Winter 2004 Volume 7, Issue 4

The WIHS Woman

The Connie Wofsy Women's HIV Study

NEW STUDIES

By Jane Pannell

In collaboration with researchers at San Francisco General Hospital, we are working on two new studies which examine the rate at which new T-cells replace old ones in HIV-positive people. These are important studies for women because we think hormones play a big role in the process. We will be enrolling both men and women and comparing the results of the two groups.

For Men & Premenopausal women: (ages 18-45)

We are looking for HIV positive men and women who have never taken any HIV medications, and whose T-cells are between 500 and 750. (*Some people who have taken antiretrovirals for only a short time in the distant past may also be eligible – if you think this is you, please call me).*

If you are interested in participating in this study, we will ask you to come in for one or two screening visits. We will draw blood and do a brief interview about your health history.

If you are eligible and decide to participate, we will ask you to come to the General Clinical Research Center at San Francisco General Hospital for a 24-hour hospital stay. While you are in the hospital, you will receive IV (intravenous) deuterated glucose. This is a special sugar, which can be traced in the body, and allows us to track the turnover of T-cells. You will also be asked to drink deuterated water, which tastes and feels just like regular water and can also be traced in the body. During this time, small amounts of blood will be drawn via a small catheter (tube) in your arm. We will also be collecting saliva and urine specimens.

After you leave the hospital, you will be asked to drink small amounts of deuterated water every day for 6 weeks. You will come back to San Francisco General four times during the next two months for outpatient blood, urine, and saliva collections. These visits generally last less than a half hour.

About 4 weeks after these blood draws are finished you will be reimbursed **$600** by check. We can also provide transportation reimbursement.

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You will be asked to repeat the 24-hour hospital stay and the follow-up visits about once a year for the next 4 years. For each of these, you will be paid another $600.

For Men & Menopausal women who are about to start Hormone Replacement Therapy (HRT):

We are looking for HIV positive men and women who are planning to start HRT. If you are interested in participating, we will ask you to come in for a screening visit. We will do a brief interview and a blood draw to check your reproductive hormone levels.

If you are eligible, we will ask you to drink deuterated water at home several times a day for 3 to 6 weeks, *before you start your HRT.* At the end of this cycle, there will be a blood draw. You will then start your HRT, under the guidance of your healthcare provider.

Once you have been on HRT for 6 months, we will ask you to come back for another cycle of drinking the water for 3-6 weeks. We will do one blood draw at the end of that cycle.

Participants will be reimbursed **$240** by check after completing each part of this study.

If you are interested in either of these studies, please call Jane at 415-353-9767 or toll-free at 866-476-5109.

New WIHS Sub Study Launched

by Anna Groskin, Sub Study Coordinator

Many of you have heard about the Metabolic Study and several of you have already participated in it. It's an exciting new study looking at the metabolic effects of HIV infection and antiretroviral therapy, as well as menopause and aging. These effects include changes in body fat, insulin problems such as diabetes, and decreased bone density (osteopenia and osteoporosis).

The Metabolic visit consists of two things, 1) an oral glucose tolerance test, and 2) DXA scan of your bones. We will now be adding three new things to the study visit in an effort to learn how diet and exercise affect women's health: a food and exercise questionnaire and a physical fitness evaluation. The questionnaires will be filled out between blood draws for the oral glucose tolerance test, and the one-hour physical fitness evaluation, which will include a treadmill test and a muscle strength test that will take place at the end of the Metabolic visit.

We're starting out with a small number of women, approximately 60 women. If you are coming in for a Metabolic study visit, are still getting your period, and are HIV- or HIV+ (and not taking antiretrovirals), you'll be eligible for the additional study. You will be reimbursed $10.00 for filling out the questionnaires, and $20.00 for completing the fitness test at the end of your visit. You'll be hearing from us soon if you're eligible!

Letter from Uganda: An AIDS Doctor's First Trip to Africa

By Eddy Machtinger, MD, Assistant Professor Women and Children's' Specialty Clinic, UCSF

My friend Lisa invited me last summer to visit her in Uganda, Africa. She is an American AIDS doctor, like I am, and has been working in Uganda for the past 2 years at a small AIDS clinic. I had never been to Africa before and wanted to go for a long time. So much history has taken place in Africa and it is also the place most affected by HIV/AIDS. I wanted to see for myself what it was like there.

Uganda is a small country in the eastern part of Africa (see map). It is the size of the state of Oregon and has about 24 million people. For the most part, it is a safe and peaceful country. However, some of its neighbors, such as Rwanda, the Congo, and the Sudan – are among the most dangerous places in the world. Most people in Uganda speak English and are farmers. It is a very poor county – the average yearly salary is $300.00. But it is well known for being one of the most beautiful countries in the world, with rivers and mountains and lush green forests.

After more than 20 hours of traveling, I finally arrived in the capital city of Uganda, called Kampala. Kampala is a busy modern looking city with tall buildings and well-dressed people. Ugandans are very friendly. On the streets of Kampala and in the countryside, people come up to you and say "Hello, you are most welcome" and just want to find out more about you and why you are there. One of the first things I noticed was how many kids there are there. Big groups of them came up to me every day and wanted to talk and play. At first, it didn't seem like a country with one of the highest rates of HIV/AIDS in the world.

But Uganda has been very affected by HIV/AIDS. Millions of Ugandans have died (no one knows exactly how many). About 1 in 10 people have HIV, which is more than 20 times the rate of HIV in the United States. There are more AIDS orphans in Uganda than in any other country (880,000). And most upsetting, almost no AIDS drugs have been available to prevent people from getting sick and dying from the disease. The government and the people themselves are to poor to pay for them, even at reduced prices. Because of AIDS and poverty, the average person only lives to be 45 years old. This is the reason I saw so many children and so few old people.

I spent most of my time working with Lisa at her small clinic. Most of the people working with her are volunteers who are positive themselves or have had family members die from HIV. Part of what she does is visit people in their homes who are too sick to come to clinic. By going with her and her team, I was able to get a much better understanding of the AIDS epidemic.

Most of the people we visited were women whose husbands had already died of HIV. Their houses are made of mud and straw but were very neat. The women were gracious hosts, even though many were weak. Almost every woman was caring for her own children and a number of orphans. For this reason, I never saw a single homeless child. Most visits were very sad. People were quite sick and there was little the team could do to make them healthy.

When I visited the main public hospital, it too

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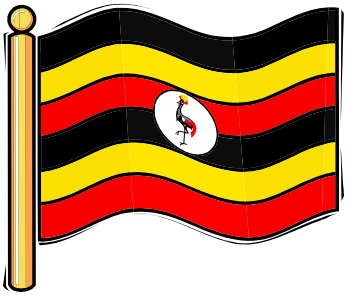
was filled mostly with incredibly sick women.

I couldn't help wondering who would take care of all the children when more and more of the women died.

Despite the sadness and loss, there does seem to be hope. After many years of delays, the United States and other countries have recently promised to begin supplying HIV medications to Uganda. However, it remains unknown when this will start or how many people will get treated. In the meanwhile, the Ugandans will keep trying their best to care for themselves and the orphans.

Map of Central & South Africa



Flag of Uganda

CAB CORNER

by Ann Groskin, CAB liaison

The WIHS National Community Advisory Board (NCAB) met November 2nd, a day before the WIHS Executive Committee (EC) Meeting, in Chicago. Sheila Bryant, the Northern California NCAB representative, attended both the NCAB and EC meetings. Part of her job as NCAB representative is to bring back information to the WIHS women here in Northern California, and to share it in the WIHS Newsletter. Here are some of her notes about the meetings, and some important points she thought WIHS women would want to know about.

The NCAB meeting began with an introduction of the newest representative, Kathy Moore, from the Washington, DC WIHS. Alice Williams, a representative from the Chicago WIHS, was voted chair of the NCAB. It was decided that the chair position would rotate alphabetically through the sites. Sheila will take the chair position in three rotations, and is now a voting member of the NCAB.

Some of the things that were discussed at the NCAB meeting included the New Orleans Conference that the NCAB members attended in September 2003. Each member will be writing up a summary of the workshops they attended at the conference, and these will be distributed at a later time. The NCAB also

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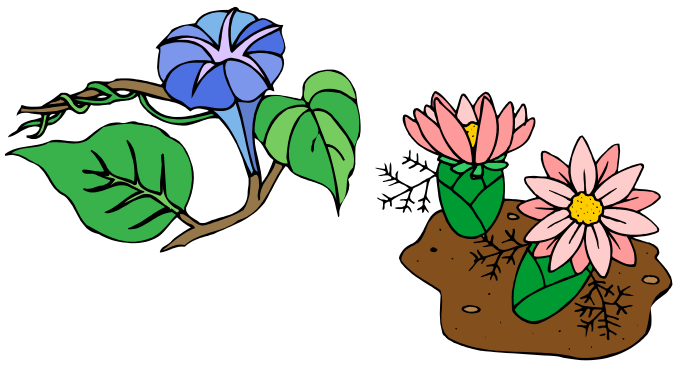
talked about the new cardiovascular disease initiative in the WIHS, which will start in visit 20 (April, 2004). The new protocol might include carotid artery ultrasounds, noninvasive and painless tests to help determine if there are any blockages in the carotid arteries (arteries in your neck that bring blood to the brain), but the details are still being worked out. The NCAB also discussed the idea of women bringing their medications to their WIHS visit so that WIHS staff can identify them. This has not been decided upon yet, either.

The WIHS EC meeting was held Monday through Wednesday after the NCAB meeting. Sheila and the rest of the NCAB representatives attended workshops and information sessions held by WIHS researchers. One of the workshops that really got Sheila's attention was "A Look to the Future: HIV, Cognition, and Menopause and Aging." As a 46-year-old woman who is HIV-positive, she could really relate to the presentation. She was thrilled to see that there was a research initiative that directly applied to her personal situation.

The next Northern California CAB event will be held some time in February. We will be hosting a viewing of the film "Reflections Unseen," a documentary film in which several WIHS women starred. More information to come, so stay tuned!



Here's to your Health

This is a four part series on smoking and its related health issues among women that will be published in the four WIHS Newsletters for the year 2004. Much of the information presented has been excerpted from numerous references from major tobacco companies, and also includes extensive research compiled by the Surgeon General's Office. It is the intent of the editorial staff to present to its readers the facts about smoking, the consequences and results of smoking as it relates to one's health, how to quit the habit, and finally staying nicotine free.

Part 1 -The Facts About Smoking
Excerpted from: *Women and Smoking, A Report of the Surgeon General - 2001*

This year alone, lung cancer will kill nearly 68,000 U.S. women. That's one in every four-cancer deaths among women, and about 27,000 more deaths than from breast cancer (41,000). In 1999, approximately 165,000 women died prematurely from smoking-related diseases, like cancer and heart disease. Women also face unique health effects from smoking such as problems related to pregnancy.

In the 1990s, the decline in smoking rates among adult women stalled and, at the same time, rates were rising steeply among teenaged girls, blunting earlier progress. Smoking rates among women with less than a high school education are three times higher than for college graduates. Nearly all women who smoke started as teenagers - and 30 percent of high school senior girls are still current smokers.

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Smoking is the leading known cause of preventable death and disease among women. In the year 2000, far more women died of lung cancer than of breast cancer. Despite all that is known of the devastating health consequences of smoking, 22 percent of women smoked cigarettes in 1998. The gender gap among women and men smokers is narrowing at an alarming rate. Since 1980, approximately 3 million women have died prematurely from smoking-related neoplastic, cardiovascular, respiratory, and pediatric diseases, as well as cigarette-caused burns. Each year during the 1990's U.S. women lost an estimated 2.1 million years of life due to these smoking attributable premature deaths. Additionally, women who smoke experience gender-specific health consequences, including increased risk of various adverse reproductive outcomes.

Smoking prevalence was highest among American Indian or Alaska Native women, intermediate among white women and black women, and lowest among Hispanic women and Asian or Pacific Islander women. By educational level, smoking prevalence is nearly three times higher among women with 9 to 11 years of education than among women with 16 or more years of education.

Much of the progress in reducing smoking prevalence among girls in the 1970's and 1980's was lost with the increase in prevalence in the 1990's: current smoking among high school senior girls was the same in 2000 as in 1988. Although smoking prevalence was higher among high school senior girls than among high school senior boys in the 1970's and early 1980's, prevalence has been comparable since the mid 1980's.

Smoking declined substantially among black girls from the mid 1970's through the early 1990's; the decline among white girls for this same period was small. Smoking during pregnancy appears to have decreased from 1989 through 1998. Despite increased knowledge of the adverse health effects of smoking during pregnancy, estimates of women smoking during pregnancy range from 12.9 percent to as high as 22 percent.

Since the late 1970's or early 1980's, women are just as likely to attempt to quit and succeed, as are men.

Smoking prevalence among women varies markedly across countries; it is as low as an estimated 7 percent in developing countries to 24 percent in developed countries. Thwarting further increases in tobacco use among women is one of the greatest disease prevention opportunities in the world today.

Lung cancer is now the leading cause of cancer death among U.S. women; it surpassed breast cancer in 1987. About 90 percent of all lung cancer deaths among women who continue to smoke are attributable to smoking. Exposure to environmental tobacco smoke is a cause of lung cancer and coronary heart disease amount women who are lifetime nonsmokers. Infants born to women exposed to environmental tobacco smoke during pregnancy have a small decrease in birth weight and a slightly increased risk of intrauterine growth retardation compared to infants of non-exposed women.

Factoid: Postmenopausal women who currently smoke have lower bone density than do women who do not smoke.

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Factors Influencing Tobacco Use Among Women

Excerpted from: *Women and Smoking, A Report of the Surgeon General - 2001*

Girls who initiate smoking are more likely than those who do not smoke to have parents or friends who smoke. They also tend to have weaker attachments to parents and family, and stronger attachments to peers and friends. They perceive smoking prevalence to be higher than it actually is, are inclined to risk taking and rebelliousness, have weaker commitment to school or religion, have less knowledge of the adverse consequences of smoking and the addictiveness of nicotine, believe that smoking can control weight and negative moods, and have a positive image of smokers.

Women who continue to smoke and those who fail at attempts to stop smoking tend to have lower education and employment levels than do women who quit smoking. They also tend to be more addicted to cigarettes, as evidenced by the smoking of a higher number of cigarettes per day, to be cognitively less ready to stop smoking, to have less social support for stopping, and to be less confident in resisting temptations to smoke.

Women have been extensively targeted in tobacco marketing, and tobacco companies have produced brands specifically for women, both in the United States and overseas. Tobacco ads and promotions targeted to women indicated that such marketing is dominated by themes of both social desirability and independence, which are conveyed through ads featuring slim, attractive, athletic models. Between 1995 and 1998, expenditures for domestic cigarette advertising and promotion increased from $4.90 billion to $6.73 billion. Tobacco industry marketing, including product design, advertising, and promotional activities, is a factor influencing susceptibility to and initiation of smoking.

The dependence of the media on revenues from tobacco advertising oriented to women, coupled with tobacco company sponsorship of women's fashions and of artistic, athletic, political, and other events, has tended to stifle media coverage of the health consequences of smoking among women and to mute criticism of the tobacco industry by women public figures.

The Surgeon General of the United States has stated aptly:

> *" When calling attention to public health problems, we must not misuse the word 'epidemic.' But there is no better word to describe the 600-percent increase since 1950 in women's death rates for lung cancer, a disease primarily caused by cigarette smoking. Clearly, smoking-related disease among women is a full-blown epidemic."*

In our next issue of the WIHS newsletter, we will be detailing the consequences and results associated with cigarette smoking.

YOU CAN QUIT NOW!

DON'T WAIT!

Call these telephone numbers:
800-662-8887 (English)
800-456 6386 (Spanish)
800-400-8917 (Mandarin and Cantonese)
800-778-8440 (Vietnamese)
800-556-5564 (Korean)
1-800-NO-BUTTS

WIHS women with HIV and HCV co-infection:

Are you interested in learning about the health of your liver?

We are recruiting WIHS women with **HIV and Hepatitis C (HCV) infection** for a sub-study to learn about new ways to study fat in the liver. To be eligible for this study, you must be both HIV and Hepatitis-C Positive, and you must be overweight.

If you are eligible, we will ask you to come in for two visits. During the first visit, you will have blood drawn and a MRI scan of your liver. The MRI scan will measure the amount of fat in your liver and the amount of fat in your belly.

At the second visit, you will have a liver biopsy done by an expert in liver disease- only if (1) you have not had a liver biopsy done in the last few years, (2) the MRI scan does not show severe liver disease already and (3) you do not have a bleeding disorder-the blood that we draw at the first visit will check for this.

A liver biopsy is the best way to find out about the health of your liver and is recommended in people with HCV, especially if you are thinking about getting treatment for your HCV. You will be reimbursed $25 for the MRI scan and $100 for the liver biopsy.

If you are interested in being in this study and have HIV and HCV, please call Jane at 415-353-9767 or toll-free at 866-476-5109.