southeast.

Investigators from the Centers for Disease Control and Prevention (CDC) are studying an outbreak of HIV among North Carolina college students, focusing primarily on young black men.

Specifically, CDC investigators are surveying both HIV-positive and HIV-negative young black men to evaluate differences and better determine effective intervention strategies, says **Lisa Fitzpatrick**, MD, MPH, CDC medical epidemiologist. "Another reason this investigation is important is because it will highlight the critical need of health resources in the South," she says. "Rates of HIV are continuing to increase in the South despite dropping everywhere else in the country, or at least leveling off."

That trend is evident in North Carolina where between 2001 and 2002, there was a 9.6% increase in HIV infection; and from 2002 and through the end of September 2003, there was a 5% increase in HIV infection, says **Evelyn Foust**, MPH, branch head of HIV/STD Prevention and Care for the North Carolina Department of Health and Human Services in Raleigh.

In November 2002, North Carolina officials and investigators began screening all HIV-negative blood

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samples for HIV RNA to detect acute infections.

The Screening Tracing Active Transmission program for HIV RNA screening that North Carolina now conducts on 120,000 samples per year is the only state program of its kind in the country, Foust says.

While RNA screening is expensive per sample, researchers have discovered a way to make it cost-effective through a multistage pooling process that was launched as a pilot project in North Carolina two years ago.[1] **(See *AIDS Alert*, June 2002, p. 75.)**

RNA testing is done on blood samples from the people who visit STD and HIV clinics, counseling, and testing programs, Foust says. The screening program's success at identifying newly infected individuals and trends proves that screening for acute infection is an important state mission, she says.

"We found that we are able to find people who may have been infected two-to-three weeks ago," Foust explains. "Had we not been doing testing for acute HIV infection then, we might not have discovered [the outbreak] for a year or two."

Within three months of starting the screening program, they found five acute cases of HIV, two of which were among male college students who were attending different colleges within the same county, says **Lisa Hightow**, MD, MPH, infectious diseases fellow at the University of North Carolina in Chapel Hill. The study was presented at the 41st annual meeting of the Alexandria, VA-based Infectious Diseases Society of America recently held in San Diego.

Hightow and co-investigators found that 25 of 146 newly infected men in central North Carolina attended 11 colleges, and a sexual network linked seven of the campuses. Also, 88% of these men were African-American, and the same percentage were men who have sex with men.[2]

"So we were concerned that something was going on in the college population," Hightow says. "Then we did a retrospective review of state HIV surveillance records."

After examining the files, which included demographics, risk factors, and places of employment, from January 2002 to March 2003, investigators found 29 cases of HIV-positive college students of which 28 were men, Hightow explains. "And the cases were increasing when you plotted the epidemic curve," she says.

The newly diagnosed HIV cases involved students at 12 different colleges, Foust says.

When investigators compared HIV-positive college men with noncollege men, they found that the newly diagnosed college men were more likely to be African-American, to have sex partners who were either only male or both male and female, to use club drugs, and to meet their sex partners over the Internet and through bars and clubs, Hightow explains. By creating a chart linking sexual partners, researchers discovered that while the cases were spread out among colleges, the colleges could be linked on the chart, she adds.

Investigators also found that between 40% and 50% of all new infections of HIV in the state occurred among people younger than 25, Foust says. A significant percentage of these new infections also were among college students.

"About 14% of new diagnoses in the 18-25 age group were among college students," Hightow points out. "We found 56 cases of newly diagnosed HIV among college men in that age group, compared with 367 newly diagnosed men in that age group who were not in college."

Investigators notified the universities where HIV cases were found before they presented their data for the first time at the 2003 National HIV Prevention Conference held July 2003, in Atlanta.

Then in August, the CDC team arrived. Its investigation should conclude by the end of 2003, Fitzpatrick says.

"Now that we've discovered the problem, we're moving to the point where we have to do something about it," Foust says. "It's of concern and depressing to me that here we are in 2003, and we have identified a new generation that has apparently not heard or has heard and not embraced the prevention messages that will keep their generation safe from HIV infection."

This outbreak is a wake-up call for North Carolina and other southern states where there are problems with access to health care, cultural taboos regarding discussions of sex and HIV, and continued discrimination and stigma attached to homosexuality, she states. "We have to work with communities to identify those barriers and to create safer places for people to seek voluntary counseling and testing," Foust says.

Sexual education and HIV prevention messages also need to reach young people, and this also has been lacking, she continues.

"For the most part, in North Carolina and the South, the schools do not take the lead in providing health education around transmission of disease through sex, so there's a huge gap there," Foust says. "I think that's one of the things that is contributing to the lack of awareness in our

young people who have sex."

North Carolina and the state's long-standing minority colleges are collaborating in a program called Project Commit to Prevent, which provides peer education training for HIV counseling and testing.

Close to 40,000 students are enrolled at the 12 institutions, which are participating in Project Commit to Prevent, says **Phyllis Gray**, MPH, project manager for the North Carolina Division of Public Health in Raleigh. Gray is in charge of the project. North Carolina has more historically minority colleges and universities — most of which date back more than 100 years — than any other state, she says.

HIV and STD data show that these institutions typically are located in counties in which there are high rates of HIV and STDs, Gray explains. "When you look at who these communities are, you see they are communities of color; and when you look at the data in general and see who is disproportionately affected by this disease, you see they are communities of color. It only makes sense to go to these universities and ask them to use the strength they have to not only focus on student populations, but in time, to work with us in reaching the larger populations around their campus," she says.

North Carolina public health officials contacted the 11 black colleges and the one Native American college in the state and began to work with them to enhance on-campus counseling and testing options and prevention education. **(See story about the Project Commit to Prevent, at right.)**

While public health officials anticipate that this program will have a positive impact on the HIV epidemic's spread among college students, they also plan to implement changes suggested by the CDC after the investigators have completed their research and report.

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State works with colleges on testing and prevention

State officials say more funding is needed

North Carolina's recent discovery of an HIV outbreak among college students across a wide network of universities has made the public health challenge clear: Either make effective prevention, testing, and counseling services available to at-risk youths, or expect in a few years to add more young people to the state's waiting list for HIV medications.

Operating on a shoestring budget, the state has implemented a Project Commit to Prevent program. It includes collaboration from 12 minority colleges to provide HIV and STD prevention and risk-reduction education programs on campus, enhance the capacity of health services on campus, and strengthen links between institutions and other HIV/STD service providers, says **Phyllis Gray**, MPH, project manager in the North Carolina Division of Public Health in Raleigh. Gray is in charge of the new Project Commit to Prevent, which is being implemented at the 12 colleges.

The state has agreed to provide $111,000 in funding for HIV prevention at the institutions where state officials recently identified students who have been newly infected with HIV, she says. The public health branch has provided additional funding for testing and counseling training and peer educator training, but the money that's available remains insufficient to expand the program to include services such as rapid testing, Gray adds.

To public health officials, the dichotomy between what they could do to stem the recent HIV outbreak and what they can do, given funding limitations, is frustrating.

"We have the ability to detect new outbreaks like this one, but we don't have the resources to deal with it," says **Evelyn Foust**, MPH, branch head of the HIV/STD Prevention and Care, North Carolina Department of Health and Human Services in Raleigh.

As any state official such as Foust who works with the AIDS Drug Assistance Program (ADAP) can assert, it's considerably cheaper to prevent new infections than to handle the cases once infection has taken place. However, even that funding, whether from the federal government or state, is hard to find. "I'm confused about how many bodies with new HIV infection we have to keep

counting before the South gets attention," she says. "I don't feel hopeless about it, but I feel angry and frustrated; we have an incredible amount of work to do."

Nonetheless, the project has been well received at the targeted campuses, and it is beginning to succeed with some of its HIV prevention goals. Here's how the program works:

- **State health officials seek partnerships with colleges.**

"We made contact with each campus using an invitation to a partner approach, and we invited representatives from their student health services, both from the nursing department and the health education department," Gray says. Invitations also were sent to college chancellors and presidents' offices. "We had an exploratory meeting in February 2003, to lay out the nature and scope of the problem as we saw it and to listen to them say what they thought would be an appropriate role for each campus," she explains.

State health officials asked the college representatives what sort of resources were needed for them to provide better HIV and STD prevention work. Although all of the colleges have STD testing available, some of them have to charge students for the service; so it's questionable how much students seek STD services on campus, she says. Several colleges already were doing innovative peer education work that could be adapted to fit an HIV model, Gray says.

Through the meetings, state officials learned none of the colleges offered HIV testing and counseling services on their menu of student health services but would rely on the local health departments to come on campus to provide the service, she notes. "They spoke about a hesitancy among students to be seen at the student health services on a particular day of the month when HIV testing might be offered. Sometimes students were referred off-campus for testing and counseling."

However, the drawback to referring students off-campus is that they may delay being tested because the site requires finding time and transportation that are not always easy for college students, she points out.

- **The program emphasizes student participation.**

At the first partnership meeting, college representatives said the project needed to involve students and empower them to help make decisions about the best way to launch the program on campuses, Gray says. As a result, each campus has an advisory committee, and students are represented on each of the planning groups.

Also, there is a peer educator training program, and each campus sends four representatives to the training. The representatives are lead recruiters who return to the schools to talk about peer education on their campuses and to organize the program, she adds.

"Eleven campuses already had peer educators, so many of the schools were going to add HIV and STD education as a component of what they were doing," Gray explains. "Some of the schools had date rape education and substance abuse as part of their peer outreach."

One of the schools decided to focus peer education solely on HIV and STD issues, and another school decided to expand its HIV/STD efforts

The school that had an HIV/STD peer education program in place prior to the Project Commit to Prevent serves as a consultant to other peer educators, she says.

Peer educators provide dorm outreach and organize safe sex messages to be presented at various campus activities. "Part of the program is to get other student leaders on campus to take [HIV education] on as part of some of their school activities, such as having sororities and fraternities do this as community service work," Gray says.

Early next year, the state will sponsor a project leadership forum for all 12 schools, she states.

"We'll pull together not only the peer educators, who will be doing the hard, grass-roots work, but other peer leaders on campus to come to a student forum with the goal of looking at how you can make this a lasting initiative on your campus and how you can make a difference in your community," Gray says.

- **Testing and counseling services are designed for colleges.**

Project Commit to Prevent has designed counseling and testing training specifically to be used on college campuses. Training was provided to college representatives July 2003, she says.

The training was similar to what has been provided to local health departments and nontraditional testing and counseling sites, Gray explains. "They were trained for pre- and post-counseling."

Also, state health officials conducted an inventory of all the campuses to see whether they had the capacity to do the HIV testing, and all of them do, she adds.

"The state is going to pick up the cost of their having the blood work analyzed, so they'll send samples to the state lab," Gray says.

Once the college staff completed the training, they were given a lab ID number and were told to

call the program for assistance once they were ready to begin offering HIV counseling and testing services to students.

The calls have been coming in slowly as some of the colleges still had a bureaucratic process to complete before the testing services could be implemented, Gray points out. "Last week, the director of one of the student health services said that she'll inform any student who comes into the clinic that the HIV test is available, and that if the student has done any of these risk behaviors, the student may want to be tested," she says.

The colleges will vary in how aggressively they will market their HIV services, Gray notes.

- **Students are surveyed about HIV knowledge and risk behaviors.**

One of the institutions developed a student knowledge and behavior assessment that was distributed to the coordinators who head the project on each campus, she says.

"The coordinators received a copy of the assessment, and we jointly looked at it and made modifications," Gray says. "Every school is going to use the assessment as part of their baseline data."

Questions on the assessment include:

— How much do you know about HIV?
— Where do you now get your information?
— Have you ever been tested for HIV before?
— Do you think you're at risk for HIV?
— Have you been sexually active?
— Did you use protection?

"Our goal is to get as many surveys done as possible," she continues. "Everyone is aiming for 300 to 400 surveys per campus, and each campus will receive their own information."

The state will receive a composite of all of responses, which will give state health officials a good idea about what the students know and how the state should best design intervention programs targeting those most at risk, Gray adds. ■

How a Nashville church became prevention leader

Faith ministry reaches out to MSM, prostitutes

The Metropolitan Interdenominational Church of Nashville, TN, was about 3 years old in 1984 when the congregation learned that one of the founding members had died of a little-known disease called AIDS.

"We were unaware of what the disease was, and so we began to educate ourselves," says the Rev. **Edwin C. Sanders II**, a senior servant and a founding member of the church. "And that education translated into our getting involved in doing education, initially in our church community, but then in our larger community."

Now 20 years later, the church has paved new ground in showing what a faith-based institution can do to educate the public about HIV/AIDS and provide compassionate care to people who are infected with the disease.

In 2002, about 5,000 people received help from the church's First Response Center, and 296 people received case management assistance, says **Sharon L. Crawford**, PhD, executive director of Metropolitan Interdenominational Church First Response Center, which houses all of the church's ministries.

The church also spreads its HIV education and prevention to other churches through the Metropolitan Interdenominational Church — Technical Assistance Network (MICTAN), which receives funding from the Centers for Disease Control and Prevention (CDC) of Atlanta, says **Jacqueline Fleming Hampton**, PhD, capacity building and evaluation coordinator of MICTAN. **(See story about MICTAN, p. 155.)**

With programs that target the African-American community, men who have sex with men (MSM), and disenfranchised people, the church has been filling in a gap that AIDS activists and public health officials long have lamented: The church is able to reach at-risk minorities and others who may not acknowledge their own HIV risk behaviors, and at the same time, the church is able to offer acceptance and understanding for people who are HIV-positive.

"The church is the place where people turn to when they're in a crisis," Sanders says. "The church ends up being the hub of benevolence in our community."

For Crawford, who was a member of the church before she was hired to head the First Response Center, the combination of faith and health is a natural fit. "From a biblical perspective, Christ went to those who others didn't go to, and he brought comfort to them and healed them," she says. "What you hear from our church is that it's our role to provide assistance and services to respond to the needs of those who are oppressed, disenfranchised, and disconnected from mainstream society."

Here are some of the programs offered through the church's First Response Center:

- **Men of Faith, Men of Color Prevention, Education, Enhancement, & Referral**

This project targets African-American men and women who are at risk for HIV infection through a variety of services, including the Prevention Education Enhancement & Referral (PEER) service. "We have a women's prevention curriculum that targets African-American women, but have begun using it for everybody," Crawford says. "We offer it in two arenas, including institutional settings, such

Church becomes leader in mobilizing others

When a Nashville, TN, church spreads the word about HIV/AIDS education, the repercussions can be felt hundreds of miles away.

The Metropolitan Interdenominational Church mobilizes churches in Tennessee, Alabama, and elsewhere to offer their congregations and communities education, information, and understanding about HIV and AIDS.

"We feel that if you're going to mobilize faith communities, then you need the leaders themselves to be equipped and knowledgeable about all aspects of HIV and the new developments that surround HIV prevention," says **Jacqueline Fleming Hampton**, PhD, capacity building and evaluation coordinator of the Metropolitan Interdenominational Church — Technical Assistance Network (MICTAN).

With funding from the Centers of Disease Control and Prevention (CDC) of Atlanta, for capacity building, the MICTAN program has held workshops for pastors and deacons and has been contacted in the past three years by more than 80 churches requesting technical assistance, she says.

While MICTAN is available to provide assistance to organizations that contact the CDC, most of its work has been proactive, Hampton adds. "We build a lot of grass-roots organizations that are not funded at all, and we see them get funding. We provide technical assistance so that they can posture themselves to reach more individuals."

Sometimes MICTAN's efforts result in small changes, such as a church that now makes HIV pamphlets available to parishioners, when previously the church never addressed the subject. Churches also have held mini-health fairs where HIV is featured, and church choirs are beginning to sing healing music for their congregations. "We did a major community mobilization event where we had singer Richard Smallwood and the Nashville Community Choir," Hampton recalls. "As a result of that, some churches have begun to identify music they can use as healing songs for their congregations."

In other cases, MICTAN has lit a spark under other churches, encouraging them to take a leadership role in addressing HIV education in their communities. For instance, a physician who learned about MICTAN through a Metropolitan church member visited the Metropolitan Interdenominational Church First Response Center to ask for help in providing an HIV prevention and education workshop through his Montgomery, AL, church, she says.

"Individuals will call us because we may have been at a conference, doing a major paper or presentation, or talking about how to mobilize," Hampton explains. "Our presence also has ignited ministers to become part of community planning groups, when they normally would not have even known about the group."

Here are some of the programs and assistance offered by MICTAN:

✔ **Workshops and conferences**

MICTAN held a two-day clergy forum and deacon leadership conference in Montgomery in which more than 50 people attended. The program also has held summer workshops for faith-based organizations. These workshops cover community resource development, community needs, and mobilization work.

✔ **Technical assistance upon request**

MICTAN staff teach other organizations how to develop infrastructure, conduct a community needs assessment, create community awareness, develop networks, establish linkages, and make HIV policy, Hampton points out. Other services include providing skills building, information transfer, technical consultations, and MICTAN will develop brochures and other educational materials for organizations that are inexperienced with this, she says.

✔ **Cultural sensitivity**

MICTAN staff teach ministers and others how people with HIV and AIDS may look like a lot like themselves and people in their congregation.

"In our presentations, we make a concerted effort to let individuals know this is not a gay disease, and gay-bashing will not be the solution to the problem," Hampton adds.

"We want them to understand how behavior [affects] the probability of contracting HIV, and it's not the church wall that protects you from this," she says. "You have to dig deeper and realize that there are other core issues that put a person into a situation where they become involved in risky sexual behavior, and there is no way to look out at your congregation and identify who is [HIV]-positive and who isn't."

✔ **Testing counseling certification training**

MICTAN provides a pre- and post-test counseling and certification training program in which ministers are trained to counsel people about HIV at the time of the HIV test.

The program is offered to small groups and includes training with the rapid HIV test, Hampton says. ■

as the county jail and residential treatment facility; and we offer it in a retreat format."

Retreats are one-day, eight-hour workshops for women in faith-based settings, she says.

The curriculum, which also can be set up in six shorter sessions, provides a holistic overview of HIV risk behaviors. "It's for women who don't necessarily see themselves as being at risk, but may be at risk because they're ill informed and don't have good information about HIV and the risk of HIV," Crawford says. "It focuses on helping women understand themselves better by increasing self-awareness, self-efficacy, and providing them with information that will help them make better decisions about their health and behavior."

Another component of PEER focuses on men who have sex with men (MSM), again targeting a group that doesn't receive HIV prevention messages within the community, she says.

"A lot of men in faith settings are on the down low, meaning they aren't going to places where they could access information," Crawford explains. "And they're more at risk because they engage in clandestine meetings when they're out of town and where they think they're safe, and no one will find out."

These men might be having sex with male prostitutes in exchange for drugs or money, she says.

"Although there are a lot of prevention activities for [MSM], I don't think we have a lot for that particular population," Crawford adds.

Through the Men of Faith project, staff outreach workers also target men on the streets, including male prostitutes.

"They offer meals to male prostitutes and offer them a place to come and talk," she says. "They may come to us because they are living with HIV or because they used drugs but weren't revealing they were engaging in MSM behavior."

These men also may be referred to substance use programs and treatment.

Often, the MSM reached by the program heard about it through their own churches and went to the Metropolitan church's First Response Center because they were assured of their anonymity and told they could receive confidential HIV testing, Crawford says.

She contends the program, which is in its infancy, is beginning to show signs of success because of the trust that is building between the minister who helps run the program and the MSM of color who seek help.

"The minister is very careful not to do anything that would break that relationship of trust," Crawford says.

- **First Response Wellness Center**

Supported by Ryan White funds, the wellness center has various support groups, including one for women, a coeducational support group, and a group that provides services to MSM, says **Beverly Glaze-Johnson**, BSW, case manager of the First Response Wellness Center.

The center also offers nutritional counseling and referral, transportation services, a comprehensive wellness plan, and pastoral counseling and care, she says.

It's support services include individual and family counseling, emergency rental and utility assistance, and financial help for homeless individuals and others who need money to obtain a state identification card and birth certificate.

"We take them down to the driver's license bureau and help them get state identification," Glaze-Johnson says. "We will provide clients with a gift card to take to a local grocery store so they can feed their family."

The program receives referrals from AIDS service agencies, clinics, hospitals, and medical providers, she says. "We work with a largely inner-city population, and when people are in crisis, many times the first place they turn to for help is the church."

- **Metropolitan Community AIDS Network (Metro CAN)**

Metro CAN works to improve health within the African-American community through providing a variety of services, including:

  - — HIV-prevention community outreach;
  - — HIV risk-reduction interventions;
  - — HIV testing and case management services;
  - — referrals for substance abuse treatment;
  - — referrals for health and mental health services;
  - — spiritual nurturing and support, including a psychoeducational support group for women and men in recovery;
  - — weekly recreational outlet for people in recovery.

- **Outreach to injection drug users and substance abusers**

Methadone Outreach Recruitment Retention & Enhancement provides assistance to African-American injection drug users through a collaboration with Middle Tennessee Treatment Center. The treatment center provides methadone maintenance treatment to opiate users, as well as other

services, including medical evaluations and care, counseling, detoxification, acupuncture, and testing for tuberculosis and STDs.

The First Response Center also has an Alcohol and Drug Coordination program in which HIV-positive individuals are assisted with gaining access to alcohol and drug treatment services. The program also assesses substance abuse problems, refers people to treatment facilities, and provides intensive case management.

- **International HIV/AIDS outreach**

Through Partners For Life (PFL), the church provides an international ministry that seeks to establish partnerships between faith-based and community-based organizations with South African orphanages, where many children have lost their parents to AIDS. PFL recruits United States organizations and identifies and recruits orphanages in hopes of providing some relief and assistance to some of the estimated 420,000 children orphaned by AIDS. ■

Special Coverage of 41st IDSA Conference

Study: Syphilitic hepatitis connected to liver disease

Diagnosis is uncommon, but does occur

Investigators in Washington, DC, have discovered cases of HIV patients who have significant liver dysfunction that is caused by secondary syphilis instead of the usual suspects of hepatitis C, medication side effects, and substance abuse.

"We had a few patients we were diagnosing initially, and we decided to look for more cases and see if there were any more within our program and practice, and we found a few more cases," says **Charu J. Mullick**, MD, a resident and fellow at George Washington University in the department of infectious disease in Washington, DC.

"A lot of times you have patients with liver function abnormalities that you can attribute to alcohol abuse or medication side effects," she says. "But one thing to keep in mind is that syphilis also can affect the liver."

Since 2001, investigators identified five HIV-infected patients with syphilitic hepatitis, and all five had a rash. Jaundice, fever, and abdominal pain were each experienced by two patients.[1]

The patients who had jaundice were admitted to the hospital to find out what was causing the condition, Mullick notes. Clinicians screened each of the five patients for syphilis as part of a general lab work-up, and that's how the infection was discovered, she says. "Most of these patients previously had negative syphilis serologies."

Previous syphilis tests were conducted from six months to 1.5 years earlier, Mullick adds.

The case series suggests that clinicians should consider syphilitic hepatitis as a potential cause for liver dysfunction when they are treating HIV-infected patients, she says.

"If there are liver abnormalities, they should keep syphilis in mind," Mullick adds.

With syphilitic hepatitis, the treatment is antibiotics, and the liver will return to normal, so it's easy to diagnose and easy to treat, if clinicians think to check for this infection as well as other potential causes of hepatitis, she explains.

There are little data on how HIV patients are affected by secondary syphilis, which is why Mullick and co-investigators decided to study this co-infected population. "We're trying to understand why syphilitic hepatitis is undiagnosed and unreported, and as we gather more patients we may have an answer," she says.

Reference

1. Mullick CJ, Liappis AP, Benator DA, et al. The presentation of syphilitic hepatitis among HIV-infected patients: A case series. Presented at the 41st annual meeting of the Infectious Diseases Society of America. San Diego; Oct. 9-12, 2003. Abstract 625. ■

Special Coverage of 41st IDSA Conference

Primary care doctors fail to offer tests, survey says

Medical students need additional training

A new survey shows that most primary care practitioners often fail to offer HIV testing to their sexually active patients, and many even neglect to offer the test to pregnant patients.

With estimates that the HIV epidemic in the United States affects nearly 1 million people and one-third of these people are undiagnosed, testing and counseling should be a routine part of physicals and physician-patient care as is recommended by the Centers of Disease Control and Prevention (CDC), says **Curt G. Beckwith**, MD, infectious disease fellow at Brown University

School of Medicine in Providence, RI.

"Right now, testing is done on a targeted basis," he says. "If a patient presents with some kind of disease syndrome consistent with HIV, or if the physician is suspicious the patient has HIV, then that's how they do testing."

The current CDC and medical community push is for HIV testing to become as routine as a Pap smear, where it's given routinely without first going through a risk assessment, Beckwith says. "That way you will diagnose more people with HIV because it's a routine part of medical care."

Beckwith and co-investigators decided to see if medical practitioners were doing routine HIV testing by surveying 108 family practitioners and 63 internal medicine house officers from Rhode Island. They also surveyed 516 fourth-year medical students from 19 states.[1]

Physicians were asked whether they routinely offer HIV testing to patients, and a separate question asked whether they routinely offered the test to pregnant patients. "That is one setting where the recommendations are stronger," he adds. "Without exception, every pregnant woman should be offered an HIV test."

The survey found that 86% of practitioners did not routinely offer HIV testing to all sexually active patients, and about half were not routinely offering it to their pregnant patients, Beckwith says. The family physicians surveyed may be providing obstetrical care, but that distinction wasn't made in the survey.

Since the survey clearly showed that HIV testing isn't being done routinely, perhaps because of time and financial constraints, investigators separated the answers from medical students and residents to see if they are offering the HIV testing often enough, given that most of these physicians are in hospital settings, he explains.

"We looked at medical students to see how much they were being educated on HIV testing and counseling; and basically, they were not being educated enough," Beckwith says.

For instance, 81% of the medical students had not received formal training in HIV testing and counseling, and 94% of the medical students believed HIV testing should be a part of the medical school curriculum to provide them with formal training, he points out.

"Residents aren't doing enough HIV testing, and they are not being trained enough," Beckwith says. "So we're saying we need to concentrate more on teaching medical students how to do it and teach residents how to do HIV testing and counseling."

Residents should be encouraged to ask themselves of every patient, "Should I test this patient for HIV?" he states. "Right now, they're not thinking about it."

In the outpatient settings, primary care physicians should consider suggesting to all patients, ages 18-55, that they have an HIV test every year if they are sexually active," Beckwith says. "Patients who are sexually active with multiple partners should get a test every six months."

If a patient is married and opts out of the test, then that's OK, because it's the fact that the physician is thinking about it that's important. he says. "If you offer the test in that way, then the patient will begin to expect it, and it will be a more acceptable thing. And they don't have to be asked about their drug use and sex life if you make testing routine." And that really is the whole point: to make HIV testing so routine that it eventually will lose the social and political stigma, he adds.

Reference

1. Beckwith CG, Boutwell A, Simmons E, et al. Barriers to routine HIV testing and counseling. Presented at the 41st annual meeting of the Infectious Diseases Society of America. San Diego; Oct. 9-12, 2003: Abstract 611. ■

AIDSinfo starts new Live Help web service

AIDSinfo recently began a new service on its web site called Live Help. AIDSinfo is a web site sponsored by agencies within the Department of Health and Human Services. AIDSinfo presents federally approved information on HIV/AIDS treatment and prevention guidelines, a comprehensive database of both government and industry-supported HIV/AIDS clinical trials, and information about approved and experimental HIV/AIDS drugs, and vaccines.

Live Help provides confidential, one-on-one assistance via the Internet in an instant-message-like setting. AIDSinfo information specialists are available Monday through Friday, 12 p.m. to 4 p.m. Eastern Time.

Live Help can help learners navigate the web site and/or answer questions about HIV/AIDS research, clinical trials, and treatment. Staff are trained health information specialists who are knowledgeable about HIV/AIDS hotlines, publications, web sites, and other information about

HIV/AIDS-related resources.

For more information, go to: http:aidsinfo.nih.gov. Live Help can be accessed by going to http:aidsinfo.nih.gov/live_help/. ■

FDA Notifications

Gilead issues letter about virologic failure

Gilead Sciences Inc. in Forest City, CA, has issued a "Dear Health Care Professional" letter describing high rates of virologic failure in patients treated with a once-daily triple NRTI regimen containing Didanosine (ddI, Videx EC), Lamivudine (3TC, Epivir), and Tenofovir (Viread).

Here's a copy of the Oct. 14 letter from **Jay Toole**, MD, PhD, senior vice president of clinical research for Gilead:

"Gilead Sciences Inc. is writing to inform you of a high rate of early virologic failure and emergence of nucleoside reverse transcriptase inhibitor [NRTI] resistance associated mutations observed in a clinical study of HIV-infected treatment-naive patients receiving a once-daily triple NRTI regimen containing didanosine enteric coated beadlets [Videx EC, Bristol-Myers Squibb], lamivudine [Epivir, Glaxo-SmithKline], and Tenofovir disoproxil fumarate [Viread, Gilead].

"These new data are consistent with the high rates of virologic failure observed in several recent clinical studies that have evaluated the use of triple NRTI regimens.

"Based on these results: Tenofovir DF in combination with didanosine and lamivudine is not

CE/CME *directions*

To complete the post-test for *AIDS Alert*, study the questions and determine the appropriate answers. After you have completed the exam, check the answers **on p. 160.** If any of your answers are incorrect, re-read the article to verify the correct answer. **This concludes the current semester.** Complete and return the enclosed evaluation form to receive your credits.

CE/CME *questions*

This concludes this CE/CME semester. **(For directions, see box, below left.)**

21. In the summer of 2003, an investigative group from the CDC visited North Carolina to study an HIV outbreak among which group of people?
    A. homeless people
    B. injection drug users in the Triangle area
    C. college students at traditionally minority colleges
    D. young urban professionals in the state's major cities

22. The Metropolitan Interdenominational Church of Nashville, TN, has an extensive HIV counseling, prevention, testing, and care program that targets disenfranchised at-risk groups, as well as others in the community who are at risk for HIV infection. What is a potential group that a church, such the Metropolitan church, can reach that other organizations may not be as successful in reaching?
    A. churchgoing or other minority men who have sex with men but do not identify themselves as gay or bisexual
    B. low-income minority women
    C. teen-age injection drug users
    D. homeless people

23. When a clinician sees an HIV-infected patient who has liver abnormalities, which of the following is a fairly rare cause for which the patient should be tested?
    A. hepatitis C
    B. alcohol abuse
    C. medication side effects
    D. syphilitic hepatitis

24. The CDC says HIV testing should be offered routinely to sexually active patients. Rhode Island investigators surveyed family practice doctors and residents to see how often the test is offered routinely, and made this discovery:
    A. HIV testing was not offered routinely to all sexually active patients by 86% of practitioners, and about half did not routinely offer it to pregnant women.
    B. About 35% of clinicians routinely offered the HIV test to all sexually active patients.
    C. More than 60% of clinicians routinely offered the HIV test to all sexually active patients, and more than 90% routinely offered the test to all pregnant patients.
    D. none of the above

recommended when considering a new treatment regimen for therapy-naive or experienced patients with HIV infection. Patients currently on this regimen should be considered for treatment modification.

"In a 24-week, single-site, pilot study (N=3D24) designed to evaluate the safety and efficacy of a triple NRTI once-daily regimen of didanosine EC (250 mg), lamivudine (300 mg), and Tenofovir DF (300 mg) in HIV-infected treatment-naive patients, Jemsek, et al. (Oral Communication, September 2003) have identified a high frequency of virologic failure (91%), which was defined as < 2 log10 reduction in plasma HIV RNA level by Week 12. Resistance testing was performed on 21 patients; 20 patients (95%) had M184I/V, and 10 of these patients (50%) had K65R in addition to M184V. As a result of this high early failure rate, study enrollment was stopped.

"Suboptimal virologic response has also been reported with the use of the triple NRTI regimen abacavir/lamivudine/zidovudine (Trizivir) (Gulick 2003) and abacavir/didanosine/stavudine (Gerstoft 2003), and similarly early virologic failure and high rates of resistance mutations have been reported with abacavir/lamivudine/ tenofovir DF (Farthing 2003, Gallant 2003). Overall, these studies demonstrate a lower response rate in patients on a triple NRTI regimen.

"Furthermore, they indicate that patients who achieve viral suppression on a triple NRTI regimen have a higher rate of virologic failure.

"Please report all adverse events, following or coincident with the use of Viread, to Gilead Global Drug Safety at (800) GILEAD-5, option 3 — or to the FDA MedWatch Program by phone at (800) FDA-1088; by fax at (800) FDA-0178); by mail (using postage-paid form) to MedWatch, FDA, 5600 Fishers Lane, Rockville, MD 20852-9787; or via the Internet at www.accessdata.fda.gov/scripts/medwatch." ■

CE/CME *answers*

Here are the correct answers to this month's CE/CME questions.

21. C
22. A
23. D
24. A

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. ■

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