Summer 2004 Volume 8, Issue 2

The WIHS Woman

The Connie Wofsy Women's HIV Study

New WIHS Sub-Study
The Cardio-Vascular Study

By Claudia Ponath

During visit 20, the WIHS is starting a new study at all the national WIHS sites: **The Cardio-Vascular Study**. This study looks at women's risk of developing heart disease. There is some indication from other studies that people with HIV and people who take certain HIV medications may have an increased risk of developing heart disease, so the WIHS researchers want to take a closer look at the risk for heart disease in the WIHS women.

There are three components to this new study: The **first** component we have already been doing – we are asking those of you who are fasting for their core visit if we can collect an extra two tubes of blood. Blood from these tubes will be used for special lab tests for heart disease that are not usually done in a clinical setting.

The **second** component requires an extra study visit. This visit consists of an ultrasound of the right carotid artery - that is the artery in your neck. An ultrasound is a safe and painless procedure that is used to take a picture of your artery. It is a way for us to measure how thick the wall of your artery is. A thickened wall of the artery in your neck may be a risk factor for heart disease. Depending on the result, we may ask you to come back for another ultrasound 3 years later. At this visit, we will also ask you to complete a short food questionnaire. The visit will take place at the San Francisco VA Medical Center at 4150 Clement Street at 43rd Ave. The VA is easily accessible by public transportation (the 38 Geary goes right there, and the UC shuttles also go out there). Parking is also easily available. The whole visit will take about one hour and the reimbursement is $30. We will start these visits in July.

The **third** component is that for those women who tell us that they have had any serious cardio-vascular illnesses, such as a heart at-

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tack, a stroke, or a hospitalization due to congestive heart failure, we will ask permission to look at the medical record for those illnesses. We look forward to seeing you at VA for your ultrasound!

Thank you all for continuing to participate in the Women's Study. We truly appreciate your commitment to the study!

Cancer updates from the Women's Interagency HIV Study (WIHS)

By Nancy Hessol

The WIHS has participated in the National Cancer Institute-funded AIDS and Cancer Specimen Bank (ACSB) since 1999 and has collected fresh-frozen tissue from the cervix, vagina, and vulva. Specimens from the three eastern WIHS sites are sent to the George Washington University Medical Center ACSB; specimens from the other three WIHS sites are sent to the University of California, San Francisco, Specimen Bank. Through December 2003, the WIHS has contributed to the ACSR 743 fresh-frozen tissue biopsies, 555 peripheral blood mononucleocytes, and 1566 plasma specimens from women seen during 430 biopsy-specific WIHS visits.

Important Study Findings

Human papillomavirus (HPV) type 16 is the cause of approximately half of all cervical cancers. It is important, therefore, to determine the characteristics that distinguish HPV 16 from other HPV types. A preliminary result based on baseline data in the WIHS suggested that the prevalence of HPV 16 might have a weaker association with immune status in HIV-infected women than that of other HPV types. To address this issue, researchers examined HPV test results from repeated study visits in the WIHS and a similar multicenter cohort study the HIV Epidemiology Research Study (HERS). This analysis systematically compared individual HPV types on the strength of their association with immune status, as measured by CD4 cell counts in HIV-infected women. The results suggest that HPV 16 may be better at avoiding the effects of immune surveillance, which could contribute to HPV 16's strong association with cervical cancer. (Strickler et al. J Natl Cancer Inst 2003;95:1062-71)

Numerous epidemiological studies of HIV-uninfected women have examined immunological responses to cervical HPV infection by measuring antibodies to virus-like particles (VLPs). A couple of small studies have looked at seroreactivity to HPV VLPs among HIV-infected women and found a higher HPV seroprevalence among HIV-infected women than among HIV-uninfected women, but neither study examined other risk factors for HPV seropositivity. A recent study examining serum specimens from women enrolled in the WIHS and the HERS found that HPV -16 seropositivity was associated with lifetime number of sex partners ($p<0.001$) among both HIV-infected and HIV-uninfected women. Approximately 50% of HIV-infected women had serological evidence of prior HPV-16 infection, but only about 5% had an HPV-16 cervical infection at baseline. Despite the higher prevalence of HPV infection in this group, most HIV-infected women are able to control HPV-16 replications at the cervix, and reactivation, if it occurs, is not very common. (Viscidi et al. J Infect Dis 2003;187:194-205.)

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Women with HIV express oncogenic HPV at high rates, and persistent HPV infection has been linked to invasive cervical cancer (ICC) risk. Longer survival with highly active antiretroviral therapy (HAART) may allow ICC to emerge in women who might otherwise have died as a result of opportunistic infections. To determine the magnitude of ICC risk for women receiving regular medical care and standard cancer prevention services, cervical cancer incidence was examined in the WIHS. No incident ICC cases were observed in HIV-uninfected WIHS participants during 2375 woman-years of observation. During 8260 woman-years of observation in HIV-infected WIHS participants, eight putative incident cases of cervical cancer were identified but only one was confirmed, yielding an incidence rate of 1.2/10,000 woman-years (95% confidence interval, 0.3-6.7/10,000 woman-years). The difference in incidence between HIV-infected and HIV-uninfected women was not significant (P=1.0). This showed that ICC is uncommon in HIV-infected US women participating in a regular prevention program. (Massad et al. AIDS 2004;18:109-113.)

Few studies have assessed the effectiveness of HAART on reducing the incidence and recurrence of oral lesions. A recent study investigated just that among 503 HIV-infected WIHS participants over six years of follow-up. Analysis of the data demonstrated a strong decrease in candidiasis after HAART initiation. No changes were seen in hairy leukoplakia or warts. Higher HIV-1 RNA was associated with a greater incidence of candidiasis and hairy leukoplakia, but not warts. These findings indicate that recurrence and incidence of candidiasis are reduced by HAART, and that recurrence is reduced independently of CD4 and HIV-1 RNA. (Greenspan et al. J Dent Res 2004; 83:145-150.)

The HIV epidemic has been associated with an increased incidence of specific types of cancers. However, less is known about cancers occurring in HIV-infected women than men. To determine the risk of cancer among HIV-infected and at-risk HIV-uninfected women, investigators compared cancer incidence data from the WIHS to data from the population-based United States SEER registry. In summary, HIV-infected WIHS women had increased incidence rates for Kaposi's sarcoma and non-Hodgkin's lymphoma, but not for invasive cervical cancer. Both HIV-infected and uninfected women had increased incidence rates of lung cancer, when compared to population-based expected rates. (Hessol et al. 7th International Conference on Malignancies in AIDS and Other Immunodeficiencies, Bethesda, MD, April 2003.)

A number of studies, including the WIHS, have found HIV-infected women to have lower than expected rates of breast cancer. Investigators therefore examined the distribution of various established breast cancer risk factors among women in the WIHS cohort. There was no increased risk of incident breast cancer among either HIV-infected or HIV-uninfected WIHS women. Fewer WIHS women, compared to the general population, were found to be at high risk of breast cancer based on a number of factors known to reduce risk: lower social class, early age at first childbirth, high parity, and low alcohol intake. These findings indicate that the apparent deficit of breast cancers among women in the WIHS can be explained by their overall lower risk, given the distributions in this population of a number of established breast cancer risk factors. (Preston-Martin et al. 7th International Conference on Malignancies in AIDS and Other Immunodeficiencies, Bethesda, MD, April 2003.)

CAB CORNER

By Anna Groskin,
Dear WIHS Women:

I know you're all used to hearing from me about sub studies, but now I have some personal news to share. When I started working at the WIHS two years ago, I knew it was going to be an amazing experience. But I did not realize then that it would be an experience that would shape the rest of my life. I've decided to pursue a career in medicine and will be leaving the WIHS at the end of April to take classes in preparation for medical school. It has been a joy and an inspiration to get to know all of you that I have been lucky enough to meet. I want you all to know what a strong and beautiful group of women you are, and I hope that some day soon we will cross paths again. If my Californian fiancé has anything to do with it, I may be back in the Bay Area in a few years! Good luck to you all and have a fabulous summer!

Best,
Anna Groskin

CAB NEWS
By Michelle Barry, CAB liaison

In May, the National Community Advisory Board (NCAB) met a day before the WIHS Executive Committee (EC) Meeting in Rockville, Maryland. Sheila Bryant, the Northern California NCAB representative who attended both meetings highlighted some of the interesting topics that were discussed at the two meetings.

At the NCAB, representatives from various WIHS sites across the nation gathered to discuss what has been going on in the study. Alice Kim, a representative from the Chicago WIHS, spoke on how this year marks the tenth anniversary for the WIHS.

There was also discussion about low oral study attendance and the possibility of stopping the study. Sheila stressed the importance of making oral study appointments for the study to continue.

Periodically, the NCAB representatives participate in conference calls to discuss important issues that may be of interest to WIHS patients. Sheila was assigned to two conference calls, one on liver and hepatitis, and the other on drug use and HIV.

Yvonne Barranday, the Project Director for the Los Angeles WIHS site, spoke about the upcoming cardiovascular disease (CVD) study and how the various WIHS sites were preparing for it. This study involves taking an ultrasound image of a major artery in your neck, the carotid artery. Researchers are hoping to learn more about the risks for heart disease in women. This study should be up and running by the end of July.

At the EC meeting, several workshops and presentations were held by various WIHS researchers. Several sessions were held on "AIDS and Aging." Since women with HIV are living longer, chronic disease is now becoming a significant issue. The principal investigator of our Northern California WIHS site, Dr. Greenblatt, discussed the Sex Steroid Substudy and how researchers are studying the effects of HIV infection and HIV medication use on menopause.

Sheila also had the opportunity to show the film "Reflections Unseen," a documentary

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that she along with several other WIHS women had starred in. The video includes women who talk about what it was like when they got their diagnosis and how they are living with HIV today. Many doctors and researchers were able to view the film, and Sheila was very pleased with their positive feedback. In fact, many of them requested copies to show others at their WIHS sites. If you are interested in viewing this video, stay tuned for the date and time of our next local CAB meeting! We will be showing the video again at that time. Or if you would like a copy of the video, you can contact Carol Edwards-Bluitt at the Perinatal Council at 510-779-3183 for more information.

Looking for HIV-positive volunteers for a study of Human Growth Hormone

By Jane Pannell

Dr. Laura Napolitano and researchers at the Gladstone Institute in San Francisco are studying the effects of human growth hormone on the immune system and are looking for HIV-infected women volunteers.

Growth hormone plays an important part in the development of the immune response and may help restore the immune system in people with HIV disease. This study is looking at the experimental use of growth hormone to increase the size of the thymus and cause an increase in the number of T-cells.

All participants will receive growth hormone, either in the first year of the study or the second. Participants will be taught how to perform the injections of growth hormone by the study coordinator, and will inject the growth hormone under the skin every night for 12 months.

This is a 2-year study, with study visits once a month. Each visit is a little different, with different procedures done each time.

Participants are reimbursed between $10 and $75 per visit, depending on what procedures are done. There is a $100 bonus at the end of Year 1 and Year 2.

You may be eligible if you are HIV-positive and have a T-cell count less than 400 with a viral load of less than 5,000 copies. In addition, we only want women who are taking at least two anti-HIV medicines. *And, to be in the study you need to have veins that are easy to draw blood from!*

You cannot be in the study if you have a history of heart disease, diabetes, carpal tunnel syndrome, or some forms of cancer. You cannot be in the study if you are pregnant or breastfeeding or planning to become pregnant. You cannot participate if you take steroids (hormones) or IL2.

If you would like to find out more about this study, please call Jane Pannell at 353-9767 or toll-free at 866-476-5109.



Here's to your Health

This is the third installment of a four part series on smoking and its related health issues among women. In Part 1, we discussed the facts about smoking that was excerpted from "Women and Smoking, A Report of the Surgeon General – 2001". In Part 2 we examined the consequences and results of smoking as it relates to your health. In this issue (Part 3) we will share some real life experiences on quitting smoking and how individuals were able to quit using the Five Keys for Quitting as was outlined in Part 2.

Part 3 – Five Keys for Quitting, or Five Ways to Improve My Life

Someone once said, "there is no dignity or self-esteem associated with smoking". Simply put, "it's a one way street to ill health, however, you have it in your power to put it in reverse." Many people may not know that nicotine is one of the most addictive substances known to mankind. Once absorbed into the blood stream it can take many days to pass out of the body. This is probably one of the major reasons quitting is so hard to do. Another difficult situation is being around people who smoke. Second hand smoke can be absorbed through your lungs and raise the nicotine levels in your blood stream, thus giving the effect of smoking without actually lighting up a cigarette. Consequently, it is imperative that, whenever possible, avoid being in the same room with a smoker. These are just a few suggestions on how to begin to break the cigarette smoking habit.

This author was once a cigarette smoker. I started smoking at 18 years of age. Like many, stresses in my life, along with peer pressure, eventually got me involved with cigarette smoking. Before too long I was smoking three packs a day of unfiltered cigarettes. As if filtered cigarettes would have made a difference to my health. It didn't take long before the effects of smoking paid me a visit. Dry persistent cough, wheezing, shortness of breath, and fluid build up in the lungs. It was easy to rationalize it all away. After all, there were so many people around that smoked that had the same effects happening to their bodies, they all seemed healthy. Seemingly healthy is the biggest denial phrase in the world. What does seemingly healthy really mean? Is coughing for fifteen minutes without stopping, while your ribs feels like they have been kicked by a mule, seemingly healthy? Is stopping to catch your breath between phrases in a conversation, because of shortness of breath, seemingly healthy?

Before the five keys for quitting were ever invented, and before all the laws were passed about smoking in public places, and the cost of cigarettes was under 25 cents per pack, or $2.50 carton, there was no compelling reason to quit smoking. Everybody smoked, it was cheap, extremely available, there was always a vending machine next to the candy machine in every gas station across the USA, they were in coffee shops, hotel and motel lobbies, even in hospital waiting rooms. Also, it was very easy to acquire a cigarette from someone who wasn't going to quit smoking. "Hey, can you spare a cigarette", was the catch phrase of the quitter. Why quit, when you can get free cigarettes from a stranger. Fellow smokers gleefully would give a cigarette to anyone who would ask for one. There was this fellowship of smoking that could not be denied.

That was thirty five years ago, believe it or not, it's easier to quit smoking today than it was then. The vending machines have all dis-

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appeared, one is not allowed to smoke in public places, the cost of a pack of cigarettes averages $3.50 with the cost going up with no end in sight, this could be one compelling reason to quit smoking. One interesting comparison is that of the cost of a pack of cigarettes versus minimum wage. If you lived in Kansas, and the cost of a pack of cigarettes is $3.50, you would have to work over an hour to afford that pack. If money is not an issue, then maybe your HEALTH is! You can definitely and irreversibly quit smoking, I did! I may not have know it then, but the five keys for quitting smoking were right in front of me. I found a partner who wanted to quit smoking as much as I did. This was my support. You can't quit alone, it's much too difficult. We got ready to quit by interviewing former smokers and learned their techniques, some might call it a support group today, but what's in a phrase, it worked then and it will work for you now. We never stopped checking in on each other sometimes on an hourly basis, we never stopped asking our support group for help and advice. We learned new skills ourselves, and modified our behavior. As we realized that the nicotine was slowly dissipating from our system, we would strictly avoid smokers, and the smoking environment. Difficult to do thirty five years ago. All restaurants, and public places allowed smoking. We stopped going to restaurants, we became more aggressive in asking people around us not to smoke. The most difficult was asking good friends not to smoke in your presence. Many complied with our request, but many did not. They slowly went from good friends to acquaintances. The difficulty was choosing between good health and good smoking friends. As the months rolled by and the nicotine cleared from our systems, the craving for tobacco became diminished, and eventually non-existent. We have been smoke free for over thirty years. In short, find a good friend who is willing to help you through this part of your life. Being smoke free and tobacco free is the single most important thing I have ever done in my life. As for my best friend who quit smoking cigarettes with me, well, she's a healthy grand mother now, with healthy children and of course, healthy grand children. I dread to think what her children would have gone through if she had not quit smoking. You fill in the blanks.

You have read about all the health consequences in the past two issues of The WIHS Woman and the editorial staff hope that in this issue we've given our readers some insight and perspective about the challenges surrounding quitting the cigarette habit. Always remember the five keys for quitting, keep it as a mantra in your head, recite it out loud if you think it will help:

- Get Ready
- Get Support
- Learn new skills and behaviors
- Get medication and use it correctly
- Be prepared for relapse or difficult situations

Toll Free Phone Numbers:

1-800-NO-BUTTS (1-800-662-8887)
1-800-45-NO-FUME (1-800-456-6386)-Spanish
1-800-778-8440—Vietnamese
1-800-838-8917 Mandarin & Cantonese
1-800-556-5564 Korean
1-800-933-4TDD (1-800-933-4833) - Hearing Impaired (TDD/TTY)
1-800-844-CHEW (1-800-844-2439) Smokeless Tobacco

In our next issue of The WIHS Woman we will share some methods and techniques to staying nicotine free.

Hepatitis C and Alcohol Study
University of California, San Francisco

UCSF is conducting a long-term research study to find out more about the effects of light to moderate drinking of alcohol in patients with chronic Hepatitis C infection.

Eligibility:

- If you have the Hepatitis C infection, you may be eligible to take part in the study.

Participation includes:

- In-person and telephone interviews
- Providing blood samples
- Having a physical examination

EACH year for a total of **4** years

FOR EACH VISIT, VOLUNTEERS MAY RECEIVE $25 TO $100 FOR THEIR TIME
(Amount depends on time required)

FOR MORE INFORMATION
CALL (415) 514-0800